MINUTES

ASSEMBLY JUDICIARY COMMITTEE
April 14, 1977

Members Present:	Chairman Barengo
	Assemblyman Hayes
	Assemblyman Banner
	Assemblyman Coulter
	Assemblyman Polish
	Assemblyman Price
	Assemblyman Sena
	Assemblyman Ross
	Assemblyman Wagner

The meeting was called to order at 7:10 a.m. by Chairman Barengo. The people wishing to testify were sworn in as they came forward to testify.

AB 562 and ACR 28: Assemblyman May appeared before the committee on these two measures and testified on both simultaneously. He gave the committee some historical background on both measures and pointed out that there was a similar bill last session. He stated that he, and others, were concerned that there are so few trusts like the Fleischmann Foundation and the Corde trust which is in probate. He stated that he felt the Fleischmann Foundation was too valuable to allow to expire, under its existing tems, without giving more thought to it. He said that as a result of the passage of ACR 67 last session that it was found out that there were many problems involved, including the IRS changes in 1969 which effect trusts, and that the limitations which are placed on this type trust are so stringent and demanding, that the amounts of trusts created have dropped off dramatically. And, he felt it was unlikely that any will be created in the near future as a result of those restrictions.

Mr. May then read from a news release which is attached and marked Exhibit A.

He explained that the first two paragraphs in AB 562 are extremely important. He stated that it sets forth a legislative declaration of intent and knowledge of the historical impact of trusts in the past. He said it also includes a declaration to encourage the retention and creation of private charitable trusts and foundations. He stated that the balance of the bill sets out the procedure which must be followed to disburse the proceeds of the trust or foundation through the courts. He pointed out that the important part of this bill is that there is provision at the end of the court hearing for the method that the court will use in determining what will happen to the trust or foundation. This includes a provision for taking into consideration all the factors which should influence the retention or dissolving of the fund.

In summation he stated that he felt this bill's intent was that before an asset as valuable as a private foundation or trust, as few in number as they are, is that they should be reviewed perhaps by the judicial body before they are allowed to dissolve themselves.

ACR 28, he stated, was simply and expression of feeling by this legislative body, the Senate concurring, with regard to the Fleischmann Foundation specifically, that the legislature finds that the Fleischmann Foundation and the work it has done in the state and the good that it has done, should be, if at all possible, continued.

In answer to a question from Mrs. Wagner, Mr. May stated that the Fleischmann Foundation is, according to the bulletin attached as Exhibit D, the only sizeable foundation presently operating in Nevada and that it was extremely unlikely that any new private foundations will be formed. And, he stated that he did not believe that any new foundations had been formed since the IRS change in law in 1969. At that time Mr. May presented to the committee a graph and information which indicates the drastic drop in private trusts since 1969, not only in Nevada but throughout the nation. That graph and information is attached and marked Exhibit B. That concluded his presentation to the committee.

Chairman Barengo read to the committee a letter from Julius Bergen, Chairman of the Fleischmann Foundation expressing four of the five directors of the foundation's opposition to AB 562 which is attached and marked Exhibit C.

Mr. Jordon Crouch, Director and Executive Vice President of the Nevada Bankers Association, speaking for all the eight banks in Nevada, and their 2 billion dollars in trust assets. He stated that this was a very difficult time for him because he had very close freinds on both sides of this issue. He state that the NBA tries to keep a low profile and appear only when they feel they absolutely should do so. He stated that AB 562 would have adverse effects on all trusts if it were to pass. He stated that their primary concern was that they felt that a man should be able to do what he wants to do when it comes to disposing of his own assets and property. He said that he felt Mr. Fleischmann had made it exceedingly clear when he set up his trust what he wanted to do with his funds and that Mr. Fleischmann was a very positive person. He explained that when the foundations was first set up there was about $60 million in the fund and they have given away some $60 million and the remainder in the trust is around $111 million. And, of the portion which had been disbursed, some $40 million had been used in Nevada.

He stated that if he were speaking strictly as a banker, it would be very clear, that he would not want this piece of business dissolved, rather keep it. And, he stated, he felt that as a personal thing, most people would want it to continue. But, he pointed out that that is not the point in this case. He said that the important thing was what the grantor stated in his will. He then handed out to the committee the report which Mr. May had referred to earlier entitled, "Report of Study of Ways of Encouraging Private and Community Foundations", bulletin number 77-21 of the LCB, which is attached and marked Exhibit D. He read to the committee from section 4 (a) and continued for four paragraphs.

He said that this covered his testimony except that he felt that by this legislation people who might possibly want to begin foundations and trust, will feel taht the state of Nevada has attacked the sovereignty of those types of institutions and be skeptical as to whether or not their wishes would, indeed, be carried out as they had set out.

Mrs. Wagner told Mr. Crouch that she still did not understand why the bankers would be in opposition to this bill. He stated that the reason they are opposed to it is that they feel that it will undermine the security of the trust and, perhaps, deter any further trust being set up in Nevada because of the questions which will come up in people's minds.

Chairman Barengo asked Mr. Crouch if it wasn't possible that the reason the foundation was originally set up to be liquidated in 1980 was because of the structure of the laws at the time the foundation was set up. And, that it should be interpreted within the confines of the laws at that time. Mr. Crouch stated that he felt that Mr. Fleischmann had indicated exactly what he wanted and that he could not interpret it any other way and added that he was not an attorney.

Mr. L. J. McGee, Chairman of the Trust Committee of the Nevada Bankers Association and also representing Pioneer Citizen's Bank, next addressed the committee. He stated that his comments would be brief and that he wanted to let the committee know that on behalf of the Trust Committee of the Nevada Bankers Association they do endorse Mr. Crouch's statement. He stated that there were two other members of the committee present and they wished to add some remarks to those of Mr. Crouch.

Mr. Don Brown,Vice President of Valley Bank, Las Vegas, pointed out that section 4, page 1, would effect the variety of charitable remainder trusts or trusts wherein at some point the trust terminates with a charity as the beneficiary thereof. He suggested that the committee consider that the private trusts or trusts created under a will wherein a specific charity is designated that those trusts be exempted from this bill. He stated that he interprets this bill to possibly include those types of trusts and that he felt that they should not be touched by it.

In answer to a question from Mrs. Wagner regarding section seven, Mr. Brown explained that if someone leaves a remainder type trust to his survivors with a specific charity as the ultimate beneficiary on the survivors demise, then they have to go through all the provisions of section seven in order to do that and still the judge could modify that wish and he did not believe that to be proper. He wanted to know what there was in this bill to prevent that judge from changing that beneficiary.

Mr. John Cockle, Senior Vice President and Head of the Trust Department of Nevada National Bank and attorney, stated that he agreed with the comments of those bankers who had commented before and that he would like to add that while it is more difficult to create a private foundation or charitable trust, under the tax laws in effect currently, these trusts are still being considered by people of means, in excess of $1 million. He stated that if this bill were passed it would be necessary to advise those people that it would be possible that their intent as to distribution of the trust would be thwarted by the courts. And, for that reason they should consider a different jurisdiction for their trust or foundation. He remarked that it was basic that people of wealth would like to have that wealth distributed in the manner in which they prescribe.

Mr. Rene Ashleman stated that he felt there should be a matter of law pointed out in this discussion. He stated that the law has not been for more than a hundred years that a person could set up a charitable instrument and be free from interference by the court or legislature in its entirety. In fact, he said, the IRS changes in 1969 was just such an interference. He pointed out, therefore, that no bankers had the right to say that no one could interfere with the trusts which are established. He then referred to the Franklin vs. Attorney General of Massachusetts case which is attached and marked Exhibit E, where this type of thing had gone to court before. This case pointed out that the directives can be changed when certain circumstances, such as a change in social circumstances, come about. He then explained the historical basis for the case. Mr. Ashleman pointed out that some trust directives become obsolete and there must be some way to redirect those funds. He said this is extremely touchy because people cannot peer into the future.

He stated that he felt when one was dealing with a client who wished to set up this type of trust or foundation, one of the concerns should be that what you are setting out may become obsolete. He said that the history of these cases have been numerous, where the beneficiary is no longer in existence when the trust is dissolved and he felt that it might even be helpful to have this provision in the law so that they would know that they could be reassured that it would be dissolved in light of the changes, social, economical, etc.

He said he felt that one of the reasons that Mr. Fleischmann had set out the dissolution of the foundation was that he was apprehensive that the trustees would not grant out the money and it would become perpetuating and bureaucratic rather than carry out his wishes and grant out the monies, even though in this case this has not happened and, in fact, is prevented from happening by the new IRS laws.

He said he did not have any quarrel with the changes that Mr. Brown had suggested. However, he did not feel this bill was a dramatic change from the law as it has been and he did not think that there should be any vast difference in what should be told to a person who would be thinking about setting up a trust and he urged passage of the bill.

Mr. Jim Joyce, lobbyist, was next to speak and he gave to the committee a copy of a petition which urged passage of the bill. The petition is attached and marked Exhibit F. He stated that he and the other lobbyists who had signed the petition had done so because the felt there was a need to pass this type of social legislation. He pointed out all of the various benefits that the people of Nevada had received from the foundation and stated that they felt that should continue.

Mr. Joyce explained that he is a charter member of an organization in Las Vegas which was funded by Fleischmann Foundation monies, in part, and he felt that that and the help it has given to various other organizations is critical in this state. In conclusion he pointed out to the committee that he felt they should keep in mind that one of the strongest social awareness actions they could take this session would be to pass AB 562.

Mr. Fran Breen was next to speak to the committee on this bill. He stated that he was not speaking as a lobbyist in this matter, nor was he appearing as a representative of the Fleischmann Foundation of which he is a trustee. He said that his main intent was to supply the committee with some information on this issue.

Mr. Breen suggested an amendment which he felt would answer the bankers objections. It would be on page two and he would submit the exact language and location to the chairman later. This amendment would be to add language to the effect that it would apply only to foundations or charitable organizations where they were to terminate and there were no specific designated remainderment. This would allow an organization to specify their ultimate beneficiary and avoid the rules of this bill.

He gave the committee the following financial information on the Fleischmann Foundation as of June 30, 1976: 1. Net worth $114, 880,000, 2. Income for year, $5,134,000, 3. Taxes paid, $196,000, 4. Amount distributed in grants totally since inception,$76,393,000 of which Nevadans have received $39,742,000, or some 52%.

He stated it was his understanding from the personal secretary to Mr. Fleishmann that there were three reason for distributing the trust, and they were: 1. A tendency to accumulate the income and not distribute it for charitable purposes, 2. A tendency to bureaucracy, 3. That each generation should take care of its own. And he pointed out that the 1969 tax act made these types of concerns less important and, of course, were instituted after the trust was set up by Mr. Fleischmann.

Mr. Breen stated that this bill would only provide that this would be reviewed prior to termination.

In answer to a question from Mrs. Wagner, Mr. Breen stated that last year the foundation distributed just under $6,000,000 in grants.

In answer to a question from Mr. Banner, Mr. Breen stated that upon dissolution the funds would be distributed somewhere within the 50 states at the discretion of the trustees in 1980. No exact terms are known at this time as to where the money will go specifically.

In answer to a question from Mr. Price, Mr. Breen stated that their were no children or heirs involved in this estate to whom the funds might be distributed. Therefore, the entire amount of the assets at the time of distribution would be used.

AB 608 and AB 609: Judge Guinan first addressed these bills. He stated that these bills were the result of a request from the District Judges Association.

AB 609: Judge Guinan stated that he apologized for the lateness of the bill and that they had intended to introduce it when AJR 1 was presented. He stated that the purpose of AB 609 was to clean up the language in the statutes to indicate which functions belong to which office. He stated that that was its only purpose and that they were not trying to change the status of either position but to designate which functions belong to each office. He also stated he did not feel this bill should be controversial.

AB 608: Judge Guinan pointed out that all the sections included in AB 609 are included in this bill and this additionally covers the ability to diminish the office of county clerk by removing therefrom the ex officio duties of court clerk. This would be, in essence the same as AJR 1, except that it would be done by statute. However, he felt that since this bill was introduced to late in session and because he felt the bill still was in need of amendment, he suggested that this bill be postponed until next session.

He said he did feel that the passage of AB 609 was important because the courts are only interested in the duties of the court clerk and this would set those out specifically.

In answer to a question from Mr. Polish, Judge Guinan stated that this bill would not effect the smaller counties at all except that the district court would be able to direct the court clerk in her duties as they were set out, even if that person were the same as the one who performed the duties of the county clerk.

Mrs. Loretta Bowman also gave testimony on these bills. She stated that she needed some clarification on AB 609. Judge Guinan responded to her question stating that the county clerk would still be the court clerk, in some instances, and this bill would only set out the functions that belong to each office. Mrs. Bowman stated then that she would be in favor or AB 609 and opposed to AB 608.

Mr. Bob Broadbent, Nevada Association of County Commissioners, said that all the counties, with the exception of Washoe County, are opposed to the transfer of the court clerk from the county clerk. He stated that recently in Clark County they had come up with something that this bill would have helped them with. He stated that he felt this would affect the county budgeting problems because this might lead to the judges adding employees since they had direction over the court clerks. He said that they felt that the answer to the problem was to put the courts under the state system and eliminate the counties from jurisdiction in this area. He said he felt the bills were premature in light of the up coming interim study of putting the courts under the state system. He urged that both the bills be held till next session for consideration. He also pointed out that they were told at the beginning of session that AJR 1 was necessary because the changes could not be implemented by statute. He felt that seeing what the electorate would do with AJR 1 was important before considering these.

A discussion followed on this between Mr. Ross and Mr. Broadbent. Mr. Ross asked Mr. Broadbent what the opinion of the county commissioners would be if the courts were state funded. Mr. Broadbent stated that they would only be interested to know how far the funding would go and added that they have and are in favor of state funding of the courts. But, he stated, that they would not know their formal opinion until they had a chance to see the proposed bill.

Judge Guinan responded that he wanted to point out that AB 609 had nothing to do with budget or salaries or separation of the offices.

Mr. Wayne Blacklock was next to testify. He is the District Court Administrator in Clark County. He stated that he was in support of AB 609 and AB608 but agreed with Judge Guinan in regard to the postponement of AB 608 this session. He gave the committee some of the facts regarding the budgeting questions which had been raised by the previous people. He stated that they are in the process of trying to organize and manage the judiciary so that it can be operated functionally, efficiently and well. He felt that AB 609 is a step in that direction and would help the interim study, inasmuch as it would delineate the responsibility of the offices for them. He therefore felt that that was a very non-controversial bill and that it would help everybody all the way around.

In answer to a question from Mrs. Wagner, Mr. Blacklock stated that in the areas of their budget which were overspent they were mandated areas statutorially and there have been recommendations made.

AB 559: Assemblyman Wagner explained the purpose of the bill to the committee as introducer of the bill stating that she felt most of the bill was self-explanatory and that the language was basically taken from California law and felt that it could be done economically and the rights, in printed form, should be given to the patients.

She pointed out that the bill carries no enforcement clause and that could be included if the committee felt it was necessary for the bill. She said she felt it should be voluntary now and if violations occurred then a section on enforcement could be added next session. She stated that the reason she introduced this bill is because she had known of flagrant violations and this might help in that area.

Chairman Barengo asked Mr. William Isaeff to notify Mr. Trounday of this bill and if he had any comments on it to contact the committee.

Mrs. Marge Brewer was the next person to testify on this bill and her comments are attached and marked Exhibit G. (with attachments). Along with he comments are also other letters in support of this bill which she submitted to the committee and are the attachments to that Exhibit. In response to a remark from Mr. Ross, Mrs. Brewer stated that perhaps discussion of files by name could be reason for taking a doctor before the board of medical examiners, however, she felt that informing the patients of their rights was important.

Mrs. Anna Hicks, Nevada Nurses Association, was next to testify stating that her association was in favor or the bill. However, she stated that she questioned line five on page one, wondering if that was to be in the opinion of the patient or in the opinion of the health care provider. She also referred to section 2, page 3, and stated that she did not want this to become an implementation problem and that perhaps this information could be supplied to the patient on the back of or in connection with the admissions forms. She just didn't want it to become burdensome to the staff.

Bishop Divine Ruth Turner of Reno stated that she had been victim of a course of treatment which she had not requested or been informed of and felt that under this statute the doctor would know that it was now the law that he should inform the patient of the treatments and their possible side effects. She stated that she was in strong support of this bill.

Mr. Paul Prengenman was next to speak in favor of the bill He said that he would like to address the problem from a slightly different angle and he hoped that this would clarify some points which had been raised during prior testimony. He distributed some information to the committee regarding the way that hospitals across the nation were responding to declarations of patient's rights.

His prepared outline of comments and the material he quoted, is attached and marked Exhibit H (with attachments). He also pointed out that some states, including Maine, have proposed some patient responsibilities and they are included in that package of exhibits and marked with an asterisk.

Dr. William L. Thomas, Administrator of the Nevada State Bureau of Health Facilities, Nevada Divison of Health, testified next. He stated that their department was responsible for the licensing and certification of health care facilities in the state. He stated that because of this responsibility they would propose an amendment to the bill on line 17, after the word case, which would read: "Unless an affirmative duty is imposed by other provisions of law, to submit any report from such records to the health division or any local health authority." This language is attached and marked Exhibit I and is excepted by the deletion of the request that it also be reflected in 2 (h) of the bill, as their only concern is section 1.

Mr. William Isaeff, Deputy Attorney General, stated that he saw two problem areas in the bill. He stated that there is an apparent conflict with SB 185 which is the access to medical records bill of the medical malpractice package. He suggested an amendment to sections one and two to state on lines 15 and 41, respectively, to amend to read "him. Except as otherwise provided by law, written". He stated that this would take care of the concerns of the board of medical examiners, the Attorney General's office, and probably the hospital's internal committees and hospital review boards. He said that all of these uses, of course, are strictly and highly confidential. He also stated that this would resolve Dr. Thomas' problem, if SB 185 is passed.

Dr. John Sandee, Nevada Medical Association, said that his association was opposed to the passage of AB 559. He then explained to the committee that it was his feeling and that of the association that most of the rights set out in this bill are already being given to the patients by the doctors and he did not feel that they had to be set out by statute. He stated that many of the patients who he deals with would not fully understand the rights if they were told to them because they are under such a strain when being treated medically.

He also pointed out to the committee that many of these ethical points of the bill are already provided for by review of the ethics committee and the board of medical examiners. He stated that people have always had the right to walk out of a hospital if they did not want treatment, but, that it was extremely difficult sometimes to get them to sign a form refusing treatment if they did not want to sign it.

Dr. Sandee pointed out also that many times the patients which come into the facilities are drunk or so irrational that it is extremely difficult to deal with them politely or considerately and therefore he felt they had responsibilities also.

He stated that Washoe Medical Center had around 105 admissions per day and he felt that this requirement to make each patient aware of his or her rights would take at least two additional people on the staff and would be expensive. He said that he felt that way becuase he did not feel you could just hand them their rights written out and that there would not be questions as to an explanation of those rights. He stated that WMC is trying to cut down on programs now, and he felt this could not be implemented because of that problem.

Discussion followed and Mr. Coulter suggested that the rights be posted in each office or facility publicly. And that he had talked to Jo Powell who is on the board of Washoe Medical Center and she had stated she felt passage of this bill was top priority.

Dr. Sandee stated that if this were to pass, he felt there should be and enforcement provision with it. Otherwise there was no was to make sure it was carried out. He also stated that he would have no objection to the notice being posted instead of given to each patient separately.

Mrs. Wagner stated that she had no objection to having notice posted or some different manner and also would not oppose a responsibility section, though she did not know if it would be in time for the Senate to pass on if they added a major amendment such as that.

Mr. Prengenman commented to the committee that he did not feel posting the rights would be sufficient because people do not go into a hospital in the same manner or under the same conditions that people go into other places that have notices posted to make them aware of other things. This ended formal testimony and there was a short break.

COMMITTEE ACTION:

AB 608: Mr. Sena moved for an Indefinite Postponement. Mr. Ross seconded the motion and it carried.

AB 609: Mr. Ross moved for a Do Pass. Mrs. Hayes seconded the motion and it carried. Mr. Polish and Mr. Sena voted no.

ACR 28: Chairman Barengo introduced into the record a letter from the Nye County Board of County Commissioners which urged passage of this measure. The letter is attached and marked Exhibit J.
Mr. Sena moved for a Do Pass. Mr Polish seconded the motion and it carried. Mr. Ross voted no.

AB 562: Mr. Polish moved for a Amend and Do Pass. Mr. Sena seconded the motion. The exact language of Mr. Breen's amendment will be given to Chairman Barengo. The motion carried with Mr. Ross and Mr. Coulter voting no.

AB 247: Mr. Price presented the proposed amendments which had been agreed upon by both sides to the committee and they are attached and marked Exhibit K. Mr. Ross moved for an Amend and Do Pass. Mr. Sena seconded the motion and it carried.

AB 559: The amendments which were proposed to include, "as provided by law" which was suggested by Mr. Isaeff (see testimony) and the committee decided to amend the bill by deleting on page 2, line 10, the words "in substance".
Mrs. Wagner moved for an Amend and Do Pass. Mr. Ross seconded the motion and it carried with Mr. Sena and Mr. Polish voting no.

AB 580: The committee delayed action on this bill.

SB 151: Mrs. Wagner moved for a Do Pass. Mr. Ross seconded the motion and it carried unanimously.

There being no further business, Mr. Sena moved for adjournment and Chairman Barengo seconded the motion and the meeting was adjourned at 10:30.

Respectfully submitted,

Linda Chandler

Linda Chandler, Secretary

EXHIBIT A

February 16, 1977

At a meeting of the Max C. Fleischmann Foundation today, the following Resolution was adopted:

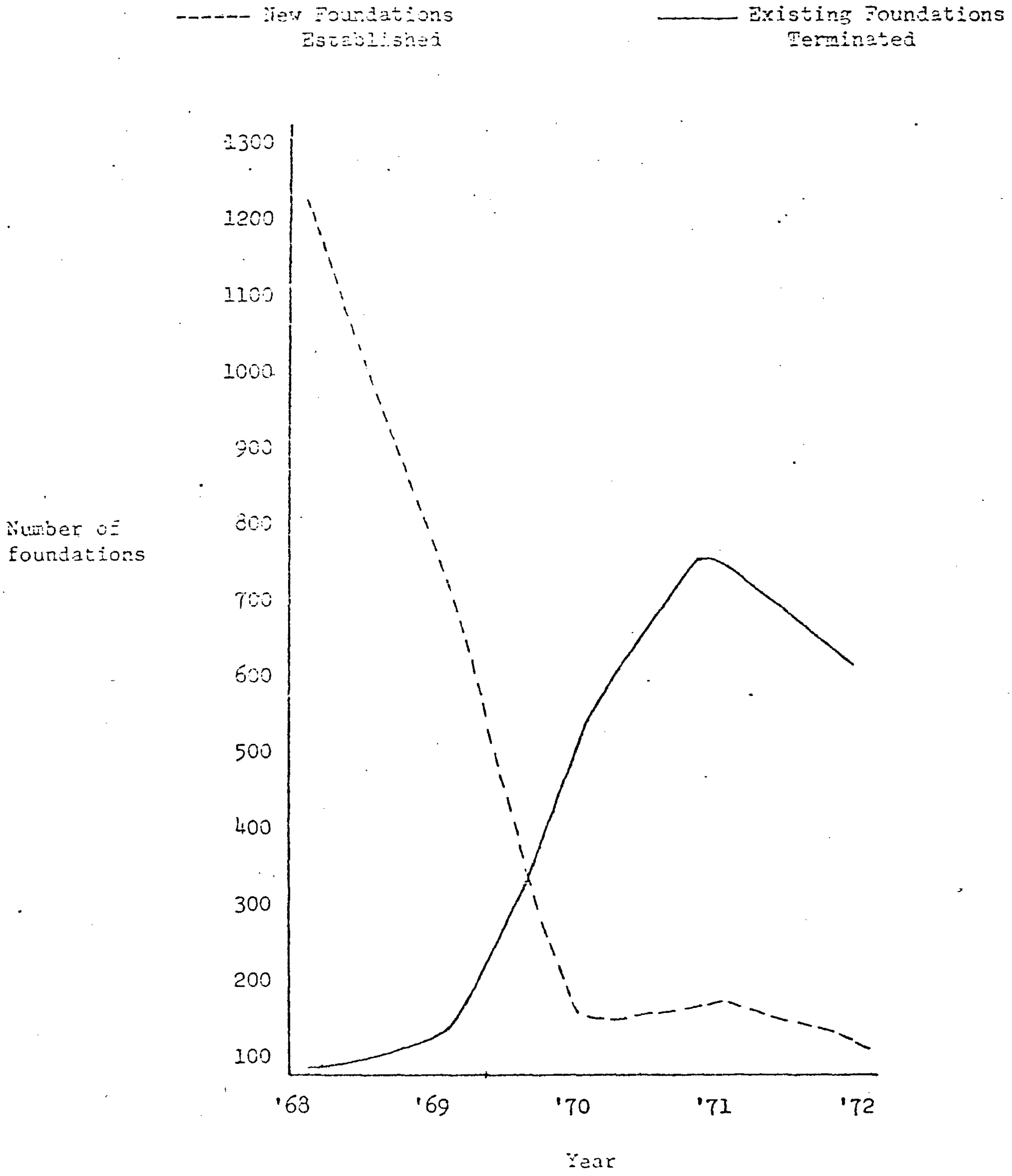
In conformity with Max C. Fleischmann's wishes, as expressed in the trust agreement, the trustees will distribute the Foundation's total assets and terminate its activities by July 4, 1980.

Furthermore, in conformity with what the trustees believe was Major Fleischmann's intent, if any grants are made to grant making organizations such as community foundations, such grants shall not exceed $1,000,000.

EXHIBIT B
(w/attachments)

FIGURE 13

FOUNDATIONS ESTABLISHED/TERMINATED 1968 - 1972
CUMULATIVE OF 12 STATES



From "Analysis of Foundation Center Data on Creation, Dissolution and Reclassification of Private Foundations," Washington, D.C., October 25, 1974, prepared by Caplin & Drysdale and The Foundation Center in Washington, D.C.

~~IRS agents averaged six days on each foundation audit (FIGURE 12) -- an average which excludes several larger foundations, one of which reported that its audit ran for approximately 2-1/2 years and covered records from four fiscal years. IRS audit activity was further tabulated by type of foundation and size (TABLES 6 and 7). On the average, company foundations were audited less often than non-company foundations. Foundations with over $5 million in assets averaged two audits since 1969, while those with less than $5 million averaged one.~~

~~Survey respondents were asked whether the agents auditing them seemed knowledgeable in foundation law and practice and if they made any efforts to influence the direction of the foundation's grant-making activities (EXHIBIT 10). Only 78 of the 489 respondents indicated that the agents did not seem knowledgeable about foundations, and only 21 of 520 respondents indicated that IRS auditors attempted to influence their foundations' grant-making activities, particularly by discouraging scholarship and expenditure responsibility grants. Most foundations, however, found IRS agents to be knowledgeable and reported no efforts to influence programs.~~

10. Birth and death rates: An important Tax Reform Act effect, but still difficult to quantify, is its impact on the creation or birth of new foundations and the termination or death of existing ones. In the spring of 1974, the Senate Finance Subcommittee on Foundations asked the IRS for figures on foundation terminations, the

number of 501(c)(3) organizations created after 1969, and the asset value of foundations formed after the 1969 Tax Act. Although the IRS indicated earlier in the year that its data were not organized in ways to provide answers to the questions, subsequent communication from Commissioner Alexander addressed these matters. 1/ The Commissioner reported that current assets of foundations established since the 1969 Tax Reform Act were some $977 million. On the other hand, organizations classified as private foundations since the 1969 Act and which subsequently terminated their exemption produced the following numbers:

	Terminations	Assets
Operating foundations	43	$ 1,502,768
Non-operating foundations	4,892	83,419,552
	4,935	$84,922,320

Although these death and birth rate data are not directly comparable, the figures might lead one to the conclusion that the ratio of new private foundation dollars to those now lost to the field is quite favorable. Closer inspection of this information indicates that such a conclusion is not justified. The IRS termination figures do not include the many organizations that discontinued operations as a result of the Tax Reform Act of 1969 before they were

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1/ Letter from Commissioner Donald C. Alexander, Internal Revenue Service, to Howard Marlowe of Senator Vance Hartke's Staff, October 2, 1974, reprinted as Appendix C, Hearings Before the Subcommittee on Foundations,on the Role of Private Foundations in Public Broadcasting, September 9 and 10, 1974, at pp. 146-148.

classified as private foundations, nor encompass foundations that have already distributed substantially all of their assets but have not yet filed a final return. At the same time, while the data on foundation termination appear to be considerably understated, the asset holdings of new foundations, conversely, seem much too high.

Our research strongly suggests that IRS birth-rate figures must include many foundations already functioning before the Act took effect, with nothing new about them except that they had to apply for and did receive an IRS exemption letter for the first time after the 1969 Act took effect. Then, too, the IRS figures would include a substantial group of organizations established in nascent and irrevocable form as pre-Act testamentary or living charitable trusts, but which matured and only found their way into IRS exempt organization rolls thereafter. Pre-Act foundations in this category would include, for example, testamentary charitable trusts established by persons dying before the Act's effective date, but funded at the close of the administration of the estate, after the Act took effect. IRS figures on new organizations also do not discriminate between operating and non-operating foundations. Their figures would also apparently include recently formed entities primarily funded by foundation grants, such as the Drug Abuse Council and The Police Foundation.

Data collected by The Foundation Center for purposes of <u>The Foundation Directory</u>, Edition 5, reinforce these reservations.

Even with access to returns of all organizations filing as private foundations in post-TRA years, The Center could identify only about 50 organizations qualifying for Directory size limitations ($1 million in assets or annual charitable expenditures of $500,000 or more) with possible post-TRA creation dates. Assets of these organizations are about $200 million for the year of record, which does not begin to approach the $977 million figure of IRS. 1/ Moreover, a majority of these "new" Directory foundations also appear to fall under the "prior law" or "foundation created" categories described above.

In addition to the foregoing, a more recent analysis of the creations and dissolutions of private foundations in a twelve-state area shows that a very sharp drop occurred in the creation of new foundations from 1968 to 1970, with a levelling off at the new lower level after 1970. 2/ Likewise there was a sharp increase in dissolutions. Although dissolutions were declining by 1972 and the number of creations was remaining fairly constant, the "death-rate" of foundations continued to far exceed the "birth-rate." These trends are in sharp contrast to the situation prior to 1969, which showed 1,228 foundations being established in 1968 as opposed to 71 terminations. In these twelve states in 1972, 128 foundations were established, while 605 foundations were terminated (FIGURE 13).

1/ Because of the size limitations referred to, Edition 5 lists only about 10%, numerically, of all private foundations. However, Directory listed foundations are believed to account for some 80% of all foundation grants and 90% of all foundation assets. It seems patently inconceivable that new but smaller foundations would account for the difference between Center and IRS figures.

2/ "Analysis of Foundation Center Data on Creation, Dissolution and Reclassification of Private Foundations," Washington, D.C., October 25, 1974, prepared by Caplin & Drysdale and The Foundation Center in Washington.

The study just referred to also traced the history of the some 1,300 organizations in existence in 1962 that were surveyed for the 1965 Treasury Report on private foundations. 1/ It was found that 12% of them -- 160 foundations -- are no longer in existence, and that less than 5% had acted to change their status to that of a public charity. In this group, there were twice as many dissolutions (99) during the three years after the 1969 Act became effective as in the previous eight years. Although the study shows that dissolutions were concentrated primarily in smaller foundations, both medium and large foundations also showed an accelerated rate of dissolution after 1969.

The most comprehensive collection of current evidence is that developed by Professor John Simon of Yale Law School in testimony before the Senate Finance Subcommittee on Foundations in October 1973. 2/ Citing 11 different and miscellaneous indicators, 3/ Professor Simon concludes that early returns provide some support for the "grim estimate" that "The bell may well have faintly tolled for the private foundation; it is now to be found only in captivity

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1/ U.S. Congress, Senate, Committee on Finance and House of Representatives, Committee on Ways and Means, Treasury Department Report on Private Foundations (89th Congress, 1st Session, Committee Print, February 2, 1965).

2/ Hearings Before the Subcommittee on Foundations, Committee on Finance, United States Senate, October 1 and 2, 1973, on Private Foundations, p. 174 et. seq. Professor Simon's testimony was also largely reprinted in Foundation News (January/February 1974) pp. 11-18.

3/ These indicators of foundation birth and death rates cited by Professor Simon are reprinted here as EXHIBIT 11.

and there are strong doubts about its ability to reproduce." 1/

One element of the grant-making community has clearly benefited from the heightened death rate of private foundations -- namely, the community foundation sector. As previously noted, a limited survey in early 1973 identified some 20 community foundations that had received assets valued in excess of $60 million from 91 dissolving private foundations since the Act took effect. This flow has continued, and we believe that many other types of public charities have received substantial sums from such terminations. There is also a concurrent birth rate phenomenon. Community foundations currently report less resistance by donors to suggestions that they establish a fund within the community foundation, instead of creating a new foundation.

Thus some of the contributions that would have been made to private foundations before the enactment of the 1969 Tax Reform Act are undoubtedly being given to public charities. That appears to have been the intent in the minds of at least some legislators when the more stringent requirements were imposed for gifts to private foundations in 1969. However, it has not been possible so far to determine whether any major shift-over has occurred, and, as pointed out by John R. Labovitz, the diversion of funding from the private foundations is not necessarily going to benefit the public charities. Charity as a whole may actually receive less funds because donors will be

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1/ Taggart, John Y. "Charitable Deduction." Tax Law Review (November 1970) p. 63.

less willing to contribute without the previous advantages of giving to private foundations. 1/

Birth and death rate trends are also reflected in figures on post-Act gifts to existing foundations. In the Council's basic survey for this report about one-third of the responding foundations received new gifts during their most recent tax year. TABLES 8 and 9 show breakdowns for inter vivos gifts and bequests by foundation asset category. About 21% received inter vivos gifts and about 15% received testamentary gifts; these figures include some 3% that received both. Total new money reported was $161.2 million, with two-thirds derived from bequests.

A comparison of the Council's survey figures with a Treasury estimate of contributions to foundations in 1962 2/ suggests that there has been a significant drop in the proportion of gifts received from living donors. The 1964 Treasury survey of 1,300 organizations reported a total of $833 million of contributions to foundations in 1962. Over half of this total was in the form of gifts from living individuals, while approximately 21% was in the form of bequests. This ratio change suggests the significance of the much less favorable income tax treatment, discussed below, of contributions to private

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1/ Op. cit., p. 102. Labovitz stresses the necessity of analyzing overall giving patterns among donors who gave to private foundations before 1969 -- a topic to be addressed in the Michigan Survey Research Center's study for the Commission.

2/ Treasury Department Report on Private Foundations, op. cit., p. 71.

non-operating foundations. A comparison between the two studies also supports the observation that gifts to foundations have declined in recent years.

Moreover, an indeterminable but substantial portion of these "new" gifts can be presumed to have been made pursuant to estate plans established well before the Tax Reform Act and governed by prior law. The two largest gifts reported, accounting for more than 25% of the gifts, seem clearly of this nature. Nor have existing plans escaped unscathed. As one survey respondent put it in explaining the absence of current contributions --

> In our case....our founder has been unable to contribute one dime because their [sic] annual contributions are far in excess of 20% of their gross income. To avoid drying up we will be forced to limit our grants more or less to annual earned income whereas, in the past, we always paid out much more than we earned because the family channeled its gifts to [the] Foundation.

A prospective donor has many hurdles to jump before he can decide to establish a new private foundation. He must consider administrative burdens, program restrictions, the investment tax, pay-out obligations, and filing requirements. An intangible is the in terrorem effect of the possibility of personal liability for penalty taxes under the self-dealing, jeopardy investment, and taxable expenditure sections of the Code. Donors and their advisors may be reluctant to ask people in whom they have confidence to serve as foundation managers in these circumstances. Beyond these factors, three tax rules specifically relate to and directly discourage the process of creation:

> The primary disincentive is the rule which in effect treats a gift of appreciated property to a private non-operating foundation as if the donor had sold the property and realized a gain, unless the foundation redistributes an equal amount (in addition to other pay-out requirements) within a year.
>
> There is a 50% - 20% differential in the amount that an individual can deduct for cash contributions to a "public charity" as compared with a gift to a private non-operating foundation, coupled with the donor's inability to carry forward excess foundation contributions.
>
> The stock divestiture requirements of the Act's excess business holdings rules, not infrequently acting in concert with foundation pay-out requirements, present considerable problems for potential founders whose nest egg consists of a family business interest.

The first two of these disincentives apply for income tax purposes only, but as Professor Simon's Subcommittee testimony points out, "...most foundation donors want to begin to fund their foundations while they are alive; if they have to wait until death for the foundation to get going, there is a good chance they will not start at all."

The negative effects of the divestiture requirements can also be strong. To abstract briefly what is generally considered the most complex section of the Internal Revenue Code, private foundations are prevented, now and in the future, from receiving a gift of anything but a <u>de minimis</u> part of a donor's control stock unless the combined voting interest of the foundation, the donor, and those related to him (or closely associated with the foundation) is brought below 20% within five years of the gift. Moreover, special liberalizing rules applicable to divestiture of control stock already held by existing private foundations do not apply to new control stock gifts. Gifts of control stock not treated as made prior to May 27, 1969 do not benefit from special accumulated earnings rules encouraging to corporate redemptions, and only a five-year divestiture period is allowed for new gifts, as against 10- to 35-year transition periods for control stock held by foundations on May 26, 1969. 1/

Yet available evidence suggests that control stock is a major source of new foundations of substantial size. Control stock is likely to be appreciated stock. According to the Peterson Commission's Report to the Senate Committee on Finance in October 1969, substantially more than one-half of all foundations in the $10 million and over category have at some time held stock of companies in which the foundation and the donor together owned at least a 20% interest -- precisely the form of asset covered by the Tax Reform Act prohibitions.

1/ The fact that required divestiture is delayed for foundations holding control stock when the Act took effect does not mean these rules have no effect for ten years. IRS Commissioner Donald C. Alexander reported to the Subcommittee on Foundations in June 1974, that about $17 million in 4% excise tax collections during the government's 1972-73 fiscal year were derived from more than $400 million in realized capital gains by ten very large foundations, and he attributed the recognition of these gains to foundations putting themselves in a position to comply with the excess business holding rules.

EXHIBIT C

TELEPHONE: AREA CODE 702
329-9252

MAILING ADDRESS:
P. O. BOX 1871, RENO, NEVADA 89505

MAX C. FLEISHMANN FOUNDATION
SUITE 309, SECURITY NATIONAL BANK OF NEVADA BUILDING
ONE EAST LIBERTY STREET
RENO, NEVADA

April 13, 1977

Mr. Robert Barengo
Chairman of the Assembly Committee
on Judiciary
Nevada State Legislature
Carson City, Nevada 89710

Dear Mr. Barengo:

I understand that a hearing on Assembly Resolution 28 and Assembly Bill 562 will be held before the Committee on Judiciary on Thursday, April 14th. If the above is correct, I would like to make the following statement:

I firmly believe that Major Fleischmann is entitled to have his Foundation terminated as he so clearly specified. In my conversations with him in the 1930's and 1940's, when he was thinking about establishing his Foundation, he stated his belief that each generation can be and should be relied upon to provide for its own needs as they arise in each generation. His clearly stated intent was that all of his assets go to the benefit of the people throughout the United States while some of his appointees and associates were still alive.

Mr. Barengo, I respectfully request that this and the following statements be read to the Committee on Judiciary during the hearing.

Signed:

Julius Bergen

Julius Bergen, Chairman
Max C. Fleischmann Foundation

We, the undersigned trustees of the Max C. Fleischmann Foundation, wish to express opposition to any legislation intended to alter what we believe was Major Fleischmann's intent, as stated in the Trust Agreement, to terminate the Foundation in 1980.

We are proud of the quality and careful procedures followed in arriving at the total of some $80 million in grants we have made. Over 50% have been made directly to grantees in the State of Nevada. Other substantial grants, such as for research, both medical and scientific, indirectly benefited Nevadans.

In termination we expect to make grants with the same care and with the aid and advice of recognized authorities in their fields so that the end result will be in accordance with the donor's directive and with the welfare of Nevadans and the residents of all other states.

Signed: Thomas L. Little
Thomas L. Little

Sessions S. Wheeler
Sessions S. Wheeler

Walter Orr Roberts
Walter Orr Roberts

Trustees, Max C.
Fleischmann Foundation

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REPORT OF THE STUDY OF WAYS OF ENCOURAGING PRIVATE AND COMMUNITY FOUNDATIONS:

LCB BULLETIN NO. 77-21

HTTP://WWW.LEG.STATE.NV.US/LCB/RESEARCH/1977INTERIMREPORTS/BULLETIN77-21.PDF

EXHIBIT E

43 N.E. 92; Schofield v. Wood, 170 Mass. 415, 416, 418, 49 N.E. 636; Shrigley v. Boston Symphony Orchestra, Inc., 287 Mass. 300, 302–303, 191 N.E. 420; Simons v. Murray Realty, Inc., 330 Mass. 194, 196–197, 112 N.E.2d 264; note, 62 Harv. L.Rev. 669, 671.

Exceptions sustained.

FRANKLIN FOUNDATION

v.

ATTORNEY GENERAL and others.

Supreme Judicial Court of Massachusetts.
Suffolk.

Argued Nov. 5, 1959.

Decided Jan. 5, 1960.

Action in equity by foundation against Attorney General, Commonwealth, and city of Boston to implement act providing in effect that portions of fund which had been bequeathed to inhabitants of town of Boston and would be distributable to the city and to Commonwealth on termination of trust shall be paid over to foundation for benefit of institute but that payment shall not be made and trust shall not terminate until decree of Supreme Judicial Court authorizes such payment and termination. Reservation and report was by Williams, J., without decision. The Supreme Judicial Court, Wilkins, C. J., held that although testamentary program for loan of portions of fund to young artificers had ceased all usefulness, charitable objective of testator to make gift at end of 200 years, when trust would terminate, of part of fund to the city and part to Commonwealth, had not become unreasonable under current conditions, and Supreme Judicial Court therefore would not exercise its equitable power to terminate the trust.

Decree in accordance with opinion.

1. Charities 🔑30

In action by foundation against Attorney General, Commonwealth, and city of Boston to implement statute providing in effect that portions of fund which had been bequeathed to inhabitants of Boston and would be distributable to the city and to Commonwealth on termination of trust, shall be paid over to foundation for benefit of institute, but that payment shall not be made and trust shall not terminate until decree of Supreme Judicial Court authorizes such payment and termination, Commonwealth was properly a party. St.1958, c. 596, §§ 1, 2.

2. Charities 🔑30

Purpose of act providing for payment to Franklin Foundation for benefit of Franklin Technical Institute of trust fund bequeathed by Benjamin Franklin to inhabitants of town of Boston was to enable Supreme Judicial Court to make decree respecting termination of trust fund which was distributable in part to Commonwealth and in part to city of Boston. St.1958, c. 596, §§ 1, 2.

3. Appearance 🔑8(3)

In action by foundation against Attorney General, Commonwealth, and city of Boston to implement statute providing in effect that portions of fund which had been bequeathed to inhabitants of town of Boston and would be distributable to the city and to Commonwealth on termination of trust shall be paid over to foundation for benefit of institute, but that payment shall not be made and trust shall not terminate until decree of Supreme Judicial Court authorizes such payment and termination, although answer entitled "answer of Attorney General and Commonwealth", as written, was answer of Attorney General alone, inclusion of Commonwealth in title thereof constituted general appearance. St. 1958, c. 596, §§ 1, 2.

4. Charities 🔑2

Termination of testamentary trust fund established by Pennsylvania citizen and, upon termination, distributable in part to Commonwealth of Massachusetts and in part to city of Boston was matter for determination under Massachusetts law, which was law governing administration of the trust.

5. Charities 🔑36

Under testamentary provisions bequeathing fund to inhabitants of town of Boston to be let out upon interest to young artificers and directing that at end of 100 years, managers of fund should lay out part of fund in public works, and that at end of 200 years, part of fund was for disposition of inhabitants of town and part for disposition of state government, making of loans to young artificers was not sole purpose of trust, but there was a purpose to make gift to city of Boston at centennial and gift to city and Commonwealth at end of 200 years.

6. Charities 🔑30

Although testamentary program for loans to young artificers of money from fund bequeathed to town had ceased all usefulness, charitable objective of testator to make gift at end of 200 years, when trust would terminate, of part of fund to city and part to Commonwealth had not ceased to become unreasonable under current conditions, and Supreme Judicial Court therefore would not exercise its equitable power to terminate the trust. St.1958, c. 596, §§ 1, 2.

7. Charities 🔑30
Trusts 🔑61(3)

If continuance of trust is necessary to carry out material purpose of trust, beneficiaries cannot compel termination of trust, and this principle applies to charitable trusts.

8. Charities 🔑30

Principle that, if continuance of trust is necessary to carry out material purposes of trust, beneficiaries cannot compel its termination, applied to any consent by city of Boston or Commonwealth to alter codicil whereby testator bequeathed fund to inhabitants of town of Boston to be let out upon interest to young artificers, and directed that at end of 100 years, managers of fund should lay out part in public works, and that at end of 200 years, when trust would terminate, part of fund was for disposition of inhabitants of town of Boston and part for disposition of state government. St.1958, c. 596, §§ 1, 2.

9. Trusts 🔑61(1)

Decision whether purposes of a trust had been achieved is a judicial matter, and court alone can make that decision. St. 1958, c. 596, §§ 1, 2.

10. Charities 🔑30

Under statutory provisions to effect that portions of fund, which had been bequeathed to inhabitants of town of Boston and would be distributable to city of Boston and to Commonwealth on termination of trust, shall be paid over to foundation for benefit of institute, but that payment shall not be made and trust shall not terminate until decree of Supreme Judicial Court authorizes such payment and termination, there was no determination that public policy favored termination of the trust, and there was at most an attempt to consent to procedure outlined in the provisions of the statute. St.1958, c. 596, §§ 1, 2.

11. Charities 🔑30

Under testamentary provisions bequeathing fund to inhabitants of town of Boston to be let out upon interest to young artificers, and directing that at end of 100 years, managers of fund should lay out part in public works, and that at end of 200 years, when trust would terminate, part of fund was for disposition of inhabitants of town and part for disposition of state government, although there was no longer any possibility of making loans to artificers, fund would not be turned over to foundation pursuant to statutory provisions for payment of the fund to foundation for benefit of institute. St.1958, c. 596, §§ 1, 2.

12. Charities ⚷36

Under codicil whereby testator substituted for bequest of £2000 for improvement of river, provisions bequeathing £2000 to inhabitants of town of Boston to be let out upon interest to young artificers, directing that at end of 100 years, managers of fund should lay out part in public works, and recommending that river be made completely navigable, entire emphasis was not on benefits of loan plan, but there was shown only preference that sum available at end of 100 years be available in whole or in part as means of improving river, rather than that the £2000 be so available.

13. Charities ⚷30

Where testator bequeathed fund to inhabitants of town of Boston to be let out upon interest to young artificers and directed that at end of 100 years, managers of fund should lay out part in public works, and that at end of 200 years, when trust would terminate, part of fund was for disposition of inhabitants of town and part for disposition of state government, and testator stated in will that he hoped that no part of fund would lie dead or be diverted to other purposes but that eventually there could be loans to artificers in other towns, accumulation of fund was not to cease if such accumulation could not be accomplished by such loans, and fact that trust would not attain amount estimated by testator at end of 200 years did not require present termination of trust.

◆

William H. Kerr, Boston, stated the case.

Noel Morss and Edward W. Raye, Boston, for plaintiff.

Richard H. Gens, Asst. Atty. Gen., for Attorney General.

Before WILKINS, C. J., and SPALDING, WILLIAMS, COUNIHAN and CUTTER, JJ.

WILKINS, Chief Justice.

This bill in equity is described in the briefs as brought "to implement St.1958, c. 596," which is entitled, "An Act providing for the payment to The Franklin Foundation for the benefit of the Franklin Technical Institute of the trust fund bequeathed by Benjamin Franklin to the inhabitants of the town of Boston." The defendants are the Attorney General, the Commonwealth, and the city of Boston "as it is trustee of a fund commonly known as the Franklin Fund, and as it may otherwise be interested in said fund." The Attorney General has filed a document entitled "Answer of the Attorney General and the Commonwealth of Massachusetts," which, as written, is an answer of the Attorney General alone. The city of Boston filed an answer. Both answers in substance admit the allegations of the bill but express various doubts as to the validity of the act. The case has been reported without decision by a single justice upon the bill of complaint and the answers.

Statute 1958, c. 596, § 1, reads, "That portion of the fund bequeathed by Benjamin Franklin to the inhabitants of the town of Boston in trust which is distributable to the commonwealth on termination of the trust shall be paid over to The Franklin Foundation for the maintenance, extension or otherwise for the benefit of the Franklin Technical Institute, and as to said portion said trust shall thereupon terminate; provided, however, that such payment shall not be made and said trust as to said portion shall not terminate unless and until a decree of the supreme judicial court authorizes such payment and termination." Section 2 makes an identical provision for "That portion of the fund * * * which is distributable to the city of Boston on termination of the trust." Section 3 made the provisions of § 2 subject to acceptance by vote of the city council approved by the mayor. Such acceptance and approval were duly given. The market value of the fund on February 28, 1959, was $1,578,098.

Benjamin Franklin, a citizen of Pennsylvania, died on April 17, 1790, leaving a will dated July 17, 1788, and a codicil dated June 23, 1789, which were proved and allowed on April 23, 1790. By the codicil, which is lengthy, he bequeathed £1000 sterling each in trust to the inhabitants of the town of Boston and to the inhabitants of the city of Philadelphia. The history of the bequest to Boston appears in our previous decisions. Higginson v. Turner, 171 Mass. 586, 51 N.E. 172; City of Boston v. Doyle, 184 Mass. 373, 68 N.E. 851; City of Boston v. Curley, 276 Mass. 549, 177 N.E. 557; Franklin Foundation v. City of Boston, 336 Mass. 39, 142 N.E.2d 367.

The £1000 in trust to Boston "shall be managed under the direction of the Select Men, united with the Ministers of the oldest Episcopalian, Congregational and Presbyterian Churches in that Town; who are to let out the same upon Interest at five per Cent per Annum to such young married Artificers, under the Age of twenty five Years, as have served an Apprenticeship in the said Town; and faithfully fulfilled the Duties required in their Indentures, so as to obtain a good moral Character from at least two respectable Citizens, who are willing to become their Sureties in a Bond with the Applicants for the Repayment of the Monies so lent with Interest according to the Terms herein after prescribed." The loans are intended to assist the borrowers in setting up in business, and are to be between £15 and £60. "And as it is presumed that there will always be found in Boston virtuous and benevolent Citizens, willing to bestow a part of their Time in doing good to the arising Generation, by superintending and managing this Institution gratis, it is hoped that no part of the Money will at any time lie dead or be diverted to other purposes, but be continually augmenting by the Interest, in which case there may in time be more than the occasions in Boston shall require, and then some may be spared to the Neighboring or other Towns in the said State of Massachusetts who may desire to have it, such Towns engaging to pay punctually the Interest and the Portions of the principal annually to the Inhabitants of the Town of Boston. If this Plan is executed and succeeds as projected without interruption for one hundred Years, the Sum will then be one hundred and thirty one Thousand Pounds," of which the managers are then to lay out £100,000 in public works. "The remaining thirty one thousand Pounds, I would have continued to be let out on Interest in the manner above directed for another hundred Years, as I hope it will have been found that the Institution has had a good effect on the conduct of Youth, and been of Service to many worthy Characters and useful Citizens. At the end of the second Term, if no unfortunate accident has prevented the operation, the Sum will be Four Millions and sixty one Thousand Pounds Sterling; of which I leave one Million sixty one Thousand Pounds to the Disposition of the Inhabitants of the Town of Boston and Three Millions to the Disposition of the Government of the State, not presuming to carry my Views farther." "I have perhaps too much flattered myself with a vain Fancy, that these Dispositions, if carried into execution, will be continued without interruption, and have the Effects proposed * * * I think that tho' unforeseen Difficulties may arise, expedients will be found to remove them, and the Scheme be found practicable * * *."

At a town meeting on May 25, 1790, Boston accepted the bequest, and in March, 1791, received $4,444.44 from the executors. The managers met on April 8, and the first loans to artificers were made on or about May 3, 1791. Until February 23, 1822, when Boston became a city, the selectmen and ministers designated in the codicil managed the fund. From then until 1902 the aldermen or mayor and aldermen acted with the ministers as managers. Following the decision in 1904 in City of Boston v. Doyle, 184 Mass. 373, 68 N.E. 851, the management of the fund has been in the ministers and in the mayor and eight other persons appointed by the Supreme Judicial Court for the county of Suffolk. By St. 1908, c. 569, the managers were incorporated as the plaintiff corporation and empowered to manage what is now called Franklin Technical Institute.

For the first few years of the operation of the fund substantially all of it was kept loaned to artificers. Thereafter until 1811 the number of properly qualified applicants progressively decreased. By 1836 less than six per cent of the fund was so employed, and by 1866 less than one per cent. No loans have been made since 1886. This situation has been brought about by difficulty in finding sureties, changes in economic conditions, and decline in the number of articled apprentices.

From about 1819 the managers invested that part of the fund not used in loans in obligations maturing in not longer than five years. From 1827 to 1931 most of the fund was invested with the Massachusetts Hospital Life Insurance Company. Since 1931 the fund has been invested in diversified securities.

On January 1, 1894, the fund was $431,395.70. On January 17, 1894, there was paid from the fund to the city treasurer (now collector-treasurer) $329,300.38, as the sum to be laid out at the end of the first hundred years.[1] This money and accumulations of income, aggregating $435,000, were spent in the establishment and equipment of Franklin Union (now Franklin Technical Institute, St.1941, c. 212) along with an equal sum given by Andrew Carnegie. Franklin Foundation v. City of Boston, 336 Mass. 39, 142 N.E.2d 367.

Franklin Technical Institute offers courses in engineering technology leading to a degree and provides training at the post-high school level in industrial technology. Its educational standards are high, and it is recognized as one of the leaders in the technical institute field. Its enrollment has been sharply increasing in recent years. In October, 1958, there were 356 students in the day school and 729 in the night school. Operating revenues are derived from tuitions, endowment income, and gifts. On June 30, 1958, the book value of invested funds managed by the plaintiff for the benefit of the institute was $679,712, consisting of the Carnegie Fund of $502,236, the title to which is in the city, and $177,476 held by the plaintiff in its own name. The institution is currently operating on a balanced budget, but could effectively employ additional funds in strengthening its present services and particularly in enlarging its facilities and staff to serve an increased student body. The need for expanding technical institute education is imperative both in this Commonwealth and in the nation.

It is impossible to employ the fund in loans to the class of persons and upon the terms prescribed by the testator. The plaintiff has considered the possibility of obtaining leave of court to modify these terms, but in the opinion of the plaintiff it is not practicable to employ the fund or any substantial portion in making loans under any modification of the testator's plan which would advance young persons of the general class contemplated by him, or its approximate equivalent or serve any public or charitable purpose, while at the same time providing reasonable assurance of the preservation and increase of the fund.

[1-3] 1. The Commonwealth is properly a party to this suit. In Glickman v. Commonwealth, 244 Mass. 148, 149, 138 N.E. 252, 253, it was said that "the common-

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[1] The fund had not attained £131,000, as expected in the codicil. The amount paid was 100/131 of the principal, or $298,602.04, with interest from July 1, 1891.

wealth cannot be impleaded in its own courts except with its consent, and, when that consent is granted it can be impleaded only in the manner and to the extent expressed in the statute." The statutory reference in that case was to G.L. c. 258, § 1, reading, "The superior court, except as otherwise expressly provided, shall have jurisdiction of all claims at law or in equity against the commonwealth. * * *" An express purpose of St.1958, c. 596, was to enable this court to make a decree respecting the termination of a trust fund which is distributable in part to the Commonwealth and in part to the city of Boston. The Legislature must have contemplated that the Commonwealth could be made a party. The inclusion of the Commonwealth in the title of the answer of the Attorney General constituted a general appearance. The absence of a detailed answer is unimportant. The entry of a proper decree is still the issue in the case. See Publico v. Building Inspector of Quincy, 336 Mass. 152, 153, 142 N.E.2d 767.

[4] 2. The trust was to be administered in this Commonwealth for two hundred years. Termination is largely a matter for determination under the law governing administration of the trust, in this case the law of Massachusetts, which may govern this trust in other respects. See Boston Safe Deposit & Trust Co. v. Alfred University, Mass., 157 N.E.2d 662, and authorities cited. Restatement 2d: Conflict of Laws (Tent. draft No. 5, April 24, 1959), § 298. No question of the possible relevance of Pennsylvania law has been argued. As to this we need make no decision. But see Restatement 2d: Conflict of Laws, § 295, comment a and reporter's note tentative draft, p. 177. Certain cases may be noted in which the law of a State other than that of the domicil of a testator or a settlor has been applied, in determining substantive as well as administrative problems, to a trust in the course of administration in such other State. Amerige v. Attorney General, 324 Mass. 648, 659–660, 88 N.E.2d 126; National Shawmut Bank v. Cumming, 325 Mass. 457, 463–464, 91 N.E.2d 337. See Restatement 2d: Conflict of Laws, § 294, and reporter's note tentative draft, p. 169.

[5, 6] 3. We are of opinion that the record does not disclose facts sufficient to cause us to exercise our authority in equity to terminate the trust. We need not speculate as to any other possibilities not now presented. In stating one ground for our opinion we do not intimate that there may not be other serious objections to the plan projected in St.1958, c. 596. The plaintiff argues as though the making of loans to young artificers was the sole purpose of the testator. We are unable to agree with this contention, as we think that Franklin had another purpose, which was to make a gift to the city at the centennial of the fund, and to the Commonwealth and to the city at the two hundredth anniversary of the fund. In 1891 the money was to be expended on public works, and in 1991[2] the money is to be at the disposition of the State and city government, whether to be expended on public works or other public purposes is beside the point. See Franklin Foundation v. City of Boston, 336 Mass. 39, 45, 142 N.E.2d 367. Franklin estimated what would be the principal sum in one hundred years, and, after deducting £100,000, he estimated what would be the accretion to £31,000 in a second hundred years. He then made an unequal division between the Commonwealth and the city of the estimated fund in 1991. We are not convinced that his charitable objectives have ceased to be in accord with the public interest or have become so unreasonable under current conditions that we should exercise our undoubted equitable power of termination even if the loan program has ceased all usefulness.

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[2] A question as to whether the precise date of termination is to be in 1990 or 1991 does not require a decision at this time.

[7, 8] "If the continuance of the trust is necessary to carry out a material purpose of the trust, the beneficiaries cannot compel its termination." Restatement 2d: Trusts, § 337(2). Rowland v. June, 327 Mass. 455, 458, 99 N.E.2d 283, and cases cited. Gordon v. Gordon, 332 Mass. 193, 196–197, 124 N.E.2d 226; Springfield Safe Deposit & Trust Co. v. Stoop, 326 Mass. 363, 365, 96 N.E.2d 161; Scott, Trusts (2d ed.) § 337. This principle applies to charitable trusts. Scott, Trusts (2d ed.) § 367A. It applies to any consent by the Commonwealth or the city to alter Franklin's codicil.

[9, 10] The decision whether the purposes of the trust have been achieved is a judicial matter. The courts alone can make that decision. That the Legislature so recognized in enacting c. 596, §§ 1, 2, abundantly appears from the provision that "payment shall not be made and said trust * * * shall not terminate unless and until a decree of the supreme judicial court authorizes such payment and termination." We do not accept the plaintiff's argument that there has been a legislative determination that public policy favors termination. At most the Legislature was attempting to give consent to the procedure outlined in c. 596.

[11] 4. Although no present occasion has been shown for termination there need be no sterile accumulation. Notwithstanding the plaintiff's contrary opinion alleged in the bill, some charitable outlet, even with the plaintiff, probably could be found for use of the income until 1991. That there is no possibility of making the loans contemplated by the testator is no reason to hand over to the plaintiff the principal of a fund which under the codicil was never to be given to the managers at any time. Rather than risk an application of the doctrine of cy pres in the courts, where the plaintiff would have to take its chances with other charities, it relies upon a statute the effect of which it seeks to enlarge.

The plaintiff enumerates provisions of the bequest which, it urges, show that "the entire emphasis is, on the benefits of the loan plan, and on that alone, as the purpose of the continuing trust." We shall mention those which merit discussion.

[12] First, it is said that the testator substitutes the bequests to the two cities for a bequest of £2000 in the will for the improvement of the Schuylkill River, understanding that "such a Sum will do but little towards accomplishing such a Work, and that the project is not likely to be undertaken for many Years to come." Later in the codicil, in giving the same directions respecting the disposition and management of the donation to Philadelphia as had been given to Boston, the testator states with respect to the use of the £100,000 to be given at the end of the first hundred years, "I also recommend making the Schuylkill compleatly navigable." All that this shows is a preference for the availability of all or part of £100,000 in one hundred years to £2000 at the time of the gift as a means of improving the Schuylkill.

[13] The plaintiff also refers to the testator's expressed hope that no part of the fund will at any time "lie dead" and that it will not be "diverted to other purposes." It is argued that this must mean "during the continuation of the trust," since he himself diverts the sum to other purposes thereafter. The words of Franklin, fully quoted above, refute this argument. To restate what the codicil says, "it is hoped that no part of the Money will at any time lie dead or be diverted to other purposes, but be continually augmenting by the Interest, in which case there may in time be more than the occasions in Boston shall require, and then some may be spared to the Neighboring or other Towns in the said State of Massachusetts who may desire to have it, such Towns engaging to pay punctually the Interest and the Portions of the principal annually to the Inhabitants of the Town of Boston." We

agree that the reasonable interpretation is that there may be loans to artificers in other towns, but we see an equally dominating intent to accumulate for the gifts of principal in one hundred and two hundred years. We also agree that Franklin did intend that the accumulation should be achieved by the device of making loans to young artificers. But we have been shown nothing to justify the suggestion that he would wish all accumulation to cease if not capable of accomplishment in that way. That the trust will not attain by the date set for termination the principal amount estimated by the testator is unimportant. We observe in the codicil an intent to provide substantial gifts to future generations in the two cities. We shall not defeat that intent by destroying the trust now as to the Commonwealth and the city of Boston.

No useful purpose would be served by analysis of the cases cited by the plaintiff. Franklin's codicil is unique.

5. A final decree is to be entered to the effect that the Commonwealth is properly a party to this suit, and that the trust is not to be terminated under St.1958, c. 596.

So ordered.

EXHIBIT F

RESOLUTIONS IN SUPPORT
OF A.C.R. 28 AND A.B. 562

WHEREAS, The State of Nevada, its political subdivisions, municipal corporations, educational and charitable institutions and organizations have over the years been the fortunate beneficiaries of substantial grants of money from the Max C. Fleischmann Foundation of Nevada for necessary and worthwhile projects which could not have realities without such financial assistance; and

WHEREAS, It is believed that the people of the State of Nevada will further benefit from the continued existence of such foundation; now, therefore, be it

RESOLVED BY THE UNDERSIGNED REGISTERED LOBBYISTS that the Assembly and the Senate adopt A.C.R. 28 and unanimously pass A.B. 562 which would make the foregoing possible.

Steven F. Stucker
Milos Terzich
Fred L. Hillerby
Deborah L. Sheltra
Keith J.
Charles R. Bell
Gene Milligan
Richard G. Pugh
E. L. Newton
E.S.

Denis Peterson
Robert L. Petroni
Shirlee A. Wedow
Jeneane Harter
C. A. Soderblom
Virgil B. Anderson
Marcia Stapleton
Harold J. Jacobsen

Thelma Calhoun

Grant Bushop

Henry [illegible]

Gayle Smookler

Russell W. McDonald

Joyce L Woodhouse

Ruth I Ross

James Shields

Robert E Warren

Richard L Garrett

James A. Joyce

EXHIBIT G
(w/attachments)

Honorable Robert Barengo, Chairman
Judiciary Committee

RE: AB559

I first became aware of the issue of patients' rights when I became a patient. Last summer I had the misfortune to require a rather complicated and serious medical procedure. Upon consulting three doctors in the Reno area I was referred to the University of California Medical Center in San Francisco.

I received on my first visit a statement of my rights as a medical patient... I had not been aware previously that I was entitled to any!

As a concerned and frightened individual, it was extremely comforting to:

1. Be informed of all the alternatives available to me and the risks involved in each.

2. To know how much the procedure would cost.

3. To know who would be involved in the procedure as well as the initial recovery.

4. Most importantly, to be involved in the decisions and to be regarded as a

thinking, feeling human being. This greatly reduced the fear.

Upon my return to Reno, I inquired of the library, etc. if there was any such statement of rights in Nevada. I then contacted Assemblyman Wagner and asked her. On my next trip to San Francisco, I received from the hospital Administration Office a copy of the California Medical Patients' Rights. This is the basis upon which Assemblyman Wagner had AB 559 drawn.

The need for a statute of this nature is not new in Nevada. In 1971 Nevada's Comprehensive Health Planning Agency conducted a study and recommended adoption of a Patients Rights Statement. In a recently completed study Bulletin #77-7 dealing with "Skilled Nursing Facilities" reiterates the need. In 1971 the American Hospital Association issued a "Patients Bill of Rights"... the first article reads "The Patient has a right to considerate and respectful care." I am certain that our excellent Nevada Hospitals subscribe to this policy... however, there seems to be a tendency to not inform the patient.

AB 559 does not ask Nevada doctors and hospitals to make any changes in their procedures. It only asks that they inform their patients that they do have rights and that the doctor/and/or hospital will make every effort to give them some semblance of consideration.

To quote Dr. Arthur Kern, M.D. Author of "Hospitals are No Place for Sick People":

> "My quarrel is with the attitudes, from doctors down to attendants, that the patients in their care — suffering human beings — are no more than bodies in the shop for repairs."

I urge a Do Pass recommendation for AB 559.

Thank you.

Sincerely,
Marjorie I Brewer

April 14, 1977

3104 Demetrius
Las Vegas, Nevada 89101
April 12, 1977

The Hon. Robert Berango
Assemblyman, District 29
Chiarman, Committee on Judiciary
Nevada State Legislature
Carson City, Nevada

Dear Mr. Berango,

May I request that this letter be entered into the record of testimony in support of Assembly Bill 559?

I speak in support of AB 559 both as a registered lobbyist (#77-73) for the "Political Action Committee to Establish a VA Hospital in Las Vegas and a Medical School at UNLV" and personally.

AB 559 "Establishes certain rights of medical patients", which follows a growing national trend to clearly delineate, by statute, the rights people have assumed they posses, but which have, unfortunately, been often forgotten or, worse, conscously subverted, for many reasons. I do not believe we have to debate whether or not the rights of medical patients are being respected, or why. Indeed, toomany cases of disrespect for the rights ofmedical patients exist. The number of medical malpractice lawsuits in our Courts and the skyrocketing cost of medical malpractice insurance prove this.

The language of thei Bill speaks clearly and explicitly to the most often expressed and most viable complaints we in the'Political Action Committee' have heard both from veterans and other residents of this State. This Bill and what it sets forth in its language is long overdue. We think the informed consent clause will decrease the number of complaints from medical patients because they will understand what is happening before it happens. We also think this Bill will serve to refresh the minds of a few medical practitioners who have forgotten the patients rights. Too often, a medical practitioner will be so busy that he, or she, will rush through a patient's treatment and therefore add, unfortunately, to the feeling many patients have that medical practitioners are 'cold' or callous.

The Political Action Committee respectfully urges you to favorable consider AB 559 and to report it out of your Committee "Do Pass".

Please accept my apologies for being unable to appear in person. Thank you.

Respectfully submitted,

Rick Kuhlmey

Rick Kuhlmey

April 11, [redacted]

Judicial Committee
Rob Barengo, Chairman
Legislative Bldg.
Carson City, Nevada 89701

Dear Sirs:

I support Bill #AB559 which deals with the right of medical patients.

There is a definite need for a statement of rights for all of us, I feel. We are all patients or potential patients. With the push for a four year medical school it is especially important.

I urge passage of this bill. Thank you—

Very truly yours,
Lois

April 12, 1977

Mr..Barengo:

This letter is in reference to Assembly Bill No. 559 relating to medical patients and their rights.

I am extremely in favor of everything stated in this new section and strongly recommend that it be added.

So many people just take it for granted that all these things are automatically done for a person when he becomes ill and needs a doctor or hospital. It's only when one has actually required very much medical attention that they can really relate to the articles stated.

I think it's time people didn't have to take a doctor's word as gospel in these matters and that they were able to have more of a say in their own feelings and personal being and to be assured they will receive consideration and respect no matter what their decision may be or their social standing.

People are tired of being left so much in the dark as to their medical rights and made to feel helpless about doing anything about them.

I know I'd feel much better entering a hospital knowing I was guaranteed these rights by law.

Yours very truly,

Mary K. Miller

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A PROFESSIONAL CORPORATION

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ROBERT E. CLARK, J. D.
GLADE L. HALL, J. D.
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RENO, NEVADA 89505
(702) 329-1315

SUITE 205
WINCHESTER PLAZA
1700 EAST DESERT INN ROAD
LAS VEGAS, NEVADA 89109
(702) 734-8191

April 13, 1977

REPLY TO: Reno Office

TO WHOM IT MAY CONCERN:

I have reviewed the provisions of Assembly Bill 559 presently referred to the committee on judiciary. This office has represented numerous doctors concerning matters associated with patient care and patient relations, particularly the malpractice problem, and is also representing several malpractice claimants.

Accordingly, we feel we have a view of both sides of the doctor-patient relationship. Based on this experience, I believe AB 559, as enacted into law, would provide guidelines for both doctors and patients to know what should be expected from this relationship. It would be beneficial to both doctors and patients and may even have the affect of minimizing the medical malpractice problem that our system is presently confronted with.

Accordingly, I would indicate my strong support for passage of this bill.

Very truly yours,

LAUB, CLARK & HALL, LTD.

Glade L Hall

GLADE L. HALL

GLH:mn

Mr. Chairman - Members of the Judiciary Committee

Ex H

EXHIBIT H (w/attachments)

Here Represting myself - speak in favor of this Bill AB 559

Timing - Last Legislature - Patient Rights for Clients at NMHI

- this Legis - Extend Med School to 4 years.
- Now you're considering Patients Rights Bill

Might be interesting to look + see what Hospital Response has been -

UNR Life + Health Science Lib

- Journals - Magazines Dealing with Hospitals Medical Care
- chiefly Publication Hospitals → Journal of Amer. Hos. Assoc → our Leading Hospital Assoc.

AHA in 1972 issued First Patient Bill of Rights - urged all its member hospitals to support + implement it

Summarize since 1968 - 74

First Article → Pub Opinion surveys done by govt, private Polling Organ, Hospitals, Newspapers →

Read 2 quotes
① Respect is First Demand
② High quality Health care is a Right → expectation of all

How have Hospitals Responded since the AHA's 1972 Dec. of Rights

4 Trends have Emerged

① Patient Advocacy Systems

② Information / Feedback Effort

③ Community Involvement

④ Review of Laws Concerning Medical Care

Advocate – Ombudsman

#1 Patient Advocates – Full Time Job
- Complaints, problems, unmet needs
- Estab Relationship with Patient

Aggressively pursued by AHA

Professional Assoc Developing
- Society of Patient Reps
- Lutheran Hospital Grievance Committee

Patient Advocate Recently Named at NMHI

#2 Information / Feedback

Booklets → Hosp, ACLU, Denenberg in PA.
Statements → when you register
~~Also~~
Info Duties → Maine Case

Feed back – Interviews by Volunteers
- Questionairres, Appraisal Forms

#3 Community Involvement →
Patients Rights Workshops

Kings County Hosp in New York City

Make Community aware of whats available before they need it

Hosp had open house + criticism/comment sessions

#4 Medical Care Laws - are being Reviewed
Patient Consent Laws
Malpractice Legis-lation

Summarize →

It appears that From the 1972 Statement of Patient Rights has emerged some of what I consider to be healthy Trends in Medical Care.

Included article About
Mentions one other experiment - Logical Extension of these trends - but in the area of Hospital Services not medical care →
being closely watched - written up in several journals

Guaranteed Services Program at
Blanchard Valley Hospital in Findlay, Ohio

10 years of Malpractice Probs -

Get All Hospital personnel Involved
Set Aside Fund For Reimbursement
Refunding 90% of it.

hospitals

JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION

Volume 49
Number 16
August 16, 1975

Published semimonthly by the American Hospital Association
John Alexander McMahon, president

LABOR RELATIONS

SPECIAL REPORT

PATIENT RELATIONS

DESIGN

CAPITAL CLOSE-UP

AMBULATORY CARE

LABORATORY

FOOD SERVICE

PHARMACY

EDUCATION AND TRAINING

NURSING

REGULAR FEATURES

(Please turn to the following page)

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hospitals

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AMERICAN
HOSPITAL
ASSOCIATION

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John Alexander McMahon, president

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JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION

COMMUNITY RELATIONS

workshop airs patients' rights

A more understanding relationship can be achieved if the hospital is willing to meet and discuss mutual problems with the community it serves

by Andre L. Lee and Godfrey Jacobs

THE CONCEPT of "patients' rights" has been a nebulous and increasingly crucial issue in the complex, chaotic medical care system existing in this country today. Institutionalization of medicine and the possibility of national health insurance have brought us even further down the road of socialized medicine and impersonalization of treatment. "Health care is a right" has become the rallying cry for community-based health-concerned organizations and has presented hospital administrators with the perplexing problem of defining and protecting the rights of patients who utilize their institutions. Thus far, responses to the problem have been seen in the creation of patient health advocates, hospital-based patient grievance committees, and a changing attitude on the part of hospital administrators.

Unfortunately, the patient enters the arena of health care totally unarmed and unaware of his rights. He is quickly faced with the stark reality that he is not alone—no one else knows his rights either. The important question is why it is difficult to recognize these rights and, even more important, what can the hospital do to bring about this recognition.

Kings County Hospital Center is a 2,250-bed municipal hospital located in the heart of Brooklyn. It serves a predominantly black and Puerto Rican indigent population. With a staff of approximately 7,000 employees, 26 clinics (the outpatient department averages 450,000 annual visits), and 3 emergency suites (325,000 annual visits), the hospital experience is representative of attempts to provide service to an aroused community while es-

(LEFT) THE patient has the right to every consideration of his privacy during medical treatment. Those not directly involved with the patient's care must have the patient's permission to be present during examination. (ABOVE, CENTER) The patient has the right to considerate, respectful care. (ABOVE, RIGHT) The hospital should provide the patient with information concerning his continuing health requirements following discharge.

tablishing the concept of patient involvement in hospital operation. As a subsidiary of the New York City Health and Hospitals Corporation, it is required to have a Community Advisory Board. In addition, the hospital maintains an office of public affairs, which works in close association with the board in fostering a working relationship between the hospital and the community.

As a result of this continuing effort, the first "Patients' Rights Workshop" ever conducted in a hospital in New York City was planned and carried out with remarkable success. The National Association of Health Service Executives and the Kings County Hospital Center combined to pull together the resources of Kings County Hospital and the interests of the community. The central theme of the workshop—which is probably a misnomer, for it closely resembled a forum—was to make the community aware of the services available at the hospital, to provide the community with the opportunity to express any opinion or complain about any aspect of the hospital, and, most important, to advise the patient of his rights, even though, to the embarrassment of the hospital, some of the rights would be difficult to observe. A handbook

(Please turn to page 42)

The Authors

Andre L. Lee (left) is acting director of Highland Park (Mich.) General Hospital. At the time that this article was written, he was an administrative resident at Kings County Hospital Center, Brooklyn, N.Y. Mr. Lee received a bachelor's degree from Michigan State University, East Lansing, and a master's degree in hospital administration from Cornell University, Ithaca, N.Y. He is a nominee of the American College of Hospital Administrators and a member of the National Association of Health Service Executives. **Godfrey Jacobs** is director of public relations at Kings County Hospital Center.

statement on a patient's bill of rights

Affirmed by the Board of Trustees, Nov. 17, 1972

The American Hospital Association presents a Patient's Bill of Rights with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, his physician, and the hospital organization. Further, the Association presents these rights in the expectation that they will be supported by the hospital on behalf of its patients, as an integral part of the healing process. It is recognized that a personal relationship between the physician and the patient is essential for the provision of proper medical care. The traditional physician-patient relationship takes on a new dimension when care is rendered within an organizational structure. Legal precedent has established that the institution itself also has a responsibility to the patient. It is in recognition of these factors that these rights are affirmed.

1. The patient has the right to considerate and respectful care.

2. The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his behalf. He has the right to know, by name, the physician responsible for coordinating his care.

3. The patient has the right to receive from his physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedures and/or treatment.

4. The patient has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his action.

5. The patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in his care must have the permission of the patient to be present.

6. The patient has the right to expect that all communications and records pertaining to his care should be treated as confidential.

7. The patient has the right to expect that within its capacity a hospital must make reasonable response to the request of a patient for services. The hospital must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically permissible, a patient may be transferred to another facility only after he has received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer.

8. The patient has the right to obtain information as to any relationship of his hospital to other health care and educational institutions insofar as his care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating him.

9. The patient has the right to be advised if the hospital proposes to engage in or perform human experimentation affecting his care or treatment. The patient has the right to refuse to participate in such research projects.

10. The patient has the right to expect reasonable continuity of care. He has the right to know in advance what appointment times and physicians are available and where. The patient has the right to expect that the hospital will provide a mechanism whereby he is informed by his physician or a delegate of the physician of the patient's continuing health care requirements following discharge.

11. The patient has the right to examine and receive an explanation of his bill regardless of source of payment.

12. The patient has the right to know what hospital rules and regulations apply to his conduct as a patient.

No catalog of rights can guarantee for the patient the kind of treatment he has a right to expect. A hospital has many functions to perform, including the prevention and treatment of disease, the education of both health professionals and patients, and the conduct of clinical research. All these activities must be conducted with an overriding concern for the patient, and, above all, the recognition of his dignity as a human being. Success in achieving this recognition assures success in the defense of the rights of the patient. ■

on patients' rights, modeled after the handbook distributed by the Martin Luther King Neighborhood Health Center, was compiled.

Advance publicity on the workshop went out in the form of press releases to the city news media, leaflets, posters, announcements on black and Spanish-speaking radio stations, and two radio interview shows, one of which was a Spanish program. In addition, letters were sent by the community board to various community organizations. The letters were followed by telephone calls.

The lobby of the hospital's main building was selected for the workshop site because of its adjacence to adult and pediatric emergency treatment areas and because of its reasonable proximity to the outpatient department.

Displays, complete with brochures designed for Medicare/Medicaid, sickle cell anemia and lead poisoning, and the Kings County master plan, were set up. A panel comprised of individuals from within the hospital who made themselves available for answering questions and discussing all areas of health care was selected. Again, the main emphasis was to make the patient cognizant of his rights and of the benefits available to him. To avoid the criticism that the hospital had presented a coached panel or had selected those individuals who would give the establishment point of view, panel members were from various ethnic backgrounds, held no common status within the organizational structure, and varied decidedly in views and speaking ability.

Speakers were limited to a two-minute presentation to allow as much time as possible for questions. The location of the workshop proved to be a valuable asset because the audience changed continually, averaging 150 persons at any one time. Questions proceeded at a lively pace, ranging over a broad spectrum of hospital operation. As anticipated, the questions centered around the following points:

1. There is a long waiting time in outpatient clinics and emergency department.
2. Treatment of patients in overcrowded spaces and in a disrespectful manner seems to occur regularly. Also, respect and an atmosphere of caring are lacking from treatment by physicians and supportive personnel.
3. Ability to pay or the means of payment should not decide how one is to be treated.
4. The community is not aware of the existence of many services offered by the hospital.

There were some accusations of racism, administration inadequacy at all levels, and hospital isolationism. The hospital took the opportunity to determine the patients' ideas on quality and finance. Many of the responses on quality focused not on the methodology of treatment but rather on supportive services, such as ambulance, food, and x-ray. When attendees were asked if they felt money was being spent wisely in the health field, an overwhelming response was affirmative. Any money spent to alleviate human suffering was welcome, although there was some negative feeling about expenditures on research. Research was thought questionable because of the belief that minority groups,

---

patient's rights

A patients' advocate tilts with the British Parliament to protect her association's membership rights to privacy in hospitals

A one-woman lobby in London, Helen Hodgson, manages a Patients' Association and researches, clarifies, and defends its 2,000 members' rights under the National Health System. The association's purpose, according to Mrs. Hodgson, is not to undermine the cradle-to-grave care guaranteed by her government and paid for by her fellow citizens, but to make sure patients get what they are entitled to.

Although the National Health System legally provides for the treatment of patients, the necessarily complex and bureaucratic system does not specify the conditions under which patients as people should be cared for. As advocate Hodgson puts it, "We have been trying for years to get legislation introduced and passed in Parliament particularly in municipal hospitals, were being experimented on.

Many panelists took the opportu[illegible]ty to express their views about the [illegible]eration and direction of the hos[illegible]al. This lent legitimacy to the workshop and raised an even more vital point—informing patients of their rights is only a halfway measure; all hospital personnel must become informed of these rights and make an effort to see that they are enforced.

The experience of the workshop and the resultant requests for repeated workshops demonstrated that it was fruitful for patients and hospital alike. Because the hospital took the initial step in establishing communication with the patients it serves without regard to possible exposure to embarrassing questions, it instilled in the community the idea that the hospital has shortcomings that can be resolved only through mutual cooperation. Hostility was evident, but certainly consumer ignorance of the hospital's problems breeds hostility and contempt and, in the long run, only serves to impede progress in the delivery of health care.

It has not been assumed that one patients' rights workshop will redress the ills of years of neglect nor, for that matter, cement a relationship of understanding. It does, however, represent a giant step toward dealing with the problem of community relations directly, no matter how painful. A successful effort requires an administrative staff unafraid to face the problems a potentially vocal community may raise, a medical staff dedicated to the principle of good health care, and more important, a recognition by all that the reality of patients' rights is upon us. ■

---

that protects the patient's right to privacy in our hospitals." She said, "Each time we get close, someone raises a technical objection, the bill fails, a[illegible] we have to start all over again." (It takes o[illegible] one formal objection to remove a bill from t[illegible]ocket in Parliament.)

Discriminatory treatment

Helen Hodgson maintains that private paying patients enjoy amenities and privileges not available to regular NHS patients. She cited the case of a woman who had been denied a private room in a London hospital despite her susceptibility to infection. Mrs. Hodgson explained that, "The law stipulates that private rooms are to be available if medical judgment supports the application." She added, "We are inclined to be skeptical about this refusal because the patient was told she might have a private room if she made up the difference between government allowance and the private fee."

With part-time secretarial assistance, Mrs. Hodgson writes, mimeographs, and distributes newsletters, leaflets, and other publications, including *A Guide to the Rights of a Patient.* Information about organizations concerned with particular diseases and handicaps and prepared notes for speakers who endorse the association's purpose and work are produced in the modest little third-floor office on Gray's Inn Road. Members' annual dues of $5 finance the publishing and the lobbying efforts on their behalf. (Mrs. Hodgson receives no s[illegible] from the association.)

Campaigns against involuntary human experimentation, abandoned children in hospitals, and drug safety have been conducted. If members of the association want to change physicians (a complicated and often frustrating experience in England), Mrs. Hodgson helps out. She also has been known to send copies of complimentary letters from patients to hospital officials.

Official ombudsman

For years, Helen Hodgson has been working for a health services inspector, and she believes the appointment of a commissioner is a step in the right direction. In fact there is widespread belief among hospital and health officials that when a "white paper" is issued soon, a health commissioner will be appointed whose duties include acting as ombudsman for patients.

Whether such an official, because of being on someone's payroll, can be expected to represent the individual patient as effectively as the Patients' Association has attempted to do may be a hypothetical question. However, one can safely assume that Helen Hodgson, who for a decade has conducted her patients' rights crusade, will carry on.—Louis Graff, *Director of Health Sciences Relations, University Hospital, University of Michigan Medical Center, Ann Arbor.* ■

hospitals

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ANNUAL ADMINISTRATIVE REVIEWS

REGULAR FEATURES

(Please turn to the following page)

BPA Member of Business Publications Audit of Circulation, Inc.

Patients' rights

- Patients' rights movement gains momentum
- Hospitals implement patient-representatives programs and services
- Physician-patient relationships merit and receive priority consideration

by I. Donald Snook Jr.

DURING this past year, the nebulous concept of patients' rights came into a clearer focus. It became an identifiable element in the very complex health care system. For the most part, the patient comes into the health care system unarmed and unaware of his rights. During the past year, a variety of forces were at work identifying these rights. The Statement on a Patient's Bill of Rights was affirmed by the Board of Trustees of the American Hospital Association late in 1972.[1] Dissemination of the statement generated a universally positive response. Scores of editorials commenting favorably on the bill appeared across the nation.

Patient representatives

Partially as a recognition of the patients' rights movement, a growing number of United States hospitals began programs to cope with the patients' personal problems and needs.[2] Many of these programs include a patient-grievance mechanism. The American Hospital Association endorsed the concept by organizing a professional society for directors and staff of the patient representative service programs. (The society has more than 200 members from hospitals in 39 states.) The patient representative, or hospital ombudsman, is one of the most demonstrable developments in the movement for patients' rights. Some hospitals and clinics distributed booklets to tell patients what they should expect in the way of courteous and efficient treatment from their staffs.[3]

IN RESPONSE to the patients' rights movement, many hospitals have developed patient-representatives programs to help a patient and his family cope with personal needs and problems. A director of patient services (ABOVE) visits with an elderly patient who considers her an inhouse friend.

A hospital in Montreal reports that the appointment of a patient's advocate, one of the first such appointments in Canada, has proven successful in giving the patient a way to be heard and to obtain redress for the grievances.[4] The patient representatives attempt to visit all newly admitted hospital patients. They explain their role, present information, answer questions, and provide follow-through on personal matters.[5]

There is an indication that nursing also was becoming involved in the patients' rights movement. One article pointed out that the patient-centered revolution was creating new opportunities for nurses to respond with sensitivity as well as efficiency to the needs of the patients they serve.[6] An important element, which was reemphasized in the literature, was the nurse's teaching role.[7] A nurse in the role of a parent-teacher worked successfully at a children's medical center in Texas. As a result of the patients' rights movement, discharge planning was given a new emphasis in one Illinois hospital.[8] In this institution comprehensive discharge planning was a function of an interdisciplinary team approach involving physicians, nurses, and social workers.

Response to community

Hospitals were aggressive in establishing community relations as well as reacting to the sick patients' needs. A large municipal hospital in Brooklyn and an urban hospital in Philadelphia reached out to the community. As a direct result of a New York City hospital's interest and effort, the first Patients' Rights Workshop in that city's history was planned and carried out with remarkable success.[9] Its goal was to make the community aware of the hospital's services and to provide it with a forum to express any opinions or complaints about the hospital and, most important, to advise the patient of his rights. The Philadelphia institution, like many inner-city hospitals, accepted the challenge to involve its community in planning and implementing health care programs.[10] In this particular case, hospital administration responded to a community's request to establish a health center and it involved residents in planning and decisions.

During 1973, action was directed at consumers in general and not only to patients. In Pennsylvania, a Citizens Bill of Hospital Rights directed at the public at large was released in April 1973 by the state insurance commissioner.[11] The statement, the first of its type to be formulated by a government agency, duplicates and, in some cases, elaborates on the Patients' Bill of Rights issued by the AHA. In New York City, a consumers' group in a low-income section won acceptance of a patients' bill of rights by eight medical group practices serving the area.[12] The bill was formulated because the community believed that certain independent group practices were taking advantage of the community's Medicaid residents by ordering unnecessary medical procedures and, in some instances, by providing inadequate services. One of the national consumer groups that turned its attention to the health care field during the year was Public Citizen, Inc., an outgrowth of Ralph Nader's Center for Responsive Law. One of the group's goals is "to provide consumers with an informative action-oriented manual to assist them in conducting their own evaluations of their community hospitals, to upgrade the quality of care, and to improve the consumer accountability of those hospitals."[13]

At the American Hospital Association's House of Delegates meeting in Washington, D.C., the Statement on a Patient's Bill of Rights, which previously had been affirmed by the AHA Board and released to the public media, was presented for House approval. One delegate proposed that the House stay action on the document, since he felt the document was being interpreted by the press as being mandatory policy applying to all hospitals. Another delegate thought that the typical administrator and legal counsel would find the principles in the statement inflammatory. Notwithstanding these objections, the House adopted the statement which had been prepared by its Committee on Health Care for the Disadvantaged.[14] The Catholic Hospital Association expressed its concerns over several planks in the AHA's statement. The CHA was concerned about the specific wording in the bill. The CHA Board of Trustees noted that the AHA Committee had referred to the statement as only a "guideline." The CHA with a concern to the tailoring of language and emphasis for the moral and religious beliefs, and resulting obligations of their constituents, issued its own Guidelines for Patients' Bill of Rights.[15] At the American Medical Association's House of Delegates meeting in June, the physicians took a positive stand. The delegates stated: "That the American Medical Association and the American Hospital Association cooperate in restating the principles which should underlie an appropriate 'bill of rights' for hospital patients which define and distinguish the administrative responsibilities as well as the professional responsibilities and other aspects of proper patient care a patient is entitled to expect and receive in the hospital setting."[16]

Patients' rights legislated

In at least one state, Minnesota, a patients' bill of rights which applied to hospital and nursing home patients was adopted by the legislature and took effect Aug. 1, 1973. Under the law, the eight-point statement must be posted and given to each patient on admission. The law provides, among its eight points, that a patient has the right

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to expect privacy and respect; to know which physician is responsible for coordinating his case; to obtain current information about his diagnosis and treatment, and to expect "reasonable" continuity of care. The Minnesota Hospital Association distributed the document to its members and advised them to develop a statement of patient responsibilities and to appoint patient representatives.[17] Though modeled after the AHA bill, the Minnesota document omits several of AHA's specifics, including the patient's right to refuse medical treatment to the extent permitted by law; to refuse to participate in research projects; and to receive an explanation of his hospital bill. Concerning the bill, a California medical center published a 12-page brochure titled, "What You Should Know About Your Bill." The document is given to all patients admitted to the hospital.

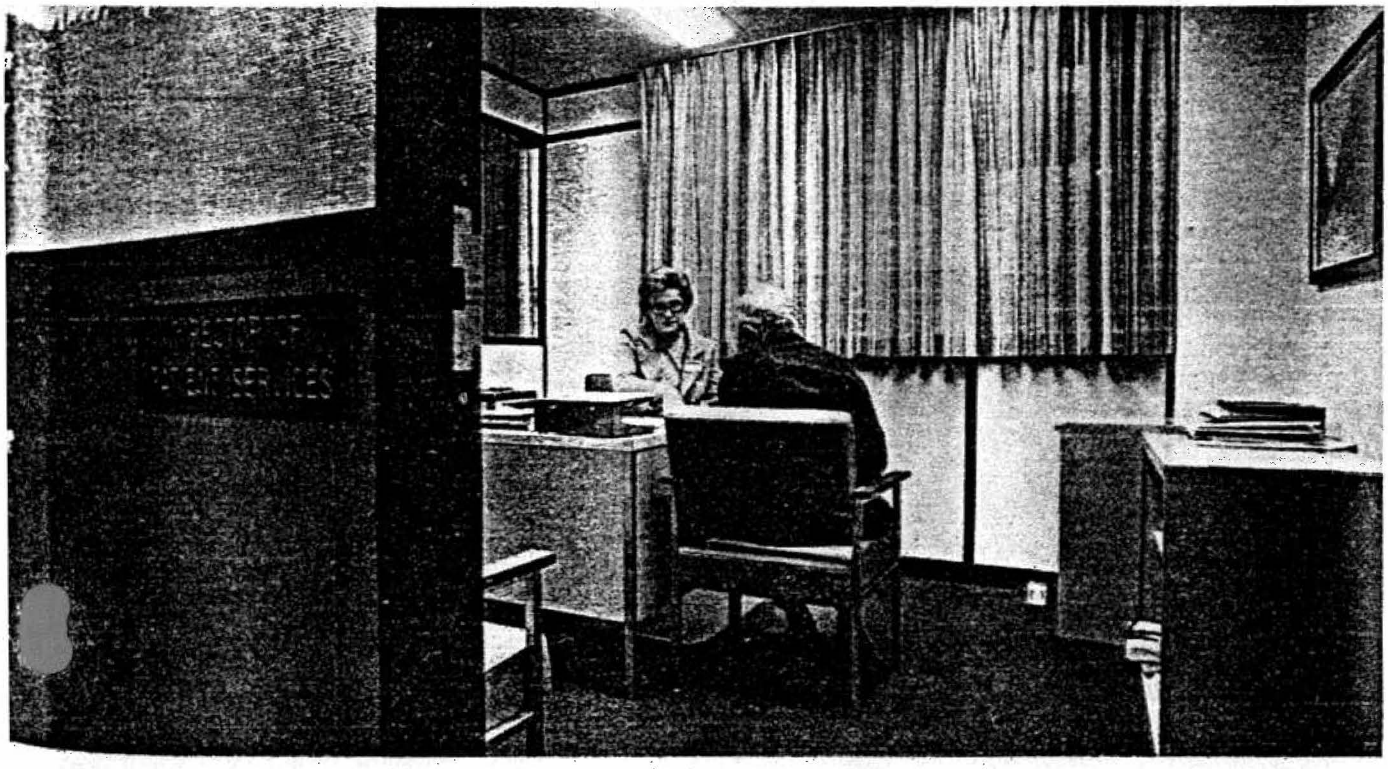
The Secretary's Commission on Medical Malpractice, Department of Health, Education, and Welfare, released its final report late in April 1973. It stated that, "an important aspect of the human dimension of the patient-provider relationship concerns the rights of patients as human beings."[18] Among the commission's recommendations were included: the adoption and distribution of a patient's bill of rights and the development of institutional patient-grievance mechanisms. The commission strongly believes that the rights of all patients should be fully protected.

Legal aspects of rights

An aspect of the law that involves the rights of patients is the right of the patient to an informed consent. In an informative three-part series of articles on consent law, two attorneys discuss informed consent court cases in which the patient has refused treatment, special problems involved in the treatment of juvenile drug abuse, and the performance of abortions.[19] A well known attorney on hospital law cautioned that if a physician fails to tell the patient about the risks involved in treatment, this may be considered negligence.[20] On Jan. 22, 1973, the U.S. Supreme Court ruled on the abortion issue. The ruling invalidated restrictive abortion laws in almost every state. Following the decision, articles appeared discussing the issue. One author asked, "Can someone acting on behalf of an unborn child take action for injury to it?" Another article asked the question whether "we should look at the body in a utilitarian sense or whether we shall attach greater value to it."[22]

Summary and projection

It is clear that the patients' rights issue is still moving ahead on several fronts. Several trends were evident in 1973. The prominent ones included the hospitals' reactions to the AHA's Bill of Rights. These took the form of encouraging consumer participation, informing their patients, and developing patient representative service programs. Another impor-



A DIRECTOR of patient services maintains contact with outpatients and with former inpatients who ask for help in solving personal and economic problems created by their hospitalization and medical needs.

tant trend was seen in the consumers' reactions to the health care system, which were expressed by organized groups in the health care institutions and in governmental agencies. A very significant trend was the issue of patients rights and the legal system. This took the form of the review of patient's consent laws and of identification of the relationship between a hospitalized patient's rights and the problem of malpractice.

✓ It would appear that hospitals will be expanding their efforts to keep patients informed of their rights, of alternatives of treatment, and of other information from time of admission through discharge. More counselors will be made available to patients. Look for an expanded effort by hospitals in the area of patients' grievances. The ombudsman or patient representative will be comprehensively involved. Perhaps in the distant future we can look for a formal and independent process to be established for the arbitration of consumer complaints against hospitals. Because of their utilization of patients in teaching and research, special emphasis will be placed on hospitals affiliated with medical schools.

In the legal arena, during the 1950s and the early 1960s, the issue was charitable immunity. In the middle 1960s, the issue was the judicial application of due-process principles to the hospital-medical staff relationship. In the 1970s it would appear that the concern is with the physician-patient relationship and particularly with the law of consent.

A DIRECTOR of patient services routinely confers with members of the medical staff and with the director of nursing services. In some instances, a director provides information about personal concerns and family relationships that account for a patient's reaction to personnel, procedures, and the hospital regimen and environment. Such information is given and used in strict confidentiality.

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CONSUMER VIEWS

Respect is first demand

Summary of surveys of patients' attitudes toward hospitals shows that their overwhelming concern is a desire to be treated humanly

IN THIS AGE of consum- ism, how do patients feel about eir hospital care and, more pre- sely, what do they think about ospitals?

Recent public opinion surveys eveal that sometimes judgments e made that have little to do ith the quality of care provided. hese may include the availability comfortable chairs for parents ho stay overnight in the pediat- cs department, the type of paint- gs in patient rooms, the brand of ffee served, the quality of tele- ision reception, and the provision newspapers in the hospital lob- y. On other occasions, the hospital ay be rated on the quality of its od, its proximity to patients' omes, and the adequacy of its arking facilities.

Unlike physicians and others ho work there, patients come to e hospital with problems they do [illegible]ant and seek to be rid of [illegible] Most are naive about the ospital environment and often arful or insecure. For these rea- ons, recent surveys demonstrate that the patient treated as a person is likely to perceive his hospital care as good and to view the hospital as a concerned and compassionate source of care that satisfies and helps to heal him. The surveys show that the public has considerable confidence in hospitals and appears to be generally satisfied with the overall medical care it is receiving.

Price secondary

The public, as more recent surveys show, is greatly concerned with availability and quality of care and does not appear nearly as critical as previously with the cost of medical care. While many still say costs are high or very high, consumers are now indicating that their bills are pretty much what they expected. This is an indication that the public is more knowledgeable about inflationary pressures in all parts of the economy and realizes that high-quality health care costs money. If high-quality health care is available, the consumer appears more willing to accept the price, particularly with government and private health insurers picking up more of the tab.

The most frequent complaints relating to availability are long waiting times, difficulty of getting to a physician or a hospital, and difficulty in getting care at night and on weekends.

Americans appear least critical of the quality of care in hospitals. In fact, most of the surveys indicate that a vast majority of those who were recently hospitalized are satisfied with the care they received.

At the same time, surveys show that the consumer is neither stupid nor complacent; he just doesn't want to buy a "pig-in-a-poke." He is looking for personalized care given by skilled, compassionate professionals.

Washington survey

The public's general satisfaction with medical care in at least one locale was disclosed in March 1974 by the *Washington Post,* which published the results of a Washington area study conducted June through August 1973 by the Bureau of Social Science Research, Inc.[1] The study shows that six of every seven local residents are at least "pretty satisfied" with their medical care, and only one in 10 expresses any measure of discontent. The Bureau is a not-for-profit organization involved in collecting and analyzing survey data, particularly on problems in the Washington area.

Interviewed were 1,209 adults in 250 locations selected to provide a representative areawide sample of households. A majority of Washington area suburban residents give their medical services the top mark of "very satisfied."

A sharp difference of opinion occurred when the answers to the question of satisfaction with medical care were broken down by family income. For example, only two of five residents living in the less affluent District of Columbia rate their medical care in the "very satisfied" category.

Sick persons appear least satisfied of all, according to the survey. Three of every 10 persons who said they are in poor health also said they are dissatisfied with care being provided by their physicians. This supports the opinion held by some that persons who are having the most extended contact with the health system are the most apt to be dissatisfied.

The survey data suggest, but do not show conclusively, that residents enrolled in group and prepaid medical plans may be more satisfied than those with private physicians. Slightly more than half of those with private physicians said they are "very satisfied," while that proportion increases to nearly two-thirds for those with group and prepaid health plans. However, only eight per cent of the respondents are enrolled in group and prepaid plans.

Persons in that category may not actually be more satisfied than people with private physicians, the *Washington Post* reported, but they may be at least as satisfied as persons who see private physicians. The survey shows that the least satisfied patients are those who must go directly to busy hospitals or clinics for treatment.

Whatever discontent exists among the poor, the young, and those in poor health, the very high satisfaction with medical care found in nearly every other group surveyed reflects an apparent nationwide feeling of trust and respect for physicians.

Dissatisfied with quality

A 1971 University of Chicago study based on interviews with approximately 3,900 families across the country nearly duplicates the results of the Washington survey.[2] It shows 84 per cent satisfied and only 10 per cent dissatisfied with the quality of their medical care. University of Chicago researchers note that 7 per cent of those queried agree with the statement, "There is a health care crisis in the United States."

"The findings suggest," the Chicago researchers said, "that the individual may tend to believe that his own personal medical care is somewhat better than what the population as a whole is getting."

Individual hospitals are finding an increased need to assess their performance. A private research firm conducted a survey of 300 former inpatients of Bridgeport (Conn.) Hospital who were discharged between Aug. 27 and Sept. 3, 1973.[3] The results are very encouraging. Approximately 90 per cent of those surveyed think that the hospital is very well run and that care and service are either as expected or better than expected. The same percentage said they would come back to the hospital rather than seek another institution.

The survey shows a tendency for attitude toward the hospital to improve as the length of the patient's stay increases. According to Bridgeport Hospital officials, patients appear to judge the hospital on admitting, food, and nursing services. They are concerned with whether their meals are hot enough and if nurses come when called. Excessive waiting time produced bad marks on the hospital survey. Patients do not like to wait more than one hour for any service, particularly when being admitted.

An interesting aspect of the Bridgeport survey is that cost on the whole did not appear to bother those surveyed. Forty-five per cent of the respondents indicated their bill was what they expected. Of those who answered the question, "Did you feel your bill was high or low?" 23 per cent said it was very high, 19 per cent a little high, 43 per cent reasonable, 3 per cent low, and 12 per cent that they didn't know.

A 1970 study on patients discharged from the Medical Center Hospital of Vermont, Burlington, a teaching hospital affiliated with the College of Medicine of the University of Vermont, produced results similar to those in the Bridgeport study.[4]

Of the 300 patients interviewed within a week after discharge between April 23 and June 15, 1970, more than 90 per cent said they had received excellent care and professed themselves well satisfied. Eighty-three per cent said they had been improved by hospitalization, and none said they had been made worse.

Many complaints, however, were received about food, noise, lack of rest, and similar irritants. A disturbing point is that, despite the high level of satisfaction noted by those interviewed, 17 per cent said they will not return to the hospital.

Once again little evidence was found that the cost of hospital care causes undue concern. More than 90 per cent said that they expected all or part of the bill to be covered by insurance—a factor that could explain the attitudes of many patients countrywide regarding their bills.

The Vermont study indicates that the patient perceives himself as more improved by hospitalization when he is less irritated by the admitting procedure, by his room environment, or by lack of information on his illness.

Those who indicated reluctance or refusal to return to the hospital appear to have been negatively influenced by the distance from home, by prior admissions, and by irritation and annoyance with admission procedures or room environment.

The study indicates clearly that respondents are satisfied with their hospital care, consider it humane and personal, and believe that the hospital helped them to learn about illness.

Need for education

Other national and state surveys conducted since 1968 point up the need for public education, the widespread concern about the rising cost of health care, and the lack of availability of health care to many people when they need it. An

An

overwhelming majority of Americans believes that high-quality health care is a right, and the surveys indicate no distinction between the expectations of the rich or poor concerning the kind of care they are entitled to.

A 1971 survey conducted by Louis Harris and Associates for the Blue Cross Association (BCA) shows that most persons apparently know less about health care than they think they know.[5] Based on interviews with 1,609 adults across the nation, the study shows 66 per cent of the respondents believe they are well informed about health care and only 28 per cent believe they don't get enough information. However, when the same persons were asked specific questions about illness and disease, a gap appears between what they say they know and what they actually do know.

For example, 65 per cent said they could recognize the symptoms of the most important illnesses. However, 30 per cent of the total could not identify any of the seven danger signals of cancer, 17 per cent could identify one of the signs, and only 13 per cent could identify four or more. Similarly, only half of the total could volunteer more than one symptom of a heart attack or heart condition, and 27 per cent were unable to identify any such symptoms.

Persons with college and high school educations, those in the 30 to 49 age group, and whites were found by the survey to be the best informed about health. Blacks and those under 30 were found to be the least informed.

Even though most of the persons questioned said they have enough health care information, 56 per cent agreed that more information about medicine and health care is desirable. Forty-one per cent said there is no need for further information.

The study also asked where the respondents get their health information. Physicians were mentioned by 51 per cent but most persons said they have only limited contact with their physicians. Twelve per cent said they never visit a physician's office, and 72 per cent visit fewer than six times a year, most often for specific complaints.

The next most common source of health information is television commercials, followed by medical columns in newspapers, medical sections in magazines, medical news on television, and newspaper and magazine advertising.

Asked which sources they find helpful and which they trust the most for reliable information, the public places physicians and hospitals at the top of the list, along with clinics.

Attitudes of poor

Previously, in 1968, Louis Harris and Associates conducted a survey for the BCA to determine how the health attitudes of the poor differ from those of the nonpoor.[6] That study indicates that poor persons believe they are less healthy than the poor in previous generations, that they are critical of the quality and availability of medical care, and that they are extremely apprehensive about their ability to pay rising medical costs. At the same time, however, their expectations for high-quality care appear to be as high as those of any group of Americans.

The poor not only believe they are less healthy than the rest of America, the survey found, but 51 per cent of poor rural whites interviewed believe their health has actually deteriorated—that they are less healthy than their parents or grandparents. In contrast, 75 per cent of the affluent Americans in the survey reported that their health is better now than it ever was.

Most of the poor in the study are convinced that the reason for deteriorated health is lack of a proper diet. Another reason cited frequently is that proper medical care is difficult to obtain.

When asked where they might turn for help in a health emergency, 54 per cent of the poor said they do not know. Almost 70 per cent of the poverty groups expressed that fear. Despite the much advertised availability of free emergency medical care, 60 per cent expressed doubt that it would be there if they need it.

Louis Harris conducted an independent study in 1971 revealing that an overwhelming majority of Americans are anxious about their ability to obtain proper, comprehensive care at a cost they can afford.[7] The Harris survey also showed that health care issues cut along traditional economic grounds. Those who are most insecure and desperate about the financial squeeze in paying for adequate health care are at the lower end of the income scale.

According to the survey, which covered a cross section of 3,123 households across the nation, 80 per cent of the American public believes that hospitals and medical costs have "risen faster than the cost of living." Nearly nine out of 10 believe that "the cost of prescription drugs is too high." Although 84 per cent of the households reported they are covered by some form of health insurance, 38 per cent believe they would not be adequately covered in the event of a major illness.

Underlying this apprehension about health benefits is the concern, expressed by 74 per cent, that "you are never sure what your health insurance covers until you have to use it." The survey shows that most Americans would be willing to increase their health insurance payments by as much as 50 per cent in order to receive comprehensive coverage.

A 1972 *Life Magazine* survey, to which some 41,000 readers responded, indicates a high degree of satisfaction among Americans with the treatment they received.[8] One-third of the respondents said the medical treatment they received in the preceding year was "excellent." Another one-third called their care "good." Approximately the same percentage said their physician appeared to "care some" or "care a lot" for them personally as patients. Only one reader in 15 called his medical care "poor."

One-third reported that their entire hospital bills were paid by insurance. Four out of five said at least 75 per cent of their bills were covered. Of those who had to pay 50 per cent or more of their bills themselves, one-half rated their medical treatment as fair to poor and said physicians were indifferent or "just doing a job."

A majority of the 41,000 respondents said they favor a plan for national health insurance (NHI) paid for by payroll deductions and administered by the federal government. However, this demand for NHI is tempered by a severe reluctance to have government do it all.

Inpatient care rated good

A 1970 Connecticut Hospital Association (CHA) survey shows that four out of five persons view hospitals favorably.[9] Although the 600 participants in the survey, which was conducted for the CHA by a private research organization, expressed concern about the rising cost of health care, 85 per cent said they believe the cost of care is beyond the control of hospital management. Of that 85 per cent, three out of four identified salaries, personnel problems, equipment costs, and inflation as the major causes of rising health care costs. Even though they related hospital salaries to rising costs, few of them said that hospital personnel are overpaid.

Survey participants rated the quality of inpatient care higher than that of outpatient or of emergency care. The major criticism of inpatient care is the shortage of nursing personnel, while major criticism of outpatient services is waiting time in obtaining care.

About one-third of those surveyed said patients are not as well informed about their medical conditions as they should be. A small percentage said that patients are sufficiently instructed about self-care after discharge.

One-half of the respondents said there are not enough hospitals, and one-fourth said hospitals are inconveniently located. Hospital billing procedures, admitting procedures, collection procedures, and parking also were identified as problems.

The Hospital Council of Northern California sponsored a 1971 survey of a cross section of the population of northern California.[10] The survey indicates that while residents think the cost of hospital care is too expensive, they believe their hospitals are providing high-quality patient care and are well run.

Confusion noted

The survey, however, shows considerable confusion and uncertainty over the public's knowledge of the reasons for hospital costs and what to do about them. Most of those surveyed believe hospital employees are not paid enough. Yet, they also believe that rising labor costs are the chief reason for rising hospital costs. In addition, the majority of respondents believe incorrectly that most of the funds for building and equipping hospitals come from federal and state government.

Sixty-four per cent expressed a good opinion of hospitals. Of those who had been in a hospital recently or had a relative in one, 71 per cent expressed a favorable attitude. The survey also shows that these persons have a better understanding of the factors contributing to hospital costs.

While the majority believe that financing of health care should be turned over to the government, they also believe that the quality of medical care will suffer if this is done.

Finally, a 1972 survey of residents of the Columbus, Ohio, metropolitan area shows that more persons have favorable attitudes about the quality of hospital care in general than they do about the quality of care in the last hospital they were in.[11] The survey, conducted for the Ohio Hospital Association by a graduate class in marketing research at Ohio State University, Columbus, shows a favorable response of 89.2 per cent to the question, "What is your feeling about the overall quality of health care in hospitals?" However, only a 68.5 per cent favorable response came to the question, "What is your feeling about the quality of care in the last hospital you were in."

At least four out of five persons gave "adequate or very adequate" ratings to the quality and safety of equipment used in hospitals, the quality of food served, and the amount of attention given them by the hospital staff.

On the question of hospital costs, nearly 66.4 per cent said they are "high, considering the care you get," 29.8 per cent said they are "reasonable," and 1.4 per cent said they are "low."

Forty-six per cent of the respondents whose last experience with a hospital was in the emergency department said they found the care to be "adequate or poor." ■

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EDITORIAL

AMBULATORY CARE: THE CENTER OF THE SYSTEM

REGULAR FEATURES

(Please turn to the following page)

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responsibilities *

Additional news coverage begins on page 115

▶ **COURT SAYS GUIDELINES USED BY COMMISSION ARE INVALID**—The guidelines used by Maryland's Health Services Cost Review Commission to review hospital rates "are invalid and of no effect," the Baltimore County Circuit Court ruled Feb. 7.

The decision was handed down after 24 hospitals filed suit, challenging the commission's use of the guidelines on all hospitals without formally adopting them as rules.

The court postponed issuing an opinion on the hospitals' challenge to the commission's authority to set specific discounts to be followed by all hospitals for Blue Cross and other third-party payers.

The commission had argued that the guidelines did not have the force of binding rules, but the court held "that the guidelines fall within the definition of 'rule' . and, not having been adopted and promulgated in accordance with the applicable law, are invalid and of no effect."

The guidelines "implement the act which the commission is to administer and specify in great detail procedures for such administration. They directly affect the rights and procedures available to the hospitals whose rates are to be reviewed by the commission. They are not concerned solely with the internal management of the commission," the court said.

It also said that the commission exceeded its statutory mandate through use of "guidelines which attempt to substitute a capital facilities allowance for depreciation."

Harry Reiff Jr., deputy director of the commission staff, said that the ruling "doesn't in any way emasculate the commission and its future." Mr. Reiff said that a meeting was scheduled Feb. 14 to discuss whether to appeal the decision. He added that the commission may go to the legislature for clarification of intent of the law establishing the commission.

The Maryland Hospital Associa[illegible] said that the hospitals involved in the action continue to support the existence of a regulatory commission.

However, it said, the commission "should start from scratch to construct tests of reasonableness that are permitted under the law," adding that failure to do so would be detrimental to the hospitals involved and would result in further legal action. ■

▶ **SERVICE EMPLOYEES STRIKE FIVE KAISER HOSPITALS, 14 CLINICS**—Approximately 4,200 nonprofessional employees went on strike Feb. 3 at five Kaiser foundation hospitals and 14 clinics located in the Greater Los Angeles area.

The strike ended three days later, however, after agreement was reached on a new 26-month contract that will provide the employees with an 11 per cent wage increase the first year, a 10 per cent increase the second year, and improved fringe benefits.

The agreement was negotiated by Kaiser and Local 399 of the Service and Hospital Employees Union, AFL-CIO, which represents the employees. The new contract, retroactive to Feb. 1, 1975, was ratified by the employees on Feb. 6.

A Kaiser representative said that the hospitals and clinics operated at near normal throughout the strike, although some elective admissions were canceled. Exempt and supervisory employees and volunteers helped staff the institution, and arrangements were made prior to the strike to ensure delivery of needed supplies, the representative said. ■

▶ **MAINE HOSPITAL DRAFTS STATEMENT DETAILING RIGHTS, RESPONSIBILITIES OF PATIENTS, PHYSICIANS, HOSPITALS**—The rights and responsibilities of patients, physicians, and hospitals are detailed in a statement adopted by the board of trustees and the medical staff of Maine Medical Center, Portland.

The statement, developed by a committee of trustees, physicians, and volunteers, says that patients have a responsibility (1) to keep appointments; (2) to furnish information about their health and past hospitalizations; (3) to show consideration for other patients, particularly with respect to visitors, smoking, and noise; (4) to indicate if they are unable to understand or to follow instructions relating to their care; and (5) to provide information necessary in determining their ability to pay for services.

Physicians have an obligation (1) to provide patients with sufficient information to allow them to consent to treatment, (2) to inform patients of the need for and the alternatives to any transfer to another institution, (3) to provide reasonable continuity of care, (4) to recommend consultation with other physicians when requested or indicated, (5) to advise patients of any involvement in research projects and of their right to refuse to participate, and (6) to listen and discuss any complaints patients have about their care, according to the statement.

Ensuring a patient's right to competent and considerate care, keeping patient records and communications confidential, making a reasonable response to patient requests for service, and seeing to it that patients have an opportunity to discuss complaints with hospital staff and administration are identified as hospital responsibilities. ■

▶ **"DUAL OPTION" REQUIREMENT OF HMO ACT DETAILED IN PROPOSED REGULATIONS**—Proposed regulations that spell out a provision of the Health Maintenance Organization Act of 1973 (Public Law 93-222) that requires employers to offer an HMO alternative to traditional health insurance coverage were published in the *Federal Register* Feb. 12.

The "dual option" requirement specifies that employers with a quarterly average of at least 25 employees must provide an HMO alternative when there is a qualified HMO available in the locality and when the plan is offered to the employer.

The proposed rules describe employer/employee contributions and the relationship of the dual option to the National Labor Relations Act. The deadline for public comment on the proposed regulations is March 31.

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ADMINISTRATIVE REVIEWS

REGULAR FEATURES

(Please turn to the following page)

1615

Patient relations

by Ruth Ravich

A PATIENT representative (left) participates in a bedside conference with a patient in order to reassure him and, if appropriate, she will share her perception of his attitude and needs with other personnel who may be involved in his care.

- Patient representatives verbalize inarticulate and reluctant consumers' concerns and complaints
- Feedback may pinpoint need to improve or change procedures
- Hospital staff and personnel should be oriented to the role and function of a patient representative

THE PATIENT representative or hospital ombudsman, little known as recently as five years ago, is a rapidly expanding new profession and component in health care services. The position addresses itself to making the hospital experience for inpatients and for those served by ambulatory care facilities more humane and personalized, to having patients feel that hospitals "care as well as cure," and to recommending changes in hospital policies and procedures so that services become more responsive to patient needs. The representative must be a generalist familiar with policies and personnel in all departments of a health care institution, and he must be able to contact staff at any level to obtain needed services. He must develop an overview of the hospital system and, when necessary, he must open communication between departments.

The need for an interface between patients and health care providers is well documented in the literature. Szasz states that "It is not enough that we in the health professions do a technically competent job of healing the patient's body. We must do an equally competent job of safeguarding his dignity and self-esteem."[1] Kosnik says that the health system must become responsive to the total needs of the patient . . . familial, personal and societal."[2] One survey of outpatient and emergency departments showed that "the outstanding finding was the depersonalization shared by all patients who felt they were merely numbers, no longer individuals."[3] A summary of surveys of patients' attitudes about hospitals confirms that their "overwhelming concern is a desire to be treated humanly."[4] This lack of individualization is an outgrowth of the increasing complexity of modern medical technology and our system of medical education also increases this depersonalization, which emphasizes the precision of laboratory tests and X rays over human concerns.

Another development leading to the need for someone to speak on behalf of patients is evidenced by a survey that shows that 53.7 percent of patients interviewed were self or lay referred directly to a specialist.[5] These patients formerly would have relied on their primary physician for information about their care and for an explanation of hospital procedures.[6] Their personal physician also would have interceded for them when they were caught in a bureaucratic system without the power or expertise to disentangle themselves. Patients often are unable to articulate complaints and reluctant to put them on paper. Because it is his primary job, the patient representative can take the time necessary to establish friendly contact. He also is skilled at helping patients express their feelings and concerns.

Feedback, a critical factor

When complaints, problems, and unmet needs are funneled through a central ombudsman's office, data can be collected to pinpoint problem areas and bottlenecks to service. Morgan says that we have not always succeeded in meeting the needs of patients through provision of what is appropriate. She suggests that we must find a way to incorporate feedback into what we are doing for the public and use information to improve or change services.[7] Ravich and Rehr describe a feedback mechanism using patients' problems to recommend change in service delivery. They also discuss the patient representative's ability to open communications within the institution because of free movement among the various departments and observation of the linkages essential to sound care.[8]

The AHA Society of Patient Representatives, which was organized in 1972, has 350 members from hospitals in 41 states, the Panama Canal Zone, and Canada.

Educational meetings for its membership during the past two years have focused on such topics as:

- How to establish a patient representative program
- Fostering change for optimum patient care
- Understanding the hospital system
- Strategies for modifying the system
- Knowledge of prerogatives and procedure of other departments
- Orientation of new staff to patient representative programs
- Good interstaff relationships
- Communication: confrontation vs sensitizing

According to a survey conducted by the AHA, patient representatives serve in every size hospital from the smallest, with 6 beds, to the largest, with more than 1,000 beds. There is a patient representative in 24.4 percent of hospitals reporting; the largest percentage, 45.5, serve in 400-500 bed hospitals. The majority of patient representatives report to an administrator in the institution. However, in some cases, although the patient representative works in the hospital, he reports to a community board.

Networks of health care ombudsmen also are being formed. The ombudsman of Blue Cross-Blue Shield of northeastern New York was appointed to listen to the health needs of the community and channel the consumers' opinions to management. Patient representatives of the Health and Hospital Corporations of St. Louis and of New York City have central offices to which patients may bring their concerns regarding the use of these municipal hospital systems. The value of ombudsmen for nursing homes is being explored in a study developed by the U.S. Department of Health, Education, and Welfare in which ombudsman offices have been established at state and local levels in several states to deal with patient and family complaints in these institutions.[9] When the goals of the institutions and the community are the same, the patient representative who is institutionally based seems quite effective. When confrontation is needed to effect changes, the ombudsman may need to function from a community base.

A valuable resource person

Resistance to the ombudsman, often encountered from medical, nursing, social service, and ancillary personnel, sometimes is based on a concern that the patient representative will take over tasks rightfully assigned elsewhere.[10] Some employees see themselves as the patient's advocate and feel no other should be appointed. Experience already has shown that where the appropriate person is selected, the representative comes to be viewed as a valuable resource person who is knowledgeable about the hospital and the community, and who provides help both to patients and to staff.

The ombudsmen must orient new staff, medical and ancillary, to the goals of their programs. They also must make a continuous assessment of the need for reorientation in areas that present special problems. In addition, representatives should attempt to change staff attitudes by bringing the patient's feelings and perception to the awareness of employees. A very interesting pilot program in staff orientation, "What Makes the Patient Tick?" is described by Rimmer.[11]

The necessity for teaching consumers to use the health care system is particularly important at the present time.[12] Several representatives conduct tours of the hospital facilities to acquaint patients with the physical plant and the services offered. Efforts to familiarize consumers with patient representative programs are made by distributing booklets to ambulatory care patients and by including descriptive material in preadmission kits.[13] Glasser is mentioned as holding an orientation course for

The Author

Ruth Ravich is coordinator of the patient service representative program at the Mount Sinai Medical Center, New York City. Mrs. Ravich received a B.A. degree from Brooklyn College. In 1972-73, she served as the first president of the Society of Patient Representatives, sponsored by the American Hospital Association. She is a consultant to the board of directors and a member of the drug committee of the East Harlem Health Council, and she is a member of the American Public Health Association. Mrs. Ravich also is a member of the National Academy of Sciences committee on biomedical research in the Veterans Administration.

assistants in surgeons' and internists' offices so that they may better prepare their patients for hospitalization.[14]

Volunteers utilized

Most representatives make an effort to speak with as many hospitalized and ambulatory care patients as possible to ask about satisfaction with the care received and assist with problems. In an attempt to add to the number of personal contacts, several programs are experimenting with the use of specially selected and trained volunteers who work under a professional patient representative. This expands the ability of the program to personalize the hospital experience. Volunteers often are able to solve minor problems and to act as a referral source to the patient representative staff for more pressing concerns.[15,16]

The patient representatives also fill many other roles. One representative says that her scope is anywhere and everywhere on her 66-acre medical complex.[17] Some representatives recommend and develop programs to be turned over to other staff when they are operational. However, the representative must try to stay free from rigidly assigned duties that will reduce contact with patients and staff. In this way he can have the overview that points up the gaps to be filled. Among a patient representative's functions in various institutions are patient and health education, liaison with the hospital community to open access to health services, conducting tours of facilities, providing information about resources outside the institution, providing language banks for non-English-speaking patients, and linking elderly patients who are being discharged from the hospital, with telephone reassurance programs.[18]

The President's Commission on Medical Malpractice, U.S. Department of Health, Education, and Welfare, recommended that all hospitals establish effective patient-grievance mechanisms, and urged the Secretary to make such programs a prerequisite of Medicare and Medicaid payments. In many hospitals, this recommendation could lead to appointment of a patient representative who can function as an advocate for the patient without being an adversary to the system. Annas and Healey state that hospitals should adopt a patient rights advocacy system and that hospitals considering such a system "should recognize not only the public relations value of such a move, but also, from the perspective of resolving doctor-patient grievances at the hospital rather than in the courts, the legal wisdom as well."[19]

The literature has identified multiple roles for the patient representative. A next step should be evaluation of these functions and their effectiveness in terms of patient and staff satisfaction and of system responsiveness.

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of the patient's right to procreate."

An injunction requiring the state and federal authorities to provide counseling, instructional material, and consent forms in Spanish and to have all written materials, whether in English or Spanish, to be written at a level appropriate to the population served also is sought. ■

Patients' rights chapter added to NY hospital code

The New York State Hospital Code was amended on May 8 by the State Hospital Review and Planning Council to include a patients' rights chapter.

Under the amendment, hospitals are required to "establish written policies regarding the rights of patients and shall develop procedures implementing such policies."

The 15 rights listed in the code include ones:

- to considerate and respectful care,
- to the name of the physician responsible for coordinating care, upon request,
- to the name and function of [illegible] person providing health care services to the patient,
- to refuse treatment, as permitted by law, and to be informed of the medical consequences of the action,
- to refuse to participate in research and that human experimentation be performed only with informed effective consent,
- to examine and receive an explanation of bills, regardless of source of payment,
- to know the hospital rules and regulations that apply to patient conduct, and
- to treatment without discrimination as to race, color, religion, sex, national origin, or source of payment.

The code addition, which became effective May 15, must be available upon hospital admission to each patient or patient's representative and be posted in conspicuous places within hospitals. ■

Medical society proposes [illegible] preservation committees

Maryland's state medical association has recommended that a committee be established at every hospital and nursing home in the state for the purpose of aiding patients' families, physicians, and paramedical personnel in making life and death decisions for totally incompetent patients.

Each Life Preservation Advisory Committee would be composed of an M.D. other than a patient's attending physician, a religious counselor who reflects the spiritual outlook of the institution, a layman, a spiritual adviser chosen by the patient and/or his family, and a member of the patient's family.

The chairman of the medical society committee that drafted the recommendation said that "the optional use of a Life Preservation Advisory Committee does not spread the burden of decision but provides a proper consensus." Although all normal medical procedures must be followed, "extraordinary 'heroic' treatment should be avoided if it is recognized as hopeless and detrimental to the patient and the patient's family," the society said. ■

Duncan to head Hill-Burton

MR. DUNCAN

The new director of the Division of Facilities Development in the U.S. Department of Health, Education, and Welfare's Bureau of Health Planning and Resources Development is Edgar N. Duncan. Mr. Duncan is former assistant surgeon general in the U.S. Public Health Service Commissioned Corps. He has been with the corps since 1955. ■

BC claims increase in WI; inpatient stays decrease

According to Blue Cross of Wisconsin, Milwaukee, although the average length of inpatient hospital stays decreased in the state during 1974, claims were 17.7 percent higher than they were in 1973.

The increase was attributed to a growing use of Plan benefits, to a new dental program, and to a rise in the cost of health care.

Blue Cross noted, however, that while the Consumer Price Index rose 12.2 percent during 1974, average daily hospital charges in the state rose 10.4 percent. A voluntary rate review program instituted by Wisconsin hospitals and the Plan was cited as a factor in containing charges. ■

Surgical demand can be met by specialists, study says

Although surgery is being performed in the United States by 94,000 physicians, this country's surgical demands can be managed adequately by the 52,000 board certified surgeons and the 12,000 surgical interns and residents, according to findings of the "Study on Surgical Services for the United States" (SOSSUS).

The information, released in late June, is based on research begun in 1970 that involved 10 committees of surgeons from university and community hospitals who studied 10 aspects of surgical services.

According to the study, stricter hospital regulation for granting surgical privileges is the only way to solve the problem of physicians performing surgery without suitable credentials or training.

In addition to stricter hospital credentialing, SOSSUS also said manpower standards for surgery should be strengthened by "continuous monitoring and control of residency output and board certification," and "periodic reassessments of fitness, performance, and competence."

It said the term "surgeon," should be strictly defined to include board certified and board qualified persons or those older persons who have demonstrated long service as effective surgical specialists.

Surgical specialties, like most medical specialties, tend to be heavily concentrated in urban areas, and, furthermore, there is a close correlation between distribution of surgeons and availability of hospital beds and other facilities, regardless of the area, the study said.

The report was unable to identify large or small areas of the United States that are significantly undersupplied with personnel qualified to perform surgical procedures.

The three-volume study, to be published by the U.S. Government Printing Office, was coordinated

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Sometimes a local church has some land available, and is willing to get behind a community garden. That happened in Appleton, Wisconsin, where a Catholic priest, Father Wilbert Staudenmaier, made 259 plots available to families for just $5 each. And 90 percent of the work was done for them by a local farmer, who plowed and prepared the field and cultivated several times during the summer.

Many cities and towns are now including gardening projects as part of their regular recreational programs. Syracuse, N.Y. and Baltimore, Md., have started "Adopt-A-Lot" programs that eliminate unsightly, littered lots while feeding people at the same time. In Syracuse, gardeners can select a site from a "list of lonely lots." Then the city cleans up the lot, plows the soil and marks off individual plots.

"People made the program work, people as unique as each part of town and each adopted lot," says Roberta Wieloszynski, coordinator of the Syracuse project. "Senior citizens and school children, mothers and fathers, students, community groups and neighbors raked and planted and got to know each other. Old-fashioned neighborliness cropped up on every lot."

In Boston, where plots in Fenway Gardens have been made available to citizens since 1942, a park department spokesman says, "A lot of people never would get out of the house without these plots. I imagine the commissioners would like to redevelop the area but what a hue and cry there would be if we tried to take away these gardens."

Banks, service clubs and local industry are also getting into the act by sponsoring community gardens. Some provide land, while others put up cash to cover the administrative costs of preparing and maintaining the site. It's good public relations. Other companies get into gardening as a fringe benefit for their workers. RCA David Sarnoff Research Center in Princeton, N.J.; Dow Chemical Co. of Midland, Mich.; and Lederle Labs of Pearl River, N.Y., are just a few of the firms with gardens where employees often tend their garden plots during lunch hour.

Here at Rodale Press, employees have been able to rent garden plots for the past two years. More than 15 families participated the first year, and the program was so successful that it has been expanded to include a second garden site. Employees paid just $10 for the opportunity to raise all the fresh vegetables they could eat —and then some. At harvest time, surplus zucchini, lettuce, kale, broccoli, cucumbers and other delicious produce started piling up in offices. Much of it was given away to those who hadn't signed up for plots first time around. This year they'll know better!

So what are you waiting for? Make this the year that you do more than just *read* about the health and nutritional benefits of fresh, organically homegrown fruits and vegetables. Whether you're living in a furnished room or a penthouse, there could be a community garden plot in your future. ☐

Why Must a Hospital Patient Lose His Human Rights?

Today's hospital patient has been deprived of so many of his rights, he could be compared to a prisoner or committed lunatic. That's the conclusion of George J. Annas, director of the Center for Law and Health Sciences at Boston University Law School.

First of all, the patient "almost never comes to the hospital voluntarily," Annas writes in the Fall, 1974 *Civil Liberties Review*. Upon admission, he must sign a number of vaguely-explained forms, then his clothes are taken away, and replaced with a one-piece uniform. The patient is given a plastic wristband with a number written on it, a number that becomes more important than the patient's name, says Annas. Once settled in his room, the patient has no right to privacy. Doctors, nurses, students and aides enter without knocking, and examine and treat the patient without explanation.

Most patients are never allowed to see their own records. "The only legal method by which hospital patients in more than 40 states currently may get to view and copy their medical records is by filing a medical malpractice suit," writes Annas.

Although doctors are legally bound to explain proposed treatments and possible consequences, and to obtain the patient's consent before proceeding, they often just go ahead on their own. As a result, some estimate that as many as two million unnecessary surgical and other procedures are performed in the U.S. each year, Annas points out. Hysterectomies, appendectomies and tonsillectomies head the list.

SUCH *NEEDLESS SURGERY* is most likely to occur in teaching hospitals, which stress education of future doctors rather than patient care. Annas describes an actual incident in one such hospital: "When a student-investigator questioned a resident as to why a particular patient was having a hysterectomy instead of a tubal ligation, for example, he was told: 'We like to do a hysterectomy, it's more of a challenge . . . you know a well-trained chimpanzee can do a tubal ligation . . . and it's good experience for the junior resident . . . good training.'"

Why hasn't more been done to guarantee the rights of hospital patients? For one thing, most patients are too sick to really care, says Annas. Secondly, the average hospital stay is too short for individual patients to organize and assert themselves.

To correct further abuses and make hospitals "more responsive to human needs and human rights," Annas proposes a 23-point Bill of Rights for hospital patients. His twenty-third point would give all patients 24-hour-a-day access to a new breed of health worker called a patient's advocate. It would be the advocate's job to advise the patient and guard his legal rights. ☐

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Why would a community hospital stick its neck out and actually guarantee satisfaction? Here's the inside story.

The Best Hospital Deal Going

Charles Franklin Jenkins

YOU HAVE HEARD Satisfaction Guaranteed Or Your Money Back a million times. But can you imagine a hospital making that offer? No? Well, I couldn't either.

After I was registered and bedded down at Blanchard Valley Hospital, in the town of Findlay, Ohio, I found a large supplemental card in the customary hospital portfolio. It listed the rules and regulations for the institution, covering everything from visiting hours to penalties for pinching nurses. That card said in reasonably large print:

"Blanchard Valley Hospital's and Blanchard Valley Extended Care Facility's Guarantee to Our Patients—

"Although we can't guarantee the results of your medical care, we do guarantee:

"1. That the services you receive will be performed to your satisfaction. This includes your nursing care, your food, the cleanliness of your room, services of all our ancillary departments, and our Emergency Department. In fact, any and all service you receive at Blanchard Valley Hospital or in the Blanchard Valley Extended Care Facility.

"2. If you are not satisfied, the service(s) which do not meet your expectations will not be charged to you, subject to the simple requirements listed in 3A through E below."

At this point, I paused, took in a deep breath, and smugly said to myself, "Here is where they crawl out from under their promises." So I read on, anxious to see how they would do it.

"3. If you are not satisfied with the service(s) you are receiving at Blanchard Valley Hospital or the Blanchard Valley Extended Care Facility, charges for such service(s) will not be billed to you IF:

"A. You advise us within 24 hours of the time service(s) is not rendered to your satisfaction and if, upon investigation, your complaint is found to be justified, the 'no charge' guarantee will be in effect and your account will be credited with an appropriate amount representing the costs of such service(s).

"B. The guarantee stated above does not cover waiting for services in those departments where a more seriously ill patient is treated first.

"C. To be eligible for the 'Guaranteed Services Program' all of your past accounts must be paid in full.

"D. Because of the nature of human illness, we cannot guarantee the results of your medical care nor can we guarantee the services provided by your physician(s) or dentist(s).

"E. Patients wishing to discuss and/or take advantage of the 'Guaranteed Service Program' should call Extension 251. A member of the Administrative Staff is on call 24 hours per day and will contact you immediately upon receiving your call."

The document went on to give other details that satisfied me we were playing with an unmarked deck.

Second Surprise: Fine Food

Since my treatment permitted a regular diet, I was ready for the unappetizing, distasteful stuff hospitals call food. So much so, that on my first day I requested my wife to bring some bananas on her next visit as nutrient insurance. I remembered the nearest thing I'd had to fresh food before was a portion of a lettuce leaf about the size of a one-cent postage stamp tucked under sugar-loaded Jell-O.

Imagine my surprise when an attractive young miss swished through the door passing out menus for the morrow, and I saw fresh orange juice or fresh grapefruit offered for breakfast as well as conventional tomato juice and stewed prunes. There was also a hot cereal, a choice of eggs, hash brown potatoes, and crisp bacon.

Lunch was tempting with hot soup, a choice of two fresh salads, three entrees, three vegetables, a fresh strawberry sundae.

Dinner raised your spirits with a selection from clam chowder, two delightful salads (tossed or cottage cheese), entrees of broiled halibut, roast turkey, with dressing, gravy and cranberry sauce, or grilled liver (real, not fried), with sautéed onions and mashed potatoes, broccoli, garden peas. All of which was topped off with a peach half or baked custard or an apricot dessert.

All meals listed a variety of breads, such as white, whole wheat or rye, and sometimes corn bread for an extra treat. Beverages covered everything but booze—regular coffee, decaffeinated coffee, tea, hot chocolate, whole milk, skim milk.

Judging quality, flavor, portions, service, and whatever other standards you want to consider, a comparable dinner in a commercial restaurant would not leave enough change from a 10-dollar bill for a tip.

After three days of such unexpected splendid fare, I felt compliments to the chef were long overdue.

"When do you suppose it might be convenient to speak to the manager of the food department?" I asked.

"If there is anything wrong, maybe I can help," an employee replied.

"There is nothing wrong," I quickly replied. "The food service is so fantastic, so much better than I had dreamed was possible in a hospital, that I just wanted to tell the manager what a good job was being done."

"It's Mr. Lewandowski. I'll have him get in touch with you."

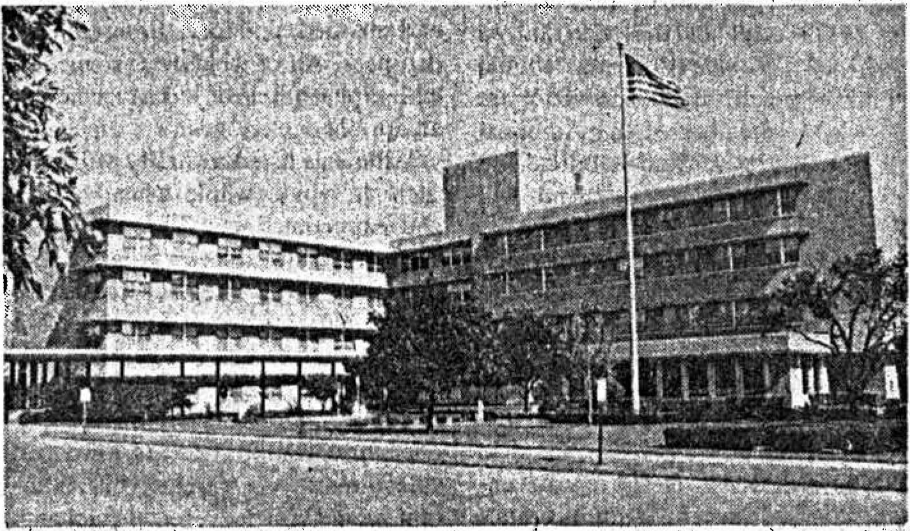
Dick Lewandowski popped into the room later that afternoon. He looked much younger than his extensive experience indicated.

"You must be sort of an odd ball," I greeted him. "You are not serving the customary hospital garbage. How come?"

He grinned shyly. "All we try to do is serve the kind of food we like to eat ourselves."

He frankly admitted that he is not a natural food convert per se, but he does believe fresh fruits and vegetables are our best food items. When he can't get sufficient supplies of those, he reverts reluctantly to frozen fruits and vegetables. One of the few canned items used is beets, because no frozen nor local supply is available.

A small hospital like Blanchard Valley, located in a small rural town in Ohio, is the unlikely setting for a major breakthrough in improving hospital-patient relations.



How Is This Possible?

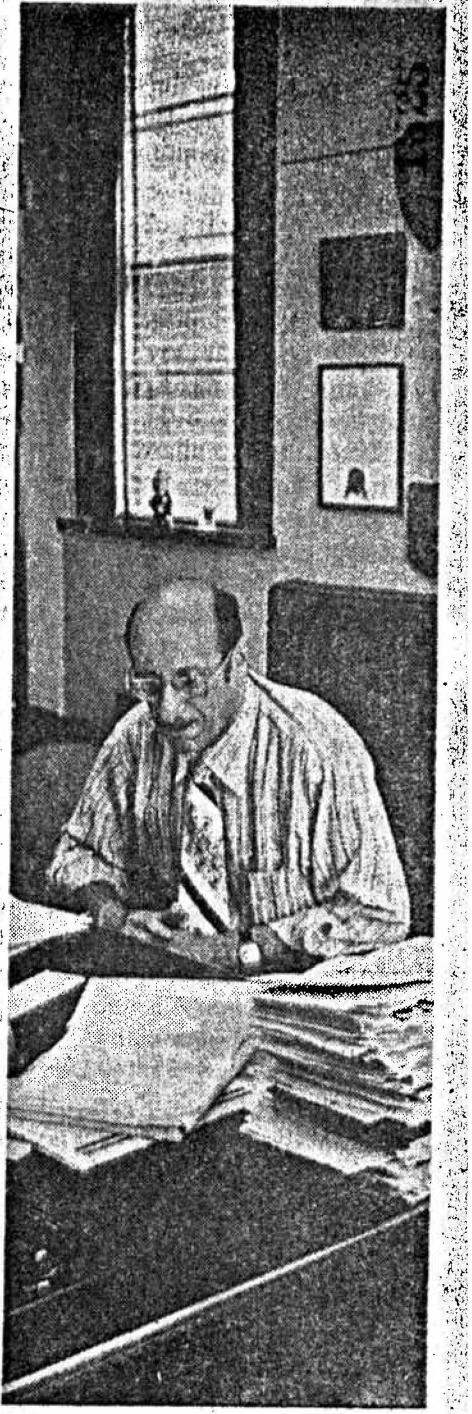
When I checked the idea of guaranteed services by a hospital with B. Dean Cornell, now retired from a lifetime of hospital administration and teaching in the Chicago area, he was amazed to hear that any hospital was daring enough to try such a scheme. Cornell said that few if any patients understand the astronomical costs facing a hospital. Most people think in terms of a 40-hour week, whereas a hospital must plan for 168 hours of salaries, including professionals. Costs are there at all times, busy or slack. On top of all this, most customers, i.e., patients, don't feel good when they arrive and may feel worse later.

Finally he said, "I can't understand why Ruse would stick his neck out like that when he doesn't have to."

So I asked William Ruse, President of Blanchard Valley Hospital, why he stuck his neck out when he didn't have to.

"I'll admit it sounds very strange," he said. "In fact some people may question our thinking process when we guarantee hospital and nursing home services from cradle to grave with no strings attached. A guarantee that says, 'If you are not happy with what we do, you don't pay.'

"We fence the guarantee with a few reasonable statements," he continued. "We can't guarantee the results of your care. Nor can we guarantee the care of your private physician. That's about it though. Unhappy with your meals?—You won't be charged for them. A lumpy mattress caused you to have a restless night?—We simply subtract your room rate for that day. Got stuck with a square



William Ruse is a super-progressive hospital administrator who holds degrees in science, pharmacy, business administration and even law.

needle by the lab technician? O.K., no charge for that lab test. Call for the nurse and she didn't respond rapidly enough? O.K., credit an hour of the nurse's time. If you're delayed longer, we'd better forget about the entire bill for a day."

If my own experience is any criterion, and I believe it is, there will be few if any credits needed for lack of attention. In addition to the usual signal light outside my hall door, Blanchard Valley Hospital has a microphone built into the wall which is activated by a gentle tug of a fish line hanging near each bed. Once you jerk the cord a pleasant voice asks what help might be needed. It is real, no recording. The mike was so sensitive, ordinary conversation carried your message. At no time did I or my roommate wait more than three minutes for someone to pop through the door after a request for help. Trying to find a loose rivet in Blanchard Valley Hospital service armor, I timed nearly every call in the six days there.

Ruse explains that the hospital has a two-fold objective in their radical departure from normal operating procedures.

Turning Patients Back Into People

One is to re-establish personal relations with patients. The "gallbladder" in room 444 must now become Mrs. Jones. The system isolated from patients must be ruptured and retreaded with compassion and human concern.

Psychological apprehension about an impending hospital stay statistically lengthens recovery time. To the extent that this apprehension can be overcome, a patient's visit hopefully can be reduced. They would like patients to think: "Blanchard Valley Hospital guarantees its services, which indicates the hospital must have a lot of confidence in its employees to afford such a guarantee. Therefore, I can expect reasonably good care. And I shouldn't be fearful about the care I receive."

If patients *do* think this way, their length of stay may well be shortened.

Ruse told us that the second objective, and a very important one, is to lessen the possibility of malpractice suits. During the period from 1971 to 1973, Blanchard Valley Hospital was involved in four malpractice suits. Before 1971 the hospital had not been a party litigant in a negligence suit for over 10 years. Investigation showed better communications might have prevented all four. If it had been known at the time of alleged injury that a patient was unhappy, immediate steps could have been taken to alleviate the patient's fears. This in turn could have completely aborted any need for filing a malpractice suit.

"Have these results been achieved?" I asked.

"Who can really tell without reading the mind of each patient dismissed from the hospital or nursing home?" Ruse replied. "We do know, though, since the Guaranteed Services Program was instituted November 1, 1974, that the hospital has not been involved as a party litigant in any malpractice suits. Guaranteed Services permits us to follow up on any expressed patient dissatisfaction. We try to explain why we did what we did or why we failed to do what the patient thought we should do. It is our policy to apologize even if we think a patient is totally wrong in the conclusions reached. Abject denials seldom accomplish their intended purpose regardless of the validity of the grounds upon which the denials have been made. A simple, 'Gee, we're sorry,' lets the patient know that we are human and we're not infallible. That is the philosophy of the Guaranteed Services Program," Ruse declared.

When Guaranteed Services was originally developed, $1,000 per month was budgeted as a possible maximum cost. In meetings with hospital and nursing home employees, the fact was stressed that the program was a tremendous show of confidence the Board of Trustees had in each employee. It was also promised that any amount remaining at the end of the year from the original $12,000 would be given to them as a bonus.

At the end of the first year (October 31, 1975) $11,856.43 remained. Only $143.57 had been requested in credits. A full-time employee's bonus was approximately $28.20.

Other Ways to Make Patients Feel More Secure

Even before the introduction of the Guaranteed Services Program, Ruse says, Blanchard had other patient-oriented programs. The "Aspirin Line" program implemented in 1971 provides a 24-hour service where a patient can reach a member of the administrative staff day or night if the patient has any "headache." A placard which sits at the patient's bedside simply says, "If you have a problem that cannot be resolved by your nurse, please call 'Aspirin Line.' We will try to immediately assist you in resolution of your problem."

Strange "headaches" there have been on "Aspirin Line." One patient called about toilet paper. Wondered if they rolled sandpaper by mistake. One patient due to preach the next day asked to have her sermon typed and duplicated for distribution to the penitents. It was done. One patient expressed a desire for a sauna. A plea for help came from a 67-year-old woman who had been shunted into pediatrics by a Candy Striper. Resulting confusion became so ludicrous and confounding, a full day's credit was issued. And a call came about three a.m. on "Aspirin Line" from a patient with a headache who wanted an aspirin.

Another patient-related program began in 1967. It is called simply the Patient Relations Program. A hospital representative visits patients on the third or fourth day of a hospital stay to ascertain the patient's reaction to the hospital and to explain any policy or procedures not understood by the patient. At this time a patient is interviewed as to his or her feelings about the hospital, its nursing service, food service, cleanliness of the rooms and general impression of the institution.

"With probably a world's record already established for innovations and deviations in hospital management, is there much chance of another idea incubating?" I asked.

Ruse grinned a little and replied:

"Well, we do have one idea for which the answer eludes us. We have people rushing into emergency very excited about an injury which is basically not serious. Perhaps medication and a Band-Aid would suffice. The problem is that the costs of our emergency room and the services of a physician are not necessary in such cases. But how do you gracefully explain that to a patient who believes his wound is nearly fatal without deflating his dignity? We are contemplating an adjacent room to emergency where a nurse, medications, and a basketful of Band-Aids are available. Then we might say, 'You are welcome to the emergency room and the doctor's services for $25, but for a couple of bucks you can have a nurse help you in the next room.' Of course we'll polish the final phase to make it as palatable as possible—if this is the answer."

How the Staff Feels

Not all the staff members at Blanchard are as excited about Guaranteed Services as Ruse.

Several doctors I spoke with believed that the Aspirin Line did as much to help patients as Guaranteed Services. Others doubted that it actually shortened anyone's hospital stay, although things like that are very difficult to prove one way or the other. I got the feeling that some doctors look upon special programs for patients as gimmicks, which are not needed when a first-rate job is done.

Other staff members, though, are genuinely enthusiastic about the Guaranteed Services Program. Dr. Paul Ward says he is certain that it helps increase interest in patients' needs on all floors. This, he suggested, was in contrast to some of the principles he saw in operation during extensive medical service in the military. He is also enthusiastic about Aspirin Line and believes that knowing that someone can be reached when needed increases tranquillity, which in turn contributes to a patient's progress toward regained health.

Rebecca A. Stoner, R.N., is a bundle of energy and efficiency who serves as Assistant Head Nurse at Blanchard Valley Hospital. "I have never been affiliated with nor even heard of another hospital so concerned with consideration for patients and patients' families," she vows enthusiastically. "Do you know," she adds, "that after the hospital management bought the motel across the street for additional office space, they saved several rooms for family members of patients who do not live near here? Those patients are usually here as a result of automobile accidents. They charge only three dollars a night—in this day and age!"

Bill Ruse modestly had not mentioned that. But if you think about it, that little touch shows a lot of human concern.

A lot of things at Blanchard Valley Hospital do. ☐

Editor's Note: *Health professionals who want more details about the Blanchard Valley Hospital plan can write to Mr. William E. Ruse, Administrator, Blanchard Valley Hospital, Findlay, Ohio 45840.*

1627

Cover: Right to treatment has come a long way since Morton Birnbaum's original article on the subject 15 years ago. In our cover story Dr. Jonas Rappaport details this progress made through the *Sea of Red.*

CONTENTS

Spring 1975/Volume 59, Number 2

After more than 50 years as a journal devoted principally to exchange among mental health professionals, **MH (Mental Hygiene)** in 1970 began a transition to become a publication designed for policymakers—both lay and professional—in the mental health field. The Board of Directors believes that other journals now provide effective exchange within professions and among professionals, but no regular publication exists to inform the growing number of citizens faced with major policy decisions involving future care systems and prevention.

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THOSE WHO SPEAK UP

Recent demands for accountability usher in the patient advocacy system as a means for upholding patients' rights

by TERRY MIZRAHI MADISON

Over the last several years many disparate groups have emerged with programs to obtain basic health rights, including changes in the basic organizational and policy-making structure of health services. These include articulate community and consumer groups; sympathetic health provider organizations; a few public officials; and advocate groups. The efforts by health consumers, their allies, and their public representatives to enforce accountability for services to the patient have encompassed a variety of strategies.

One response of health provider groups to this demand for accountability has been to define the scope of patients' rights through statements of principles, the most well known of which is the *American Hospital Association's Bill of Patient Rights.* This is designed to serve only as a guide for hospital use, without any mechanism for implementation or enforcement. A few progressive state legislatures have responded by passing statutes containing comparable bills of rights for patients and residents in health care facilities including, in some cases, nursing homes and mental institutions.

Before examining some of the mechanisms to implement patients' rights that have been established, it is important to understand the narrow and broad definition of such rights. The narrow view of patients' rights is defined within the context of the doctor/patient relationship, usually in an institutional setting. This view generally encompasses a set of treatment expectations aimed at giving the patient more control over that process.

The basic rights include

- the right to be treated with basic dignity and respect;
- the right to decide what is going to happen and why, including the right to consent to or refuse any treatment;
- the right to physical privacy and confidentiality of information; and
- the right to the *whole truth*, including access to medical records.

The broader definition of patients' rights includes a collective set of relationships between a whole range of providers of health care and their institutions and all consumers in a community. It is more concerned with the redistribution of power to control basic health policy decisions and resources, and gives the consumer a more meaningful role, if not complete control, over the type and distribution of health services affecting him, his family and community. Under this broad definition, the term *consumer* is expanded to include bodies of citizens representing the public (taxpayers') interest.

For example, former Pennsylvania Insurance Commissioner Herbert Denenberg's *Citizens Bill of Hospital Rights: What the Patient and Public Can and Should Expect From Our Hospitals* promotes the direct participation and input of the public in the decision-making processes affecting health institutions. In addition to urging that the boards of institutions represent and serve the entire community, he advocates the right of the consumer to

- high quality care and professional standards that are continuously monitored and reviewed;
- economical care and to hospital management that operates efficiently and eliminates unnecessary services, and duplicative and unsafe facilities;
- redress grievances through formal grievance procedures promptly and efficiently; and
- expect the hospital to behave as a consumer advocate rather than as a business headquarters for doctors in hospitals.

Another example of the broader approach to patients' rights is the *Report of the HEW Secretary's Commission on Medical Malpractice*, which explicitly recognizes

- the need for greater consumer control and accountability from hospitals;
- the importance of increased consumer input to medical licensure and professional discipline boards;
- the necessity of establishing state consumer and health affair offices and patients' grievance mechanisms; and
- the need for greater availability of legal assistance to malpractice victims.

Until recently the malpractice lawsuit was virtually the only recourse a patient had against improper medical treatment. As the public has become more sophisticated about medical practice and their rights, there has been an increasing number of malpractice suits, especially from the middle-class consumer. In addition, as a result of recent court decisions that no longer protect a public or private nonprofit hospital from being sued, the scope of litigation has been extended to include a number of law-suits brought on behalf of poor people who use publicly funded or operated health facilities.

However, while litigation remains an important and legitimate vehicle for refining and extending the scope of patients' rights, it is hardly a comprehensive means for improving health care. Generally, malpractice suits are costly, time consuming, and contribute to an unhealthy secrecy and comraderie among doctors and their allies, discouraging doctors from publicly criticizing their colleagues. More importantly, many consumer problems with doctors and health institutions do not fall within definable malpractice areas.

Another vehicle used by consumers to publicize dubious practices of certain physicians and institutions has been the use of the mass media. However, the effectiveness of publicity to expose such abuses is also limited. It it largely dependent on how susceptible the provider-institutions are to public pressures, how flagrant and tangible are the violation of patients' rights, and how persistent the consumer and his advocates are in pursuing the matter.

Given the limitations of the mal-

Ms. Madison is Assistant Professor, School of Social Work, at Virginia Commonwealth University in Richmond.

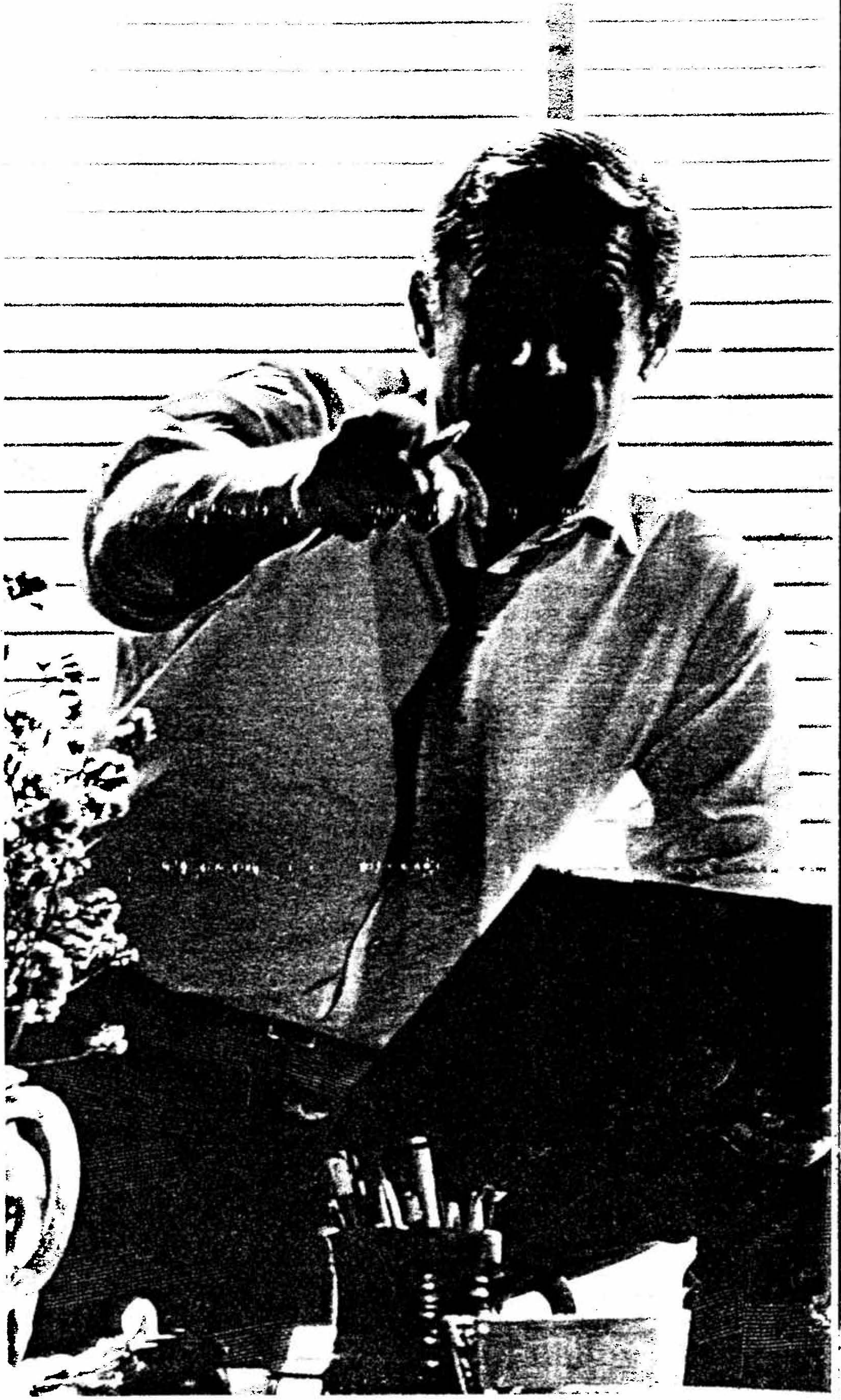
practice suit and the exposé routes to improving the quality of health care in community, the introduction of patient advocacy systems at the health institution and community levels seems to be a logical next step in holding providers accountable for health care policy and service delivery.

Whether patients' rights are viewed from the narrow or broad perspective, it has become apparent that a patient advocacy system can help both to protect the interests of patients when they enter the health system and to serve as a resource and informational link to broader-based consumer and health advocacy groups. Patient advocacy mechanisms have been established in many institutions and communities by groups of citizens and/or progressive provider groups. Most of them include an identifiable patient advocate (who may also be known as patient representative, ombudsman, patient coordinator, community relations officer, or patient liaison).

To date, most of what has been written about patient advocates falls within the narrow view of patients' rights; that is, their role in relation to patients as they enter a specific facility, usually a hospital. For example, a noted *patients' rights* expert George J. Annas sees the patient advocate's primary responsibility as assisting patients in learning about, protecting, and asserting their rights within the health care context. He stresses that the advocate exercises, at the direction of the patient, powers that belong to the patient.

Within this narrow framework of patients' rights, the patient advocate role is usually to

- work with former, current, and potential patients of the particular facility;
- formulate constructive criticism and suggestions for changing service based on patients' complaints;
- insure recipients of service that appropriate action will be taken on their problems, which might include the establishment of a formal processing of grievances; and
- develop a formal relationship with



Advocates help protect the interests of a patient when he enters the health system.

continued

the various health workers at the facility to discuss issues and problems.

Under the broader view of patients' rights, the patient advocate would have the major responsibility for identifying the gaps in health services affecting particular groups of patients or deficiencies in existing institutional services affecting the community as a whole.

In order to function effectively, the patient advocate must be recognized by such groups as hospital boards of trustees, local city health and hospital departments, standard-setting review and planning agencies (such as the Joint Commission on the Accreditation of Hospitals), professional standards review organizations, and comprehensive health planning agencies.

There are some limitations to the patient advocate role. The major one is that patient advocates rarely, if ever, can unleash effective sanction against those who have, in fact, violated patients' rights. In most instances, their tools are limited to moral suasion, tact, education, and persistence. Another extremely sensitive area for patient advocates is their relationship to the health workers. There is always a danger of alienating the consumer from the health worker unnecessarily. Patient advocates must be sensitive to the fact that it may be the lack of adequate staff, a doctor who is late, an unfair distribution of responsibilities, or a crowded appointment calendar that is responsible for long waits and unresponsive services culminating in consumer complaints.

The workers on the line—the clerks, the nurses' aides, the orderlies, the attendants, the paraprofessionals—are often part of an underfinanced and inequitable health system. However, they may take an inordinate amount of blame for what's wrong. Thus, patient advocates need to communicate their understanding of the workers' situation to the workers and, where possible, help them channel their complaints to their union (if one exists), to the administration, or to the trustees.

In this way, some of the antagonism and suspicions of workers toward patient advocates may be lessened. By

SUGGESTED GUIDELINES TO AFFECT STRONGER PATIENT ADVOCACY SYSTEMS

- Given the difficulties inherent in creating a meaningful patient advocacy system, patient advocates should be directly responsible to or part of a community-based consumer group and not identified as an integral part of the institution's staff.
- The patient advocate needs supervised access to all administration and staff in the health facilities. They should be invited to sit in on staff meetings and to participate on those bodies responsible for monitoring quality care, e.g. utilization review committees.
- The presence of patient advocates should be well publicized. They need regular and open access to all patients served by the program, both inside and outside the facility. They should include meetings with patients in the clinic and in the community so that they can observe and analyze their problems and discuss services with them.
- The patient advocate should be allowed to prepare and distribute literature freely, including whatever patients' rights statement is adopted by the institution. There should be designated areas within the facility for the posting of notices. Complaint and suggestion forms should be routinely distributed to patients and community residents.
- The patient advocate should have the authority to investigate and expedite conflicts and follow them through until they are resolved or mediated. It is essential that an administrative mechanism be established to insure that suggestions and criticisms made by patients and consumer advocacy groups be dealt with in an effective manner. This should include a built-in system to allow for abritration of disputes when the administration or provider involved does not respond to the individual patient's grievance or a group demand. Where possible, well-founded complaints should be so handled so as to assure that they need not be repeated in the future, and publicized so people are aware of the outcomes. An ideal arrangement would be the formation of an independent consumer and provider board so that the patient advocate does not have to have the sole authority or responsibility for rectifying a particular problem.
- One of the most important functions of the patient advocate is to encourage consumers to be their own advocates by instilling in them an understanding of their rights as well as obligations to others. The traditional doctor-patient relationship has caused patients to be rather passive and unquestioning participants. This reluctance on the part of patients to formally register complaints or to ask too many questions is particularly prevalent among those who do not speak English or who are overburdened and poor. Thus, the patient advocate may have to use persuasion and tact in encouraging patients to register grievances. In such cases, patient advocates can try to bring several patients with similar problems together and to obtain support for a patient from community groups and the patient's families. Patient advocates can encourage persons with particularly serious grievances to dramatize and publicize them by promising to provide the necessary support and corroborating testimony. To facilitate patient openness, the administration should accept the patient advocate's presentation of facts without requiring the patient's testimony.

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bringing both groups together to discuss those issues on which they can work together, the patient advocate can help health workers and consumers see their common goals toward improving health care delivery. In the long run, it may be the patient advocate's most important role.

Patient advocates should continuously make the linkage between the narrower and broader view of patients' rights. For even in the best of settings, they will not be able to improve the delivery of health services by themselves. Of necessity, they will work with many varying community interests that, at times, will conflict. Any information, statistics, and ideas that they gather can be channeled to concerned groups and individuals for response and action if so desired.

In the meantime, patient advocates can help develop standards for health care, so that patients can better judge the quality of care they are receiving. Examples of moves in this direction are the Consumer Guides to Local Doctors and Hospitals, prepared by consumer and advocate groups in many communities. Patient advocates can also encourage more public participation in the public hearing process required by the Joint Commission on Accreditation of Hospitals at the time it reviews an institution's accreditation.

For those who fear that patient advocates will create unnecessary conflict, it should be noted that one important advantage is their potential ability to temper patient antagonism and to stop dissatisfaction from spreading. By explaining the nature and function of various staff members and the facility itself to the patients, patient advocates can insure a more harmonious relationship between them and the facility. This, in time, can insure more cooperation on the part of both the patient and his family in the treatment process. If further justification is needed, many hospital authorities have recognized that patient advocacy systems are a means of reducing malpractice suits and negative public relations at a time when the demand for accountability is growing.

MH

EXAMPLES OF PATIENT ADVOCATES AND PATIENT ADVOCACY SYSTEMS

Society of Patient Representatives. Formed by a group of hospital-based represenatives of the American Hospital Association, this society includes members who work in more than 350 hospitals. It is developing guidelines for patient representatives and supports the concept of patients' representative as advocates for patients. The society is also willing to work with consumer and other interested groups to establish patient representative systems in local hospitals.

Yale-New Haven Patient Advocates. As a result of a community survey examining patients' treatment in the emergency room and outpatient clinics of the medical center, a group of concerned citizens and professionals got together to establish a central office with a patient advocate to explain procedures and terminology, and to represent the patient in his requests for help on specific problems. Each patient admitted to the hospital is given a bilingual patients' rights handbook and a flier explaining how to contact the patients' assistant.

Lutheran Hospital Grievance Committee. Organizers from the Cleveland Legal Aid Society and low income families and their representatives from the west side of Cleveland founded the committee in 1972. After surveying 300 homes to define the needs of the community, they discovered Lutheran Hospital had no pediatrician on call though the hospital was situated near a housing development. In addition, there were no translators, no follow-up in the emergency room, no transportation, no drug dispensary, and very few bilingual staff. A public meeting with the chief administrator and a few trustees, good publicity from the local news media, and further pressure from the community brought some concrete results: the hospital hired a pediatrician and agreed to set up a grievance committee.

Pittsburgh Free Clinic Patient Advocacy Program. This program grew out of the observation of several free clinics that many of the patients needed help in dealing with the hospitals or health centers to which they were referred. They take a city-wide rather than a one-institution approach to advocacy, emphasizing the discussion of legal rights of patients, developing training sessions for administrators and workers, and reviewing referral information. Advocates operate desks at the various free clinics for immediate problems, collect and disseminate information about different facilities in the area, arrange back-up systems to see if patients are satisfied with the clinic and with referrals, and accompany patients needing hospitalization or other care to a particular institution. Advocates will also speak to community groups.

Consumer Commission on the Accreditation of Health Services. The commission is trying to gather facts on the quality and high cost of health services. The major emphasis has been on the New York City hospitals, where they have been helping community groups get involved in hospital accreditation procedures. They have focused on pressing hospital boards of trustees to become more representative of the communities they serve. They also are beginning to rate area hospital services and identify the deficiencies and superiorities of each institution.

McCall's

JULY 1975 The Magazine for Suburban Women VOL. CII NO. 10

ARTICLES

FICTION

RIGHT NOW

BEAUTY

FASHION

HOME MANAGEMENT AND DECORATING

FOOD

FEATURES

Cover Photograph by Tom Wargacki

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BY WILLIAM A. NOLEN, M.D.

WHAT YOUR DOCTOR OWES YOU

Doctors love to talk about their practices. Listen in at any gathering of physicians, and all you'll hear is discussion of interesting diseases, new medicines, clever operations. Unfortunately, most doctors prefer to talk about medicine only to each other. When it comes to talking to their patients, they're like clams: It's almost impossible to pry a word out of them. Here are three examples from my recent mail:

Helen, a 38-year-old business executive, had a breast lump removed under local anesthesia. Her surgeon was supposed to call her two days later to tell her whether the tissue contained cancer. When she didn't hear from him on Thursday—when the 48 hours were up—she called his office and was told, "The doctor decided to get away for a long weekend. He'll be back on Monday." Helen had to wait three more days to learn that her breast lump was benign.

Jim, a 45-year-old truck driver, went to the hospital by ambulance at nine o'clock one morning, complaining of severe chest pain. His wife, Rose, home with two young children, called the hospital three hours later to find out whether [illegible] had, in fact, had a heart attack. She was told that Jim's doctor was in conference and would call her back later. When she hadn't heard after another two hours, Rose called again and was told that the doctor "must have forgotten to call—better try his office." Almost eight hours after Jim had left in the ambulance, Rose was finally able to reach his doctor. She learned then that Jim *had* had a heart attack and was in the hospital's intensive-care unit.

Louise, 48, went to her doctor complaining of repeated episodes of abdominal discomfort occurring, usually, just after she had eaten. The doctor examined Louise, told her it was probably "either an ulcer or your gallbladder," wrote a prescription and told her to "come back in a couple of weeks if you're still having trouble; then we'll get some X rays." Louise wanted to ask what the pills were for, what sort of diet, if any, she should follow, what kind of X rays might have to be taken, what they would cost, whether her insurance would pay for them. But the doctor disappeared and the nurse ushered Louise out before she had a chance to ask any of these questions.

All three of these patients received [illegible], scientific medical care from [illegible] doctors, and yet every one of them was mistreated. They, and their families, needed and deserved more—and more prompt—information than they got. These patients were all victims of what might be called "the doctor–patient communication gap." This gap, in my opinion, is one of the most serious problems in medicine.

Interestingly, and characteristically, these patients let their doctors get away with the mistreatment. They wrote and complained to me and they probably complained to their friends and relatives, but they never said a word to their doctors. They should have; otherwise, those doctors are going to go right on ignoring their patients' rights.

Let's be candid: Doctors run the world of medicine. We decide who will go to the hospital and who will be treated at home; who will receive what medicine; who will have an operation and who will not. We have all the power.

There are valid reasons for this concentration of power. Someone has to be "captain"; otherwise, medical care would become fragmented and potentially dangerous. Physicians, since they have the necessary education and training, are the logical leaders. We are the ones best suited to take ultimate responsibility for patients' care.

But, as has been said so often, power corrupts, and a bit of corruption has manifested itself in our medical system. Doctors' power as "captains" seems to have blinded some of them to the fact that they are only *part* of the health team and that they owe more than their scientific knowledge to the patients they are supposed to serve. Some doctors have become not just captains and leaders but dictators.

As a reminder to physicians that they are *not* dictators, a "Patient's Bill of Rights" has been proposed by a number of organizations. The American Hospital Association recommends that each hospital adopt one. There is no national law that compels adoption of such a bill, but in Minnesota, where I live, there is a state law that does so. For those of you unfortunate enough to live elsewhere, here is a copy of our Bill of Rights. Each patient who enters the hospital is given a copy.

PATIENT'S BILL OF RIGHTS

1. Every patient and resident shall have the right to considerate and respectful care;

2. Every patient can reasonably expect to obtain from his physician or the resident physician of the facility complete and current information concerning his diagnosis, treatment and prognosis in terms and language the patient can reasonably be expected to understand. In such cases that it is not medically advisable to give such information to the patient, the information may be made available to the appropriate person in his behalf;

3. Every patient and resident shall have the right to know by name and specialty, if any, the physician responsible for coordination of his care;

4. Every patient and resident shall have the right to every consideration of his privacy and individuality as it relates to his social, religious and psychological well-being;

5. Every patient and resident shall have the right to respectfulness and privacy as it relates to his medical-care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly;

6. Every patient and resident shall have the right to expect the facility to make a reasonable response to the requests of the patient;

7. Every patient and resident shall have the right to obtain information as to any relationship of the facility to other health care and related institutions insofar as his care is concerned; and,

8. The patient and resident shall have the right to expect reasonable continuity of care, which shall include but not be limited to what appointment times and physicians are available.

This bill of rights is, in my opinion, a very reasonable, conservative document. The "rights" it describes are really only matters of common courtesy. Although this bill speaks only of the patient in a hospital, it is equally applicable to all professional relationships between patient and doctor—in the office, over the telephone, in the home. It embarrasses me, as a physician, to realize that the doctor–patient relationship has degenerated to the point that it has become necessary to spell out all these "rights."

A bill of rights is, of course, only a piece of paper. If it is really going to help patients, then it has to be enforced—and no police officer is going to collar a physician and throw him into jail because he hasn't explained to a patient why he prescribed "those yellow pills." Practically speaking, the only one who can see to it that the patient's rights are protected is the patient. If you want information or care you deserve and aren't getting, you're going to have to make demands. Based on my own experience of 15 years of private / *turn to page 18*

continued

practice, I have a few simple practical suggestions on how to go about it.

1. Often, when I see a patient while making rounds at the hospital, she'll say, "I know there's something I wanted to ask you, but I can't think of it right now." If questions occur to you between visits to the doctor, either in the hospital or his office, write them down so you won't forget them. It will save your time and his.
2. If you want news about a relative in the hospital and if you're legally entitled to that information, call the doctor and ask for the information. But if there are ten relatives who want the information, don't have all ten call—please. Let one person serve as interrogator for the rest of the family. Your doctor *can't* spend all his time on the telephone. Fair is fair.
3. If your doctor's explanation is unclear or incomplete, if you don't understand or aren't satisfied with what he has told you, tell him so. If you don't tell him you're unhappy, there's no way for him to realize that he's failed you. He'd much rather have you complain to him than to your friends or your family lawyer. Give him a chance to help himself.

4. Like everybody else, doctors are busier at some hours than at others. If you want a lengthy discussion of some facet of your care and if it isn't an emergency, you might say, "Doctor, if you're too busy to talk now, when will it be convenient?" He'll appreciate an opportunity to select a mutually convenient time.
5. Finally, it's only reasonable to expect that some doctors and some patients just won't get along well together; that's the way people are. So if you're not satisfied with the care your doctor is giving you—or if the rapport between you simply isn't good—ask him either to call in a consultant or find you another doctor, whichever you prefer. Don't put up with an unsatisfactory relationship just because you're afraid of hurting his feelings. Your health is far too important for that. (You may find that the doctor is just as glad to be rid of you as you are to be rid of him. I can think of a number of patients I've treated over the last 15 years whom I'd have been delighted to transfer to some other doctor's care. But—like my dissatisfied patients, I suppose— I didn't want to hurt anyone's feelings.)

Patients, speak up! It's past time for your voices to be heard. ■

Dr. Nolen regrets that he is unable to answer individual queries from readers.

[illegible] Sniper

United Press International

Two policemen help officer, wounded in afternoon assault, past air vent riddled with holes. Sniper [illegible] lies between parts of his rifle, destroyed in assault.

[illegible] artillery positions [illegible] Syrian tanks and two radar stations were destroyed in the early action, the radio added, and two Syrian soldiers were killed and eight wounded.

Israel announced that its planes flew seven raids throughout the day. All planes were said to have returned. A spokesman said the planes attacked guerrilla encampments, Syrian Army bases, artillery positions and radar stations.

One target, described [illegible]

Artillerymen dueled along Golan heights border (1). Israel's jets struck as far north as Latakia (2).

Little Progress Reported In U.S.-Soviet Arms Talks

By BERNARD GWERTZMAN

Special to The New York Times

WASHINGTON, Jan. 8—Well-placed Administration officials said today that the United States and the Soviet Union had failed to make any significant progress in their latest round of talks on the limitation of strategic arms.

The officials, in separate interviews, provided the first details about the renewed talks on arms limitation, which took place in Geneva from Nov. 21 to Dec. 21.

The talks are scheduled to resume in Geneva on Feb. 27 with U. Alexis Johnson, who has been Under Secretary of State for Political Affairs, replacing Gerard C. Smith as the chief American negotiator. Mr. Johnson's nomination to the new job was confirmed by the White House today.

Offensive Arms Discussed

The round of talks that ended in December marked the opening of the second phase of the arms-limitation discussions. They were devoted primarily to the quest for a comprehensive treaty putting limits on all offensive strategic weapons.

The first round of the talks was completed in Moscow last May with a comprehensive treaty on defensive strategic weapons and a five-year interim accord putting certain limits on land-based and submarine-launched offensive missiles. The two sides agreed to seek a more comprehensive agreement on offensive weapons in the second phase.

In the Geneva round, one high Administration official

Continued on Page 4, Column 2

LAIRD SAYS SAIGON IS READY ON ARMS

Calls Vietnamization Ended, With Army Fully Capable of Providing Security

By ERIC PACE

Special to The New York Times

WASHINGTON, Jan. 8—Secretary of Defense Melvin R. Laird told the House Armed Services Committee today that "from a military standpoint, the Vietnamization program has been completed."

In the first public appearance by a Cabinet member before a Congressional body during the current session, Mr. Laird said that more than $5.2-billion in new equipment had been delivered to the South Vietnamese armed forces and that they were now "fully capable" of providing security against the North Vietnamese within the borders of South Vietnam.

Mr. Laird said this made possible "the complete termination of American involvement in the war" even if peace talks failed. But he reiterated the Nixon Administration's position that ending the United States involve-

Continued on Page 12, Column 3

there was no sign that either side had changed the positions [illegible] between them broke down last month and the United States began its intensive 11-day bombing attack on the Hanoi-Haiphong area.

Mr. Kissinger, President Nixon's adviser for national security, and Mr. Tho, the Hanoi Politburo member charged with responsibility for the talks, met for four and a half hours in suburban Gif-sur-Yvette in a house owned by the French Communist party, which the American and North Vietnamese negotiators often used [illegible]

Affability Is Absent

The two men are due to meet again at 10 A.M. tomorrow in a house chosen by the United States delegation.

The North Vietnamese, all hosts today, took care to avoid any of the displays of affability—released smiles and handshakes—that frequently marked the previous two rounds of talks in November and December. Those gestures had provoked waves of hope and gloom around the world.

Mr. Tho and his staff arrived for the session first and they did not appear at the door either to greet or to bid goodby to Mr. Kissinger and his aides. On arrival, after waiting outside in the heavy and wet weather, Mr. Kissinger pushed the door open himself.

In statements they gave on arriving in Paris over the weekend, both Mr. Kissinger and Mr. Tho spoke of this third attempt at agreement in terms of an ultimate effort.

'The Decisive Moment'

Mr. Tho had said that "now the decisive moment has come either to settle the Vietnam problem rapidly and sign the agreed text or to continue the war."

Mr. Kissinger had said that President Nixon had sent him to "make one more major effort."

An official who has been following the talks closely said that as far as he knew, neither side had made any promises or new proposals that led to the renewal of negotiations today, beyond cessation of bombing above the 20th Parallel.

This new session was reportedly arranged primarily through frequent contacts between American and North Vietnamese envoys during the period when negotiations were suspended. The French Government kept in touch with both

Continued on Page 12, Column 5

[illegible]eeks Transit Unit [illegible] Over Toll Roads

By [illegible] SULLIVAN

[illegible] programs and goals for future [illegible] he has no intention of resubmitting the [illegible] reform program that was overwhelmingly defeated last July in the Assembly.

But the Governor then proceeds to propose a series of programs, topped by his mass-transit recommendation, that are expected to generate considerable controversy before both houses end their sessions sometime next June.

The loudest furor, most likely, will be generated by the Governor's mass-transit recommendation, which would in effect call for a legal consolidation of the New Jersey Turnpike, the [illegible]

Continued on Page 25, Column 2

GOVERNOR ASSAILS DRUG-BILL CRITICS

Says Courts Must Conform to the Needs of Society—Will Offer Plan Today

By ALFONSO A. NARVAEZ

Special to The New York Times

ALBANY, Jan. 8—On the eve of the submission to the Legislature of his narcotics-offense sentencing proposals, Governor Rockefeller today castigated judges who said last week that the plan would be unworkable.

"I am totally intolerant of the position that we should not protect the people because it won't work in our system, because we need plea bargaining to clear our court calendars," the Governor said.

"From a judge's point of view, that's a big deal. He clears his calendar, he goes home and everything looks fine. I'm concerned about society, about protecting the people, and therefore I think we've got to conform our courts to the needs of society and society's protection to the needs of the [illegible]

[illegible]

[illegible]ck Jesuit College Here, [illegible]ental Seminary, to Shut

[illegible]

Hospital Patients' 'Bill of Rights' Backed

By LAWRENCE K. ALTMAN

An individual's right to choose death by rejecting medical therapy and a patient's right to obtain a full explanation in clear, concise terms of his medical condition were affirmed in a 12-point "Bill of Rights" that the nation's leading hospital association issued yesterday.

The American Hospital Association, with headquarters in Chicago, approved the "Bill of Rights" [illegible]

[illegible] ment and make copies available to all patients.

Among the major points that the statement affirms are the rights to considerate and respectful care, privacy of a patient's own medical care program, confidentiality of medical records, a clear understanding of which doctor is in charge of his overall care, the options that exist for treatment of his condition and whether experimentation is involved in such therapy.

Most of the statement's points have been put forth here and there. For example, in 1961 the American Medical Association's legal department said that a patient has the right to withhold his consent to lifesaving treatment and impose his own conditions on this therapy. But this statement was made to doctors in a publication not widely available to patients.

[illegible] tion has done is to collect the [illegible] commonly questioned situations and put them in [illegible]

NEWS INDEX

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1638

Dallas Festival Honors Minnelli

Art Dealer Wins Stay on Appeal

Marginalia Revue At the New City

Pollini Plays Piano In Concert for Peace

[illegible] for Breast Tumors Set

By JANE E. BRODY

The American Cancer Society and the National Cancer Institute announced yesterday the selection of the first three of 20 planned breast cancer detection centers across the country. The centers will provide free examinations for the detection of this leading killer at an early curable stage.

One of the new centers, the Stella and Charles Guttman Breast Diagnostic Institute at [illegible] East [illegible] Street in Manhattan, is already operating and is in the process of expanding its annual screening capacity from 18,000 to 28,000 patients.

The two other centers, expected to be ready to screen patients within three or four months, are at the Emory University School of Medicine in Atlanta and the University of Louisville School of Medicine in Kentucky. Each center is expected to screen at least 5,000 women aged 35 and older each year.

The centers, which, according to current plans, will all be part of a 20-center national network fully operational within the year, are designed as demonstration projects to show the feasibility and merit of screening for breast cancer. This disease is the leading cancer killer among women in this country, striking 72,000 women and taking 32,000 lives each year.

The screening program was conceived a year ago by the cancer society as a possible means of reducing the breast cancer mortality rate, which has been level for the last several decades. Currently, 45 per cent of breast cancers are discovered by the women themselves at a stage when only 40 per cent can expect to be alive five years later. But if the disease is detected at its earliest stage—before there is any visible lump and when the malignancy is still confined to its site of origin—more than 90 per cent can be cured.

The screening techniques to be used by the detection centers—medical history, physical examination, mammography or xeroradiography (special X-ray techniques) and thermography (a heat-sensitive photograph)—are said to be able to detect 80 to 85 per cent of breast cancer cases at this early stage.

The Guttman Institute, under the direction of Dr. Philip Strax, pioneered in the use of these advanced techniques as screening tools for breast cancer. Dr. Strax, Louis Venet and Dr. Sam Shapiro of the Health Insurance Plan of New York demonstrated in a study of 62,000 women that the annual use of these methods could result in one third fewer deaths from breast cancer.

Women seeking an appointment at the Guttman Institute are advised to call the New York City Division of the American Cancer Society, PL 9-3500.

The cost of the project will be shared by the cancer society and the cancer institute, with a [illegible] for the first two years of the [illegible] centers.

[illegible] are the 12 points recommended by the American Hospital Association [illegible]

[illegible] respectful care.

2. The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment and prognosis in terms the patient can reasonably be expected to understand.

3. The patient has the right to receive from his physician information necessary to give informed consent prior to the start of any procedure and/or treatment.

4. The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of his action.

5. The patient has the right to every consideration of his privacy concerning his own medical care program.

6. The patient has the right to expect that all communications and records pertaining to his care should be treated as confidential.

7. The patient has the right to expect that within its capacity a hospital must make reasonable response to the request of a patient for services.

8. The patient has the right to obtain information as to any relationship of his hospital to other health care and educational institutions insofar as his care is concerned.

9. The patient has the right to be advised if the hospital proposes to engage in or perform human experimentation affecting his care or treatment.

10. The patient has the right to expect reasonable continuity of care.

11. The patient has the right to examine and receive an explanation of his bill regardless of source of payment.

12. The patient has the right to know what hospital rules and regulations apply to his conduct as a patient.

American Hospital Association Backs Patients' 'Bill of Rights'

Continued From Page 1, Col. [illegible]

be the first generally available public policy statement from a national health organization that specifically defends what courts have already ruled — that an adult patient with no prognosis for recovery has a right to die without medical therapy.

The association said that because of the complexities involved in medical care, it expected hospitals to raise many questions of interpretation about specific cases. The bill could also pose administrative problems for some hospitals until they work out a mechanism—if such does not already exist—for fully answering a patient's questions.

The hospital association said publication of the bill at this time reflected a growing wave of consumer action in health and medical affairs.

Publication was intended to make more effective communications between doctors and patients, particularly because the traditional physician-patient relationship takes on a new dimension as more Americans receive care in an institutional setting [illegible] doctor's private office.

Dr. John A. McMahon, president of the hospital association, said that the 12 points are subject areas that have always needed to be spelled out to the patient so that he would know what his rights are in the hospital setting.

At least two medical centers have already issued modified versions of the rights statement. More than two years ago, the Martin Luther King Medical Center in the Bronx began giving ambulatory patients an illustrated booklet "Your Rights as a Patient." The booklet also includes a list of the patient's duties and a complaint form.

Since last September, the Beth Israel Hospital in Boston has given each patient a similar pamphlet, which stipulates that a patient has a right to die without therapy.

Nevertheless, many doctors still have conflicts in treating such patients. Dr. Nancy L. Caroline of the University Hospital in Cleveland, for example, pointed out in a recent issue of "The New Physician," a professional journal, the problem posed by one patient who felt the time had come for him to die but how the medical staff had [illegible] his decision.

Protesters Cement Locks Of Army and Draft Office

Music: Exploring Flute's Potential With Dunkel

Hospital Patients' 'Bill of Rights' Backed
By LAWRENCE K. ALTMAN
New York Times (1857-Current file); Jan 9, 1973; ProQuest Historical Newspapers The New York Times (1851 - 2005)
pg. 81

Hospital Patients' 'Bill of Rights' Backed

By LAWRENCE K. ALTMAN

An individual's right to choose death by rejecting medical therapy and a patient's right to obtain a full explanation in clear, concise terms of his medical condition were affirmed in a 12-point "Bill of Rights" that the nation's leading hospital association issued yesterday.

The American Hospital Association, with headquarters in Chicago, approved the Bill of Rights as a national policy statement after a three-year study by its board of trustees and four consumer representatives.

Though a hospital will not lose accreditation if it rejects the policy, the association expects that its 7,000-member institutions will adopt the statement and make copies available to all patients.

Among the major points that the statement affirms are the rights to considerate and respectful care, privacy of a patient's own medical care program, confidentiality of his medical records, a clear understanding of which doctor is in charge of his over-all care, the options that exist for treatment of his condition, and if experimentation is involved in such therapies.

Most of the statement's points have been put forth here and there. For example, in 1961, the American Medical Association's legal department said that "a patient has the right to withhold his consent to life-saving treatment" and impose his own conditions on his therapy. But this statement was made to doctors in a publication not widely available to patients.

What the hospital association has done is to collect the most commonly questioned situations and put them in one document for the benefit of hospitalized patients.

The document is believed to

Continued on Page 30, Column 4

American Hospital Association Backs Patients' 'Bill of Rights'

Continued From Page 1, Col. 8

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Doctor and Patient Bill of Rights a Break With Old Paternalism

By LAWRENCE K. ALTMAN

News Analysis

There was a time when patients chose just one doctor to treat their every ailment, held him in awe, took his word for everything, did not want to know what was in their medical charts, accepted without question the decisions that he made on their behalf and went to a hospital only to die. In those not so distant days past, the physician had little reason to communicate with his patients other than in a paternalistic manner. Now, medicine is more complex, and the nature of modern medical practice has changed the traditional doctor-patient relationship to the point where on Monday the American Hospital Association issued a 12-point Bill of Rights for patients.

Patients today are often treated by several doctors who may practice the most sophisticated specialties in widely separated offices or as a group in a clinic or a hospital. Sometimes one doctor does not know what another is prescribing for the same patient.

Patients go to hospitals for a host of things that doctors used to do in their offices. The doctor engages less in small talk and much more in questions relevant to the physiology of the patient's body.

The doctor tends to speak in scientific rather than simple terms; patients pretend to understand but often do not. Wherever the doctor and the patient meet, communications exist.

But doctors say they have less time to explain what's wrong because the knowledge they have gained is difficult to translate to a patient. And many patients complain that the quality of communications lags behind the sophistication of the care doctors can now deliver. [illegible]

Today, medical paternalism is rapidly being challenged by health consumerism, as patients are demanding a greater role in making decisions about their medical care.

More people want to know more about what doctors record in their charts because they have a better appreciation of how a disorder can affect the quality of their lives. Courts are telling doctors that they must spell out for the patient not only the choices but also the risks of available therapies.

The patient's Bill of Rights puts together what doctors and hospitals have long recognized as the patient's rights but have lagged in communicating directly to the public.

The expectation that many nurses and aides will hand such a document to patients as they enter a hospital is a revolutionary step for medical centers, which have been under fire from many critics of the health system.

The criticisms reflect not only the high costs of modern medicine but also the growing sophistication of the public about health matters. More people have learned more about science and medicine in high schools and colleges in recent years and have a degree of fascination for medicine that many of their elders did not share. They learn more about medicine every day from the news and entertainment media.

In the process, many younger Americans are paying for and living with the consequences of modern medical therapy that is helping 11.8 million Americans live beyond 70 and 3.8 million beyond 80. The growing number of older people is increasing the importance of [illegible] Americans [illegible] medicine [illegible].

Yet for some the information can be too great a burden, and there is a growing [illegible] about the right to die without medical therapy. The patient's Bill of Rights, recognizing a body of law that exists, affirmed the patient's right to choose death by rejecting medical therapy.

The statement also affirms the right to due consideration when doctors and medical students examine a patient.

As more Americans are covered by third-party payments from private insurance companies like Blue Cross and Federal programs like Medicare, those who once were charity patients now are treated as private patients.

This change has had its impact on where medical students and young doctors are taught.

Traditionally, doctors were taught in charity hospitals like Bellevue. Now, more and more are taught in private hospitals, which have affiliated with medical schools to share costly human and physical resources.

This means that as more private patients benefit from the expertise of medical school professors, more private patients have become teaching cases.

The Bill of Rights ensures that the patient is made aware of this fact. It also reinforces the need for "informed consent" from a patient to whom his doctors recommend an experimental treatment. Last decade, when medical school faculty promotions were heavily influenced by research accomplishments, some critics charged that professors had a greater desire to treat a patient for purposes of writing a research paper rather than for the patient's needs.

But the Bill of Rights will also have an impact on physicians practicing in community hospitals. Doctors [illegible] have [illegible] communicate at length with patients have been [illegible] retreats, [illegible]

The Bill of Rights specifies that doctors must explain a patient's medical condition in terms the individual can be reasonably expected to understand. The Bill of Rights entitles the patient to a concise, precise summary of the information collected in his chart and to have access to his records when necessary.

It emphasizes the need to preserve confidentiality of a patient's medical records, a problem of growing concern among doctors and patients. As more aides, clerks and nonphysicians have access to hospital records, more opportunity exists for breaches in confidence.

As Dr. William A. Nolen, who practices surgery in Litchfield, [illegible]

Doctors have long discussed among themselves such critical questions as how much should be done to prolong a patient's life. Now physicians like Dr. Robert H. Williams of the University of Washington in Seattle are sharing such discussions with the public as a means of helping the layman prepare for death.

Dr. Williams has had an unusual perspective on the subject of death because he was resuscitated after a heart attack more times than his doctors could count. Dr. Williams's book, "To Live and to Die: When, Why and How," which goes far beyond his own experience, is scheduled to be published by Springer-Verlag of New York this spring.

Seniority System In Congress Gets A Double Setback

Special to The New York Times

WASHINGTON, Jan. 9—The absolute seniority system for selecting the chairmen and ranking minority members of Congressional committees moved closer to extinction today.

Republican Senators voted unanimously to let the Republicans on each committee decide who their ranking member should be. The decision would be subject to confirmation by the entire body of Republicans in the Senate. Today's vote ratified a tentative vote taken yesterday.

Meanwhile, a special committee of Democrats in the House voted, also unanimously, to recommend to their party's caucus that each committee chairman be chosen by vote of the caucus.

Congressional reformers believe that in nearly all instances the senior members of each committee will be selected as the leaders. But they contend that the new party rules would permit a challenge if a majority of party members believed one of these committee leaders to be [illegible].

The first test of the new [illegible] may come in the House Republican Conference, where Representative John N. Erlenborn of Illinois is expected to challenge Representative Frank Horton of Rochester for the position of ranking Republican on the Government Operations Committee. [illegible]

Doctor and Patient: Bill of Rights a Break With Old Paternalism
By LAWRENCE K. ALTMAN
New York Times (1857-Current file); Jan 10, 1973; ProQuest Historical Newspapers The New York Times (1851 - 2005)
pg. 24

Doctor and Patient: Bill of Rights a Break With Old Paternalism

By LAWRENCE K. ALTMAN

There was a time when patients chose just one doctor to treat their every ailment, held him in awe, took his word for everything, did not want to know what was in their medical charts, accepted without question the decisions that he made on their behalf, and went to a hospital only to die. In those not so distant days past, the physician had little reason to communicate with his patients other than in a paternalistic manner. Now, medicine is more complex, and the nature of modern medical practice has changed the traditional doctor-patient relationship to the point where on Monday the American Hospital Association issued a 12-point Bill of Rights for patients.

News Analysis

Patients today are often treated by several doctors who may practice the most sophisticated specialties in widely separated offices of as a group in a clinic or a hospital. Sometimes one doctor does not know what another is prescribing for the same patient.

Patients go to hospitals for a host of things that doctors used to do in their offices. The doctor engages less in small talk and much more in questions relevant to the physiology of the patient's body

The doctor tends to speak in scientific rather than simple terms; patients pretend to understand, but often do not. Wherever the doctor and the patient meet, communications exist.

But doctors say they have less time to explain what's wrong because the knowledge they have gained is difficult to translate to a patient. And many patients complain that the quality of communications lags behind the sophistication of the care doctors can now deliver.

Today, medical paternalism is rapidly being challenged by health consumerism as patients are demanding a greater role in making decisions about their medical care.

More people want to know more about what doctors record in their charts because they have a better appreciation of how a disorder can affect the quality of their lives. Courts are telling doctors that they must spell out for the patient not only the choices but also the risks of available therapies.

The patients' Bill of Rights pulls together what doctors and hospitals have long recognized as the patient's rights but have lagged in communicating directly to the public.

The expectation that many nurses and aides will hand such a document to patients as they enter a hospital is a revolutionary step for medical centers, which have been under fire from many critics of the health system.

The criticism reflects not only the high costs of modern medicine but also the growing sophistication of the public about health matters. More people have learned more about science and medicine in high school and college in recent years and have a degree of fascination for medicine that many of their elders did not share. They learn more about medicine every day from the news and entertainment media.

In the process, many younger Americans are paying for and living with the consequences of modern medical therapy that is helping 11.8 million Americans live beyond 70 and 3.8 million beyond 80. The growing number of older people is increasing the importance of geriatrics in American medicine.

Yet for some the infirmities can be too great a burden, and there is a growing discussion about the right to die without medical therapy. The patients' Bill of Rights, recognizing a body of law that exists, affirmed the patient's right to choose death by rejecting medical therapy.

The statement also affirms the right to due consideration when doctors and medical students examine a patient.

As more Americans are covered by third-party payments from private insurance companies like Blue Cross and Federal programs like Medicare, those who once were charity patients now are treated as private patients.

This change has had its impact on where medical students and young doctors are taught.

Traditionally doctors were taught in charity hospitals like Bellevue. Now, more and more are taught in private hosptials, which have affiliated with medical schools to share costly human and physical resources.

This means that as more private patients benefit from the expertise of medical school professors, more private patients have become teaching cases.

The Bill of Rights ensures that the patient is made aware of this fact. It also reinforces the need for “informed consent” from a patient for whom his doctors recommend an experimental treatment. Last decade, when medical school faculty promotions were heavily influenced by research accomplishments, some critics charged that professors had a greater desire to treat a patient for pursposes of writing a research paper rather than for the patient's needs.

But the Bill of Rights will also have an impact on physicians practicing in community hospitals. Doctors, too busy to communicate at length with a patient, have been known to retreat behind a smokescreen of scientific terminology.

The Bill of Rights specifies that doctors must explain a patient's medical condition in terms the individual can be reasonably expected to understand. The Bill of Rights entitles the patient to a concise, precise summary of the information collected in his chart and to have access to his records when necessary.

It emphasizes the need to preserve confidentiality of a patient's medical record, a problem of growing concern among doctors and patients. As more aides, clerks and nonphysicians have access to hospital records, more opportunity exists for breaches in confidence.

As Dr. William A. Nolen, who practices surgery in Litchfield, Minn., pointed out in his book, “A Surgeon's World,’ gossip about a patient's case history can come from nurses, hospital staff and doctor's wives.

Doctors have long discussed among themselves such critical questions as how much should be done to prolong a patient's life. Now, physicians like Dr. Robert H. Williams of the University of Washington in Seattle, are sharing such discussions with the public as a means of helping the laymen prepare for death.

Dr. Williams has had an unusual perspective on the subject of death because he was resuscitated after a heart attack more times than his doctors could count. Dr. Williams' book, “To Live and to Die: When, Why, and How”, which goes far beyond his own experience, is scheduled to be published by Springer-Verlag, of New York, this spring.

Better Homes and Garden

THE IDEA MAGAZINE FOR BETTER HOMES AND FAMILIES APRIL, 1974; VOL. 52,

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FAMILY HEALTH Gerald M. Knox

What are your rights as a patient?

During a school health examination, a heart murmur is detected in a seven-year-old boy and reported to his mother. When she asks the family doctor about it, he merely waves aside her concern and puts her off by saying, "Don't worry about it."

A young man consults a neurologist about recurring headaches. After examining him, the physician states that he has found nothing wrong and sends him on his way. No suggestions are offered as to how to obtain relief or pursue the matter.

A family paying $28 a month for health insurance finds that their son's appendectomy leaves them obligated for $300 over the amount covered by their policy, just for hospitalization. For a while, they refrain from seeking any medical care at all, even when it is clearly needed, rather than add to the debt.

In these three cases, disappointment and frustration were encountered in connection with health care. And these examples are but a small sampling of the endless ways in which efforts to secure the best health protection can be stymied. Among the many roadblocks are long waits for emergency treatment, impersonal doctor-patient relationships, soaring medical costs, and language barriers. Where does the fault lie? In the trend toward specialization? Some say so. In runaway technology? Probably, to a degree. In the shortage of doctors? Of course. In American mobility? That, too. But the real question is, can the patient do anything about it? The answer, in a word, is *yes*.

As the circle of interest in consumer affairs grows wider, it has come to include the practices and problems of medical care. In the light of what is being learned, the totems of old are beginning to topple. The patient, who is no less a consumer than when he pays for any other service, is being released from his role as the silent nonparticipant in his own health care, and given a voice. What's more, he's being encouraged to use it as a means of exercising his rights. What do "rights" have to do with medical care? A great deal. They are the lever by which a patient can maintain his fair share of control over what's happening to him.

Here's a rundown on your rights as a patient, and some of the ways they can work to your advantage:

You can be selective

It is perfectly permissible to check out the background and training of a member of the medical profession. The inquiry, which can be a direct one, is not likely to offend the doctor who recognizes your right to quality care. Most doctors will, in fact, readily supply you with pertinent information about themselves on request, and without rancor.

Another way to make sure that a doctor is qualified to treat you is to contact your local or county medical society, or your neighborhood or community hospital, for information. While they will not recommend one physician over another, they will give you the names and qualifications of as many accredited physicans in your area as you might care to have. And if you think you need to see a specialist—a gynecologist or an orthopedist, for example—bear in mind that general practitioners have usually made enough contacts in the community to help you select one who is conscientious and competent, as well as qualified. Doctors do not, as is sometimes rumored, profit from referrals; not, anyway, if their license to practice medicine means anything to them.

Bear in mind, too, that well-directed inquiries can protect you from falling into the hands of quacks who, despite the law, still manage to exploit the health needs of unsuspecting victims. Generally, it's a good idea to be wary of any practitioner who guarantees an instant cure for serious or chronic ailments, uses one method of treatment for all disorders, produces written testimonials from patients as proof of his medical capabilities, or rails against the injustices inflicted upon him by the medical profession.

You can change doctors

Staying with the same doctor has obvious advantages. He's formed a medical picture of you in his mind, and he's recorded your past illnesses, your health problems and assets, and the results of tests you may have taken. If you've been seeing him for any length of time, he's also had the opportunity to get to know you as a person, as well as a patient. All of this can prove to be valuable when you come to him for medical advice.

At the same time, the mere fact that a doctor has your medical history in his files shouldn't bind you to him if you're not completely satisfied under his care. Neither should embarrassment or a misplaced sense of loyalty. Unless you value your doctor's judgment and trust him enough to follow through on his recommendations, you're doing yourself, and probably him as well, an injustice. Records can easily be transferred and no one, least of all the medical profession, would dispute your right to seek out a doctor in whom you can have full confidence.

You don't have to settle for a single opinion

According to the dictates of medical ethics, you're well within your rights when you set out to corroborate the findings of any doctor. Most doctors would not, of course, hesitate to call a consultant or send you to a specialist if they have any uncertainties about your condition. Even if the doctor seems to harbor no doubts, but you do, there's reason enough to obtain a second opinion. You can ask that a consultant be brought in on your case, or take the initiative yourself.

A second opinion can be particularly helpful when it comes to the advisability of surgery, which is sometimes debatable. One doctor might, for example, believe in routinely removing tonsils and adenoids, while another suggests the operation only if they are clearly causing a health problem. The necessity for other commonly performed operations, such as hysterectomies and hemorrhoidectomies may likewise be

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Patient's rights?

open to question.

There is, in addition, always the element of risk and the danger of complications to consider when contemplating surgery. Explore all alternatives before agreeing to an operation. Here two medical opinions—preferably your family physician's and a surgeon's—are better to work with than one. And a third opinion, obtained independently of the other two, can't hurt either.

You're entitled to a reasonable amount of time and attention

A "good doctor-patient relationship" is a phrase that is bandied about freely today, but it means different things to different people. While one patient wants his doctor to be a confidant, another wants his to stick strictly to medical matters. Others might seek solicitude, cautiousness, a "gentle touch," or a sense of humor in a doctor.

Whatever you, personally, may expect from your doctor when you go to him with a health problem, you have a right to expect that he has set aside the time, and summoned up the interest, to: (1) give you a chance to talk about the problem, (2) examine you, (3) record the details, (4) discuss it with you, (5) suggest what steps you can take to solve it, and (6) answer any questions you may have. Moreover, you have a right to his undivided attention (except, of course, for unavoidable interruptions like emergency calls) during the time allotted to you.

And you have every right to expect the following as well:

Privacy—You should be able to talk frankly with your doctor without fear of being overheard. Your remarks or revelations should be held in the strictest confidence. Your health records are privileged information and should not, unless you give your permission, be made available to anyone who is not directly involved in your care.

Continuity of care—A competent backup doctor should be standing by to answer your calls, take over your care, or respond to any emergency that may come up when your own doctor is unavailable. Your doctor should be prepared to explain how and where you can get such services as rehabilitative treatment, outpatient care, and hospital care at home if you need them. It is also a doctor's responsibility to arrange for hospitalizing you or transferring you from one hospital to another, if the occasion arises.

The preservation of personal dignity—The manner in which you are cared for should in no way be affected by your race, creed, cultural background, or social standing. Neither should your financial situation or the source of your payment have any bearing on the respectful and considerate care that is every patient's due.

Full information is yours for the asking

"What the patient doesn't know can't hurt him," may have been a byword in the medical profession at one time, but not any longer. The tendency today is for doctors to come out from behind the smoke screen of technical terms and level with the patient. That means, in effect, that you not only have the right to ask questions, you have the right to expect truthful answers and explanations you can understand. You have the right, in other words, to know as much—or, for that matter, as little—as you want to about your condition, care, or treatment, including the doctor's diagnosis, the purpose and results of tests, and the name and possible side effects of medications he may prescribe.

According to some recent psychological studies, surgical patients in particular suffer much needless anxiety when they are kept in the dark. While it's true that anyone who faces surgery is bound to be somewhat apprehensive, it's equally true that fear of the unknown only intensifies such feelings. A surgeon can, in a matter of minutes, provide the reassurance that comes with knowing, in advance, exactly what will happen during any medical procedure related to surgery. That brief explanation can help a patient immeasurably, and should not be regarded as "taking up too much of the doctor's time."

You can refuse treatment

You have the final say-so and can, whatever your reason, refuse to go along with any and all forms of proposed medical care. An exception to the rule, of course, would be if your refusal endangers the life of a minor or a person who is incapable of speaking for himself, or jeopardizes the health of the community. Other than that, a doctor can do no more than fulfill his role as an advisor concerning your health; whether or not you act on his counsel is your personal decision.

Needless to say, the decision to refuse treatment is not one that

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Patient's rights?

should be made arbitrarily and without due consideration. The doctrine of "informed consent" by which the medical profession abides takes into account your right to be advised of the possible consequences of your refusal. It also confers on you, by its very wording, the right to know the disadvantages as well as the benefits of your treatment. Once you've seen all sides of the issue, you'll be in a better position to decide whether to accept or reject treatment.

A natural extension of the right to refuse treatment is the question of the terminally ill patient. Does he have the right to choose death in preference to artificial or mechanical aids that can keep him alive, but cannot improve his condition or lead to his recovery? Several courts have ruled that he does have the right, but the privilege of choice is his alone.

You're not obliged to participate in experiments

Admittedly, new drugs and new surgical procedures must be tried out on someone before they gain acceptance as conventional methods of treatment. But if you happen to be that "someone," you certainly have a right to know it. What's even more important, you have a right to know if you are being exposed to any danger. As a patient, your needs and safety are of primary importance; as a subject in a scientific study, they could, conceivably, take second place to scientific knowledge.

You may, of course, be willing—either for the sake of your own health, or for medical advancement—to take part in a research study or submit to experimental treatment. But even then you would be well-advised to withhold your consent at least until you have gathered all the relevant facts and satisfied yourself that the prospective gains actually outweigh the possible risks.

Medical costs must be disclosed to you

Discussion of medical fees has traditionally been a delicate subject. Doctors have avoided bringing it up for fear it might make them sound mercenary, and patients usually don't mention it perhaps in the belief that they would be creating the impression that money is more important to them than their health. To bridge the communications gap, the President's Price Commission has asked that signs indicating willingness to discuss fees be displayed in doctors' offices. But sign or no, you have a right, and the need, to know just what your medical care will cost. You can find out simply by asking.

Fees for medical care do not, of course, always coincide with medical insurance coverage. That makes it imperative to familiarize yourself with the exclusions and limits of your policy. If the terms are not spelled out clearly, or if they are presented in incomprehensible language, request clarification. The insurance company that refuses to comply is suspect. You have the right to know what you're paying for, the right to collect all that is coming to you.

You can apply your rights to hospital care

A hospital's first responsibility is—and always has been—to its patients. The trend today is to reassure the patient of that fact by affirming, in writing, his rights while under hospital care. According to the determinations of the American Hospital Association—which urges its member hospitals to relay the information—a hospital patient has rights that include those already outlined and the following as well:

- The right to ask for an explanation of the consent form he is given to sign when he's admitted
- The right to refuse to agree to a section, or sections, of the standard consent form and still receive the best possible care the hospital can offer under the circumstances
- The right to be informed of any special rules regarding diet, visitors, telephone calls, and the like, that apply to him
- The right to know the names of the persons in whose charge he has been placed
- The right to refuse to be observed for purposes other than his care and treatment
- The right to inquire into any aspect of the hospital's administration or affiliations
- The right to examine his bill and request an accounting
- The right to emergency care without reservation
- The right to leave the hospital without his doctor's permission, as long as he or she absolves the hospital staff of responsibility and is not carrying a communicable disease
- The right to be informed of the reason if he is to be transferred to another facility, and to expect that the hospital will assume the responsibility for making the necessary arrangements
- The right to adequate and clear instructions in self-care and health maintenance after his discharge from the hospital
- The right to complain if he is dissatisfied with the care he receives.

Some hospitals are taking the patients' rights concept a step further by inviting their patients to fill out a questionnaire where they can evaluate the care they received during their stay and offer suggestions for improvement.

Finally, volunteers known as patient representatives, or ombudsmen, have appeared on the scene in some 400 hospitals across the country. In general, a patient representative acts as a liaison between the patient and the staff, thereby cutting red tape and facilitating the solution of problems. Specifically, he may be called upon to perform a variety of duties such as conveying a complaint about food service, interpreting for a non-English-speaking patient, and keeping concerned relatives posted. Overall, he helps humanize hospital care. And always his main objective is to see to it that patients' rights are observed. ■

(Written in cooperation with Lilian Rothman, a noted medical writer.)

EXHIBIT I

JOHN H. CARR, M.D., M.P.H., F.A.A.P.
STATE HEALTH OFFICER

NEVADA STATE DIVISION OF HEALTH
BUREAU OF HEALTH FACILITIES
CAPITOL COMPLEX
505 EAST KING STREET
CARSON CITY, NEVADA 89710

(702) 885-4475

April 13, 1977

MEMORANDUM

TO: Assembly Judiciary Committee

FROM: William L. Thomason, D.D.S.
Administrator, Bureau of Health Facilities

SUBJECT: Assembly Bill 559

The Bureau of Health Facilities in order to carry out its responsibilities under Nevada Revised Statutes, Chapter 449, and certification of Medicare/Medicaid facilities in the State suggest the following amendment to this bill.

> Sections 1 (e) and 2 (h) add to end of sentence:
>
> unless an affirmative duty is imposed by other provisions of law to submit any report from such records to Health Division or any local health authority.

WLT/cif

EXHIBIT J

ALEXANDRIA N. METSCHER
COUNTY CLERK
AND EX-OFFICIO CLERK OF
THE BOARD

ANDREW M. EASON
ROBERT H. CORNELL
~~XXXXXXXXXXXXXXX~~
Donald J. Barnett

Board of County Commissioners

Nye County

STATE OF NEVADA
PHONE 482-3330 P. O. BOX 1031
TONOPAH, 89049

April 5, 1977

Honorable Robert R. Barengo
Chairman, Assembly Judiciary Committee
Assembly Chamber
Legislative Building
Carson City, Nevada 89710

Re: <u>A.C.R. 28</u>

Dear Mr. Barengo:

During the many years of the existence of the Max C. Fleischmann Foundation of Nevada, Nye County has been the recipient of many grants which have enabled its residents to enjoy facilities and services which, without this financial assistance, would have been outside the realm of our financial ability. Like all Nevadans, we are aware of the tremendous favorable impact that similar grants have had on every community in this State, all of which have helped perpetuate the memory of this great benefactor. The trustees of this foundation have served commendably, and, in addition to protecting the trust assets and making sound investments, have been especially cognizant of the problems unique to the rural areas of Nevada.

The Board of County Commissioners of Nye County strongly urges the unanimous approval of A.C.R. 28. If the fine work of the Fleischmann Foundation may be perpetuated in any lawful means, it is our opinion that every effort should be made to accomplish that end.

Very truly yours,

BOARD OF NYE COUNTY COMMISSIONERS

By: Andrew M. Eason
Andrew M. Eason, Chairman

By: Robert H. Cornell
Robert H. Cornell, Member

By: Donald J. Barnett
Donald J. Barnett, Member

By: P. M. Neighbors
P. M. Neighbors, Administrator

AME/rk

cc: Honorable Melvin D. Close, Jr.
Chairman, Senate Judiciary Committee
Senate Chamber
Legislative Building
Carson City, Nevada 89710

Honorable Mike O'Callaghan
Governor of Nevada
Executive Chamber
Carson City, Nevada 89701

Max C. Fleischmann Foundation of Nevada
One East Liberty Street
Reno, Nevada 89501

EXHIBIT K

ASSEMBLY ACTION	SENATE ACTION	ASSEMBLY / SENATE AMENDMENT BLANK
Adopted ☐ Lost ☐ ate: nitial: oncurred in ☐ ot concurred in ☐ ate: nitial:	Adopted ☐ Lost ☐ Date: Initial: Concurred in ☐ Not concurred in ☐ Date: Initial:	Amendments to Assembly / Senate Bill / Joint Resolution No. 247 (BDR 18-133) Proposed by Committee on Judiciary

977 Amendment Nº 807 A

Amend section 1, page 2, line 15, delete "chapter.]" and insert:

"chapter. All money so received shall be deposited with the state treasurer for credit to the Nevada equal rights commission gift fund which is hereby created.]"

Amend section 2, page 2, line 33, delete "employ." and insert "employ.]"

Amend section 2, page 2, delete lines 34 through 38 and insert:

AS Form 1a (Amendment Blank) 3044A

Drafted by LP:ml Date 4-12-77.

To Journal
(3) CFB

"When a complaint is filed, the commission may hold an informal meeting to attempt a settlement of the dispute. No further action may be taken if the parties agree to a settlement.

2. If an agreement is not reached, the commission shall conduct an investigation into the alleged unlawful practice. After the investigation, if the executive director of the commission determines that an unlawful practice has occurred, he shall attempt to mediate between or reconcile the parties. The party against whom a complaint was filed may agree to cease the unlawful practice. If an agreement is reached, no further action may be taken by the complainant or by the commission.

3. If the attempts at mediation".

Amend section 2, page 2, delete lines 46 through 49 and insert:

"(2) Pay to the aggrieved person any actual damages suffered because of the practice."

Amend section 2, page 3, delete lines 12 and 13 and insert:

"ment ordered, the court shall award the aggrieved party actual damages."

Amend section 4, page 3, line 29, after "chapter." insert:

"All money so received shall be deposited with the state treasurer for credit to the Nevada equal rights commission gift fund which is hereby created."

Amend section 5, page 3, line 32, before "Complaints" insert "1."

Amend section 5, page 3, between lines 36 and 37 insert:

"2. The complaint shall specify the alleged unlawful practice and shall be signed under oath by the complainant.

3. The commission shall send to the party against whom an unlawful discriminatory practices is alleged:

(a) A copy of the complaint;

(b) An explanation of the rights which are available to him; and

(c) A copy of the commission's procedures."

Amend section 6, page 3, line 41, delete "prior to" and insert: "after the preliminary meeting and before".

Amend section 12, page 5, delete line 34 and insert: "damages [and punitive damages], together with court costs and a reason-".

Amend section 15, page 6, line 17, delete "1 year" and insert "6 months".

Amend section 16, page 6, delete line 34 and insert: "[the] actual damages, [and for the additional sum of $250,] to be"

Amend the bill as a whole by adding a new section, designated section 20, following section 19, to read as follows:

"Sec. 20. Sections 1 and 2 of this act shall become effective at 12:01 a.m. on July 1, 1977."