lessly ill persons is not the cause of death. It would be novel and ironic to conclude that this person has a right to remain on a ventilator in a country where there is no general right to health care. It also does not strike me that the physician is imposing his quality of life standard on this patient in that he would provide treatment if this woman had any personal sensation of her quality of life.

It is unusual to challenge the conclusions of a family in these decisions. The rarity of such challenges, however, may sometimes be an acknowledgement of the legal difficulties of doing so rather than the lack of merit to such an action. We believe that informed consent or refusal refers to therapies which would be medically indicated as possibly serving the patient's personal medical interests. Ethicists agree there is no obligation to provide futile therapies, though a variety of definitions of futility are currently being explored.

The proposal that the intellectual construct of "substituted judgment" justified by "respect for autonomy" infinitely empowers a family over a reasoned medical conclusion that a treatment cannot serve the patient's interests defies experience and common sense. Certainly, no practitioner would be thought remiss for declining to provide this woman with a heart transplant even if it would sustain her life. I do not believe that the relative boundaries of professional and family spheres can be precisely demarcated at this time. I do believe that Helga Wanglie, at 87, with endstage pulmonary disease, and irreversibly unconscious, is surely beyond the proper exercise of our most aggressive healing powers. I welcome comments on this case.

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Linares Case: In-House Counsel Defended

Dear Editor:

This letter is prompted by the symposium on the *Linares* case in the winter 1990 issue of *Law, Medicine, & Health Care*. I found the content of the various articles concerning the case very interesting but I was disturbed by the tone and extent of some of the comments about how the hospital's attorney, Max Brown, fulfilled his responsibilities. I note that the most critical comments concerning his performance did not come from practicing attorneys. I believe that the lack of a law practice orientation, or not being an attorney, tends to make critics of an attorney's course of action somewhat unrealistic. It is worth noting that Nancy Wynstra's piece–she has a role at the institution she serves very similar to that of Mr. Brown–demonstrates an understanding of the pressures upon the attorney as a counselor.

Whether the attorney counseling a hospital in a complicated situation, such as that involved in the *Linares* case, is a house counsel or is with a law firm, the attorney must always be aware of who his client is. Patients, and physicians on the hospital staff who are not employees, are not clients of the attorney. While I do not ignore the existence of responsibilities owed patients and physicians by the hospital's attorney, the content of the legal guidance is controlled by the attorney-client relationship.

I tend to agree with the critics who gave the opinion that the potential for liability for both the hospital and the physician was minor. However, in dealing with physicians, it has been the experience of many attorneys, myself included, that physicians' fear of involvement in legal proceedings is so great that they often demand a degree of assurance that an attorney, in good conscience, often cannot provide. Thus, to assume that casting the potential for legal involvement in terms of probabilities, rather than possibilities, would ordinarily satisfy physicians, is to be unrealistic in many situations. I have no personal knowledge of the climate within Mr. Brown's institution respecting liability concerns, but I would not underestimate the concern that might be felt, even if it were objectively unwarranted.

In addition, considerations other than legal ones may intrude. Termination of care for a patient without private insurance or personal resources may raise concern in hospital management about misinterpretation of motives by the media. A hospital that facilitates a patient's family obtaining a court order to terminate care may become suspect. Perhaps, ideally, media attention should not be a factor in health care decision-making, but it sometimes is.

Readers of the symposium should look upon the various articles discussing the *Linares* case as a kind of precedent, in the sense that attorneys, physicians and institutional administrators, by reading them, can gain a better understanding of the complexity of the termination of care situation. Mr. Brown felt uncertainty because there was no definitive decision of the Illinois Supreme Court. While some of his critics point to decisions of courts in identical issues, it is necessary to keep in mind that the reason we have those court decisions, which can be used as a source of guidance, is precisely because the attorneys in those situations often felt, because of the concern of their client institutions and physicians, that it was necessary, in one way or another, to prompt or to secure a judicial resolution of the issues. Note that Mr. Brown himself, in the piece he coauthored, indicated he would do things differently based on his experience.

I would like to make two additional points. First, some attorneys, when faced with a situation where they are called upon to assess the nature and extent of the legal risks attendant to a course of action, prefer not to have their clients be the parties that bring

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about law-clarifying litigation regarding a subject for which there is no authoritative precedent within the jurisdiction. They point to the expense of litigation and seem to encourage what they view as the more conservative approach, which they believe will avoid litigation–an avoid a "test case" approach. Institutions have budgets for legal expenses as for other cost items. The attorney who pushes for the decisive precedent may be viewed as having his own economic or social action agenda.

Second, a good many attorneys who serve health care institutions, whether in an in-house role or with a law firm, in situations such as that exemplified by the *Linares* case, gain the explicit approval of the institution's management to inform the physician that the institution will stand behind him or her in the situation, and leave it to the physician to decide whether to withdraw the treatment or continue it. In that scenario, the hospital attorney is able to assure the physician, even if the physician is not an employee of the institution, that, in making the determination, the physician should feel secure that necessary legal assistance, if a problem because of the decision arises, will be furnished by the institution to the physician. The physician, thus, would be more likely to look at the problem as one that requires other than just a technical, legal response. In short, hospital management should strongly support conscientious physicians.

Hindsight, usually faultless, is sometimes accompanied by arrogance. I have learned over the course of years that many initial thoughts of mine about inadequate legal counsel, after I gained additional information and an understanding of the particular context of the problem, were incorrect, and such experiences have led me to be much more cautious in my criticism of the legal advice of others.

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Medicaid Planning: Ethically Questionable?

Dear Editor:

The Fall 1990 edition of *LMHC* contained an article by John J. Regan entitled "Financial Planning for Health Care in Older Age: Implications for the Delivery of Health Services." In this article, Mr. Regan explains methods used by the middle class to shelter assets for the purpose of qualifying for Medicaid nursing home benefits. Although he briefly addresses some of the serious ethical objections to this practice, the author does not adequately examine the impact of "Medicaid planning" on America's health care financing crisis.

Medicaid is a public assistance program, i.e. welfare. It was intended to assure access to mainstream health care for poor women and children. Gradually, however, Medicaid has become the primary third party financing source of nursing home care for the middle class. By encouraging healthy middle class and affluent clients to qualify for public assistance, Medicaid planners may unwittingly divert scarce welfare resources away from the truly needy.

But this "reverse Robin Hood" problem is not the only negative social impact of Medicaid planning. The expectation of something for nothing discourages more responsible financial planning such as the purchase of private long-term care insurance. The increase in people who rely on Medicaid's "low cost care of uncertain quality" strains the nursing home industry's ability to provide adequate care to everyone. The implicit emphasis on estate preservation for heirs instead of easy access to the best private care available suggests a misplacement of priorities.

The reputation and future effectiveness of the emerging new practice of "elderlaw" depends on properly addressing these and many other similar issues. Therfore, one of Mr. Regan's comments is especially disturbing. He says: "The most common problem put to the elderlaw practitioner is how to keep an older person's assets within the family and yet allow the person to qualify for Medicaid." If Congress and the taxpayers get the idea that this is what elderlaw is mostly about, all of its many beneficial contributions will be overshadowed by a cloud of ethical doubt.

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