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

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

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

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Medicaid Planning: Ethically Questionable?

Dear Editor:

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

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

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

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

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