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CSHA 2004 FALL SEMINAR

The CSHA 2004 Fall Seminar is scheduled for Friday, November 5, 2004 at the Westin Hotel, Millbrae (near San Francisco International Airport). Please visit ***www.csha.info*** for program details and registration information.

FEATURE ARTICLE

Promoting Good Pain Management in California

BY KATHRYN L. TUCKER, J.D.
COMPASSION IN DYING FEDERATION

In recent years, a tremendous amount of attention has been focused on the need to improve pain management, particularly in the context of treating pain at the end of life. One significant catalyst for this heightened focus on pain management was litigation to legalize the choice for physician-assisted dying -- in particular, two cases decided by the U.S. Supreme Court in 1997, in *Glucksberg v. Washington*[1] and *Quill v. Vacco*[2]. [3]

The increased attention to improving end-of-life care in general, and pain management in particular, has produced a spate of reports assessing and comparing pain policy among the states[4]. For example, the Pain & Policy Studies Group ("PPSG") recently published its REPORT ON ACHIEVING BALANCE IN STATE PAIN POLICY (2003) (the "Report")[5], and gave California a grade of "C" for pain policy. As explained below, California deserves a significantly higher grade for its extensive efforts to promote good pain management.

PAIN POLICY IN CALIFORNIA

California has in fact taken a leadership role among the states in working sedulously to enact policy that promotes good pain management. Thus, California deserves a far higher mark, at least an A-, for its efforts. New York also got a grade of "C," although it has not adopted legislation or taken any regulatory action comparable to California's accomplishments described below. Assigning California and New York the same ranking with respect to pain policy calls into question not only the validity of the Report, but the whole enterprise of state-by-state grading on this issue. Those who are seeking to promote better pain management need more useful tools.

California is among the most progressive states in the nation in attempting to improve pain care. The California Legislature passed an Intractable Pain Treatment Act ("IPTA") in 1990. This "safe harbor" legislation provides that "[n]o physician or surgeon shall be subject to disciplinary action by the board for prescribing or administering controlled substances in the course of treatment of a person for intractable pain."[7]

In 1994, the Medical Board of California ("MBC") provided all California physicians with a copy of the clinical guidelines for pain management issued by the U.S. Agency for Health Care Policy and Research, and adopted a policy statement encouraging aggressive pain care.[8] Subsequently, the MBC adopted an official guideline regarding pain management, which specifically identifies failure to manage pain adequately as "inappropriate prescribing."[9] By explicitly designating undertreatment of pain as inappropriate prescribing, the MBC expressly has recognized that this is a form of professional misconduct, and thus it is subject to the full range of sanctions. It was not until 2004 that the Federation

of State Medical Boards promulgated a policy recognizing as much.

In 1997, the California Legislature passed the Pain Patient's Bill of Rights.[10] This law provides, in pertinent part, that "[a] patient suffering from severe chronic intractable pain has the option to request or reject the use of any or all modalities to relieve his or her severe chronic intractable pain."[11]

In addition, a physician applying for California licensure who entered medical school after June 1, 2000 must complete a medical school curriculum that includes training in pain management and end-of-life care.[12] Also, California physicians and surgeons (with limited exceptions) must attend Continuing Medical Education courses on pain management and the treatment of dying patients.[13] California law also requires all licensed health care facilities to assess and chart pain routinely, along with other vital signs.[14]

Thus, clinicians providing care to patients in California do so in an environment that is rich with information about the duty of the clinician to treat pain attentively and aggressively. This environment makes ignorance of modern pain management practices and principles unacceptable. California's record of consistent effort to promote improved pain care places it at the forefront of the states in grappling with the serious public health problem of undertreatment of pain.

Litigation

Based on California's established pain policy, some plaintiffs and complainants in administrative actions have asserted that the pain management provided to certain patients was inadequate. In some instances, they have succeeded in convincing juries and/or regulatory authorities that the deficient pain care violated the patients' rights, and that the responsible health care providers should be held accountable. Under California's medical negligence laws, pain and suffering damages do not survive a patient's death[15], so *survivors* cannot recover damages for the patient's pain at the end of life on a malpractice theory, although living patients might well be able to recover for inadequate treatment of pain. However, the IPTA does not impose any obligations on doctors or establish any standards of conduct. Thus, a doctor cannot "violate" the IPTA in a way that could support a claim of negligence *per se*. The MBC Guidelines for Prescribing Controlled Substances for Pain give doctors general directions for pain care, but the Guidelines do not have the force of law. Nevertheless, they should make it easier for plaintiffs to establish that deficient pain management is outside the standard of care.

Although survivors cannot recover pain and suffering damages under a medical negligence theory, some have surmounted this limitation by framing their claims for inadequate pain management under California's Elder Abuse and Dependent Adult Civil Protection Act ("EADACPA"), Welfare and Institutions Code Section 15600 *et. seq.*, which includes within its definition of elder abuse "[t]he deprivation by a care custodian of goods or services that are necessary to avoid physical harm or suffering,"[16] and expressly permits survival of an elder or dependent adult's pain and suffering claim.[17] EADACPA also permits successful plaintiffs, including survivors, to recover attorneys' fees. This strategy, however, presents the additional significant burden or convincing the jury by clear and convincing evidence that the physician's conduct in failing to treat the patient's pain constituted "recklessness, oppression, fraud, or malice," rather than simple negligence.[18]

Two recent cases illustrate the trend of suing under EADACPA for inadequate pain care, *Bergman v. Eden Medical Center*[19], and *Tomlinson v. BCC*[20]. Both cases involved men in their 80s who were dying of lung cancer. Mr. Bergman was treated over a five-day hospitalization at a northern California hospital, where he was provided Demorol (specifically not recommended for treatment of cancer pain[21]), on an "as needed" basis -- as opposed to regular dosing around the clock, the appropriate approch to bringing cancer pain under control[22]. Regular assessment of his pain level was done on a ten-point scale. Most of his recorded pain levels were seven and above. His physician did not consult with a pain specialist. Mr. Bergman was discharged to receive home hospice care, and at the time of his discharge, his pain level was a ten. Mr. Bergman died several days later. In the litigation that ensued, it was revealed that his attending physician had not been educated adequately in pain management. He was unaware of the many clinical practice guidelines governing treatment of cancer pain, and unfamiliar with accepted principles and practices of modern pain management.

The jury found the physician to have been reckless

and awarded $1.5 million to the patient's survivors. (This award was reduced by the judge to the $250,000 pain and suffering limit.) The judge awarded plaintiffs' attorneys fees, and applied a multiplier, finding the case advanced the public interest.

In the *Tomlinson* case, Mr. Tomlinson was treated at an acute-care hospital and then admitted to a nursing home[23]. The pain management at both facilities was inadequate. *Tomlinson* was less publicized than *Bergman*, but represented even broader accountability. In response to complaints, the Attorney General's Office brought formal charges on behalf of the MBC against the nursing home physician involved in caring for Mr. Tomlinson[24]. In addition, the California Department of Health Services issued a Class A Notice of Deficiency to the nursing home where the patient resided, finding numerous violations of code provisions pertaining to pain and symptom management, and ordered extensive corrective action[25]. The civil case alleging elder abuse was scheduled to be tried to a jury in April 2003, but the parties reached a settlement prior to trial [26].

Conclusion

California plainly has made significant efforts -- through both the Legislature and the licensing and regulatory agencies -- to understand and correct the problem of inadequate pain treatment in a multifaceted and persistent manner. This ought to earn California recognition as a leader among the states in this effort. Although the facts of the *Bergman* and *Tomlinson* cases suggest that the message has not yet reached all healthcare providers, those two cases have been widely publicized, and undoubtedly have heightened awareness of this issue among physicians. That awareness, coupled with the requirement that all California physicians receive training in pain management -- and MBC enforcement of that requirement -- should begin to yield improvements in the provision of pain management in the state. Attorneys for healthcare providers also can promote better pain management by ensuring that their clients are sensitive to the issue, which will help to reduce their liability exposure in this era of increased elder-abuse litigation.

Kathryn L. Tucker

Kathryn L. Tucker is Director of Legal Affairs for Compassion in Dying Federation, a national non-profit public interest organization dedicated to improving end-of-life care and expanding the rights of the terminally ill. She also is Of-Counsel, Perkins Coie, LLP. In addition, Ms. Tucker is an Affiliate Professor of Law, University of Washington School of Law, and Seattle University School of Law, teaching health law. She is a frequent speaker and writer about end-of-life care andissues.

Ms. Tucker is recognized as a national leader in efforts to promote improved pain care to seriously ill and dying patients, including development and introduction of legislation to promote better pain management and palliative care. She also represents patients and physicians in litigation over dying patients' rights to adequate end-of-life care -- including treatment of pain -- as well as control over the manner and timing of their deaths. Ms. Tucker served as co-counsel to the plaintiffs in both the *Bergman* and *Tomlinson* cases. She also served as lead counsel in the *Glucksberg v. Washington* and *Quill v. Vacco* cases, arguing the *Glucksberg* case before the U.S. Supreme Court, and serves as co-counsel representing terminally ill Oregon patients in defending Oregon's Death with Dignity Act against an ongoing challenge by U.S. Attorney General John Ashcroft.

ENDNOTES

1 521 U.S. 772, 117 S. Ct. 2258 (1997).

2 521 U.S. 834, 117 S. Ct. 2293 (1997).

3 *See e.g.*, Institute of Medicine, Approaching Death, Improving Care and The End of Life 206 (National Academy Press 1997) ("Deficiencies in care of the dying were recognized well before the recent assisted suicide. . .court challenges. Nonetheless, much of the recent attention to deficiencies in end-of-life care arose only when the issue of assisted suicide came before the Supreme Court.")

[4] The Pain & Policy Studies Group, Report on Achieving Balance in State Pain Policy (2003); National Association of Attorneys General, Improving End-of-Life Care: The Role of Attorneys General (2003); Last Acts, Means to a Better End: A Report on Dying in America Today (2002).

[5] The PPSG is based at the University of Wisconsin Cancer Center. The Report may be found at www.medsch.wisc.edu/painpolicy.

[6] Report at 11.

[7] Cal. Bus. & Prof. Code § 2241.5. The PPSG considers such laws to have both helpful and harmful aspects. Thus, according to the PPSG, the existence of an intractable pain treatment act is not entirely positive. This author has suggested elsewwhere that these laws can and should be improved by providing a mechanism that encourages clinicians to take advantage of the safe harbor such laws provide. *See* Kathryn L. Tucker, *Improving Pain Care: A Safe Harbor is Not Enough*, Health Lawyer, Vol. 11, No. 4, May 1999.

[8] Medical Board of California, Prescribing Controlled Substances for Intractable Pain, May 6, 1994.

[9] Medical Board of California, Guidelines for Prescribing Controlled Substances for Pain, July 29, 1994 (revised 2003).

[10] Cal. Health & Safety Code § 124960. California is the only state to enact such a measure.

[11] Cal. Health & Safety Code § 124960(h).

[12] Cal. Bus. & Prof. Code § 2089.

[13] Cal. Bus. & Prof Code § 2190.5 (2002).

[14] Cal. Health & Safety Code § 1254.7

[15] Cal. Code of Civ. Proc. § 377.34.

[16] Cal. Welf. & Inst. Code § 15610.07(b). *See also Norman v. Life Care Centers of America, Inc.*, 107 Cal. App. 4th 1233, 1239 (2003).

[17] Cal. Welf. & Inst. Code § 15657. However, such damages are subject to the $250,000 limit imposed by Cal. Civ. Code § 3333.2(b).

[18] Cal. Welf. & Inst. Code § 15657. *See also Covenant Care, Inc. v. Superior Ct. (Inclan)*, 32 Cal. 4th 771, 779-780 (2004) (discussing the heightened remedies available under EADACPA).

[19] *Bergman v. Eden Med. Ctr.*, No. H205732-1, Superior Court, Alameda County, California. The *Bergman* case received wide coverage in the local, regional, specialty, and national press. *See e.g.*, Tanya Albert, *Doctor Guilty of Elder Abuse for Under-treating Pain*, American Medical News, July 23, 2001; Mark Crane, *Now You May be Liable for Under-treating Pain*, Medical Economics, September 2001; Porter, Rebecca, *Failure to treat pain is elder abuse jury finds*, Trial, The Journal of the Association of Trial Lawyers of America, September 2001; Shapiro, David W., M.D., J.D., *Inadequate Treatment of Pain*, Professional Liability Newsletter, May/June 2001; Troy, Tom, *New Type of Suit: Pain Treatment*, The National Law Journal, July 2, 2001.

[20] Contra Costa County Superior Court, NO. C-02-00120.

[21] Agency for Health Care Policy and Research, Clinical Practice Guideline No. 9: Management of Cancer Pain, Publication 94-0592 (1994), Table 10, Table 15.

[22] Agency for Health Care Policy and Research, Clinical Practice Guildeline No. 9: Management of Cancer Pain, Publication 94-0592 (1994), pp. 52-53.

[23] The *Tomlinson* case is discussed in detail in Kathryn Tucker, *Medico-Legal Case Report and Commentary: Inadequate Pain Management in the context of Terminal Cancer -- The Case of Lester Tomlinson*, Pain Medicine, Vol. 5, No. 2, pp. 214-217 (June 2004).

[24] *In the Matter of the Accusation Against: Eugene B. Whitney, M.C.*, Case No. 12 2002 133376, filed March 13, 2003.

[25] Letter to Ginger Tomlinson dated 4/15/03, re: Complaint No. 14-0017012.

[26] For press coverage of Tomlinson case see, *Doctor Accused of Poor Treatment*, Tri-Valley Herald, March 20, 2003; Suit Filed Over Pain Treatment of Ill Man, Contra Costa Times, March 28, 2003. The willingness of all defendants to settle prior to trial reflects an awareness in the defense bar that failure to treat pain adequately will be considered outside the bounds of acceptable conduct.

FEATURE ARTICLE

ROUNDTABLE: CSHA Senior Bar's Thoughts on the Origins and Practice of Healthcare Law

EDITED BY
BRUCE JOHN SHIH, ATTORNEY AT LAW

INTRODUCTION

Twenty-four years ago, ten California lawyers had the vision to create the California Society for Healthcare Attorneys. Since then, CSHA has bestowed six lifetime memberships, including five of the founding members.

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Recently, we invited the Founding and Lifetime Members to a teleconference roundtable to share their thoughts on a variety of topics about the practice of healthcare law in California and we were pleased that many of them were able to do so. Lois Richardson, Executive Director of CSHA, joined them for the roundtable. We have edited their comments and will publish selected excerpts in this issue about how they started practicing law -- and in future issues about the education and role of healthcare lawyers. We believe you will find their comments inspirational and thought provoking. Our thanks to the participants, and also to Susan Gill, Executive Assistant for CSHA, for coordinating the teleconference and the revisions to the transcripts.

CSHA Board Members David Kalifon, Esq. and Bruce Shih, Esq. served as moderators.

ORIGINS OF HEALTHCARE LAW PRACTICE

MODERATORS: How did the practice of healthcare law begin in California?

LUDLAM: Well, the origin really starts on the medical side rather than the hospital side as far as healthcare alone is concerned. As the doctors became organized in the 1920s, a controversy developed over the issue of how they would provide healthcare and how they would fund it. There were also issues with the state government under Governor Olson, who proposed a mandatory health insurance plan.

And at that point, the California Medical Association (CMA) was involved on those issues and the use of legal counsel, as I recall. As far as I know, the original legal counsel for the CMA was Harley Peart.

So, the original issues relating to lawyers involved in healthcare and that battle occurred between the CMA and – well, to a degree – Governor Warren. Governor Warren also had a health plan. I can remember even before I got my license, I was circulating petitions fighting Governor Warren's plan in the Legislature. After that it became the battle between the CMA and the American Medical Association (AMA) over any type of a health insurance plan for California. And we had the cycle of the internal squabbles within CMA to come up with a policy relating to health insurance. This was eventually resolved in the late '30s with the provision for the funding of the Blue Shield.

MEMEL: Jim [Ludlam,], when did Howard Burrell come in?

LUDLAM: Burrell came in a little after that time. He came in after Blue Shield was formed. Then the question developed as to whether anything would develop on the hospital side in the way of insurance, because Blue Shield was just insurance for physician care and did not include hospitalization, initially.

MEMEL: And how did he get this assignment?

LUDLAM: Through friendship with Ritz Heerman. Ritz Heerman was the superintendent – they called him superintendent in those days – of the California Hospital in downtown Los Angeles–now the California Medical Center. They formed the Lutheran Hospital Society, a nonprofit corporation, which acquired the California Hospital, which was then owned by a doctor. They came up with the concept of a Blue Cross plan, which was a duplication based upon an original health plan that was produced by a group of teachers in Texas who contributed a dollar a month to a health plan.

Ritz and Howard came up with the idea of a hospital plan. Those first Blue Cross plans were solely for hospital employees, and then later were broadened to include other people. That was when Ritz and Howard got together and the Lutheran Hospital Society loaned $5,000 to an entity they called Blue Cross of Southern California or the Hospital Service of Southern California. I believe that was around 1938.

WEISSBURG: Jim, was the Ross-Loos Enterprise off the ground by that time?

LUDLAM: Ross-Loos came along about the same time [in the early '30s], before Kaiser. Of course, Kaiser then came in during the war, which was later in the 1940s. The big development of the Kaiser Plan happened in the early '40s because they were covering the shipyard workers during the period of construction of the Liberty ships during WWII.

MEMEL: . . . and even though it probably wasn't well known, Jim, didn't your firm have something to do with forming doctor-owned hospitals when they came back from WWII?

LUDLAM: Well, yes. They came in after the WWII and the Hill-Burton program with the federal subsidization of the construction of hospitals. The doctors would come in and form the nonprofit corporations to qualify for the Hill-Burton funds and a number of them were building them. Afterwards, they might convert them to proprietary hospitals. There were a number of conversions -- some hospitals started as nonprofits and some started as proprietary, depending upon their source of capital.

MEMEL: Well, I first came along in 1955, and by then all the doctors that I helped to form hospitals around the state were doing it strictly as 'for profit'. They were forming primarily general partnerships – sometimes limited partnerships – owning the land and equipment and then creating operating corporations to lease it from their partnerships. Essentially, the membership or the ownership of both of those entities were the same unless you got a contractor in the picture.

One of the reasons the doctors that I worked with said they were doing it was because they were being frozen out of the nonprofit hospitals by the older physicians who were still there and hadn't gone off to war. They were having all kinds of problems so they needed a shop of their own. I guess that for some of them it wasn't that reason, but rather it looked like a very lucrative business to get into to.

WEISSBURG: Well, that's true, Sherwin. Also, there was a bit of a war going on between the osteopaths and the MDs because they hadn't gotten together yet, and some of the doctors felt that the nonprofit hospitals were just taking too long to get their act together and they preferred to raise the money themselves. They thought they could do it faster and get the structure and the operations going much quicker cause they were in new areas and needed these hospitals, particularly in Orange County and the San Fernando area of Los Angeles.

LUDLAM: Also, you had the development of the district hospitals when the law was changed to provide for the ability of district hospitals to levy property tax for the construction and financial support of hospitals. That activity was primarily in Northern California around the East Bay.

And then, we had the development of the Peer Review Systemstarting right after WWII. For the first time, medical staffs were organized as something more than a social activity -- they took over the issue of Peer Review for both medical staff admissions and quality oversight. That created great friction within the hospitals -- and a number of the doctors who did not prevail, shall we say, then went out and built their own hospital as they were terminated from a hospital. And there was that type of activity, too, and some very expensive litigation went on between those doctors who were excluded and the other doctors. As a matter of fact, at one time I can recall that an insurance company ran a list of figures of the complaints that they were defending by doctors against other doctors or medical staffs and they amounted to about $5,000,000 total. Well, it was a heavy litigation period with a lot of legal involvement all the way around.

WEISSBURG: I think you have to parallel the growth of health lawyers with the legislation that drove a lot of this stuff and which produced – every time the government gets involved in a business it screws it up. And for good or bad, depending on how you look at it, it calls for lawyers to straighten out the problems. And that has been, I think, a significant impetus for our growth.

SILBERMAN: An important factor at the time [1970s hospitals acquisition mode] that always drove me crazy was the fact that the executives at those companies – or my company in particular – were more interested in the number of beds they had and how it was impacting the stock market rather than quality. I wouldn't say that they had poor quality of care, but their focus was not necessarily on improving the quality of care per se, but maintaining it. The real focus was on driving the stock and the sale of the companies. And that was part of the evolution.

I found at the time there were two things that were really driving the evolution of healthcare. One was certificate of need itself, which became the ultimate graduate school in so many different disciplines. And the other, of course, was Medicare – both of which were hearing-driven and appeal-driven.

It was my understanding at the time that Medicare helped the proliferation of then Big Eight into healthcare, which helped drive the growth of lawyers getting into the field, because up until 1983, when TEFRA came along, Medicare would subsidize a prevailing party, particularly in certificate of need. So there was an incentive to go ahead and pay to have the system worked by the accountants and the lawyers.

WEISSBURG: I agree with Barry that TEFRA was certainly watershed legislation because it was the beginning of the end of cost reimbursement under the Medicare Program, and for that matter, many State Medicaid Programs which had adopted the Medicare cost-reimbursement approach. But I submit that there was equally significant California legislation which changed the landscape, at least for hospitals (if not other providers), and which spread east from California across the rest of the country.

That event occurred in 1982, and was the passage of legislation which gave us California's Selective Provider Contracting. That law, in effect, took California off of the cost-base reimbursement formula for hospital care and inaugurated a contracting system between individual hospitals and the State of California, which is now administered by the California Medical Assistance Commission (CMAC). The legislation was passed as an emergency bill and when signed by the Governor, became effective immediately. Bill Guy (late of Blue Cross of California) was named to take charge of the program and became known as the Medi-Cal Czar.

What is less known is that during the midnight session of the conference committee which reshaped the final version of the bill, representatives of the health insurance industry, including Blue Cross and Blue Shield, met with members of the committee and convinced them that there would be increased cost shifting as a result of the passage of the bill, to the detriment of these companies (and their bottom line). As a result, they succeeded in getting the conference committee to adopt amendments to the Insurance Code -- and the resulting legislation gave us Blue Cross and eliminated the insured/beneficiary's freedom of choice. This was accomplished in violation of the internal rules of both the California Senate and Assembly as the proposed amendments were not heard or approved (in public sessions) by either the health and/or insurance policy committees in the Senate or Assembly.

The direct result of this "simple" amendment allowed insurance companies, such as Blue Cross, to establish preferred provider organizations and exclusive provider organizations which severely and negatively impacted reimbursement of hospitals and physicians. One could even argue, that by logical extension, this also led to point-of-service contracts that HMOs initiated because they needed to compete with PPOs and EPOs.

Again, this illustrates something that began in California and traveled eastward and has, forever, changed the method by which hospitals and physicians, among others, are paid.

As a footnote to Barry's discussion about TEFRA, we should also add that when the law was first passed, it was based on the theory that the DRGs would allow hospitals to keep the difference between the payment made by the government for the particular treatment involved, if the hospitals' costs were less than the payment. This would, in turn, lead to increased efficiencies on behalf of hospitals. The law also provided that each year, DRGs would be increased to keep up with inflation, with a market basket of costs of goods and services in the healthcare industry. In each instance, the government reneged on its promises and for a time there were no increases in the DRG payments because the federal government itself felt hospitals were making too much money. As a consequence, they did not get the annual updates but have ultimately received an inflation factor, minus a percentage number, each year.

SILBERMAN: Now there are two thoughts that come to mind that we may want to pick up on.

First, the growth of the healthcare legal practice from my perspective had two goals. One goal was to provide what the industry wanted to accomplish, which Sherwin and Carl have alluded to. Although they have not mentioned it directly, a lot of changes in the law were driven by what the industry wanted to accomplish. The other goal was what healthcare lawyers did -- and a lot of what was passed is prolonged today because a lot, to me, is starting to seem more attorney driven.

Second, the change in the law (and frankly, the change in the economics available to pay for provider services over time) is what, in my view, has changed the practice and has caused a lot of the growth and consequently change or dissolution of a number of law firms. That's what I saw in my own experience.

LAW FIRMS

MEMEL: Jim, I remember from your book that you came in about 1940 [to healthcare practice].

LUDLAM: January 17th, 1940.

QUESTION: Charles [Forbes], when did you come in?

FORBES: I started working for the firm [Musick, Peeler and Garrett] in 1953, filing the papers. I was still a student at SC and when I passed the bar in 1956, I came in as an associate. [**Moderators' Note:** Various attorneys from Musick, Peeler and Garrett went on to start their own healthcare law firms.]

MEMEL: Well, this is Sherwin, and just in time sequence, I guess I come between Charles [Forbes] and Art [Bernstein], because I started practicing in the health law field in 1955 – although I was ghosting my father-in-law's small hospital construction as I was graduating from law school in 1954. And from then on, my involvement until the early – until about 1970, was in forming the now called "Investor owned," then called "proprietary" or "for profit hospitals" into organized associations on a state and national level. Then, after serving on the American Hospital Association Committee on the Provision of Healthcare Services – the Perloff Committee which wrote a document called "AmeriPlan" which Steve Gamble has always been very enamored of – and also serving on the

California State Medical board, I was then able to break through into the nonprofit establishment which had been extraordinarily difficult for anybody outside of Musick, Peeler and Garrett in Southern California. And in Northern California, we had Ross Stromberg's old firm, the Hanson Bridgett firm. [**Moderators' Note:** Ross Stromberg currently heads up the healthcare legal practice at Jones Day.]

We first began working with nonprofit hospitals in the 1970s, and then as time went on, law firms were more readily and visibly able to work with both for-profits and nonprofits. At one point in time, it was totally taboo to work with doctors *and* with hospitals. As the years went on, the work expanded to every type of entity – doctors, HMOs, nursing homes, for-profit, nonprofit [etc].

MODERATORS: Carl [Weissburg], please tell us how you started.

WEISSBURG: Well, first there was a firm called Memel, Memel, Jacobs and Weissburg.

MEMEL: Right.

WEISSBURG: We formed that law firm – you'll have to help me out here, Sherwin – I think in 1964.

MEMEL: Carl came to what was Memel and Memel in about 1963, and we formed Memel, Memel, Jacobs and Weissburg in 1964, I believe.

WEISSBURG: When we moved to Sunset Boulevard.

We were all together until 1970, and that firm then dissolved, and there was a firm called Weissburg, Jacobs and Gerst that was formed in 1970, that eventually became Weissburg and Aronson in 1973, and now has been merged with Foley & Lardner.

And Sherwin, why don't you tell them what happened to you after 1970?

MEMEL: I took a sabbatical in 1970. Between 1968 and 1970, I helped to form a publicly-held company that became American Medicorps. I withdrew from that company in 1970, and then did all public service.

As a strong, middle-of-the-road Democrat, I was appointed by Nixon to the Federal Health Insurance Advisory Board, which at that time was the advisory body to Congress and the Social Security Administration for the Medicare and Medicaid programs. I served on that board for almost four years.

I was asked by the American Hospital Association to be on the Perloff Committee, which wrote Ameriplan. Ameriplan became HR-1 that Al Ullman introduced into Congress as the American Hospital Association's entry into the national health insurance race.

I wrote an outline of what became that report. John Horty was on that committee. After 15 months, John Horty, myself and Dr. Crosby, who was then the CEO of the American Hospital Association, holed up at the Essex House in New York for two weeks and completed that document.

Then I became the spokesperson for the American Hospital Association, pushing that plan with the insurance industry. I remember speaking on that plan to the California Hospital Association at its annual meeting in San Diego.

There were a lot of people who were not that happy with the role of government in that plan, but I think we had done some very forward-looking thinking, and anticipated what was going to happen. To this day, I believe that we would have been better off with that plan.

Ameriplan had something called HCCs, healthcare corporations, which are regional hospital corporations. About the same time, Paul Ellwood came out with HMOs.

I was also, interestingly enough, asked by the California Hospital Association, if I would accept the one lay appointment to the medical board – 10 doctors and me – because a gentleman by the name of Tirso del Junco, who was a conservative Republican who later went on to be the head of the Republican Party in California, had come from Cuba when Castro took over.

He was holding up 400 – that number sticks in my mind – hospital-based physician contracts on the basis that it was illegal fee splitting. The California Hospital Association thought that I was a strong enough personality to deal with this firebrand, Tirso del Junco.

The short story is that, although we could not be more different, Tirso and I became fast friends. We broke the logjam right away, after I wrote a paper explaining the facts to him. I then went on to be the first lay president of a medical board in the country, under [Governor] Jerry Brown, when he signed legislation expanding the board from 11 to 17, and appointing the most unbelievable potpourri of hippies, HMO doctors, free clinic people, women's rights advocates, black nurses' league and so on.

That was a fabulous year as president. We legalized acupuncture. The Medical Board had been very estranged from the California Medical Association, and from the deans of all the medical schools because of the attitude of the 10 doctors on the Board.

With this new complement, we repaired our relationships with the deans. We repaired our relationships with the CMA. We got the protocols adopted for extended practice for nurses in negotiations with the California Nursing Association. We did a lot of fascinating things.

In the summer of 1973, I terminated my sabbatical and started working part-time with Manatt Phelps, which started with eight lawyers, lost one and went down to seven. Today [2003] it's close to 300.

I worked with them until around May of 1975. That May, I started to form Memel, Jacobs, Pierno and Gersh. I started with myself and Michael Saphier. Somebody introduced me to David Gersh, a corporate lawyer. Then my old partner, Stanley Jacobs, came to see me and told me, even though it was an anomaly, because he was a personal injury lawyer, he would like to practice with me again.

So, we formed Memel, Jacobs and Gersh. And a year or so later, Tony Pierno, who had been the [California] Commissioner of Corporations and was a good friend of David Gersh, came in and joined us, and we became Memel, Jacobs, Gersh and Pierno.

And then several years later, David Ellsworth, the distinguished real estate lawyer, came in and we became Memel, Jacobs, Gersh, Pierno and Ellsworth.

As a flashback, I had withdrawn from my association with Carl Weissburg and Stan Jacobs in 1970, and taken an office across the hall. I did my best to hold in all the client base for the guys, the United Hospital Association, Federation of American Hospitals and others.

Then I went off on my sabbatical. So, we started Memel, Jacobs, Pierno and Gersh cold, and we grew to about 144 lawyers in six cities. Of those, 26 of them were doing health law.

We grew them all, trained all of them. We had people like Doug Mancino, Bob Rosenfield, Don Goldman, and Peter Rich.

Not only were we doing the work in the health law group, but it later came out that our corporate department was doing almost exclusively healthcare mergers, acquisitions, and financings. Thus a huge part of the firm was based on healthcare.

We were one of the victims of the fallout that came about in 1986-1987, when firms like Morrison and Forester came down here and offered a young partner, who was a wonderful hospital finance lawyer, nearly double what we were paying him to be the third lawyer in their Los Angeles office doing bond work.

Then Finley Kumble came in (in a big way) from New York. They were offering $600,000 to $800,000 to partners of mine who were making $400,000.

We were being raided right and left by firms that were flying high and there was a lot of discontent. The "American Lawyer" started coming in and doing what it did – malicious, gossipy stories.

What happened was that tax exempt financing had been suspended by the Treasury for two or three years. Also, there was a downturn in the economy, so the stock market went down. Mergers and acquisitions slowed. Our corporate department, which was pretty large, barely had work, although the health practice was still booming.

We had to do some belt tightening at the exact same time as everybody was offering these huge sums to our people. The firm couldn't weather it and the "American Lawyer" stories, and it imploded in February of 1987.

At that time, I was trying to keep a public company from bankruptcy and the bank lenders in New York from foreclosing on it. I was flying all over the United States.

So, I never even moved my office. My wife and secretary did – over to Manatt, which had invited me back. Manatt, however, did not feel that it could take the entire health law group.

McDermott, Will and Emery was literally camping on our firm's doorstep at the time our partners were voting, trying to decide whether we should stay together as a firm or not, and telling the health law group that they wanted them to open – or to add to their new Los Angeles office, and if they didn't come now, the offer was going to be withdrawn. A lot of pressure was being exerted.

So, I wound up at Manatt. Those people who had kids and mortgages to worry about wound up at McDermott, Will and Emery.

I have been at Manatt now since February 1987. I started out there all alone, made use of their personnel and grew the healthcare department at Manatt to about 15 or 16 full-time lawyers – although we had a lot of other lawyers working on health law matters.

This past year [2002-03], we've added a law firm in New York that essentially does health law, with 42 lawyers. It's already up to 45 or more. They are, in my view, the premiere health law firm in New York State.

Also, we have health lawyers now in Washington, Palo Alto, Sacramento, and Orange County. I would speculate we're about 65 dedicated health lawyers now.

MODERATORS: Carl [Weissburg], could you tell us something about the firm you started up in 1970?

WEISSBURG: We formed Weissburg, Jacobs and Gerst with five of us, actually. By 1973, we were drowning in work, and at that point, I was devoting my time exclusively to the health law practice.

Bob Gerst – who had been with Memel, Memel, Jacobs and Weissburg, knew a lawyer by the name of Al Mour, who was a partner in his own firm in the valley, that did health work. Bob and Al were undergraduates at SC, and also law school classmates at SC. Bob called Al to see if Al knew of anybody that might be looking for a job, because he needed some help pretty quickly.

As Sherwin had pointed earlier, there really weren't health law lawyers in those days. We found lawyers who were skilled in various other specialties and made them health lawyers by superimposing all the health law on top of whatever it was they were doing – whether it was corporate work or tax work or labor. And that, of course, was the way we grew.

Out of that conversation between Bob and Al, we then had discussions with Al Mour and his firm (Mour, Klein, Aronson and Epstein) – because they had a health practice of their own.

But their practice was in the valley, and ours was in California and the East, because by that time I'd been serving as general counsel to the Federation of American Hospitals for three years – which Sherwin helped form – and we were beginning to break into various other kinds of hospital sponsorships.

So we formed Weissburg and Aronson through a merger on September 1, 1973. We had 11 lawyers – about half of whom were in health – and the other were primarily in litigation.

[**Moderators' Note:** In the mid-1980s, several partners from Weissburg and Aronson started the boutique healthcare law firm of Hooper, Lundy and Bookman.]

We grew that firm to about 85-plus health lawyers at the time of the merger with Foley & Lardner firm in the 1990s. At that point, we had offices in Los Angeles, San Francisco, Sacramento and San Diego in California.

We also opened up a Washington office which was incredibly successful -- so successful that our partners defected.

We decided at that point that we weren't going to stay in Washington any longer, and we brought the national practice back to Los Angeles, and that's where it stayed. So, we had lawyers flying all over the place until the merger with Foley & Lardner.

Foley & Lardner now [2003] has about 1,100-plus lawyers. We have 15 offices in the United States, an office in Europe, and one we just opened in Tokyo.

We probably have approximately 100 full-time practicing health lawyers in the firm – although, as you know, that doesn't mean that's the total number that's employed in the industry, because we always have to bring in other folks. Right now, I'm using SEC lawyers in a couple of different offices. And that's just one example of how the field has exploded.

And I'm still practicing law here in Los Angeles, where I started.

SILBERMAN: [See in-house section of this article for description of Barry Silberman's start in healthcare law practice.]

[While working in-house at Medicorp,] I had been negotiating nuclear medicine contracts with a lawyer by the name of Phil Flame. Phil told me hundreds of times how he had been with Memel, Memel, Jacobs and Weissburg, I believe, for all of six months when he found himself no longer with the firm because the firm wasn't there anymore – and at some point, created Flame, Sanger, Grayson and Ginsburg.

After about a year of discussions with them and one other firm, I was lucky enough to join them. I was with Flame, Sanger for five years. I worked – it was interesting because part of what I did was medical staff, and I found that once you got into the room, it was really a malpractice issue. I had by fortune been put in a firm that had a partner who did medical malpractice defense work, so I put him into the first hearing after the procedure. His name was Bill Ginsburg. I got him his first opportunities on radio and television, which he took to advantage later [representing Monica Lewinsky].

Bill and I teamed for a long time on doing medical staff work. I put him in the room with a doctor/lawyer. There were one or two doctor/lawyers who were proliferating the defense of the doctors during that period of time as part of the growth pattern that was going on.

Then that firm imploded. We had brought in a client, American Healthcare Management. Phil left to do their acquisition work. Bill asked me to join him and nine other attorneys, and we opened the California office for Wood, Lucksinger & Epstein.

I was then again privileged to deal with another one of the leading healthcare attorneys in the country at the time, a pioneer in Medicare by the name of Jack Wood – whom I had heard described by other lawyers as this Lincolnesque figure in a black suit -- and if you could tolerate one cigar after the other in the room, you would learn a lot.

Jack and the firm were involved after TEFRA came along in 1983 – which was interesting, because I thought that, having gone with Wood Lucksinger, I'd be able to focus totally on hospitals and not have to deal with doctors; but then TEFRA came along and brought along joint-venturing. Jack was involved in the first joint ventures.

I stayed there for a period of time, and then saw some internal political smoke signals that indicated that our litigation office on the West Coast was not conducive for transactional practice.

By total serendipity again, the one firm that I was interested in joining was Loeb and Loeb, which was managed by one of Sherwin's present partners, Bob Eller. It was Bob who brought me into Loeb and Loeb. Loeb and Loeb had, interestingly, represented Cedars of Lebanon and the two hospitals during the merger in 1974, has represented them during the whole certificate of need merger of those hospitals, and had historically represented Cedars Sinai; and, he wanted to broaden the practice.

I was there for about eight years, and had the good fortune to work with people at Cedars Sinai for a long time. I was also fortunately introduced to the oldest son of John Wayne, and that started a 17-year relationship with the Wayne family. Over the course of time I was privileged to help put together the John Wayne Cancer Institute, which broadened my involvement into the academic arena and the research arena, and then was a partner with David, as a matter of fact, for about three years before going own about six years ago.

Wood Lucksinger, really a wonderful firm, had a very interesting experience that's worth mentioning, unfortunately. I was insulated from that experience by three years. My understanding of their breakup was that part of it was growth — the day we opened the Los Angeles office I found out we'd also opened a New York office

and didn't even know about it. So, part of it was the growth. But my understanding is that they had sued one of their physician clients that they'd represented in a Medicare action for his fees.

He cross-complained for malpractice, as I understand it – this is all third hand – the theory being that they had not been aggressive enough in their representation. They got some astronomical jury award in Florida, and that award undid the firm because it just exceeded insurance coverage and a lot of other things and resulted in a multinational suit by the landlords and all of that. So, it was not pleasant for those who were involved in it. Fortunately, I was insulated from it at the time, but it was part of the history of what happened --and it was unfortunate because it was such a quality firm.

The other footnote is in a year before this organization started, giving credit to Keith Walley and a fellow named Mike Nolan, who many of you remember. The steering committee was put together for the California Society for Healthcare Attorneys. There had been enough growth of lawyers in the industry that there was a sense that maybe there should be some professional society to bring them together. I asked to be on the steering committee because I saw it as an important opportunity not only personally but I thought it was an important thing to accomplish.

We were able to launch the society. Chuck Forbes was really an ideal role model as the first president because he set a real tone for the society in terms of its professionalism, the delivery of education as one of its primary goals, and the other being a collegial organization. That word "collegial" I remember emphasizing it over and over.

So, that's sort of my zealot experience with a lot of really fine people and brilliant lawyers who have been in this industry and made it what it is today. And that evolution, I think, has set a tone for some of the issues that we'll discuss in the later sessions of what is , in my view, good for the industry versus what is good for the lawyers.

MODERATORS: Ann [O'Connell], would you tell us about the development of health lawyering in central and northern California.

O'CONNELL: Okay. For the longest time, I think, it was mainly smaller firms in Sacramento. Our firm, McDonough, Holland and Allen, was relatively large for Sacramento. When I joined, there were 25 lawyers in the firm, and two or three of us were doing kind of little bit of healthcare work. Bruce Allen had started, as I think Carl or somebody described at the beginning of lawyering, being on the board, providing free services and everything. And that's how Bruce had started with the Sutter system back in the 1950s. When I came onboard, Bruce was on the board at both Sutter hospitals in Sacramento. We also represented Roseville Hospital at the time and some of the smaller district hospitals in Northern California.

At some point Bruce decided to turn over the practice in our firm primarily to Gary Loveridge, who had just been made a shareholder in the firm. Gary and I sort of grew up together, learning healthcare law and doing certificate of need and just the general smattering of things that all of you have done as well.

I think one of the most interesting factors maybe in my own career and in the growth in Sacramento is the way the hospitals have developed out of the Sacramento area, and in particularly focusing around Sutter Health and perhaps the Catholic system, but was the incident that happened when I was a second year associate in the law firm. Bruce Allen had just gone off to Mexico, and when he left he said, "There's a small problem at Sutter. It's been turned into licensing. They may be calling you." But – and he really hadn't gone into any details of what was going on, but he did leave for Mexico and we did get a call from the district attorney who showed up at Sutter wanting to cart off all of the medical records of everybody that a particular physician had anesthetized for three or four years.

Gary and I got a crash course in almost every possible aspect of healthcare law over the next, I'd say, three to four years. We saw a cascade of work. There were opportunities. There were just incredible changes that happened in California – or in the Sacramento area's healthcare system. We saw the building of Sutter Health System when they changed from being a two-hospital system. Now I think they've got close to thirty facilities. All of that grew out of that one incident and the change in authority that happened as a result of the doctors los-

ing control of the hospital, and as a result of bringing in Pat Hayes, who started the system, and Dick Bueller who compounded it -- and the philosophy that he brought to that system.

Our firm has grown from seven to as many as 10 attorneys doing mostly healthcare work. Obviously we've got other practices and everything. Right now [2003] we've got nine healthcare attorneys.

IN-HOUSE LEGAL DEPARTMENTS

QUESTION: And Art [Bernstein], what year did you start?

BERNSTEIN: That was in 1957, when I went to work for the American Hospital Association in Chicago. I learned about Jim Ludlam and his young associate, as well as Ross Stromberg, Sherwin Memel and Carl Weissburg, and I knew that they were the experienced people in the field. So, although I soon got involved on the national level, it turned out that the Californians had the experience and they were dominant in the subsequently organized American Society of Hospital Attorneys which preceded the California Society.

LUDLAM: My first contact with Art was in dealing with the American Hospital Association, because Art was – I guess you were their first legal counselor, weren't you, Art?

BERNSTEIN: Not quite, but I was, for a while, the only one they had.

SILBERMAN: My own experience was starting in operations, also. And my historical perspective was knowing that – going back prior to my time – a lot of the explosion took place partly because the assassination of JFK, and Johnson getting the Great Society program and in getting Medicare passed. And it started opening up a lot of opportunities, followed in the 1970s by Sherwin, et. al. acquiring hospitals.

As a result, when I walked into California in 1971 out of a recession in the electronics industry, I walked into American Medicorp and found a 10-man industrial engineering department with an opening.

That's how I got into healthcare. It was just total serendipity and something that had come into my mind. And it was fortuitous timing because all of the acquisition – not all – but a lot of the early acquisitions had resulted in then Medicorp, American Medical International, National Medical Enterprises, and several others having been created – which Sherwin and Carl were at the forefront of doing.

I will say that I benefited directly from several gentlemen who are on this call – and one lady, also, later on. But Sherwin had pioneered a lot. By the mid-1970 – 1974, the National Health Planning Act was passed, which created certificate of need.

I was still managing industrial engineering, going to law school at the same time, but I was the only one focusing on what this new law was. And I didn't realize what I had done at the time, but I asked Carl Weissburg if he would mind coming over to my office and explaining it.

I say that, at the risk of getting a bill with 30 years of interest on it., Carl very generously sat there and walked me through the entire law and explained it – what it was, what it was intended to do. And I've been forever grateful about that.

I then became the only one at Medicorp in the western division who was really knowledgeable in both licensing and certificate of need, while I was going to law school.

I was then able, not easily – when I say not easily – to transition into the legal department for two years, because the senior VP said, "What do we need more lawyers for?" And they wanted to keep me doing operational analysis on the managed care contracts and all of that.

So, fortunately, a gentleman by the name of Fred Rosenfeld – who some of you may remember – wanted my licensing experience, which was more than anybody else had. And that's how I got into the legal department of Medicorp for two years before joining Flame, Sanger, Grayson and Ginsburg.

It was partly because the acquisition mode was going on, and this was an important part of the history in the '70s. Humana <Company: Humana Inc.; Ticker: HUM; URL: http://www.humana.com/> acquired Medicorp,

American Medical International went through its ultimate iterations, as did National Medical Enterprises, over the years.

O'CONNELL: Sutter has raided our [firm's healthcare] department from time to time. They've got something like 13 or 14 in-house lawyers that Gary Loveridge now heads up -- and he's probably taken half a dozen of them out of our firm over the years.

The Catholic hospitals in this area didn't have a similar catalystic event. But they've, in tandem with the Sutter Hospital, grown into a system, and they've built a legal department there. I think we've just all seen a real difference in the way we relate to our clients because of the in-house legal department grown up. Maybe that would be a segue into some of the in-house legal and how that's impacted the change in our practice.

Well, from my perspective they have developed in-house specialties, but they've changed the way they use outside law firms. I find it very difficult, for example, to train attorneys in healthcare law now because the bread and butter stuff that we all learned on is kept in-house. If you were starting out as a new lawyer, the place where you would want to get your projects and get the work and training would be to work as an in-house lawyer rather than as an outside lawyer, because we tend to get the projects that are more complex, and more time consuming -- therefore, they're hiring us for the expertise and don't want to pay for the training.

MODERATORS: Why do you think the in-house legal practices have developed as quickly as they have?

O'CONNELL: From my perspective, I think it's because the systems have grown so large and their needs are so complex and they were hiring out so much that they started feeling that they could support specialization within their own organization, that they could save money by not having to hire it out. Also, I think you also see that as the hospitals have affiliated with each other, the lawyers who represented the various facilities through the deals have kind of gone along with the hospitals. Lots of them have gone in-house as well. But I think they just felt that they could save money and serve their clients needs better by having a large in-house department. And I think – I see it fluctuating it. Sometimes they stay – sometimes they try to hoard projects in-house and then they'll go on a wave they realize they can't possibly do it all and then they start releasing the work out again. And I think it's impacted the way we work quite a bit.

MEMEL: I would like to comment on that. Several things happen. For example, at Centinela Hospital Medical Center (which was my client for close to 30 years), during the last 10 years of my representation it brought one lawyer in-house and then eventually brought a second person. And because of the strong personality, which many of you know about, of the administrator during those years, Russ Stromberg, he used them as he saw fit, primarily for handling medical staff, things that didn't go to litigation or to the office of civil rights for malpractice defense matters, for minutes and things like that. But anything of significance went to us as outside counsel. And the CEO went directly to me, which made for a very interesting relationship with in-house counsel. That's how it was run.

I had another client for close to 30 years, the City of Hope, which gave me extraordinary experience in technology transfer, licensing, and biotechnology as well as federal and state legislation, consortiums, cancer centers and so on. I represented that client until about the fifth chairman of the board came in. That chairman brought in a young in-house lawyer who immediately undertook to build a large staff.

I had the feeling that he wanted to be very prominent, very dominant, did not want to be overshadowed by anybody on the outside, and wanted all of his outside lawyers to be people that he was comfortable with and, for the most part, younger. So we do very limited work for that client. That lawyer totally ran legal affairs. The CEO, quite contrary to Russ Stromberg, does not intervene at all. Any lawyer that works with that hospital has to work through the in-house counsel. They have built a fairly extensive network of law firms they deal with, and in-house as well.

So, I think you can't just talk about in-house lawyers. You have to talk about the personality of the lawyer, the personality of the CEO, and the way they're organized. And I think if you've seen one in-house arrangement, you've seen one in-house arrangement, because I don't think there's any commonality. Those are my comments.

WEISSBURG: I'd just like to touch on a little bit of what you shared. I agree with a lot of what you said. But a number of large hospital systems, which we do work for, offered positions to our lawyers as in-house counsel. In one case, the individual became general counsel and in another case it was a lawyer who helped form the system. In each and every one of those instances, although I'm certain there are exceptions now and then, that has resulted in an increase in our business from the systems.

MEMEL: Well, I've had the identical experience.

WEISSBURG: I don't want anybody to think that there's a war going on between in-house lawyers and the outside counsel because I don't think that is the case. The fact is that you really do form a partnership with these folks.

MEMEL: Well, yes. I mean, one of our partners [Rick Grossman] became in-house counsel for Catholic Healthcare West in Southern California. Since he joined that organization a number of years ago, it has become an enormous client of this firm. In fact, one of my former partners [Cathy Kay, former CSHA President] is also working with Catholic Healthcare West as a freelance lawyer. That does happen.

But what I was trying to illustrate by my comment was two extremes and to make it clear that every relationship is really different.

WEISSBURG: I think that's true. I just wanted to add one other thing, which has nothing to do with in-house versus outside counsel. I think – and I don't know whether it's the chicken and egg proposition – what forced this was that hospitals got together for specific reasons. But California, I think, is a unique crucible. I'm not aware of any other state that has the variety of hospital sponsorships that we have, number one. And number two, the practice of health law seems, at least in my experience, to move from west to east, because we did things with one notable exception at least, first here. I believe the fact that we have so many different forms of sponsorship to deal with caused that.

But I think what really drove consolidation in a large measure was the need for hospitals to be able to deal with reduced payment methodologies. And they had to become much more efficient. They no longer could be freestanding. So, along with that consolidation part to gain efficiencies – and I think Ann alluded to this – was the formation of their own in-house attorneys staff.

MEMEL: In addition, as health laws have developed and the industry has become more complex, not only payer organizations, but government has had to develop healthcare lawyers in-house who specialize in things relating to the healthcare field such as a guy like Jim Schwartz, who'd been with the attorney general's office for 20 years who dealt with conversions of HMOs and conversions of nonprofit hospitals and who's now made the transition very successfully into our firm in the last three-and-a-half years.

So, you're finding a lot of movement of private lawyers into in-house and in-house lawyers in government elsewhere to outside practices, like Mac Thorton from the Office of the Inspector General going to, I think, the Sonnenshein firm, and Kevin McAnaney, from the advisory opinion division of the OIG, going out on his own practice, and others before them.

WEISSBURG: Right. Fred Entin used to be inside general counsel for the American Hospital Association and is now with us in our Chicago office. And there's a lot of movement back and forth, and I think that's good. I think that synergy is important for everybody. Because you learn from these different experiences, and it just makes us, I believe, better lawyers for our clients.

MEMEL: Do we have any analysis, Lois, of the CSHA of how many – it's probably in the directory, but I've never looked for it – how many are from private practice and how many are from government and how many are from payers?

RICHARDSON: The current membership of CSHA is 270 private practice lawyers, 75 in-house counsel, 10 government and one academic lawyer.

MEMEL: I find that number of in-house counsel really very interesting, compared to what those numbers might have been when I first started practicing, as a ratio of in-house to private practice. I think it shows tremendous consolidation in the industry to a size where they can afford in-house counsel, and a tremendous recognition of the importance of healthcare lawyers to healthcare organizations.

SILBERMAN: To me, the turning point was in 1983 with TEFRA. It only got worse as managed care expanded because what I saw happening was people becoming more and more reluctant to pay open-ended attorney fees at every level. I saw one in-house relationship change from where they brought in a firm wanting to take care of their large real estate transactions if they would do their medical staff at a very, very reduced rate or a fixed rate, or they started making deals, if you will, because of the economics. That's my definition of economics.

The hospital industry, in particular, and the doctors too went from this government subsidy where the government was in essence on a cost-based reimbursement—paying them in part for what they spent on lawyers and accountants. Then everybody went out and they built homes, if you will. They expanded their brick and mortar, and their mortgage, and all of a sudden, their allowance was cut in '83. To me, that was the turning point on the spiral. I'd be interested in others' comments on that. But it was finally an expanding unlimited demand for service on what became a more finite supply of money.

MEMEL: Also, we should bear in mind that there were legislative efforts, federal and state to limit the ability to pay attorneys' fees from reimbursement. And that was defeated.

CLOSING THOUGHTS

WALLEY: I am most grateful for the opportunity to read the transcript of the conference. I apologize for not being on the call. I was honored and humbled to read the many facets of healthcare history and change from those who were there and made it happen and are rightfully "giants" in the field.

If CSHA offered anything over the years since its formation, it made it possible to put programs in place and bring leaders together to offer cutting edge material and perspective to peers and new entrants to the field of healthcare law. The void in California was thereby filled by the generous donation of time, effort and expertise of persons such as those men and women on the conference call who gave unstintingly of themselves in order to grow and mature the field of healthcare law through decades of massive change.

I was filled with sadness as I read the transcript, however. Sadness because I realized with great poignancy that indeed an era has almost come to a close where the pioneers of healthcare law who saw and personified the "big picture" are few in number. And that those who are taking their places may not (although I pray they do!) have the breadth, vision and drive for the future to have the kind of scope of influence to shape outcomes as did these predecessors. Nevertheless, new challenges will emerge and new healthcare lawyers will arise. I hope the excitement is as strong for them as for these veterans.

I wish I had great things to add to the diverse and fascinating discussion that took place. In fact, I do not. My hat is off to those who have braved the years and met the issues head on. Because of them, we are a better state, and, where we have influenced national healthcare policy, a better nation. We have certainly provided a strong forum for assisting healthcare lawyers in California because of CSHA. Congratulations all around!

[In future issues of California Health Law News, additional excerpts from this roundtable will be published.] ??