The original documents are located in Box 9, folder "Health (2)" of the Theodore C. Marrs Files at the Gerald R. Ford Presidential Library.

THE WHITE HOUSE
WASHINGTON

Call Jack Macdonald-
I do not
know how
all this
inter-relates -
if it does.

JL

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

OFFICE OF THE SECRETARY

WASHINGTON, D.C. 20201

Carl Jack File

JUN 30 1975

MEMORANDUM FOR THE HONORABLE THEODORE C. MARRS

Attached is a brochure that was used to announce a series of workshops sponsored by the Social Security Administration on Hospital Prospective Payment. The focus of the workshops was on issues essentially unique to acute care institutions. Because of the emphasis placed on hospital reimbursement, nursing homes were not included in the mailing distribution. Mailings were made to the Governors of the States, their respective commissioners of insurance and health, and, where in existence, the States' health rate regulatory authority. Also included were State and local hospital associations, the American Hospital Association, Association for Private Hospitals, Blue Cross-Blue Shield Plans, and organizations representing commercial insurance companies. Since prospective reimbursement for long-term care was not addressed at these conferences, no repeat conferences are necessary. We do regret that any commitments made in Mr. Seidman's May 13 letter were not honored.

To date, budgetary and personnel constraints have limited the section 222 activities in the long-term care area. Staff is presently engaged in the development of a Request for Proposal (RFP) dealing with prospective rate systems for nursing homes. The RFP will solicit developmental cost studies in three areas: (1) routine services, (2) ancillary services, and (3) return on equity capital and risk.

It is anticipated that the results of the proposed developmental cost studies will provide the answers to those research issues which must be resolved prior to implementing prospective reimbursement systems in nursing homes on an experimental basis.

Mr. MacDonald's National Council on Health Care Services, the American Health Care Association, and other allied nursing home provider organizations are on the distribution list for the pending RFP.

Attached please find a draft response to Mr. MacDonald.

David H. Lissy
Executive Secretary
to the Department

Enclosures

We apparently have no record of receiving a copy of the Feldman letter of May 13.

DRAFT

Dear Mr. MacDonald:

In response to your telegram of June 2, 1975, I would like to assure you that the four workshops on prospective reimbursement were designed to address issues related to rate setting in the hospital industry. For this reason, only those organizations directly involved in hospital reimbursement were forwarded invitations. Approximately 800 invitations were mailed. Included on this distribution list were the Governors of each of the States, their respective commissioners of insurance and health, States' health care rate regulatory authorities, State and local hospital associations, the American Hospital Association, the Association for Private Hospitals, Blue Cross-Blue Shield Plans, and organizations representing commercial insurance carriers. We do regret any concern that may have resulted from apparent misunderstandings about the focus of these conferences.

I have contacted the office in the Department of Health, Education, and Welfare responsible for section 222 activities (Office of Research and Statistics of the Social Security Administration) and been informed that they have been constrained by manpower and budget restrictions that have limited their efforts in the long-term care area. They are, however,

planning to issue a Request for Proposal within the next few months that will solicit developmental cost studies in three areas: (1) routine services, (2) ancillary services, and (3) return on equity capital and risk.

It is anticipated that the results of the proposed developmental cost studies will provide the answers to those research issues which must be resolved prior to implementing prospective reimbursement systems in nursing homes on an experimental basis. A significant issue that will not be addressed in these studies is quality of care. The measurement of health care status in nursing homes will be separately addressed in other DHEW evaluations of patient assessment instruments.

Please be assured that you are on the distribution list for this Request for Proposal. If you would like further information on these activities, please feel free to contact Dr. Clifton Gaus at Room 915, Universal North Building, 1875 Connecticut Avenue, NW., Washington, D.C. 20009.

Kaple, 2-Q-2 East, Baltimore, SSA-IRE-434, 130-48543

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

OFFICE OF THE SECRETARY

WASHINGTON, D.C. 20201

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Kaple, 2-Q-2 East, Baltimore, SSA-IRE-434, 130-48543

THE WHITE HOUSE OFFICE

REFERRAL

To: SECRETARY OF HEALTH, EDUCATION Date: June 3, 1975

ACTION REQUESTED

_____ Draft reply for:
_____ President's signature.
_____ Undersigned's signature.

_____ Memorandum for use as enclosure to reply.

_____ Direct reply.
_____ Furnish information copy.

_____ Suitable acknowledgment or other appropriate handling.
_____ Furnish copy of reply, if any.

_____ For your information.

_____ For comment.

NOTE

Prompt action is essential.

If more than 72 hours' delay is encountered, please telephone the undersigned immediately, Code 1450.

Basic correspondence should be returned when draft reply, memorandum, or comment is requested.

REMARKS: I would appreciate detailed information in regard to the referenced meetings. It appears from here that this organization should be involved in such meetings. Is a repeat needed?

Description:

_____ Letter: X Telegram: Other:

To: Dr. Theodore C. Marrs
From: National Council of Health Care Services
Date: June 2, 1975
Subject: HEW Conferences on Prospective Reimbursement

By direction of the President:

Theodore C. Marrs
Special Assistant to the President

7506100109

SPECIAL
DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE

HEW 94

remain with correspondence)

western union

Telegram

LLD031 WAB090(1208)(2-019019E153)PD 06/02/75 1208
ICS IPMMTZZ CSP
2027854754 TDMT WASHINGTON DC 137 06-02 1208P EST
PMS DOCTOR TED MARRS WUX
103 OLD EXECUTIVE OFFICE BLDG
WASHINGTON DC

1975 JUN -2 PM 1:45

DEAR TED. I HAVE JUST BEEN INFORMED THAT HEW HAS ALREADY HELD THE FOUR CONFERENCES ON PROSPECTIVE REIMBURSEMENT. MR W SEIDMAN IN HIS LETTER TO ME ON MAY 13 STATED THAT OUR FOUR GROUPS NCHCS AHA FAH AHCA WOULD BE INVITED TO PARTICIPATE IN THE CONFERENCES. WE DID NOT RECEIVE ANY INVITATIONS AND THEREFORE WERE UNABLE TO PARTICIPATE IN THE SESSIONS. I AM GREATLY DISTURBED WITH THIS TURN OF EVENTS. AS YOU KNOW WE HAVE ATTEMPTED TO DEVELOP DEMONSTRATION PROSPECTIVE REIMBURSEMENT PROJECTS AS PRESCRIBED BY SECTION 222 OF PUBLIC LAW 92603. THESE EFFORTS HAVE APPARENTLY FALLEN ON DEAF EARS WITHIN THE RESPONSIBLE AGENCY IN HEW. I AM SURE THAT THIS IS NOT AND HAS NOT

western union

Telegram

WAB090-2

1975 JUN -2 PM 1:45

BEEN THE INTENT OF SECRETARY WEINBERGER NOR THE ADMINISTRATION. YOUR ASSISTANCE IN THIS MATTER IS APPRECIATED

JACK A MACDONALD EXECUTIVE VICE PRESIDENT NATIONAL COUNCIL OF HEALTH CARE SERVICES

NNNN

SF-1201 (R5-69)

SSA WORKSHOP
c/o InterStudy
123 East Grant Street
Minneapolis MN 55403

WORKSHOP

HOSPITAL PROSPECTIVE PAYMENT: ISSUES and EXPERIENCES

HOSPITAL PROSPECTIVE PAYMENT: ISSUES and EXPERIENCES

A Series of Workshops Sponsored by the Social Security Administration and InterStudy

DATES:

Boston – May 2, 1975
San Francisco – May 9, 1975
Chicago – May 16, 1975
New Orleans – May 23, 1975

APPLICATION FORM

I AM INTERESTED IN PARTICIPATING IN A PROSPECTIVE PAYMENT WORKSHOP. MY 1ST AND 2ND CHOICES ARE INDICATED BELOW.

1ST CHOICE	2ND CHOICE		
☐	☐	**Boston**	**May 2, 1975**
☐	☐	**San Francisco**	**May 9, 1975**
☐	☐	**Chicago**	**May 16, 1975**
☐	☐	**New Orleans**	**May 23, 1975**

Applicant's Name_____

Title_____

Organization Name_____

Address_____

City, State, Zip_____

Phone No._____

If My Application Is Accepted:

☐ I Will Make My Own Hotel Reservations.

☐ I Would Like InterStudy To Reserve A Hotel Room For Me.

For 1 Night _____ (Date)

For 2 Nights _____ (Date)

_____ (Signature)

BOSTON

Friday, May 2, 1975
Statler Hilton
Park Square at Arlington
$26 Single $36 Double

SAN FRANCISCO

Friday, May 9, 1975
Miyako Hotel
Japan Center
1625 Post Street
$25 Single $34 Double

CHICAGO

Friday, May 16, 1975
O'Hare Inn
Mannheim and Higgins Roads
Des Plaines, Ill.
$26 Single $32 Double

NEW ORLEANS

Friday, May 23, 1975
Le Downtowner
Du Vieux Carre
541 Rue Bourbon
$22 Single $30 Double

- There is no enrollment fee, but application must be made and confirmed in advance
- The workshop will last one day, beginning with registration at 8:45 a.m., and ending at 4:30 p.m.
- A luncheon and coffeebreaks will be provided
- Participants will be responsible for their own transportation and hotel costs
- InterStudy will arrange for participants' hotel reservations, if requested on the application form
- Workshop size will be limited to approximately 50, to maximize participation by all attending
- Enrollment is not guaranteed; participants will be selected to ensure diversity of views and experience
- Participants will be notified of their acceptance by April 10, 1975
- Application forms must be received by InterStudy no later than March 31, 1975

AHS-22046

HOSPITAL PROSPECTIVE PAYMENT

ISSUES and EXPERIENCES

A Workshop Jointly Sponsored by The Social Security Administration and InterStudy

THIS WORKSHOP WILL PROVIDE A FORUM FOR PARTICIPANTS TO OPENLY DISCUSS IDEAS, EXCHANGE INFORMATION, AND CONSIDER THE PROS AND CONS OF PROSPECTIVE PAYMENT SYSTEMS

WORKSHOP TOPICS

- THE POTENTIAL ROLE OF PROSPECTIVE PAYMENT IN NATIONAL HEALTH POLICY
- ISSUES FUNDAMENTAL TO THE DETERMINATION OF PROSPECTIVE RATES
- THE PROS AND CONS OF VARIOUS PROSPECTIVE PAYMENT SYSTEMS
- ORGANIZATIONAL MODELS UTILIZED IN THE ADMINISTRATION OF PROSPECTIVE PAYMENT SYSTEMS
- THE USE OF FORMULAS IN PROSPECTIVE RATE DETERMINATION
- THE ROLE OF THE SOCIAL SECURITY ADMINISTRATION IN PROSPECTIVE RATE DETERMINATION
- DATA AND INFORMATION SYSTEMS REQUIRED TO SUPPORT PROSPECTIVE PAYMENT SYSTEMS

DISCUSSION LEADERS

SPEAKERS AND GROUP DISCUSSION LEADERS WILL BE INDIVIDUALS FROM:

- THE SOCIAL SECURITY ADMINISTRATION
- VARIOUS ORGANIZATIONS CONDUCTING RESEARCH RELATED TO PROSPECTIVE PAYMENT
- INTERSTUDY
- OPERATING PROSPECTIVE PAYMENT PLANS

FIRST CLASS PERMIT
NO. 10019
Minneapolis MN

BUSINESS REPLY MAIL

Postage will be paid by

SSA – Prospective Payment Workshop
c/o InterStudy
123 East Grant Street
Minneapolis MN 55403

THE WHITE HOUSE
WASHINGTON

DATE: 6-2

TO:

____F. DEBACA	____PAM POWELL
____JEFF EVES	____STAN SCOTT
____VIRGINIA KNAUER	____WAYNE VALIS
____PAT LINDH	____JOHN VICKERMAN
✓ TED MARRS	____DON WEBSTER

FROM: WILLIAM J. BARODY, JR.

____FOR YOUR INFORMATION

____FOR APPROPRIATE ACTION

✓ FOR YOUR COMMENTS/
RECOMMENDATIONS

____OTHER:

St. Ignatius Manor, Inc.

S. 1009 Mill Street • Phone (509) 397-3446

Colfax, Washington 99111

26 May 1975

Mr. William J. Baroody, Jr.
Special Assistant to the President
The White House
Washington, D. C. 20500

Dear Mr. Baroody:

I recently received a copy of Mr. Wiley Cittenden's letter to you regarding the relationship of the administration and the American Health Care Association. As the National Chairman for the Nursing Homes for Nixon-Agnew Committee. I am amazed at the lack of understanding between the leaders of our industry and the H. E. W. I feel our Association is doing everything in its power to provide better care for our patients. The automratic incompetence of the bureaucrats must be stopped if we are to achieve our goals. President Ford must know now what is going on. I found him to be a fair, sensible man when he was a Congressman. It's time someone talked to him. If this situation continues, he cannot expect support from us in his future plans. I certainly will not help him or the Republican party.

Sincerely,

Roy J. McDonald

Mr. Roy J. McDonald
P.O. Box 680
Colfax, Washington 99111

99111

Mr. William J. Baroody, Jr.
Special Assistant to the President
The White House
Washington, D. C. 20500

NATIONAL COUNCIL OF HEALTH CARE SERVICES

May 1, 1975

Dr. Theodore Marrs
Special Assistant to the President
on Aging
103 Old Executive Office Building
The White House
Washington, D.C.

Dear Dr. Marrs:

Per our conversation of April 30, 1975, I am enclosing a copy of the letter Mr. Seidman sent to Mr. McMahon on April 11, 1975.

If I can be of any further assistance, please do not hesitate to contact me.

Sincerely,

Jack A. MacDonald per L.H.S.

Jack A. MacDonald
Executive Vice President

Enclosure

Suite 402 ▪ 1200 Fifteenth Street, N.W. ▪ Washington, D. C. 20005 ▪ Tel. (202) 785-4754

THE WHITE HOUSE

WASHINGTON

April 11, 1975

Dear Mr. McMahon:

The President has asked me to thank you for the letter of February 28 signed by yourself, Dr. Thomas G. Bell, and Messrs. Jack A. MacDonald and Michael D. Bromberg, following up on our discussion of February 6 about the impact of inflation on the health care field. My thanks also for the copies you sent to Dr. Marrs and to me.

We are encouraged that segments of the health care industry have taken positive steps to institute cost containment programs. Our review of the post-control period (April 1974 to February 1975) statistics on trends in medical care prices indicates that further positive actions to control costs will be required by all concerned parties. During the 10 months since economic controls were lifted, the Consumer Price Index (CPI) has increased 9.2% (11.2% annualized rate) while medical prices have increased 12% (annualized rate of 14.5%). For the same period, the composite hospital service charges index increased 15%. Thus, while the health industry has made significant strides toward cost containment, more effort will be needed to bring health cost increases back into line with price increases in the general economy. You can be assured that the Federal Government will continue to work with you in an effort to contain health costs.

Regarding the matter of prospective reimbursement, the Department of Health, Education, and Welfare (DHEW) recognizes the important potential of prospective reimbursement for cost containment and, accordingly, has greatly expanded its experimental activities under authority of Section 222 of Public Law 92-603. Thus far, priority in prospective reimbursement has been placed on hospital reimbursement. Projects are currently funded or being developed in eight States. In addition, seven contractors are completing comprehensive evaluations of the efficacy of prospective reimbursement systems which have been established in the past without Federal assistance. Also, there has been considerable activity within DHEW on the development of prototype systems which can be tested to determine their

validity and effectiveness. It is anticipated that approximately eight to ten new statewide prospective rate-setting systems could be developed in carefully controlled experimental settings.

You might be interested to know that in addition to implementing Section 222(a) of P.L. 92-603, the Department has undertaken a number of activities authorized under part (b) of that Section. One free-standing ambulatory surgical center was funded last year. We are also funding six projects which will cover new benefits in long-term care. These projects are designed to see if day care and home-maker services are viable alternatives to institutionalization of elderly persons. In addition, we are funding a study which will evaluate the effectiveness of direct reimbursement for physician assistant services.

Furthermore, I am informed that DHEW plans a series of national and regional conferences to disseminate information and stimulate interest in all areas identified in Section 222 of P.L. 92-603 as suitable for research in the area of cost containment. The four conferences on prospective reimbursement have already been announced and invitations have been sent to your office. Conferences concerning research into changes in benefits as authorized in part (b) will be announced soon. We hope these conferences will attract members of your organizations and institutions and will assist you in moving forward with us in this important activity.

We are encouraged to find your organizations are so supportive of a broadened experimental approach under Section 222. The Acting Assistant Secretary for Health, Dr. Theodore Cooper, and the Commissioner of the Social Security Administration, Mr. Bruce Cardwell, would be pleased to meet with you to discuss in more detail the scope of the Department's efforts and ways in which your input can be assured.

Sincerely,

L. William Seidman

L. William Seidman
Assistant to the President
for Economic Affairs

Mr. J. Alexander McMahon
President
American Hospital Association
840 North Lake Shore Drive
Chicago, Illinois 60611

Sorry this took so long. Hope to see you again soon.

NATIONAL COUNCIL OF HEALTH CARE SERVICES

1200 Fifteenth Street, N.W. ■ Washington, D.C. 20005

Dr. Theodore Marrs
Special Assistant to the
President on Aging
103 Old Executive Office Building
The White House
Washington, D.C.

NATIONAL COUNCIL OF HEALTH CARE SERVICES

April 1, 1975

President Gerald R. Ford
The White House
Washington, D.C.

Dear President Ford:

We appreciated very much the opportunity to meet with Mr. William Seidman, Dr. Theodore Marrs and other members of their staff to discuss matters of mutual concern in connection with the health care industry in this country.

As was indicated at the time of our meeting, February 6, 1975, we are very much concerned about the cost impact of several Federal regulations recently promulgated pursuant to the Social Security Act. That concern has greatly increased, not lessened, since the meeting.

Individual nursing homes are experiencing significant increases in their operating costs as a result of the new regulations. We refer specifically to the issuance of the following regulations: 20 CFR 405.1101(f) Dietitian Consultant; 20 CFR 405.1122 Medical Director; 20 CFR 405.1124 Nursing Services; 45 CFR 250.20(a)(3) Discharge Planning; and 20 CFR 405.1137 Utilization Review. It is our understanding that the preceding regulations were issued without a financial impact statement, such as is now requested by your Executive Order No. 11821, of the Department responsible for the promulgation of any Federal regulations. We are also unaware of any subsequent review of the regulations by the Council on Wage and Price Stability.

Mr. President, we strongly support efforts to improve the quality of patient care in our nation's nursing homes. We have offered our assistance to the Department of Health, Education and Welfare in the past and we now offer our assistance to you in assuring that the nation's nursing home patients receive quality care.

It should, however, be realized that this effort will not be without cost. We simply suggest that, as you outlined in your Executive Order 11821, the Department of Health, Education and Welfare should develop and publish cost data on regulations prior to their implementation. To correct the lack of such a statement for the above mentioned regulations, we respectfully request that such a statement be prepared by the Department of Health, Education and Welfare as expeditiously as possible. This process will now and in the future allow Congress,

Suite 402 ▪ 1200 Fifteenth Street, N.W. ▪ Washington, D.C. 20005 ▪ Tel. (202) 785-4754

State Legislatures, Consumers and Providers to make the appropriate financial and administrative judgements necessary to continue their participation in the Medicare and Medicaid programs. At the same time, it will hopefully assist in a further reduction of the spiraling cost of nursing home care in the country.

Mr. President, again we are not opposed to regulations which will improve the quality of care received by our patients. We only ask that the responsible Departments be aware of the costs of their regulations and provide the appropriate means for their attainment.

We would appreciate the opportunity to work with your staff or with the Council on Wage and Price Stability in developing additional information on this subject. We pledge our full cooperation in this endeavor.

Thank you for your thoughtful consideration.

Respectfully,

Roger C. Lipitz

Roger C. Lipitz
President
National Council of Health Care Services

Wiley M. Crittenden, Jr.

Wiley M. Crittenden, Jr.
President
American Health Care Association

NATIONAL COUNCIL OF HEALTH CARE SERVICES

March 26, 1975

The Honorable Morris K. Udall
1424 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Udall:

The members of the National Council of Health Care Services read with extreme interest your recent remarks before the American Association of Homes for the Aging on March 18. The National Council represents more than 65,000 beds of the major proprietary multi-facility health care firms. It is the only national association representing nursing homes which requires that its member facilities be accredited or accreditable by the "Accreditation Council for Long-Term Care Facilities" of the "Joint Commission on Accreditation of Hospitals."

First, let me say that we sincerely appreciate your focusing attention on the health care needs of our nation's elderly. As a presidential candidate, your attention can be very constructive in the efforts to develop some positive solutions to the problems in this vitally important segment of the health industry.

As you pointed out, the neglect of the elderly covers a broad spectrum of needs in addition to health care. The list of needs begins with the basics of everyday life such as, food, shelter, income and transportation. We need new, constructive and imaginative programs which address themselves to all of these areas including health care. The magnitude of such an endeavor will require the utilization of all our available resources in a manner similar to our country's vigorous pursuit of energy conservation. For what could be more important to this nation than the conservation of its greatest resource - its people.

A decision to eliminate a primary resource, proprietary nursing homes, from participation in this effort requires careful consideration and overwhelming evidence to sustain such a decision. We respectfully submit that such evidence does not exist. There is without question emotion in some quarters for that course of action, but not sustainable facts. Emotion is not a sufficient reason to destroy an industry, nor to deny a service to nearly one million elderly Americans who cannot wait until a replacement is found and brought up to a performance level capable of handling their needs.

The differences between non-profit and proprietary facilities have been found to be fairly insignificant. One of the nursing home industry's most persistent critics, Mrs. Mary Adelaide Mendelson, in her book Tender Loving Greed, comments that "roughly 15 percent of American nursing homes classed as non-profit...are not significantly different from their profit-making (proprietary) brethren." She discounts the differences further by

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citing a University of Minnesota study which concludes that "there are far greater differences between good and bad non-profit homes on the one hand and between good and bad proprietaries on the other than there are between the two categories."

Substantive studies conducted on the relationship between the quality of care provided to nursing home patients and the type of ownership of a facility provide fairly conclusive evidence.

Dr. Samuel Levey, Former Director of the Division of Nursing Home and Related Facilities, Massachusetts Department of Public Health, and presently Professor and Chairman of the Graduate Program of Health Care Administration at Mt. Sinai School of Medicine, New York City, completed a comprehensive study of this relationship from which he reported "A noteworthy finding was that non-profit facilities showed higher per diem costs but did not show higher quality ratings. In 1969, the average per diem cost of the non-corporate proprietary facility was $11.46, the corporation proprietary $13.52, and the charitable corporation $16.59. Regression analysis, however, revealed no significant relationship between type of ownership and quality of care." This conclusion by Dr. Levey and members of his research team was reached after a detailed review of nursing homes in the State of Massachusetts, which covered a period of years prior to and after the enactment of the Medicare and Medicaid Programs.

Another significant study, "Analysis of Selected Characteristics of a Matched Sample of Nonprofit and Proprietary Nursing Homes in the State of Washington," was conducted by Sharon Winn, MPA of the Battelle Research Institute, Seattle, Washington. In summarizing the study's findings, she concluded that "the evidence of this study does not support those who would censure the quality of care in nursing homes solely on the basis of the proprietary status of the facility." She reported specifically that there are "more similarities than differences between proprietary and non-profit nursing homes." Another study was conducted of nursing homes in the State of Minnesota, where similar findings resulted as was mentioned earlier.

The association of the profit incentive with efficiencies in the delivery of service and the inference that the efficiencies directly result in a reduction in the quality of patient care, requires further consideration. This is an allegation often repeated, which does not stand up under an objective review of the facts.

First, as the three studies mentioned above concluded, there is no significant difference in the quality of care generally provided in facilities with the profit motive, when compared to those without it.

Second, if there was an association between the profit motive and the reduction in quality, you could reasonably expect that the total cost of care in the two types of facilities would either be approximately the same or that the non-profit would be lower. This would follow since today both must meet equal standards of care, facility construction, and personnel, while the profit factor is eliminated from the non-profit facility's total costs. This is simply not the case.

Recently released data by the National Center for Health Statistics of the Department of Health, Education and Welfare, states that the average proprietary cost of care is $16.02 per patient day, while non-profit costs are running $17.33 per patient day - a difference of $1.31. If you then multiply that difference by the number of resident days (117 million) for non-proprietary facilities, the cost annually is approximately $154,400,000. Since the government pays for approximately 26 percent of the care in non-profit facilities, its share of the additional cost annually is approximately $40.1 million. This is in effect a subsidy in addition to other benefits usually enjoyed by non-profit facilities as a result of their tax exempt status.

The question, therefore, which might be justifiably asked is, if the quality and the standards are substantially the same for both the non-profit and the proprietary facilities, but the non-profit costs are higher, who is really "trading in the economics of misery"?

In a recent editorial, Professor Peter F. Drucker of Claremont Graduate School of Social Science stated that, "To earn enough to cover the genuine costs which only the so-called profit can cover, is economic and social responsibility, indeed it is the specific social and economic responsibility of business." He goes on to say, "It is not the business that earns a profit adequate to its genuine costs of capital, to the risks of tomorrow and to the needs of tomorrow's worker and pensioner, that "rips off" society. It is the business that fails to do so." That business has to make up its losses, through subsidies from the Government, a charitable organization or another third party, which has been for the most part the government in the case of the nursing home industry.

Further evidence can be offered as to the acknowledged failings of non-profit facilities, such as the numerous reports on St. Elizabeth's Mental Hospital in the District of Columbia as well as the lack of significant differences in the quality of care between facilities as a result of their ownership. However, further recriminatory statements will only serve to further divide our industry, which badly needs to bind its wounds and begin working together to solve the health needs of the nation's elderly. We would hope that Congress will recognize this need for unity and refuse countenance to those in the future, who dwell on their fellow professionals' alleged faults for personal gain. Your leadership and that of your Congressional colleagues is needed to develop the progressive and innovative programs needed by the nation's elderly.

In that vein, it should be noted that Senator Frank E. Moss as Chairman of the Senate Subcommittee on Long-Term Care of the Senate Special Committee on Aging, has released a series of reports and is presently introducing numerous pieces of legislation addressed to the problems which he and his committee have found during their more than 10 years of investigation. One bill which Senator Moss stated he will introduce, addresses a key problem facing the industry today, that of payment for services rendered under the Medicare and Medicaid programs. This is a major problem today for nursing home patients, the public, government agencies, and the industry. The possible impact of a solution to this problem should not be underestimated.

Mr. Val Halamandaris, Associate Counsel to the Senate Special Committee on Aging, stated in an interview in Modern Healthcare's March issue that in regard to the situation in New York City, "the whole problem in New York is the reimbursement system." The present Medicare and Medicaid payment systems have been documented in various studies as being non-uniform; contradictory; unresponsive to patient needs; subject to manipulation by various groups, including the Federal, State and local Government agencies; and most importantly, an actual disincentive to a provider to offer good care. A solution is needed which has incentives for providing good care, fiscal accountability, encourages and recognizes efficiencies, penalizes wastefulness and abuses, and does not discriminate against any facility because of its type of ownership.

The National Council believes that the penalities in any health care system must be meaningful and appropriate. We do not in any way condone abuses of the system or most importantly the patients. Those facilities whether they be nursing homes, hospitals, or boarding homes, which engage in such practices must be censured and penalized.

Coupled with this solution of the payment mechanism must be a greater recognition in the Social Security Act and in any national health insurance legislation of the actual needs of the elderly. We have traditionally designed the system with its benefits first and then attempted to fit the patient into it. That process must be reversed. The nature and extent of services offered by the system should be determined first by the actual needs of the beneficiary -- physical, mental, medical, and socioeconomic -- not the requirements of the financial support mechanism.

If the various incentives under the payment system, mentioned earlier, are then tied to assuring that the actual needs of the patient are met then you will see a tremendous change in the quality of care in all health facilities, not just nursing homes. However, so long as providers of services under Medicare and Medicaid must seek to fit their patients into the present unresponsive eligibility and benefit criteria, we shall all continue to have problems.

The industry itself has been responding in a positive and responsible manner to the many diverse needs of its patients and members. The National Council is for example, developing a new concept for the payment of services under the Medicare and Medicaid programs. We would be happy to discuss this with you in detail upon its completion early this spring.

Several of the Council's member firms are developing data systems for assessing individual patient and facility wide patient care. One firm is highly involved in the development of out patient and day care services for the elderly. We have numerous other projects underway which we would be happy to discuss further with you.

The American Health Care Association (formerly the American Nursing Home Association), representing more than 7,500 non-profit and proprietary facilities is particularly involved in the development of a completely new approach to delivery of long-term care services. This concept, known as Chronicare, was first conceived by the Association in

1970 and has been extensively analyzed by the Stanford Research Institute. Senator Humbert H. Humphrey and Representative Harley O. Staggers have introduced legislation to establish demonstration projects. The Chronicare concept has also found its way into several other pieces of legislation including Representative Barber Conable's proposal which you cited in your recent speech. I am sure that representatives of the American Health Care Association would be most appreciative of the opportunity to discuss the program with you.

The American Health Care Association has also developed extensive education programs and materials, a Volunteer Service Corps similar to the one found in hospitals, conducted extensive research in the area of fire safety from which they developed a Fire Safety Manual, and under a HEW grant conducted an extensive educational effort of nursing home activity directors. These are only a few of their extensive efforts to improve the quality of patient care provided by their member facilities.

The American College of Nursing Home Administrators, representing more than 5,000 licensed administrators, is actively developing extensive educational programs for nursing home administrators on both a state and national level. The curricula of their seminars cover every aspect of nursing home administration and management. In fact they are holding the first North American Symposium on Long-Term Care Administration this summer in Toronto, Canada, July 27-31, 1975.

In addition to the activities of the national organization, numerous state nursing home associations are involved in Peer Review programs, educational efforts, and research activities involving the further improvement of patient care.

In each of the activities mentioned above, the various groups are working on behalf of the entire industry, not just a segment of it. Those within the industry, who are concerned about its future and most importantly the patients it serves, realize they cannot afford to look only at their own particular segment. Rather everyone must concern themselves with the plight and needs of the entire industry.

The National Council of Health Care Services in conclusion takes strong exception to any attempt to segregate by ownership and thereby eliminate any portion of the industry from the opportunity to participate in the Medicare and Medicaid programs.

It is interesting to note that during the hearings currently being conducted in New York City by the Moreland Commission on the nursing homes there, Monsignor John Ahren of the Catholic Charities of Archdiocese of New York on Monday stated that he did "not" nor did those for whom he spoke "urge the priori exclusion of proprietary, public or voluntary sponsor."

Again we appreciate your attention to the health care needs of our nation's elderly, it is a needed and a worth-while effort and if we can be of assistance to you or your staff in answering any questions, please let us know.

Yours very truly,

Roger C Lipitz

Roger C. Lipitz
President

Ltr to AHA

I was most interested in your letter of February 28th concerning efforts of institutional health provider associations to contain cost increases on a voluntary basis. As you know, and as I have repeated in my own public statements, I am personally opposed to wage-price controls and instead favor the establishment of an economic climate in which productivity is encouraged through normal market conditions.

The restraint evidenced by the health industry since economic controls ended on April 30, 1974 is commendable and I hope your associations will continue to urge restraint in charge increases as well as expenditures so that we can maintain a control-free economy.

Your suggestion for accelerated activity in developing and testing prospective payment systems under the Medicare program is one which I find promising. Since authority for such increased experimentation exists under P.L. 92-603, I have asked the Secretary of HEW to meet with your associations to discuss the suggested appointment of a task force and what steps should be taken to assure an adequate level of experimentation in this area.

GL
Hugh MacGrane
File

July 2, 1975

Dr. T. C. Marrs
Special Assistant to the President for Human Resources
The White House
Washington, D. C.

Dear Ted and Annette:

How you folks manage to be so wonderfully gracious in the face of such devastating daily schedules is amazing.

We all thank you for everything.

At long last I have a little hard copy, descriptive of our projected goal (a global economic health system which uses our finest technology and science for the benefit of people).

The enclosure is an early stage proposal which I hope you will inspect and if worthy circulate among the several agencies which have allied interests. Is there any room for this among the Bicentennial Committee projects? We did the proposal in response to a request by the U.N. for Habitat and for planning with Comsat and N.A.S.A.

Any corrections, deletions, or additions you advise will be most helpful, I'm sure.

Affectionately always,

Hugh and Henrietta

HCM/t

PS.- I hope Dobson's ear is better. Best wishes to him and his bride - Remember to tell James of Frank's son at Albuquerque N.M.

Preliminary
Proposal For

A Real-Time
International Tele-Health
System

for demonstration to
HABITAT
United Nations Conference on Human Settlements

* Submitted to: United Nations
Center for Economic and Social Information

Submitted by: Auburn University, Auburn, Alabama and Medical University of S.C. Charleston, South Carolina
Rural Health Society, Canada and National University, Costa Rica
On behalf of: International Tele-Health Planning Group

*Also Submitted To: National Library of Medicine, Lister Hill National Center for Biomedical Communications, for approval for CTS Experimenters Project

Lewis J. Pinson, Ph.D.
Chairman, Biomedical Group

J. David Irwin, Ph.D.
Head, Electrical Engineering Dept.

Vincent S. Haneman, Jr., Ph.D.
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I. INTRODUCTION AND PROPOSAL STATEMENT

The International Tele-Health Planning Group, a multi-national, multi-university, multi-industry group, proposes operational demonstration of a real-time, twenty-four hour a day, international tele-health applications system. The proposed system will utilize existing and available satellite communications channels, ground station equipment, ground communication links and physiological instrumentation. Technical feasibility of such a system has been verified by numerous studies and by limited demonstrations.

The International Tele-Health Planning Group, within its membership, has brought together all elements essential to implementation of the proposed tele-health system. The elements may be grouped into three broad categories.

1. SERVICE - includes personnel, expertise and willingness to provide necessary services and consultation as inputs to the tele-health system.

2. TECHNOLOGY - includes feasibility and availability of hardware and methods for a tele-health system.

3. APPLICATION - includes need for and ability to use the tele-health system by personnel at remote sites.

The proposed system will be unique in providing around the clock service and in tailoring the service to best fit the needs of those persons responsible for rural health delivery at selected remote sites. The

demonstration system is designed to allow expansion in steps to the final goal of a world wide, self-supporting tele-health system.

II. SYSTEM DESCRIPTION

Inadequate health care, particularly in rural areas is a problem recognized by medical institutions, federal agencies and other interested groups. A number of proposed systems and demonstrations by various groups have shown technical feasibility and will evaluate specific facets of tele-health care application.

The system proposed by the International Tele-Health Planning Group is innovative and unique in the following ways:

- Real-time, twenty-four hour a day service is to be provided for medical emergency consultation and diagnosis.
- The proposed system is fully supported by a major medical university (Medical University of South Carolina). Additionally the Medical University of South Carolina, thru the Health Communications Network, has communication links with 23 hospitals throughout the state of South Carolina.
- Auburn University, thru its Department of Electrical Engineering, has the expertise in communications theory, computer analysis and computer data management to fully utilize the tele-health system and provide improved service to its users. Additionally the Department of Foreign Languages, the School of Veterinary Medicine and the School of Agriculture will provide services to help round-out the total tele-health service.
- Emphasis is being placed on determination of specific user needs. A symposium on rural health is planned by the International Tele-Health Planning Group to learn what services are needed by personnel in remote sites who are responsible for health care.

Thus the International Tele-Health Planning Group brings together a set of skills uniquely encompassing the total health care concept along with a proposed operational system which is technically feasible and flexible to best meet user needs.

Additional clarification of areas of responsibility is given in the following figures. Figure 1 shows a block diagram for the proposed system. It consists of two urban centers, Auburn University and the Medical University of South Carolina, serving two or three remote sites. Location of these sites as well as details of the satellite system will be coordinated with International Telecommunications Satellite Consortium (INTELSAT). Major service categories are given for Auburn University and the Medical University of South Carolina in the figure.

Four major program phases are envisioned as essential to the successful operation of the proposed real-time tele-health application system.

PHASE 1: PLANNING EFFORT - Determine details of the specific system to be demonstrated.

PHASE 2: IMPLEMENTATION - Based on results of the planning effort establish ground stations, communications links; and initiate personnel training, user protocol and an overall system operating plan.

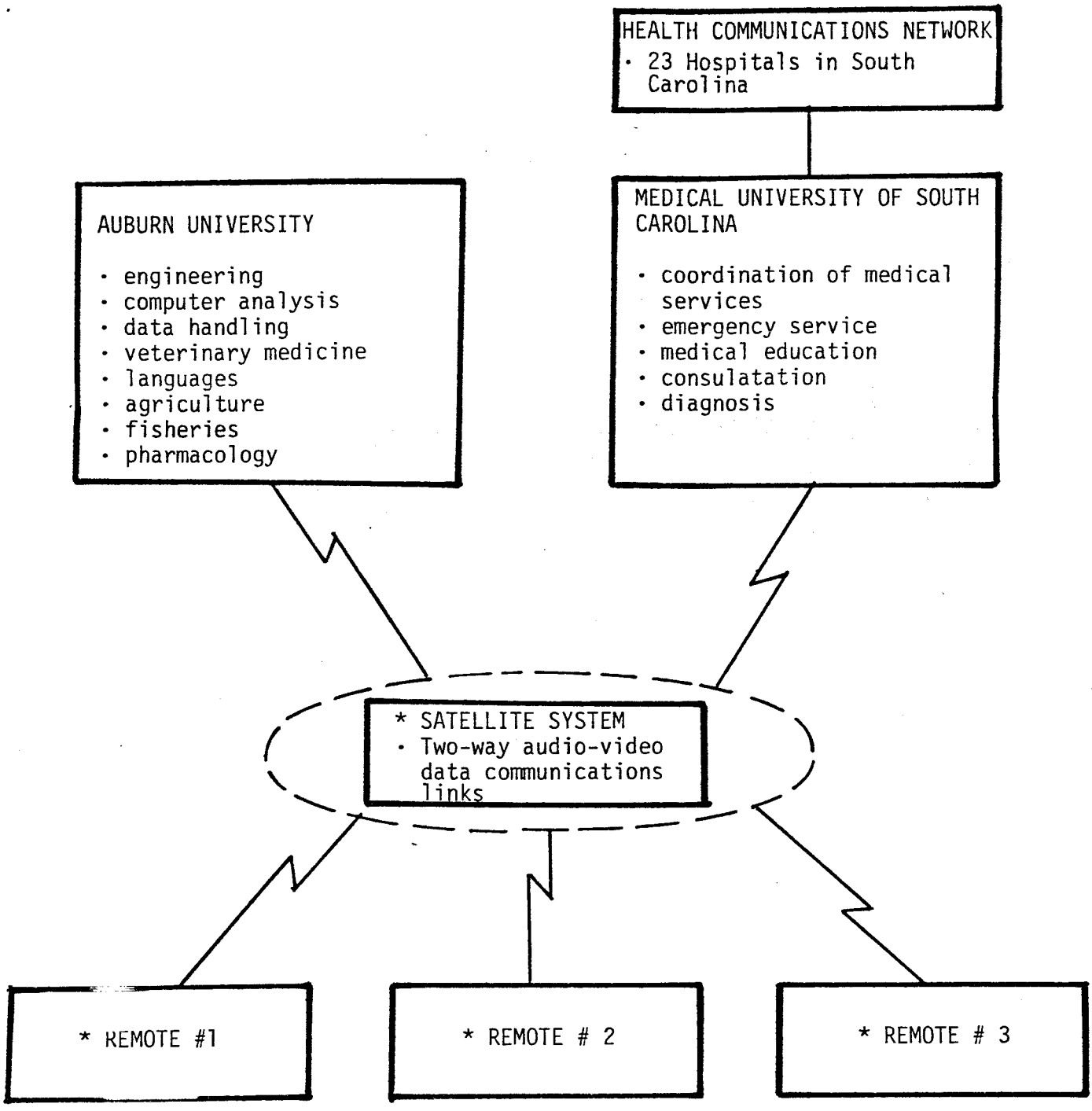
PHASE 3: OPERATION - Provide necessary manpower to operate the tele-health delivery system on a real-time, 24 hour a day basis.

PHASE 4: EVALUATION AND EXPANSION - Provide continuing evaluation of the tele-health concept through all steps of the program.

The planning effort is first and essential to the other phases. For that reason additional information of Phase 1 in the form of specific tasks is given in Figure 2. Primary coordinating responsibility for each task within the International Tele-Health Planning Group is also given. Results of the planning effort would provide all information necessary for completion of Phases 2 and 3.

It is felt that results of the proposed system in conjunction with improvements in satellite and ground station equipment, computer-aided health care, and tele-health care economics will lead to a world-wide international tele-health applications system such as shown in Figure 3. The specific ground sites shown in the figure represent those for which definite interest in the tele-health delivery concept has been expressed to the International Tele-Health Planning Group.

Phase 4, a continuing effort thoughout the proposed program involves evaluation of results and predicted economies to determine practicability of the dedicated system shown in Figure 3.



* Selection of remote sites and satellite system capability to be coordinated with International Telecommunications Satellite Consortium (INTELSAT)

FIGURE 1. Operational System Block Diagram -- International Tele-Health Applications System

FIGURE 2. PHASE I PLANNING EFFORT TASKS

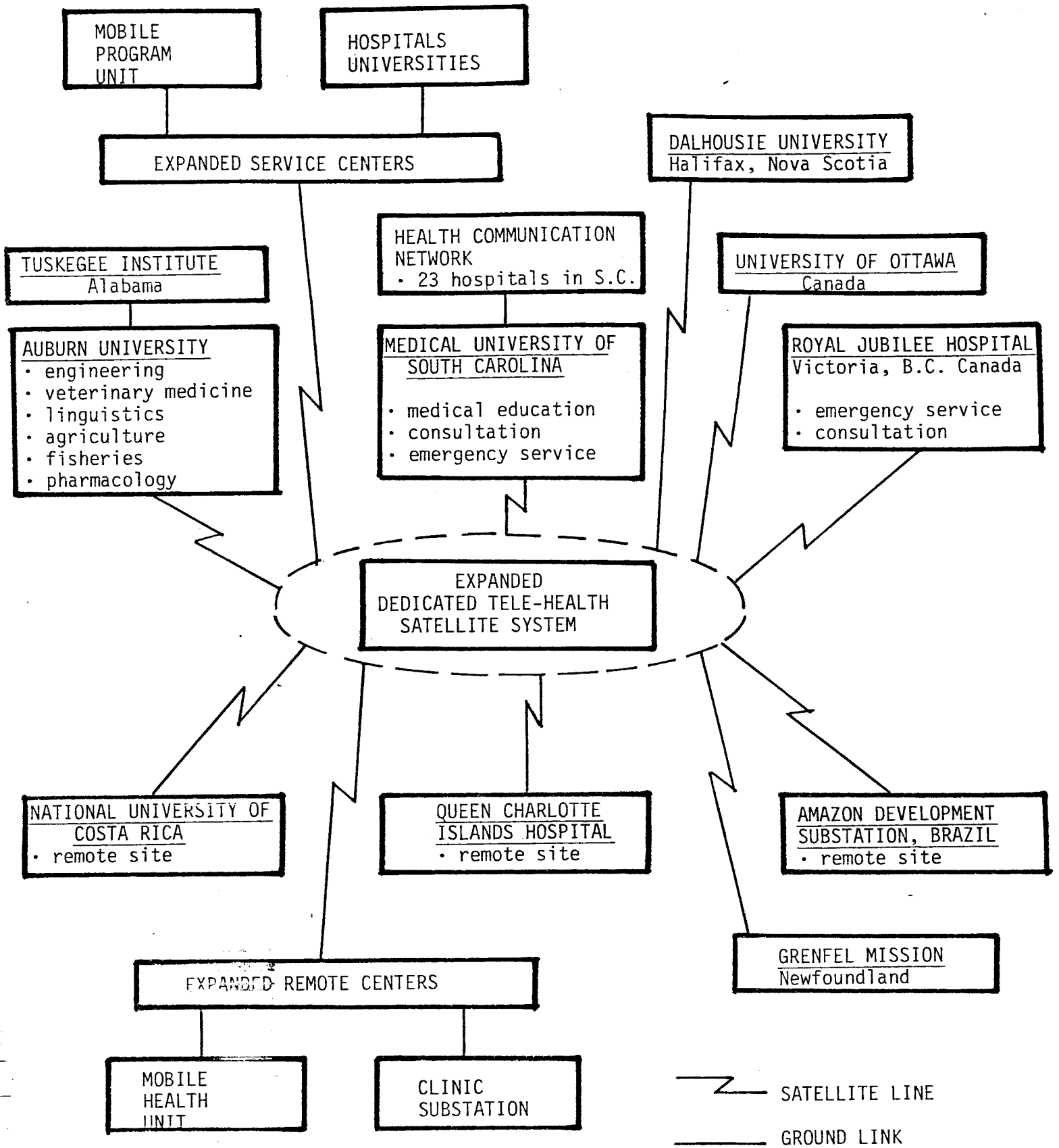
ITPG - International Tele-Health Planning Group

	TASK	ITPG COORDINATOR	COORDINATED WITH
1.	Determine number and location of ground stations, satellite channel availability and bandwidth. Consider present operational system and projected future system.	• Auburn University	• INTELSAT
2.	Determine availability, cost and capability of primary (antenna, transceivers, audio-video circuits, etc.) and auxiliary (physiological monitors, x-ray, pre-processing, etc.) ground station equipment.	• Auburn University • University of Texas, Austin	• Colorado Video • General Electric • Scientific Atlanta • Western Union • ASDA, Ltd. • Cable Video Comm. • INTELSAT • Other Industry Sources
3.	Determine specific areas of consultation for medical service (emergency and consultation, diagnosis) including scheduling, personnel, protocol, priorities, etc. Determine similar information for other service areas (veterinary medicine, agriculture, language, etc.).	• Medical Univeristy of South Carolina, • Auburn University	• Health Communication Network of South Carolina • Personnel at Remote Sites
4.	Define back-up services from hospitals, other universities, etc.	• Medical Univeristy of South Carolina • Auburn Univeristy • Rural Health Society • Royal Jubilee Hospital	• Health Comm. Network • University of Alabama • Tuskegee Institute • Other

FIGURE 2 (Cont'd) PLANNING EFFORT TASKS

TASK	ITPG COORDINATOR	COORDINATED WITH
5. Define system integration, equipment operation, computer control programming, data handling and system operational procedure documentation.	• Auburn University	• INTELSAT • Equipment manufacturers
6. Define necessary technical and medical training services to personnel at both remote and urban ground station sites.	• Medical University of South Carolina • Auburn University	• Health Comm. Network Personnel • Remote site personnel • Urban site personnel
7. Investigate improved data analysis, health care delivery techniques utilizing advantages offered by the tele-health system.	• Auburn University • Medical Univeristy of South Carolina	• Remote sites • Other ITPG members
8. Seek funding support for the operational system; evaluate success of the system; compare economies; and investigate feasibility, economy and funding sources for a world-wide tele-health concept.	• Medical University of South Carolina • Auburn University • University of Alabama at Huntsville	• All members of ITPG • National Library of Medicine • White House Office of Human Resources • INTELSAT • UNITED NATIONS • Other agencies, foundations or groups.
9. Prepare a report fully documenting results of the planning effort. This report will serve as a system implementation and user guide.	• Auburn University • Medical Univ. South Carolina	• All related groups

FIGURE 3. DEDICATED WORLD-WIDE TELE-HEALTH SYSTEM



III. PHASE I BUDGET AND PERSONNEL

The attached budget shows typical expenditures for the Phase I planning effort. The budget of $50,000 is for a three month effort with documentation to be completed within thirty (30) days following the end of the three month period.

Personnel in addition to those listed, within the International Tele-Health Planning Group, will be available on salaried or consultant basis to aid in achieving goals of the planning effort. Auburn University will administer the planning effort for the International Tele-Health Planning Group.

A start date of 1 August 1975 is proposed. Modifications to the proposal are negotiable. Questions on the proposal should be directed to Dr. Chester C. Carroll, authorized representative for Auburn University.

PHASE I - PLANNING EFFORT TYPICAL BUDGET
(3 months)

1.	Salaries and Wages	$21,034.00
	A. Participating personnel:	
	a. Lewis J. Pinson, Ph.D, Asst. Prof., Project Leader, AU	
	b. Hugh C. MacGuire, M.D., Adj. Prof., Project Leader, AU	
	c. Vince Moseley, M.D, Director, Continuing Education, MUSC	
	d. J. David Irwin, Ph.D, Assoc. Prof. & Head, EE Dept., AU	
	e. Chester C. Carroll, Ph.D., Vice-Pres. for Research, AU	
	f. David L. Christensen, Ph.D., Research Associate, UAH	
	g. Martial A. Honnell, Professor, AU	
	h. H. Troy Nagle, Ph.D, Assoc. Professor, AU	
	i. Encel H. Dodge, Dir. of Contract & Grant Dev., AU	
	j. Allied Medical University of South Carolina Personnel	
	AU - Auburn University	
	MUSC - Medical University of South Carolina	
	UAH - University of Alabama at Huntsville	
	B. Secretarial	2,000.00
	C. Graduate Research Assistants (Programming)	2,000.00
	Sub-total	$25,034.00
2.	Overhead (58% of 1.)	14,519.72
3.	Employee Benefits (18% of 1A and 1B)	4,146.12
4.	Materials, Supplies and Services	1,000.00
5.	Computer (2 hrs @ 250.00)	500.00
6.	Travel Expenses	2,500.00
7.	Communications	300.16
8.	Consultant	2,000.00
	TOTAL	$50,000.00

H. WAYNE GILLIES

July 25, 1975

Dear Ted,

Please find attached hereto a publication which I have prepared for the physicians of Texas. I thought it might be of interest to you.

Kindest regards,

H Wayne

Dr. Ted Marrs
Special Assistant to the President
of the United States
The White House
Washington, D.C. 20506

Texas Statutes Related To
The Practice Of Medicine:

the physician and the law

H. WAYNE GILLIES
ATTORNEY AT LAW
1609 NIELS ESPERSON BUILDING
HOUSTON, TEXAS 77002

Dr. Ted Marrs
Special Assistant to the
President of the United States
The White House
Washington, D.C. 20506

HERMANN HOSPITAL / TEXAS MEDICAL CENTER / 1203 ROSS STERLING AVENUE / HOUSTON, TEXAS 77025

DAN G. KADROVACH, FACHA
HOSPITAL DIRECTOR

April 28, 1975

Dear Doctor,

At my request, Mr. H. Wayne Gillies, Chairman of the Volunteer Professional Group in the Hermann Hospital Development Program, has prepared the attached summary of Texas laws pertaining to the medical profession.

Too often, physicians face inordinate liabilities for having failed to satisfy the statutory requirements placed on the medical profession by the Legislature.

It is my hope that you will carefully read this presentation and that it will be of lasting benefit to you.

I am sure you will join me in expressing appreciation publically to Mr. Gillies for spending his valuable time in preparing this summary for the Hermann Hospital Staff at no charge to the Hospital.

Sincerely,

Dan G. Kadrovach

Dan G. Kadrovach, FACHA
Executive Director, Hermann Hospital

H. WAYNE GILLIES
ATTORNEY AT LAW
1609 NIELS ESPERSON BUILDING
HOUSTON, TEXAS 77002
(713) 229-8678

Mr. Dan G. Kadrovach
Director
Hermann Hospital
Texas Medical Center
1203 Ross Sterling
Houston, Texas 77025

Dear Mr. Kadrovach:

Pursuant to your request, I have prepared the attached brief on the statutes of Texas pertaining to the practice of medicine. It is my hope that the physicians reading this presentation will realize that potential professional liability is greatly reduced by conforming their practice to meeting basic statutory requirements of this State.

In my opinion, every effort should be made to reduce the inordinate burden of litigation with which our physicians must daily live.

Yours sincerely,

H. Wayne Gillies
Chairman
Volunteer Professional Group
Hermann Hospital

HWG/pf
attachment - as stated

TEXAS STATUTES RELATED TO THE PRACTICE OF MEDICINE: THE PHYSICIAN AND THE LAW

TEXAS STATUTES RELATED TO THE PRACTICE OF MEDICINE:
THE PHYSICIAN AND THE LAW

I N D E X

M E M O R A N D U M

TO: Dan G. Kadrovach, Director, Hermann Hospital

FROM: H. Wayne Gillies, Attorney at Law

DATE: February 25, 1975

RE: Texas Statutes Related to the Practice of Medicine: The Physician and the Law

Often, those who are meant to be the beneficiaries of various statutes find the laws, as written, are the greatest barriers to their protection.

The practice of medicine and the importance it bears to the functioning of modern society has made it the subject of several legislative enactments.

The greatest difficulty encountered in preparing this memorandum was that the Texas Statutes regulating the practice of medicine are scattered throughout the statutes. There is no one place to look to find out what the physician is required by law to do. Thus, it is understandable that most physicians are uncertain what their statutory duties are. Most publications presented through the various medical journals, researched by me, have not, through the years, presented a definitive compilation of applicable statutes to the medical community.

The purpose of this memorandum is to attempt to provide some framework to the laws as they now exist. It will be divided into four parts.

Part One will discuss duties imposed by law on the practitioner. Part Two will deal generally with the liability of the physician under various statutes. Part Three will note various regulatory statutes concerning the actual practice of medicine. Finally, Part Four will be concerned with the special problem of drugs.

Two things should be kept in mind. First, the memorandum is concerned only with statutes. No attempt is made to apply case law. To do so would result in a book. Second, since violation of a statute is often considered as negligence per se, it is hoped that familiarity with statutory duties may enable the practioner to avoid potential grounds for malpractice suits against the physician, his clinic and/or the hospitals involved.

Finally, no attempt is made to evaluate the laws or to pass judgment on them. That is left for the reader, who knows infinitely more about the effect such statutes have on the practice of medicine than your writer.

I. Duties Imposed by Law

There are some acts a doctor is required to do. You have no choice. No discretion is allowed. Fortunately, the majority of these laws are directed toward reporting information and not toward treatment or examination. The duties may be divided into three classes: (i) the duty to treat or to examine; (ii) the duty to maintain records; and (iii) the duty to provide information.

A. The Duty to Treat or to Examine

Three statutes require the physician to perform certain examinations or treatment. All are directed toward preserving the well-being of the newborn.

The first time a pregnant woman comes into your office for a visit or examination, you are required to make a prenatal examination for syphilis.[1] The law directs that the blood sample be forwarded to an approved laboratory and that you retain the results in your files for at least nine months. If the woman changes doctors, you are required to forward the results to her new physician. The new physician need not make another examination. Violation of the law may result in a misdemeanor conviction with a fine of $200 to $500.[2]

Once the child is born, anyone attending the birth, whether doctor, nurse, or midwife, must take action to pre-

vent opthalmia neonatorium.[3] The statute directs the use of prophylactic eyedrops of 1% silver nitrate solution, or any other solution approved by the State Board of Health. Failure to do so can result in a fine of not less than $10 or more than $100.

Finally, the physician or other person attending a newborn baby is directed to subject the child to a phenylketonuria test as approved by the State Board of Health. If the test proves positive, the results must be reported to the county health officer. Upon confirmation, the State Board of Health and other cooperating agencies are directed to make services and facilities available to the family and the physician to the extent they are needed.[4]

If, however, the parents of the child object to administration of the test on religious grounds, the physician is not required to give the test over their objections. In fact, the statute relieves the physician of liability and responsibility when the parents or guardian refuse to give permission or to consent to the test.[5]

B. The Duty to Maintain Records

The State of Texas requires certain information and records be maintained by hospitals.

When a person is admitted or committed to any hospital or other institution, whether public or private, the physi-

cian in charge must specify for the record the nature of the disease and where, in his opinion, it was contracted. The information may be obtained from the patient where practicable; if not, from friends and relatives.[6]

In addition, the hospital superintendent, manager, or director is required to keep records of all persons admitted.[7]

The reader should recall that results of prenatal syphilis examinations must be retained for nine months.[9]

Other than the above statutes, there appear to be no other mandatory record-keeping provisions, except in the area of drugs (Part IV, infra.)

C. The Duty to Provide Information

The Texas scheme allows permissive reporting of certain types of information, and mandatory reporting of other types.

The permissive reporting statutes generally protect the physician from liability for limited disclosure, while the mandatory reporting statutes impose penalties for failure to report.

1. Permissive Reporting: Response to Approved Immunization Surveys

Any person, hospital, nursing, or rest home, sanitorium, medical society, or other organization may res-

pond to requests for information relating to the treatment of any person.[9]

There are two limitations. First, the inquiry must have been made by the State Department of Health, medical organization, hospital, or hospital committee. Second, the purpose of the inquiry must be to gain information, either to study ways to reduce morbidity or mortality, or to identify persons who may be in need of immunization.

No liability of any kind or character can be imposed on the source of the information because the soliciting organization has published its findings in summary form.[10]

Certain duties of non-disclosure are placed on the gathering person or group.

Only summaries of the data may be used for general publication. Unless the survey was conducted by the State Board of Health for the purpose of identifying persons in need of immunization, the identities of the patients must be kept confidential. In addition, all information furnished pursuant to the Act is declared privileged.[11]

The statute also protects the physician from liability when he furnishes information to hospital, medi-

cal organization, or extended care facility committees, either under state or federal law or under such organizations' by-laws and rules, as long as the information concerns a person he has treated or who is confined in the particular facility.

Finally, immunization data forwarded to the State Department of Health or to a study conducted under the auspices of the State Department of Health may not be used as evidence in any suit against the physician involving an injury related to an individual's immunization.[13]

2. Mandatory Reporting: About the Newly Born

The attending physician is required to complete and file a birth certificate within five days after birth.[14]

For still births, the person in charge of interment or removal of the body is responsible for obtaining and filing the certificate.[15] The physician is required to certify the necessary death information and to state whether or not a blood test for syphilis was made during pregnancy.[16]

Failure to perform the duties required by the Act may result in a $5.00 to $50.00 fine for the first offense, and a $10.00 to $100.00 fine and imprisonment

in county jail for sixty days for each subsequent offense.[17]

Nurses also have a duty to report any eye inflammation or redness of the eyelids they notice in a newborn under their care. Reports must be made to local health authorities, or if unavailable, to any reputable physician, within twelve hours.[18]

3. Mandatory Reporting: About Child Abuse

The Texas Family Code imposes a positive duty on any person who suspects child abuse or neglect to report.[19] Such reports may be non-accusatory, reflecting the reporter's belief that a child has been or will be abused or neglected. Reports may be made to the county welfare unit, the agency responsible for juveniles, or to local or state law enforcement officials.[20]

The law further provides oral reports shall be made immediately upon discovery, and shall be followed by a written report within five days. Anonymous reports, while not encouraged, will be accepted.[21]

As long as the person making such reports is not motivated by bad faith or malice, the reporter is immune from liability that might otherwise be incurred, whether civil or criminal, and such immunity extends to participation in any judicial proceeding resulting

from the report.[22]

After the report has been received, the appropriate county agency will conduct a full investigation and, if necessary, will petition the courts to have the child removed from his environment to a place of safety.

It should be emphasized that the policy of the chapter is to obtain information about abused or neglected children whose emotional health and welfare are in danger, so that appropriate steps may be taken to protect them. If you suspect child abuse, you should report it.

4. Mandatory Reporting: About Disease

A. In General

If a physician suspects or knows that a patient has any contagious disease, he is required to report it in writing or by acknowledged telephone conversation to local health authorities.[23] If the disease is of a pestilential nature, he must notify the President of the State Board of Health by phone or telegraph at state expense, and report any death immediately after it occurs.[24] For the purposes of the section, contagious diseases include Asiatic cholera, bubonic plague, typhus fever, yellow fever, leprosy, smallpox, scarlet fever (scarlatina), diptheria (membranous croup), epidemic cerebro-spinal meningitis,

denguetyphoid fever, epidemic dysentary, trachoma, and anthrax.[25]

Special provisions are made for certain disease, such as venereal disease and tuberculosis.

B. Venereal Disease

Anyone who diagnoses a case of venereal disease is required to report it immediately to the local health officials. Such reports must include the name, address, age, sex, race, and occupation of the diseased person.[26] Further, every physician or other person who examines or treats a person with venereal disease has an affirmative duty to instruct such person in measures for preventing the spread of the disease and of the necessity of continuing treatment until cured.[27] If the physician suspects the person is not following his instructions, he has the affirmative duty to notify local health officials.[28] The information so provided is inaccessible to the public.[29] Willful violation of the law results in forfeiture of the physician's license and a $5.00-$50.00 fine.[30]

Laboratories are required to report positive results to the Communicable Disease Services Station, Texas State Department of Health, through the local health officials.[31] Reports may be made on a weekly

basis, except for syphilis, which by law must be reported within twenty-four hours.[32] In fact, the laboratory must report monthly before the fifth usual working day of the following month, even if there is nothing to report.[33] Laboratory notifications are confidential,[34] and no contact can be made with the patient or potential contacts until the diagnosis has been reported to the state by the physician.[35]

C. Tuberculosis

There is also imposed upon the physician a duty to report cases of tuberculosis to local health officials.[36] Such reports may be made in writing or by acknowledged telephone communication, and should include age, sex, race, occupation, date of onset of the disease, and probable source of infection.[37] The physician also has the positive duty to instruct the person of methods to prevent the spread of the disease and of the necessity of treatment until cured.[38] He also has the duty to notify local health officials if he suspects the patient is disobeying his instructions.[39]

The reports of disease must be accompanied by a copy of results of all pathological findings pertinent to the disease.[40]

Violation of the Tuberculosis Code can result in

a $50.00-$500.00 fine and/or thirty days imprisonment in the county jail.

5. Mandatory Reporting: About Gunshot Wounds

Here the law is very simple. If you treat a gunshot wound, you have to report it to the local police authorities.[42] The statute places the same duty on administrators or superintendents of hospitals, sanitariums, or other institutions.[43]

Willful failure to report bullet and gunshot wounds can result in a misdemeanor conviction carrying a punishment of imprisonment up to six months and a fine not to exceed $100.00.[44]

6. Mandatory Reporting: About Death

The physician is not responsible for obtaining and filing the death certificate. This duty falls upon the person in charge of interment or of removal of the body from the district for disposition.[45] Such person is charged with obtaining the medical certification from the attending physician at death.[46]

However, if the attending physician is unable to certify the cause of death with certainty, he has a duty to report that fact to the Medical Examiner (in counties of over 500,000 persons where established by commissioner's court)[47] or to the local justice of the peace.[48] Superintendents of institutions have a similar duty, which may be fulfilled by reporting the death to the medical examiner or the city or county police departments.[49] The medical examiner or justice of the peace is required to hold

an inquest.[50]

Falsification of death information may result in a $5.00-$50.00 fine and up to sixty days in the county jail.[51] Failure to supply information, or provision of willfully false or fraudulent information, can result in a one to two year trip to Huntsville.[52]

If an autopsy is required, consent must be obtained from a person having chrge of the body of the deceased (See Part II, infra). If the deceased is also a potential transplant donor, a short-cut procedure may be utilized. Upon notification by the administrator of the transplant facility, the medical examiner or his deputy is required to hold an immediate inquest.[53] If an autopsy is necessary, the medical examiner or his deputy is authorized to examine the organ to be transplanted. After examination, the organ may be immediately released to the transplant team.[54]

Finally, if the physician is directed to perform an autopsy, reports must be filed with the office designated in the autopsy order within thirty days.[55] If tests require more than thirty days, the time period may be waived if the physician so certifies when the report is filed.[56]

II. Liability and Avoidance of Liability

Some Texas statutes specifically relieve the physician of liability for his acts. Others impose civil and/or criminal liability. Finally, others will condition avoidance of liability on the performance of other acts, eg. obtaining a valid consent.

The purpose of this section is not to set forth the development of malpractice law as it has evolved in the courts. Rather, its purpose is threefold: (1) to inform you of when you may take action without fear of liability; (2) to inform you of who may give consent in certain areas and what nature of consent is required by statute before action may be taken; and (3) to inform you of what you may not do.

A. The Good Samaritan

"Is there a doctor in the house?" In many an old movie, the familiar cry goes up when the hero has been shot or the heroine has fainted. Nowadays, with the threat of lawsuit always present, the noble practitioner might just as well hide his caduceus and silently slip away--except Texas law exempts him from liability in rendering emergency care in certain cases.

The law provides that no person shall be liable in civil damages for administering emergency care in good faith at the scene of the emergency.[57] The immunity is not com-

plete, however. The statute will not protect you if: (1) your actions are willfully or wantonly negligent, or (2) you perform such acts for renumeration or with the expectation of renumeration.[58]

Thus, as long as you are acting in good faith, and realize you do so without hope of being paid, you should be protected.

B. Consent

1. By Minors

The Texas Family Code in Chapter 34 attempts three goals. First, it tells which persons may consent to treatment of a minor. Second, it regulates the consent form itself. Third, it provides for certain circumstances where the consent by the minor is sufficient.

a. When the Parents Cannot be Found

When the minor is accompanied by a parent or guardian, the problem of consent to treatment is not present. But when such persons are not with the child, there is a danger that the adult who accompanies the minor has no authority to authorize medical treatment. The Code seeks to minimize the problem. When the persons having the power to consent by law cannot be contacted, and such persons have not given actual notice to the con-

trary, consent may be given by any one of the following: (1) a grandparent; (2) an adult brother or sister; (3) an adult aunt or uncle; (4) an educational institution in which the minor is enrolled that has received a written power of consent from the parent or guardian; (5) any adult having care and control of the minor who has a written power of consent from the parent or guardian; and (6) any court having jurisdiction of the child.[59]

You must attempt contact with the parents or guardian before consent may be obtained from one of the persons listed above. And, if you have actual knowledge that the parents or guardian have completely reserved to themselves the right to consent to treatment of the child, you may not obtain consent from such other persons, even if the parents cannot be contacted.

b. The Form and Content of the Consent

The Code also regulates the form and content of the consent in such cases. The consent form must contain the name of the minor, the name of the parents or guardian, the name of the person giving consent and his or her relation to the child,

the nature of the treatment to be given, and the date treatment is to begin.[60] Consent by persons other than the parents or guardians, as provided in Tex. Fam. Code §35.01 (1975), must be in writing, signed by the person giving consent, and returned to the doctor, hospital, or other medical facility that administers the treatment.[61]

c. When the Minor's Consent is Sufficient

There are certain instances where the minor may consent to treatment. He or she may consent to the furnishing of care by a hospital or of medical, surgical, or dental care by a physician if he or she is: (1) on active duty with the armed services, or (2) living apart from his parents, is over sixteen, and is managing his own financial affairs.[62] He or she may also consent to specific types of treatment. He or she may consent to treatment of contagious or communicable diseases which are of a type required to be reported.[63] An unwed mother may consent to treatment related to her pregnancy, but she may not consent to abortion.[64] A minor may consent to treatment for drug addiction, drug dependency, or any other condition directly related to drug use,[65]

if he is at least thirteen years of age or older.[66]

In addition, the statutes provide that a minor eighteen years of age or older may consent to donation of blood and the penetration of tissue necessary to accomplish the donation,[67] provided the blood bank operates under the supervision of a licensed physician or a hospital licensed under the Texas Hospital Licensing Law, if he receives no renumeration or compensation for his donation.[68] However, the effect of the lowering of the age of majority to age eighteen makes these provisions unclear in effect. If the person is eighteen or older, he would not now be a minor, and would seem to be free of these requirements.

If the minor gives his consent under one of the above noted statutes, such consent is not subject to doctor's disaffirmance because of minority,[69] nor is consent of the parents additionally required.[70] For added protection, the physician, dentist, hospital, or medical facility may rely on a written statement of the minor containing the grounds on which the minor has the capacity to consent.[71] A Texas licensed physician or dentist, or a hospital

or medical facility is liable only for his or its own acts of negligence in treating minors under situations where the minor gives his consent.[72]

Should you discuss the minor's treatment with his parents or guardian? The statute leaves it up to you. You may advise them of the treatment given or needed by the minor with or without his consent to discuss it with them.[73]

d. Protecting the Child in an Emergency

Special problems may be presented where a child is in immediate danger of physical or emotional injury, and no person can be found who may give consent, or when such persons refuse to consent to needed treatment. In such cases, a welfare department official, law enforcement officer, or juvenile probation officer may take possession of the child and deliver him to the juvenile court.[74] From this point on, the physician is involved only to the extent necessary to show the child is in danger. You should simply be aware that a procedure is available to obtain the necessary consent to treat the child, and of who you need to contact.

The reader should also recall that a court having jurisdiction over the child is authorized to

give consent or to authorize a temporary conservator to give consent to treatment.[75]

2. Transplant Donors: The Texas Anatomical Gift Act[76]

a. Who May Consent

Any person possessing testmentary capacity may make a gift of all or any part of his body.[77] If a person dies without expressing consent to make such a gift, others may in limited circumstances make a gift of all or any part of the deceased's body if the deceased has not expressed intentions to the contrary.[78] In order, they are: (1) a spouse; (2) an adult son or daughter; (3) either parent; (4) an adult brother or sister; (5) a guardian; or (6) any other person authorized or under an obligation to dispose of the body. The order is precise. You must ask the spouse first. If there is no spouse, you must ask an adult son or daughter, etc. In addition, if persons within a class designated by the order of persons authorized to consent are in disagreement, no valid gift may be given.

For example, if the adult son says yes, but the spouse says no, no valid gift may be made.[79] Or, if the spouse is dead, and an adult daughter says yes, and an adult son says no, no valid gift results.[80]

b. Who May Accept

Any hospital, medical school, surgeon, or physician may accept an anatomical gift for purposes of education or research.[81] Tissue banks and storage facilities may also accept for the same purposes and also for transplantation.[82] If an individual is specified by a licensed physician as being in need of therapy or transplantation, such individual may accept an anatomical gift.[83]

c. How Consent May be Given

Persons desiring to make anatomical gifts may do so in their wills. The gift becomes effective immediately upon death, and there is no necessity for probate. Even if the will is later held invalid, any person who has acted in good faith reliance upon the will need not fear liability, for the law provides that the gift remains effective.[84]

The gift may also be made in a separate document. To be valid, the document must be executed by the donor and witnessed by two credible persons.[85]

The person making the gift has a right to specify the donee. If at the time of death, the donee is not available and the donor has not expressed an intent to the contrary, the attending physician may

accept the gift as donee. If the person does not specify a donee, the attending physician may accept as donee.

In the latter two instances (where the attending physician accepts as donee), the attending physician may not participate in the procedures for removing the part or for transplantation.[86]

Where persons other than the donor are making the gift, such consent may be given either in a document or any other recorded message, including recorded telephonic communication.[87]

Of course, the donor has the right to revoke,[88] and the donee has the right to accept or to reject the gift.[89]

The document of the gift may be retained on a card in the possession of the donor, or may be given to the donee, or may be kept on file by a hospital or storage facility.[90] Any interested person may request another who has possession of the document of gift to produce it for examination upon or after the death of the donor.[91]

d. Avoidance of Liability

To avoid liability, the time of death must be determined by a physician who is not participating in

removal of the part or in the transplantation procedure.[92]

As mentioned earlier, even if the document of gift is otherwise held invalid, persons acting in good faith reliance are relieved of liability.

Finally, the act generally relieves any person acting in good faith and in accordance with the law from liability for civil damages or criminal prosecution.[93]

e. Anatomical Gifts and Required Autopsies

The act is expressly made subject to the laws regulating autopsies.[94] Fortunately, a short-cut autopsy procedure has been provided for potential transplant donors.[95] This point has already been discussed. (Part I, supra)

3. Artificial Insemination

There have been cases where semen donors have been held to be the legitimate father of the child. Some cases have even held that the wife has committed adultery authorizing divorce. Since such holdings tend to discourage semen donors, Texas had passed a law to avoid such results.

By law, the child born to an articifically inseminated woman is not the child of the donor unless the

donor is also the husband.[96]

The husband must consent to A.I.D. in writing and such writing must be acknowledged to make the child the legitimate child of both husband and wife.[97]

Thus, the donor is always protected. To protect yourself from a lawsuit based on negligence for failure to secure the husband's consent, thereby making the child illegitimate, you should secure the husband's consent in writing and have it acknowledged by a notary public.

4. Autopsies and Dissection

a. Autopsies

A physician may obtain consent to an autopsy sufficient to avoid liability. If the person is married, consent must be given by a spouse. If the spouse is not living, an adult child may consent. If the child is underage, the child's guardian, or if there is no guardian, the court having jurisdiction of the child may consent.[98]

If the deceased is unmarried, or is married but dies leaving no spouse or child, the person who may consent, in order, are: (1) father; (2) mother; (3) guardian; (4) next of kin; (5) any other person assuming responsibility of the body.[99]

The statute anticipates conflict. It provides that should two or more of the above listed persons take possession of the body, consent of one is sufficient.[100] For example, if the deceased's parents take responsibility for burial, and father says yes but mother says no, consent is sufficient to perform the autopsy.

In the event you are ever placed in a position where you are ordered by a justice of the peace to perform an autopsy, as long as you act in good faith, believing the order to be valid, you are not liable in damages if it is later determined that the order was invalid.[101]

b. Dissection

For schools, colleges, and the like to dissect bodies, they must obtain the consent of the Anatomical Board.[102] If consent is validly obtained, no criminal liability may be imposed for abuse of corpse. (This Part, infra)[103] Records sufficient to identify each body received must be maintained and are subject to inspection.

C. Commitment of the Mentally Ill

Should you certify a person as mentally ill or testify at a commitment hearing to that effect, and you are wrong,

there is always the possiblity that the patient will attempt to sue. As long as any person acts in good faith and without negligence in the examination, certification, apprehension, custody, transportation, detention, treatment, or discharge of a patient, such person is released from civil and criminal liability in performance of any act authorized or required by the Mental Health Code.[104]

D. Liability for Transplants and Transfusions

The statute[105] covering transplants and transfusions is written in the broadest of language. Its purpose is to limit legal liability arising from such procedures only to instances of negligence.[106]

Physicians, surgeons, hospitals, blood or tissue banks, and donors are protected. The statute covers donations, preparation, transplantations, and the like from one human to another.[107] It also covers persons assisting or participating.[108]

One exception is carved out. If a blood bank purchases blood with cash, and the blood contains harmful substances, the immunity provided by the section is denied.[109] The burden of proving the blood was not purchased is on the bank.[110]

However, blood banks may pay sellers of blood by check if the check is sent or delivered within fifteen days after

the donation.[111]

Thus, should the blood bank be sued, it will be required to prove that it did not pay cash for blood. Proof of a cancelled check should be sufficient, but it is advised records reflecting the blood donor, method of payment, and date of payment be maintained.

E. Prohibited Practices

1. Abortion

Even after the Supreme Court's decision in Roe v. Wade,[112] holding the Texas abortion statutes unconstitutional, the State of Texas has maintained the statutes on the books.

However, in light of the recent Edelin conviction in Boston, it is fairly certain that the Supreme Court once again will be faced with the abortion question. Dr. Edelin performed an abortion on a female during the latter part of the second trimester as authorized by Roe. He was convicted of murder, even though legally no person existed unless and until the fetus, once removed from the womb, would be able to sustain life separate from the mother.

The Texas statutes[118] prohibit performing or furnishing the means for performing an abortion, and also prohibit any attempt to perform an abortion.[114] Pen-

alty is set at two to five years in the penitentiary.

Abortion is defined as destroying the life of the fetus or embryo either in the womb or by premature birth.[115] Thus, the Edelin case would fall squarely under the Texas statute, had it not been struck down by the Supreme Court.

If death of the mother results from the abortion, it is murder.[116] If a child in the state of being born which could have been born alive is destroyed prior to actual birth, the punishment is set at five years to life imprisonement.[117]

The only exception in the statutory scheme is to save the life of the mother.[118]

The Roe case struck down these statutes. But in Boston, Dr. Edelin was convicted of murder, not for performing an illegal abortion. Should his conviction be upheld on appeal, it is fairly likely that the decision will be used to establish a new class of murder.

It is advised utmost caution be exercised in the performance of latter stage second trimester abortions.

2. Placement of Children

Texas law defines child placing activity as an ararangement for placement of a child with a third party not related to the child, or activity that aids or abets

such placement.[119] Child placing agency is defined as any person, public or private association, or corporation which assumes custody of a child under sixteen with plans for the placement of the child.[120]

When treating an unwed mother, it is possible you might be asked to help her find a suitable home for the expected child. You should realize thay if your actions fall under either one of the above definitions, you will be deemed to be conducting a child placement agency, The penalty for doing so without a license is a fine not to exceed $1,000.00 and/or imprisonment in the county jail for up to one year. Each day of violation is considered to be a separate offense.[121]

3. Abuse of Corpse

As set forth above, permission must be obtained to perform dissections. Otherwise a person commits a Class A misdemeanor if he performs any of the following acts without legal authorization: dissection; disinterment; removal; concealment; purchase; sale; or offensive treatment.[122]

Admittedly, the normal practitioner will probably never face this problem.

III. Regulation of the Practice of Medicine

In addition to the various statutes controlling the way in which you treat certain diseases, the State of Texas has felt it necessary to regulate the practice of medicine itself. The following is a brief synopsis of the pertinent statutes.

A. Unlawful Practice

Perhaps the threshold question involved in most unlawful practice cases is whether or not a person is actually "practicing medicine." Texas defines practicing medicine as professing publicly to be a physician or surgeon and offering to treat or to actually be treating any disease, disorder, deformity, injury, etc., by any system or method, or to effect cures thereof, or to do such and charge for services.[123]

To practice medicine, you must have a valid certificate. Practicing medicine without one may result in a $50.00-$500.00 fine and a visit of up to thirty days at the county P-Farm.[124] In a way, the rather broad definition of practicing medicine is good because it allows the State to stop a lot of quackery.[125] But, also it may be overbroad. A recent Attorney General's opinion[126] implies E.M.T.'s might be practicing medicine if they provide care beyond the normal scope of nursing even if they are directed by a physician by telephone or radio.

There are exceptions to the licensing requirement, faith healers being the most notable.[127] Not even the Texas Legislature has the audacity to try to license God (not yet, at least).

B. Identification of Systems of Healing

The Texas regulating scheme has separate chapters for the different forms of practicing medicine. Basically each form has it own licensing board and statutes regulating practice.[128] Each branch of medicine has its own designation. You are required by law to use the abbreviation for your particular branch of medicine in your professional correspondence.[129] The appropriate designations are set forth in the footnote.[130]

C. Registration

The law also requires you to register with the District Clerk's office in each county where you live or maintain an office before you can practice.[131] Failure to register consitutes prima facie evidence that you do not possess a certificate to practice.[132]

Practitioners and interns are also required to register annually with the Texas State Board of Medical Examiners. Physicians register when they are licensed to practice. Interns and residents are required to register as such within thirty days after beginning service and to notify the Board

within thirty days after termination.[133]

Failure to register and to pay the annual fee may result in a misdemeaner conviction carrying a $50.00-$500.00 fine and up to thirty days in county jail. Each day of violation is a separate offense.[134]

D. The Form of Practice

Medicine may well indeed be a noble profession, but doctors, like everyone else, have to eat. Medicine is in a sense, a business. The methods of practice that can be used are like any other business, with one major exception. Doctors may not use the corporate form to practice. The law prohibits incorporation by those who engage in an activity that requires a license to practice where such license cannot be issued to the corporation itself.[135]

There is a device known as the professional corporation that will allow persons to incorporate.[136] But while architects, lawyers, C.P.A.s, dentists, and veterinarians may take advantage of the act, physicians and surgeons are expressly excluded from the use of the professional corporation.[137]

You are allowed to use the professional association.[138] That act does not offer the advantages of insulation from liability offered by the corporate form. The act expressly states that the association is jointly liable with the

negligent member.[139] However, it also excludes from liability the individual members,[140] and in this manner may be more advantageous than the partnership.

E. Attracting Patients

You may not use any person, firm, association, partnership, or corporation for securing or soliciting patients if you do so by promising to employ, pay, or reward them for that purpose. Neither may any person accept payment, fee, reward, or anything of value for securing, soliciting, or drumming up patients for you.[141] If you want patients, you have to find them yourself. You cannot use others to find them for you.

You may, however, insert advertisements in newspapers, or use handbills and employ persons to distribute the handbills.[142] The advertisement may contain statements about your business and profession, and place of business.[143]

This should not be construed as a comment on the ethics of advertising by newspapers or handbills, but legally it can be done.

F. Collecting Fees

No, this section is not going to arm you with the legal ammunition to collect fees from recalcitrant patients. There are two circumstances where you are entitled to fees for performing services.

1. Examination of Rape Victims

If a law enforcement agency requests you to examine a victim of rape in order that it might use the results in its investigation or prosecution, the agency, and not the victim, is responsible for paying your fee.[144] The agency is not required to pay costs of treatment for injuries.[145]

2. Providing Necessary Medicial Treatment

The Texas Family Code imposes a duty to support the minor children on both spouses. A husband has the duty to support his wife, and the wife has a duty to support her husband if he is unable to support himself.[146]

Medical attention is considered a necessity.[147] Should you provide medical attention to one of those persons to whom support is owed, you may look to the person who owes the duty of support for payment.[148]

3. Fraudulent Conduct

If you make untrue statements or representations to procure and to withhold money or anything of value from a patient, you may be suspended and have your license revoked.[149]

For example, you may not demand your patient pay you for the services of another physician when in fact no other physician is used, and then refuse to return

his money on demand.

G. Malpractice

Okay. Not everybody's perfect. So you've screwed up and are accused of malpractice. In such cases, the district court is authorized to hear a petition seeking your suspension or revocation of your license.[150]

The statute is written broadly enough to cover fraudulent or dishonorable conduct.[151]

The statute is not mandatory, but the procedure is available to remove those doctors who are not fit to practice from the profession.

IV. The Special Problem of Drugs and COntrolled Substances

This area has been isolated because it is the one area most subject to legislative enactment. It is impossible to go into great detail because of the number and complexity of the governing statutes.

Hopefully, three ojectives will be achieved. First, the regulatory scheme will be examined in an effort to familiarize the reader with the basics. Second, the problem of drug distribution will be discussed. Third, the impact of the statutes on drug treatment programs will be noted.

A. The Regulatory Scheme

Three Acts form the basic framework for drug regulation in Texas: The Texas Food, Drug, and Cosmetic Act,[152] The Dangerous Drug Act,[153] and the Controlled Substances Act.[154]

1. The Texas Food, Drug, and Cosmetic Act

The major portions of the Act are directed toward the manufacture and sale of food, drugs, and cosmetics. The portions directed at distribution affect pharmacists more than physicians.

Section 14 defines adulterated drugs, Section 15 defines misbranded drugs, and Section 16 deals with new drugs.

Section 14 of the Act attempts to unsure that a drug will be properly labelled--that the drug is what

it purports to be. The drug must be pure. It may not consist of decomposed or defective materials, or produced under conditions that might lead to contamination.[155] Neither may it be placed in a container which might make the contents injurious to health or use a coloring not certified under the Federal Act.[156] The drug must also measure up in terms of quality as listed in official compendiums,[157] or if not listed, it must match its label.[158] Mixing and packing to reduce strength are similarly forbidden, except when done by pharmacists compounding and dispensing physician's prescriptions.[159]

Section 15 is directed at labeling by defining misbranded drugs. A drug is misbranded if the labeling is false or misleading.[160] Packaged drugs must have the name and place of business of the manufacturer, an accurate count or other measure of quantity.[161] If the Act requires statements, such as "Habit Forming," the words must be prominently displayed.[162] As far as the physician is concerned, drugs sold at retail only under a doctor's prescription must be labeled with the name and place of business of the seller, serial number and date of prescription, and the physician's name.[163]

Section 16 regulates new drugs. The thrust is to prevent distribution of new drugs until they have been adequately tested and approved. The section exempts drugs intended solely for investigational use by experts for the purpose of determining safety and effectiveness of the drug.[164] (Otherwise, a physician could be prosecuted for testing a drug for approval.)

2. The Dangerous Drug Act

The Dangerous Drug Act[165] is designed to regulate the use of dangerous drugs as closely as possible without impairing the therapeutic benefit to the public. Drugs covered by the Act are set forth in the Appendix.

As with the Food, Drug, and Cosmetic Act, the emphasis is on controlling the points of distribution.

Practitioners, researchers, hospitals, and their agents or employees are not covered by the section which sets forth unlawful acts.[166] However, such persons must make complete records of all tranquilizers, Phendimetrazine and its salts, derivatives, or compounds, and pentazocine, its salts, derivatives, and compounds.[167] The records must be maintained for two years and are subject to inspection.[168] Violation of the Act's provisions can result in a $1,000.00 fine and up to six months in jail. Subsequent violations double both--a

$2,000.00 fine and up to a year in jail.[169]

3. The Controlled Substances Act

The Controlled Substances Act[170] is the counterpart to the Dangerous Drug Act. Its primary thrust is toward drug abuse. Every person who manufactures, distributes, analyzes, or dispenses controlled substances must possess a valid registration.[171] Controlled substances are classified according to the drug schedule (See Appendix).

Practitioners may be licensed to dispense controlled substances in Schedules II through V upon proper application and payment of the fee.[172]

Schedule II substances may not be dispensed without a written prescription unless they are dispensed directly to the ultimate user by the physician.[173] Schedule III and IV prescription drugs also require a written prescription unless directly dispensed to the ultimate user, and may not be refilled more than six months after the date of the prescription nor may the prescription be refilled more than five times.[174]

In emergency situations, Schedule II drugs may be dispensed on oral prescription.[175] Schedule II prescriptions may not be refilled, nor may the original prescription be filled two days after issuance.[176]

B. The Distribution of Drugs

Many restrictions on distribution have already been discussed in analyzing the regulatory scheme.

The main problem presented is that the physician, in preparing and administering drugs to patients, crosses the professional boundary between physicians and pharmacists. The doctor would thus be practicing pharmacy without a license. To avoid this result, the Legislature expressly exempts licensed practitioners from the provisions of the pharmacist licensing laws.[177]

To be exempt, the physician must supply the drugs to the patient directly for treatment, He may not own a pharmacy or drug store that sells medicines.

C. Drug Treatment Programs

1. Regulation of Drug Maintenance Programs

It is unlawful to prescribe or administer synthetic narcotic drugs for the purpose of treating drug dependency without a permit issued by the State Department of Health.[178]

Physicians and institutions operating under the laws of the state for the purpose of providing health services may apply for a permit authorizing the prescription and administration of synthetic drugs.[179]

The Texas Department of Mental Health and Mental

Retardation has the responsibility to develop programs of drug treatment and maintenance through the use of synthetic narcotics.[180]

Failure to obtain a permit for such programs can result in a misdemeanor conviction carrying a $3,000.00 fine and up to six months in county jail.[181] The State Department of Health has the right to require reports if it wishes,[182] and may make such investigations as it deems necessary to insure compliance.[183]

A House concurrent resolution[184] expresses the Legislature's intent that the issuance of permits be regulated by the State Department of Health in such a way as to avoid "unnecessary concentration of permit holders in any neighborhood or area, as well as to prevent any unnecessary congregation of addicts, so that the program does not result in any significant influx of addicts to any residential neighborhood or area." What this means to the development of maintenance programs in the Medical Center area is left up to the reader's own imagination.

2. Minor's Consent to Treatment

It has already been noted that minors thirteen years old or older may consent to treatment for drug dependency, addiction, or any other condition related to drug

use (Part II, supra).[185] Parental permission is not required. A legally qualified physician is expressly released from liability in examination and treatment of the minor except for acts of negligence.[186]

The reader is asked to refer to the section on minor's consent for a more extensive examination of the applicable law.

3. The Limited Physician--Patient Privilege

In order to facilitate participation in drug abuse programs, in 1971 the Legislature granted a limited physician--patient privilege in the treatment of drug abuse. At common law, the physician--patient privilege does not exist. Thus, it must be created by statute, as has been done in this particular area. Communications to persons involved in the treatment or examination of drug abusers by a person who has voluntarily submitted to treatment or examination is not admissable.[187]

Information obtained may be used for statistical or research purposes if the patients' names are not revealed.[188]

Nomenclature

Sec. 2.02. The controlled substances listed or to be listed in the schedules in Schedules I, II, III, IV, and V and Penalty Groups 1, 2, 3, and 4 are included by whatever official, common, usual, chemical, or trade name they may be designated.

Schedule I

Sec. 2.03. (a) Schedule I shall initially consist of the controlled substances listed in this section.

(b) Any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, unless specifically excepted, whenever the existence of these isomers, esters, ethers and salts is possible within the specific chemical designation:

(1) Allylprodine;
(2) Benzethidine;
(3) Betaprodine;
(4) Clonitazene;
(5) Dextrorphan;
(6) Diampromide;
(7) Diethylthiambutene;
(8) Dimenoxadol;
(9) Dimethylthiambutene;
(10) Dioxaphetyl butyrate;
(11) Dipipanone;
(12) Ethylmethylthiambutene;
(13) Etonitazene;
(14) Etoxeridine;
(15) Furethidine;
(16) Hydroxypethidine;
(17) Ketobemidone;
(18) Levophenacylmorphan;
(19) Meprodine;
(20) Methadol;
(21) Moramide;
(22) Morpheridine;
(23) Noracymethadol;
(24) Norlevorphanol;
(25) Normethadone;
(26) Norpipanone;
(27) Phenadoxone;
(28) Phenampromide;
(29) Phenomorphan;
(30) Phenoperidine;
(31) Piritramide;
(32) Proheptazine;
(33) Properidine;
(34) Propiram;
(35) Trimeperidine.

(c) Any of the following opium derivatives, their salts, isomers, and salts of isomers, unless specifically excepted, whenever the existence of these salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) Acetorphine;
(2) Acetyldihydrocodeine;
(3) Benzylmorphine;
(4) Codeine methylbromide;
(5) Codeine-N-Oxide;

(6) Cyprenorphine;
(7) Desomorphine;
(8) Dihydromorphine;
(9) Etorphine;
(10) Heroin;
(11) Hydromorphinol;
(12) Methyldesorphine;
(13) Methyldihydromorphine;
(14) Morphine methylbromide;
(15) Morphine methylsulfonate;
(16) Morphine-N-Oxide;
(17) Myrophine;
(18) Nicocodeine;
(19) Nicomorphine;
(20) Normorphine;
(21) Pholcodine;
(22) Thebacon.

(d) Any material, compound, mixture, or preparation which contains any quantity of the following hallucinogenic substances, their salts, isomers, and salts of isomers, unless specifically excepted, whenever the existence of these salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) 3,4-methylenedioxy amphetamine;
(2) 5-methoxy-3, 4-methylenedioxy amphetamine;
(3) 3,4,5-trimethoxy amphetamine;
(4) Bufotenine;
(5) Diethyltryptamine;
(6) Dimethyltryptamine;
(7) 4-methyl-2, 5-dimethoxyamphetamine;
(8) Ibogaine;
(9) Lysergic acid diethylamide;
(10) Marihuana;
(11) Mescaline;
(12) Peyote;
(13) N-ethyl-3-piperidyl benzilate;
(14) N-methyl-3-piperidyl benzilate;
(15) Psilocybin;
(16) Psilocyn;
(17) Tetrahydrocannabinols and synthetic equivalents of the substances contained in the plant, or in the resinous extractives of cannabis, or synthetic substances, derivatives, and their isomers with similar chemical structure and pharmacological activity such as the following:

delta-1 cis or trans tetrahydrocannabinol, and their optical isomers;

delta-6 cis or trans tetrahydrocannabinol, and their optical isomers;

delta-3,4 cis or trans tetrahydrocannabinol, and its optical isomers.

(Since nomenclature of these substances is not internationally standardized, compounds of these structures, regardless of numerical designation of atomic positions are covered.)

Schedule II

Sec. 2.04. (a) Schedule II shall initially consist of the controlled substances listed in this section.

(b) Any of the following substances, except those narcotic drugs listed in other schedules, however produced:

(1) Opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate, including the following:
(A) Raw opium;
(B) Opium extracts;
(C) Opium fluid extracts;
(D) Powdered opium;
(E) Granulated opium;
(F) Tincture of opium;
(G) Apomorphine;
(H) Codeine;
(I) Ethylmorphine;
(J) Hydrocodone;
(K) Hydromorphone;
(L) Metopon;
(M) Morphine;
(N) Oxycodone;
(O) Oxymorphone;
(P) Thebaine;

(2) Any salt, compound, isomer, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in paragraph (1) of this subsection, but not including the isoquinoline alkaloids of opium;

(3) Opium poppy and poppy straw;

(4) Coca leaves and any salt, compound, derivative, or preparation of coca leaves, and any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of these substances, but not including decocainized coca leaves or extractions which do not contain cocaine or ecgonine.

(c) Any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, whenever the existence of these isomers, esters, ethers, and salts is possible within the specific chemical designation:

(1) Alphaprodine;
(2) Anileridine;
(3) Bezitramide;
(4) Dihydrocodeine;
(5) Diphenoxylate;
(6) Fentanyl;
(7) Isomethadone;
(8) Levomethorphan;
(9) Levorphanol;
(10) Metazocine;
(11) Methadone;
(12) Methadone–Intermediate, 4–cyano–2–dimethylamino–4, 4–diphenyl butane;
(13) Moramide–Intermediate, 2–methyl–3–morpholino–1, 1–diphenyl–propane–carboxylic acid;
(14) Pethidine;
(15) Pethidine–Intermediate–A, 4–cyano–1–methyl–4–phenylpiperidine;
(16) Pethidine–Intermediate–B, ethyl–4–phenylpiperidine–4–carboxylate;

(17) Pethidine–Intermediate–C, 1–methyl–4–phenylpiperidine–4–carboxylic acid;
(18) Phenazocine;
(19) Piminodine;
(20) Racemethorphan;
(21) Racemorphan.

(d) Unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a potential for abuse associated with a stimulant effect on the central nervous system:

(1) amphetamine, its salts, optical isomers, and salts of its optical isomers;
(2) methamphetamine, including its salts, isomers, and salts of isomers;
(3) methylphenidate and its salts; and
(4) phenmetrazine and its salts.

(e) Methaqualone.

Schedule III

Sec. 2.05. (a) Schedule III shall initially consist of the controlled substances listed in this section.

(b) Unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a potential for abuse associated with a depressant effect on the central nervous system:

(1) any substance which contains any quantity of a derivative of barbituric acid, or any salt of a derivative of barbituric acid, except those substances which are specifically listed in other schedules;
(2) Chlorhexadol;
(3) Glutethimide;
(4) Lysergic acid;
(5) Lysergic acid amide;
(6) Methyprylon;
(7) Phencyclidine;
(8) Sulfondiethylmethane;
(9) Sulfonethylmethane;
(10) Sulfonmethane.

(c) Nalorphine.

(d) Any material, compound, mixture, or preparation containing limited quantities of any of the following narcotic drugs, or any salts thereof:

(1) not more than 1.8 grams of codeine, or any of its salts, per 100 milliliters or not more than 90 milligrams per dosage unit, with an equal or greater quantity of an isoquinoline alkaloid of opium;
(2) not more than 1.8 grams of codeine, or any of its salts, per 100 milliliters or not more than 90 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts;
(3) not more than 300 milligrams of dihydrocodeinone, or any of its salts, per 100 milliliters or not more than 15 milligrams per dosage unit, with a fourfold or greater quantity of an isoquinoline alkaloid of opium;
(4) not more than 300 milligrams of dihydrocodeinone, or any of its salts, per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts;

(5) not more than 1.8 grams of dihydrocodeine, or any of its salts, per 100 milliliters or not more than 90 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts;

(6) not more than 300 milligrams of ethylmorphine, or any of its salts, per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more ingredients in recognized therapeutic amounts;

(7) not more than 500 milligrams of opium per 100 milliliters or per 100 grams, or not more than 25 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts;

(8) not more than 50 milligrams of morphine, or any of its salts, per 100 milliliters or per 100 grams with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.

(e) Any compound, mixture, or preparation containing any stimulant listed in Subsection (d) of Section 2.04 or depressant substance listed in Subsection (b) of this section is excepted from the application of all or any part of this Act if the compound, mixture, or preparation contains one or more active medicinal ingredients not having a stimulant or depressant effect on the central nervous system, and if the admixtures are included therein in combinations, quantity, proportion, or concentration that vitiate the potential for abuse of the substances which have a stimulant or depressant effect on the central nervous system.

Schedule IV

Sec. 2.06. (a) Schedule IV shall initially consist of the controlled substances listed in this section.

(b) Any material, compound, mixture, or preparation which contains any quantity of the following substances having a potential for abuse associated with a depressant effect on the central nervous system:

(1) Barbital;
(2) Chloral betaine;
(3) Chloral hydrate;
(4) Ethchlorvynol;
(5) Ethinamate;
(6) Methohexital;
(7) Meprobamate;
(8) Methylphenobarbital;
(9) Paraldehyde;
(10) Petrichloral;
(11) Phenobarbital.

(c) Any compound, mixture, or preparation containing any depressant substance listed in Subsection (b) of this section is excepted from the application of all or any part of this Act if the compound, mixture, or preparation contains one or more active medicinal ingredients not having a depressant effect on the central nervous system, and if the admixtures are included therein in combinations, quantity, proportion, or concentration that vitiate the potential for abuse of the substances which have a depressant effect on the central nervous system.

Schedule V

Sec. 2.07. (a) Schedule V shall initially consist of the controlled substances listed in this section.

(b) Any compound, mixture, or preparation containing limited quantities of any of the following narcotic drugs, which also contains one or more nonnarcotic active medicinal ingredients in sufficient proportion to

confer upon the compound, mixture, or preparation valuable medicinal qualities other than those possessed by the narcotic drug alone:

(1) not more than 200 milligrams of codeine, or any of its salts, per 100 milliliters or per 100 grams;

(2) not more than 100 milligrams of dihydrocodeine, or any of its salts, per 100 milliliters or per 100 grams;

(3) not more than 100 milligrams of ethylmorphine, or any of its salts, per 100 milliliters or per 100 grams;

(4) not more than 2.5 milligrams of diphenoxylate and not less than 25 micrograms of atropine sulfate per dosage unit;

(5) not more than 15 milligrams of opium per 29.5729 milliliters or per 28.35 grams.

Exclusion from Schedule

Sec. 2.08. A nonnarcotic substance is excluded from Schedules I through V if the substance may lawfully be sold over the counter without a prescription, under the Federal Food, Drug, and Cosmetic Act [1] and the commissioner shall have no power to include a nonnarcotic substance in Schedules I through V if the substance may lawfully be sold over-the-counter without a prescription under the Federal Food, Drug, and Cosmetic Act.

[1] 21 U.S.C.A. § 301 et seq.

Authority to Control

Sec. 2.09. (a) The legislature, under the directions hereinafter expressed, delegates to the commissioner with approval of the State Board of Health the power to add substances to, or delete or reschedule any substance enumerated in, the schedules enumerated in Sections 2.03 through 2.07 of this Act. The commissioner may not add any substance to the schedules if the substance has been deleted from the schedules by the legislature, or sought to be added to the schedules by the legislature but failed to pass when considered by a quorum of either house. The commissioner shall have no authority to extend scheduling to distilled spirits, wine, malt beverages, or tobacco.

(b) In making a determination regarding a substance, the commissioner shall consider the following:

(1) the actual or relative potential for abuse;

(2) the scientific evidence of its pharmacological effect, if known;

(3) the state of current scientific knowledge regarding the substance;

(4) the history and current pattern of abuse;

(5) the scope, duration, and significance of abuse;

(6) the risk to the public health;

(7) the potential of the substance to produce psychic or physiological dependence liability; and

(8) whether the substance is an immediate precursor of a substance already controlled under this Act.

(c) After considering the factors enumerated in Subsection (b) of this section, the commissioner shall make findings with respect thereto and issue a rule controlling the substance if he finds the substance has a potential for abuse.

(d) If the commissioner designates a substance as an immediate precursor, substances which are precursors of the controlled precursor shall not be subject to control solely because they are precursors of the controlled precursor.

(e) If any substance is designated, rescheduled, or deleted as a controlled substance under federal law and notice thereof is given to the commissioner, the commissioner shall similarly control the substance

under this Act after the expiration of 30 days from publication in the Federal Register of a final order designating a substance as a controlled substance or rescheduling or deleting a substance unless within that 30-day period the commissioner objects to inclusion. In that case, the commissioner shall publish the reasons for objection and afford all interested parties an opportunity to be heard. At the conclusion of the hearing, the commissioner shall publish his decision, which shall be final unless altered by statute. Upon publication of objection to inclusion, rescheduling, or deleting, control as to that particular substance under this Act is stayed until the commissioner publishes his decision.

(f) The commissioner, in making his decision as to which schedule a controlled substance shall be assigned, shall perform the tests enumerated in Sections 2.10 through 2.14.

(g) Within 10 days of any action taken pursuant to Subsection (a) of this section, the commissioner shall provide written notice of such action to the director and to each state licensing board having jurisdiction over practitioners.

Schedule I Tests

Sec. 2.10. The commissioner shall place a substance in Schedule I if he finds that:

(1) the substance has high potential for abuse; and

(2) the substance has no accepted medical use in treatment in the United States or lacks accepted safety for use in treatment under medical supervision.

Schedule II Tests

Sec. 2.11. The commissioner shall place a substance in Schedule II if he finds that:

(1) the substance has high potential for abuse;

(2) the substance has currently accepted medical use in treatment in the United States, or currently accepted medical use with severe restrictions; and

(3) abuse of the substance may lead to severe psychological or physical dependence.

Schedule III tests

Sec. 2.12. The commissioner shall place a substance in Schedule III if he finds that:

(1) the substance has a potential for abuse less than the substances listed in Schedules I and II;

(2) the substance has currently accepted medical use in treatment in the United States; and

(3) abuse of the substance may lead to moderate or low physical dependence or high psychological dependence.

Schedule IV tests

Sec. 2.13. The commissioner shall place a substance in Schedule IV if he finds that:

(1) the substance has a low potential for abuse relative to substances in Schedule III;

(2) the substance has currently accepted medical use in treatment in the United States; and

(3) abuse of the substance may lead to limited physical dependence or psychological dependence relative to the substances in Schedule III.

Schedule V tests

Sec. 2.14. The commissioner shall place a substance in Schedule V if he finds that:

(1) the substance has low potential for abuse relative to the controlled substances listed in Schedule IV;

(2) the substance has currently accepted medical use in treatment in the United States; and

(3) the substance may lead to limited physical dependence or psychological dependence liability relative to the controlled substances listed in Schedule IV.

Alterations in schedule: notice and hearing

Sec. 2.15. Each alteration made by the commissioner in a schedule under Subchapter 2 of this Act, except pursuant to Section 2.09(e), must be preceded by a public hearing held by the commissioner in Austin following publication of notice in at least three newspapers of general circulation in this state. The notice shall state the time and place of the hearing, which must be at least 30 days but not more than 60 days after the date of the publication, and the substance of the proposed alteration.

Republishing of schedules

Sec. 2.16. The commissioner shall republish the schedules semiannually for two years from the effective date of this Act, and thereafter annually, reflecting the changes, if any, made in the schedules. The commissioner shall publish the schedules by filing a certified copy with the secretary of state.

Dangerous drugs

Sec. 2.17. The following substances are dangerous drugs regulated by the provisions of Chapter 425, Acts of the 56th Legislature, Regular Session, 1959, as amended (Article 726d, Vernon's Texas Penal Code): [1]

(1) tranquilizers;

(2) procaine, its salts, derivatives, or compounds or mixtures thereof;

(3) any substance that bears the legend: Caution: federal law prohibits dispensing without prescription; or the legend: Caution: federal law restricts this drug to use by or on the order of a licensed veterinarian;

(4) phendimetrazine, its salts, derivatives, or compounds or mixtures thereof;

(5) pentazocine, its salts, derivatives, or compounds or mixtures thereof.

[1] Transferred to article 4476—14.

SUBCHAPTER 3. REGULATION OF MANUFACTURE, DISTRIBUTION, AND DISPENSING OF CONTROLLED SUBSTANCES

Registration requirements

Sec. 3.01. (a) Every person who manufactures, distributes, analyzes, or dispenses any controlled substance within this state must possess a valid registration. Registrations must be obtained annually from the director in accordance with rules promulgated by him under Section 3.02.

(b) Persons registered by the director under this Act to manufacture, distribute, dispense, analyze, or conduct research with controlled substances may possess, manufacture, distribute, dispense, analyze, or conduct research with those substances to the extent authorized by their registration and in conformity with the other provisions of this Act.

TEXAS STATUTES RELATED TO THE PRACTICE OF MEDICINE: THE PHYSICIAN AND THE LAW

A P P E N D I X

FOOTNOTES

[1] Tex. Rev. Civ. Stat. Ann. art. 4445a (1966). (The Texas Statutes will hereinafter be cited as T.R.C.S. art.___).

[2] T.R.C.S. art. 4445a, §7 (1966).

[3] T.R.C.S. art. 4441a (Supp. 1974-75).

[4] T.R.C.S. art. 4447e, §2 (1966).

[5] Id.

[6] T.R.C.S. art. 4477, Rule 50a (1966).

[7] Id.

[8] T.R.C.S. art. 4445a (1966).

[9] T.R.C.S. art. 4447d (Supp. 1974-75).

[10] Id. at §1

[11] Id.

[12] Id. at §3

[13] T.R.C.S. art. 4447d-1 (Supp. 1974-75).

[14] T.R.C.S. art. 4477, Rule 46a (1966).

[15] T.R.C.S. art. 4477, Rule 39(a)(Supp. 1974-75).

[16] T.R.C.S. art. 4445a, §3 (1966).

[17] T.R.C.S. art. 4477c (Supp. 1974-75).

[18] T.R.C.S. art. 4477, Rule 22 (1966).

[19] Tex. Fam. Code §34.01 (1975).

[20] Tex. Fam. Code §34.02(a)(1975).

[21] Tex. Fam. Code §34.02(d)(1975).

[22] Tex. Fam. Code §34.03 (1975).

[23] T.R.C.S. art. 4477, Rule 1 (1966).

[24] Id.

[25] T.R.C.S. art. 4477, Rule 3 (1966).

[26] T.R.C.S. art. 4445, §1 (Supp. 1974-75).

[27] Id. at §2.

[28] Id. at §5.

[29] Id. at §8.

[30] Id. at §§9,10.

[31] T.R.C.S. art. 4445c, §1 (Supp. 1974-75).

[32] Id. at §2.

[33] Id. at §2(c).

[34] Id. at §4.

[35] Id. at §5(a).

[36] T.R.C.S. art. 4477-11, §4(a)(1966).

[37] Id.

[38] Id. at §4(c).

[39] Id. at §5(e).

[40] T.R.C.S. art. 4477-12, §3 (1966).

[41] T.R.C.S. art. 4477-11, §6 (1966).

[42] T.R.C.S. art. 4447p, §1 (Supp. 1974-75).

[43] Id.

[44] Id. at §2.

[45] T.R.C.S. art. 4477, Rule 40a (1966).

[46] Id.

[47] Tex. Code Crim. Proc. Ann. art. 49.25, §6.7 (1966).

[48] Tex. Code Crim. Proc. Ann. art. 49.01, §7 (1966).

[49] Tex. Code Crim. Proc. Ann. art. 49.25, §7 (1966).

[50] Tex. Code Crim. Proc. Ann. art. 49.01, 49.25 (1966).

[51] T.R.C.S. art. 4477c (Supp. 1974-75).

[52] T.R.C.S. art. 4477b (Supp. 1974-75).

[53] Tex. Code Crim. Proc. Ann. art. 49.25, §6a (Supp. 1974-75).

[54] Id.

[55] T.R.C.S. art. 4447n, §1 (Supp. 1974-75).

[56] Id.

[57] T.R.C.S. art. 1a (1969).

[58] Id.

[59] Tex. Fam. Code Ann. §35.01 (1975).

[60] Tex. Fam. Code Ann. §35.02(b)(1975).

[61] Tex. Fam. Code Ann. §35.02(a)(1975).

[62] Tex. Fam. Code Ann. §35.03(a)(1),(2)(1975).

[63] Tex. Fam. Code Ann. §35.03(a)(3)(1975).

[64] Tex. Fam. Code Ann. §35.03(a)(4)(1975).

[65] Tex. Fam. Code Ann. §35.03(a)(b)(1975).

[66] T.R.C.S. art. 4447i (Supp. 1974-75).

[67] Tex. Fam. Code Ann. §35.03(a)(5)(1975).

[68] T.R.C.S. art. 4447j (Supp. 1974-75).

[69] Tex. Fam. Code Ann. §35.03(b)(1975).

[70] Tex. Fam. Code Ann. §35.03(c)(1975).

[71] Tex. Fam. Code Ann. §35.03(f)(1975).

[72] Tex. Fam. Code Ann. §35.03(e)(1975).

[73] Tex. Fam. Code Ann. §35.03(d)(1975).

[74] Tex. Fam. Code Ann. §§17.01, 17.04(1975).

[75] Tex. Fam. Code Ann. §35.01(6)(1975); See Tex. Fam. Code §11.11, 17.04(1975).

[76] T.R.C.S. art. 4590-2 (Supp. 1974-75).

[77] Id. at §3(a).

[78] Id. at §3(b).

[79] Id. at §3(c).

[80] Id. at §3(b).

[81] Id. at §4(2).

[82] Id. at §4(3).

[83] Id. at §4(4).

[84] Id. at §5(a).

[85] Id. at §5(b).

[86] Id. at §5(c).

[87] Id. at §5(e).

[88] Id. at §7.

[89] Id. at §8(a).

[90] Id. at §§5(b),6.

[91] Id. at §6.

[92] Id. at §8(b).

[93] Id. at §8(c).

[94] Id. at §8(d).

[95] Tex. Code Crim. Proc. Ann. art. 49.25, §6(a)(Supp. 1974-75).

[96] Tex. Fam. Code Ann. §12.03(b)(1975).

[97] Tex. Fam. Code Ann. §12.03(a)(1975).

[98] Tex. Code Crim. Proc. Ann. art 49.05, §1(1966).

[99] Id.

[100] Id.

[101] Tex. Code Crim. Proc. Ann. art. 49.04 (1966).

[102] T.R.C.S. art. 4587 (1960).

[103] Id.

[104] T.R.C.S. art. 5547-18 (1958).

[105] T.R.C.S. art. 4590-3 (Supp. 1974-75).

[106] Id. at §1.

[107] Id. at §2.

[108] Id.

[109] Id. at §3(b).

[110] Id. at §3(c).

[111] Id. at §3(a).

[112] 410 U.S. 113 (1973).

[113] T.R.C.S. art. 4512.1 et seq. (Supp. 1974-75).

114 T.R.C.S. art. 4512.1, 4512.2, 4512.3 (Supp. 1974-75).

115 T.R.C.S. art. 4512.1 (Supp. 1974-75).

116 T.R.C.S. art. 4512.4 (Supp. 1974-75).

117 T.R.C.S. art. 4512.5 (Supp. 1974-75).

118 T.R.C.S. art. 4512.6 (Supp. 1974-75).

119 T.R.C.S. art 695e, §8(a)(1)(f)(1964).

120 Id.

121 Id. at §8(a)(12)(Supp. 1974-75).

122 Tex. Pen. Code Ann. art. 42.10 (1974).

123 T.R.C.S. art 4510 (1966); See also T.R.C.S. 4510a (Supp. 1974-75). The latter article was transferred to the civil statutes upon enactment of the new Penal Code. The language of both articles is identical. If nothing else, the Legislature seems rather emphatic about it.

124 T.R.C.S. art. 4590c, §11(1960).

125 A wide variety of persons have been found to be practicing medicine within the statutory definition. See, eg Webber v. State, 370 SW2d 889 (Tex. Crim. App. 1963)(cosmetologist); Newman v. State, 58 Cr. R. 223, 124 S.W.956 (1910)("message doctor"); Larson v. State, 106 Cr.R. 261, 285 S.W.317(1926)(electrical therapeutic).

126 Tex. Att'y. Gen. Op. No. H-27 (1973).

127 T.R.C.S. art. 4504a (Supp. 1974-75).

128 See, eg T.R.C.S. art. 4513 (1960)(Nurses); T.R.C.S. art. 4529 (1960)(Pharmacists); T.R.C.S. art. 4543(1960)(Dentists); T.R.C.S. art. 4552 (Supp. 1974-75)(Optometrists); See, gen. T.R.C.S. art. 4590c (1960), as amended (Supp. 1974-75)(Basic Science Law).

129 T.R.C.S. art. 4590e, §3(1960).

130

Doctor of Medicine	: M.D.
Doctor of Osteopathy	: D.O.
Doctor of Dental Surgery	: D.D.S.

130 Doctor of Dental Medicine : D.M.D.
Chiropractor : D.C.
Chiropodist : D.S.C.
Naturopathic physician : N.D.
Optometrist : O.D.

All of the above, of course, must be duly licensed by the appropriate regulatory body.

131 T.R.C.S. art. 4498 (1966); T.R.C.S. art. 4498.1 (Supp. 1974-75). As with articles 4510 and 4510a (footnote 123, supra). The latter was transferred to the civil statutes upon the enactment of the new penal code. The language of both statutes is identical.

132 Id.; See also T.R.C.S. art. 4477, Rule 49a (1966).

133 T.R.C.S. art. 4498a, §1 (1966).

134 T.R.C.S. art. 4498a, §2 (Supp. 1974-75).

135 Tex. Bus. Corp. Act. Ann. art. 2.01B(2)(1956); T.R.C.S. art.1396-2.01B (2)(1962).

136 T.R.C.S. art. 1528e (Supp. 1974-75).

137 Id. at §3(a). The statute states as a reason for excluding use by doctors is that there are precedents allowing them to associate in joint stock companies.

138 T.R.C.S. art. 1528f (Supp. 1974-75).

139 Id. at §24.

140 Id.

141 T.R.C.S. art. 4505a (Supp. 1974-75).

142 T.R.C.S. art. 4505b (Supp. 1974-75).

143 Id.

144 T.R.C.S. art. 4447m, §1 (Supp. 1974-75).

145 Id. at §2.

146 Tex. Fam. Code Ann. §4.02(1975).

147 Woodruff v. Woodruff, 487 SW2d 791, 793 (Tex. Civ. App.--Texarkana 1972, no writ history).

148 Tex. Fam. Code Ann. §4.02 (1975).

149 T.R.C.S. art. 4512 (1966).

150 Id.

151 Id.

152 T.R.C.S. art. 4476-5 (1966) as amended (Supp. 1974-75).

153 T.R.C.S. art. 4476-14 (Supp. 1974-75).

154 T.R.C.S. art. 4476-15 (Supp. 1974-75).

155 T.R.C.S. art. 4476-5, §14(a) (Supp. 1974-75).

156 Id.

157 Id. at §14(b).

158 Id. at §14(c).

159 Id. at §14(d).

160 T.R.C.S. art. 4476-5, §15(a)(1966).

161 Id. at §15(b).

162 Id. at §15(c).

163 Id. at §15(k).

164 T.R.C.S. art. 4476-5, §16(d)(1)(Supp. 1974-75).

165 T.R.C.S. art. 4476-14 (Supp. 1974-75).

166 Id. at §4.

167 Id. at §5.

168 Id. at §§5,6.

169 Id. at §15(c).

[170] T.R.C.S. art. 4476-15 (Supp. 1974-75).

[171] Id. at §3.01(a).

[172] Id. at §3.03(b).

[173] Id. at §3.08(a).

[174] Id. at §3.08(c).

[175] Id. at §3.08(b).

[176] Id. at §§3.08(b),(e).

[177] T.R.C.S. art. 4542a, §8 (Supp. 1974-75).

[178] T.R.C.S. art. 4476-11, §1 (Supp. 1974-75).

[179] Id. at §4.

[180] Id. at §5.

[181] Id. at §11.

[182] Id. at §8.

[183] Id. at §9.

[184] House Concurrent Resolution No. 17, Acts, 62nd Legislature 2nd C.S. (1972).

[185] Tex. Fam. Code Ann. §35.03(a)(b)(1975); T.R.C.S. art. 4447i (Supp. 1974-75).

[186] Tex. Fam. Code Ann. §35.03(e)(1975); T.R.C.S. art. 4447i (Supp. 1974-75).

[187] Tex. Code Crim. Proc. Ann. art. 38.101 (Supp. 1974-75).

[188] Id.

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