HISTORY OF MEDICINE IN OREGON PROJECT

ORAL HISTORY INTERVIEW

WITH

Tom Cooney

Interview conducted June 15, 2005

by

Paul Frisch

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[Begin Track One.]

I don't have a picture, and, anytime.

FRISCH: This is an interview with Thomas E. Cooney, general counsel to the Oregon Medical Association. The interview took place on June 15, 2005 at the OMA, Portland, Oregon. The interviewer is Paul Frisch.

Tom, would you please give us an overview of your early life, birth, upbringing, and significant events, starting with the birthing room at the Portland Sanitarium.

COONEY: Well, I was born in prison. [laughter] I was actually born in Portland at the old Portland Sanitarium, which was an Adventist hospital. Pretty appropriate place for a good Irish Catholic to be born. And coincidentally, as time went on and I became a lawyer and more knowledgeable about health law, I was asked to speak to the nursing graduate class there for several years. And finally one year I asked them, "Why don't we just tape this, so I don't have to do it every year?" And they agreed. So I went back for the taping, and they asked me if I recognized the room, and I said no. And it was the very room where I was born in 1931, so it was kind of fun to go back there.

But I was born and raised in Southeast Portland. I lived right above Eastmoreland. We used to call it Berkeley in those days. And went to Dunaway Grade School. Went to Franklin High School for a year until I was asked, or suggested, that I go elsewhere. And I went to Washington High School, where I graduated. I was student body president at Washington High School. Went to University of Portland, where I was freshman class president. And graduated there in '53 with a degree in, believe it or not, philosophy. With a minor in speech and education. In the meantime, I had been in the military service during the Korean time, and was fortunate enough to be able to serve my time in the service and still graduate with my class. Played on the golf team, and the coach of the golf team was a priest. And he used to say the rosary for me every time that I would play the match, because he knew I needed all the help I could get.

From there, when I graduated, the president of the university was a priest named Father Sweeney. And I remember he came to me, and I think he was delighted that I was getting out of school there. And he said, "Well, Cooney, what are you going to do now?"

And I said, "Well, Father, I think I'm going to go to law school."

And he looked kind of stunned. But then he said, "Well, that's good." He said, "Where are you going to go?"

And I said, "Well, I think I'll go down to Willamette."

He said, “Well, that’s good.” He said, “The Catholics were never able to help you. Maybe the Methodists will be able to straighten you out.” [laughter] And I thought that was quite a comment for a president of a university to make.

I went down to my dad’s gas station to tell him I had graduated. And we used to call the gas station Cooney’s Law Clinic and Auto Repair. And he was working on a car, slid out from under the car all full of dirt and grease. And I said, “Well, Dad, I graduated from college.” And he had helped me quite a bit.

He said, “Well, boy,” he always called me boy, he said, “what is it that you do now?”

I said, “Well, Dad, I’m a philosophy major.”

And he looked at me and just shook his head and went right back under the car and didn’t say anything. So when I finally graduated from law school and was able to go to work, he was pretty glad.

One of the things I remember about Portland growing up was that it was a much smaller community. But my grandmother used to bring me downtown. And the big treat that we had was to ride the escalators at Meier and Frank’s. And as a small child, I would spend hours going up and down the escalator.

But there were two public parks right across the street from the Multnomah County Courthouse, and they’re still there. But in those days, there was the women’s park and the men’s park. And women were not allowed in the men’s park, and vice versa. So I’d always go in, sit in the park on the women’s side with my grandmother. That’s where we would spend our time.

FRISCH: How did you get interested in law?

COONEY: When I was in high school, we had a student court. And if somebody received a ticket for doing something they shouldn’t have, they were entitled to a trial. And I was appointed one of the lawyers to try the case. And a particular boy and girl had been caught necking in a car outside the high school, and they were both given tickets. And the boy was tried and found guilty. And I defended the girl, and she was found not guilty. So we always told him that he was necking out there by himself. And people talked about him quite a bit. [laughter] But that was the first taste.

Then I had a teacher, name was Nathan Berkham, and he taught business law and he kind of encouraged me, and that tweaked my interest. So (?) college, I entered prelaw. And then about halfway through, I decided I’d rather be a teacher. And in the summers I worked at the parks. And there were a lot of teachers there. And I saw how hard they had to work to make a living. And I thought maybe I’d better try law school. So I went back to try law.

FRISCH: Anything else about growing up in prewar Portland?

COONEY: Well, I remember when the war broke out, my dad had ten brothers and one girl. Dad was born in Ireland and came here from Limerick when he was about five or six. And five of the brothers volunteered to go in the service all about the same time. And we had a going away party for them at the home of one of the family. And all the men would gather in the kitchen and drink whiskey, and the women would sit in the front and criticize the men for being in the kitchen drinking whiskey. And I was about ten. And pretty soon, as is typical with some Irish families, they got in a fight among themselves and it spilled out into the street. Neighbors had to come and stop them. And I think we were actually glad to get rid of them and send them off to the war. But at one time, there were five of them in the service.

FRISCH: Oh, boy.

COONEY: I also remember the fear as a child when I would hear an airplane overhead that it might be the bombings that we were–

FRISCH: The Japanese.

COONEY: –kind of, might be bracing for. So.

FRISCH: Did anyone else but Cooneys live in Portland back then?

COONEY: No, there were just Cooneys. They were all over the place. But we lived in an Italian Irish community. And the Irish would look down their noses at the Italians. And the Italians thought the only people they could look down on were the Irish. And as the years went on, we became very fast friends. And St. Patrick's Day, they used to come to the house and feed us green spaghetti and we'd sing Italian songs, and became good, close friends.

FRISCH: You mentioned at lunch that you had some experience with a hospital in the neighborhood.

COONEY: Oh, the old Sellwood General Hospital.

FRISCH: Which is now what?

COONEY: Well, it was converted into a mental health hospital, and I don't even know that it's operational now. But it was located in old Sellwood. And as kids, when we went to, we walked from Berkeley over to the Sellwood Park, which was the only park that had a round swimming pool. And we could swim there for nothing. But we would cut through the back of the hospital parking lot. And the physician that owned that hospital was a big game hunter. And he had a cheetah. And he would drive around town with the top down on his convertible, and the cheetah would be chained to the back of the convertible, and you'd see him riding around. And we kids used to take great delight in

going through the parking lot and tormenting the poor cheetah in the cage. But the poor humor that we had at the time, we always kidded that the people that didn't make it in the hospital ended up with the cheetah. And that was kind of a bad joke, but that's the way we thought of it.

And one time I had cut my foot and went to the hospital there. And they sewed it up and forgot that there was a tendon that ran through there. And as a result, I had a toe that stuck out that I couldn't bend. And I used to break it with some regularity trying to play basketball.

FRISCH: A thought occurred to me in all this. You chose law, but if you hadn't chosen law, what do you think you would have ended up doing?

COONEY: You know, I've thought of that. At one time I thought I wanted to be a teacher. And at one time, even when I became a lawyer, I thought I might want to become a judge. And I was fortunate to have had an opportunity to teach law and medicine up at the law school for a couple of years, and found that I was bored after the second year, teaching the same thing. So I knew that teaching was not for me.

And then as a lawyer, we were able to serve as a pro tem judge in different places. And as I sat on the bench, sometimes I realized the judge's role is kind of boring, and the fun and the action is really for the lawyers in the courtroom. That's what I liked. And so I'm one of these few people that probably was glad that he chose law, because I've always liked it.

My dad, one time, was very influential, and I didn't realize it, in choosing the career that I did. And we didn't even talk about law. But when I was about twelve, I wanted to be just like him. He was a mechanic. And unbeknownst to me, I had absolutely no mechanical aptitude. And I think he probably thought he would have rather dropped dead than try and help him in the garage. But I showed up, and first thing I did that offended him was I cleaned up all of his tools and put them away so he couldn't find anything and couldn't do any work.

So in order to get rid of me, he suggested that I go out into the main parking lot. And he told me to get a floor jack, which I had an idea what that was. And he said, "Take that Buick out there and jack it up and drain the differential." And I was pretty sure the differential was in the rear part of the car.

FRISCH: That's good.

COONEY: So I took the floor jack out, and jacked it right up through the gas tank. And I ran over to my dad and I said there was something coming out of the back of the Buick. And he went out and he thought, oh, my God, and he said, "That's the gas tank. That's gasoline." And I remember he turned to me in total frustration but with sincerity. And he said, "Boy, you better make it with your mouth. You're never going to

make it with your hands." And I think that was probably the precursor of what sent me off to law school.

FRISCH: Law school.

SIMEK: I hate to interrupt at this point, but–

You've got to be careful.

SIMEK: Yeah, you're covering up a lot with–

FRISCH: A lot

SIMEK: –laughter and comments. So–

FRISCH: Okay.

SIMEK: So if you can laugh quietly, that would be great.

FRISCH: I met both your dad and your mom. And I just was, you answered with respect to your dad. I think that did it. What about your mom? What sort of influences did she have on you?

COONEY: Oh, she was the stay at home mother of the era. And she raised my sister and I. And Dad had to work a great amount of the time, so he wasn't around to be able to do a lot of things with us. And my mother was a great influence on moral and religious values, and kind of the moral conscience of the family. And she just died here not too long ago at age ninety-six. And she used to like her champagne occasionally. And we had a birthday party for her when she was ninety-five. And she came out and put her arms around me and said, "Tommy, I never thought I'd have a son as old as you are."

And I said, "Mother, that's a terrible thing to say." But that's the way she was.

FRISCH: You went to work initially where?

COONEY: Well when I first graduated from law school, I didn't have a job. And I was married and had a baby and another one on the way. And I was selling golf clubs at Meier and Frank's, both in Salem and in Portland. And so I looked for jobs in Eastern Oregon, because I didn't have anybody in the family that was a lawyer. And I went to Condon and looked for the D.A.'s job there. And found Fossil on the map and was offered a job there as a D.A. at 250 a month. And Judge Burns, who just recently died as a U.S. District Court Judge had just left the city of Burns as a D.A., and I was offered that job. And I came back to Portland and was talking to my wife. And about that time, the phone rang. And I was asked, or offered, a job at the downtown Portland firm of Maguire, Shields, Morrison & Bailey. And I took that job and then started there in 1956.

FRISCH: At that time, were you given a choice as to the kind of work you were doing? Or did it just happen?

COONEY: Well, they did. It was a firm that, in those days, it was a pretty good sized firm. There were fifteen lawyers. And they didn't have the mega firms that we did now. And they had a business sign, a litigations sign. And I remember one of the interviews that I had with one of the, unbeknownst to me, tax lawyers, business lawyers, was Nate Cohen. And I went in to talk to Nate, and he said, "Well, what do you want to do? What kind of a lawyer do you want to be?"

And I said, "Well, I don't know."

And he said, "Well, what type of law do you want to practice?"

And I said, "I don't know that. But the one thing I do know, I don't want to do any tax law." And of course that was the wrong thing to say to Nate. But in the beginning, they gave me kind of a broad spectrum of things to do. And I got a sampling of what I liked. And I knew inside that I always wanted to gravitate toward the courtroom, and that's where they put me to work.

FRISCH: You ended up working with Bill Morrison.

COONEY: Yes.

FRISCH: And was he your principal mentor?

COONEY: There were three people. Bill Morrison was the senior of the trial department. And then there were two, I say middle-aged lawyers, Walt Cosgrave and Howard Beebe that were secondary. And then I was kind of the garbage man, they called me, and carried their briefcases. And did that for a couple of years, learned how to prepare cases under them. And then Howard Beebe had a heart attack. So I was pushed in to take over his cases. And then there was a falling out between Bill Morrison and Walt Cosgrave, so I took over Cosgrave's cases, and had a very heavy trial practice for a few years until we got into medical stuff, which happened in the late '60s.

FRISCH: At that time, we had, auto accidents were fault-based. So as a young lawyer, you probably had more opportunity to try cases of lesser value than today. Is that right?

COONEY: They were. In those days, they tired cases for as little as a difference of $250. And I remember specifically one case where Mr. Morrison had told the insurance company that we were going to try the case. And I knew we could settle it for 250 bucks, and he was just trying to get me some experience. And in the morning of the trial, the lady client came in and sat down with her husband. And we started talking, and she started sobbing uncontrollably. And her husband took me out in the hall, and he said,

"Mr. Cooney, I don't think she can go through a trial. She just had cancer surgery and her emotions are terribly fragile."

So I went down the hall to my boss, Mr. Morrison, and I said, "It's not kind of us to put this poor lady through a trial when we can settle it for 250 bucks just to give me some entertainment." Or some experience. Not entertainment.

So he picked up the phone and contacted the insurance company. And I could hear him arguing that we had told them that they could try the case and now all of a sudden we wanted to settle it, and back and forth. Finally, in frustration, Mr. Morrison told the claims man on the phone, "Well, the problem has developed that the client came in, she took one look at Cooney, and we can't get her to stop crying." So that was kind of a humbling experience.

Another time, I was starting to try cases. And one of the judges that I had tried a case in front of, sensed that I was trying to imitate another lawyer in the firm. And one of the fundamental principles for people to try cases is to try and be yourself, don't try to be somebody else. But I didn't know that. And I admired this particular lawyer, and I was trying to emulate his behavior in the courtroom. And my boss, this Mr. Morrison, called me in. And in front of his secretary, who was sitting there, told me that judge so and so had called and said that I was trying to imitate Mr. X, who was a member of the firm. And I thought he was going to pay me a compliment, because I was very proud of that attempt. And he said, "Don't do that." He says, "You're not Mr. X. You're nothing but a big, dumb, skinny Irish man. Act like it." And to say that in front of his secretary, I just willowed down. And it took me about six months to get over that before I could go back to the courtroom.

FRISCH: Well I remember two stories you told me, and I think we ought to cover them both. One had to do with you going in to argue a motion. And if you'll recall what happened, that was interesting. And the other one was when you did some voir dire, and that nice lady that–

COONEY: Oh, yeah. You do remember the good things. I'd been to work about two weeks, and we had no income during that period of time. And I had one child, and another one on the way. So I was taking my lunch every day in a briefcase. And the senior lawyers would come by and ask me to go to lunch. And I'd lie and I'd say, "No, I'm expecting a client." They knew I didn't have any clients. And I'd eat my lunch at my desk.

So the last day, we were down to two slices of bread and some tuna fish. And I told my wife just wrap it in wax paper. And I'd forgotten my briefcase at the office. And I'll just stick it in my pocket in my suit. And when I get to the office, I'll just put it away.

So as I walked in the office, one of the senior lawyers said, "Oh, we've got a motion you have to argue, and it's an emergency. So rush up there." And I didn't have a clue what it was about. In fact, I had never been to the courthouse. I had to stop on the

way and look it up in the phone book to get the address where the courthouse was. Probably shouldn't tell all these dumb things that I did. But anyway, they had told me that if you start to lose the motion, just get emotional and wave your arms, and that will tell the judge that you're sincere.

So I went up and sure enough, I started to lose the motion. And I remembered the admonition to wave my arms. So I waved my arms and I jammed my hand into my pocket, forgetting that that's where the tuna fish sandwich was. And my fingers went through the wax paper into the mayonnaise and into the tuna fish. And I'm standing there in front of the judge and I kind of pause for a minute. And it was Judge Charlie Redding, who was a very great judge. And he looked at me and he said, "Counsel, are you stricken?"

And I said, "No, I just put my hand in my tuna fish." [laughs] And I figured if I could argue a case with my hand in the tuna fish, I could do most anything.

FRISCH: Well you did such a good job with that. I'd like you to tell us about your success in picking juries, especially women.

COONEY: There was a time when as young lawyers we were taught that we were not sensitive enough to the body English that the jurors were trying to, body language, rather than body English, were trying to communicate to us. And in fact, they had seminars on that subject that in order to be an effective trial lawyer you were supposed to be able to read all that stuff.

So I went to one of those seminars. And one of the things they talked about was that women tended to be more expressive than men, and you would question them, and you had to be alert to that. So, being smart and young and thinking I knew everything, I had a case to try, and I thought I'll try this out. And as we drew the jury from the panel, they would walk from the rear of the courtroom to the front, and we would watch them and try to analyze what they were trying to tell us.

And this one lady, who was obviously eight and a half months pregnant, went to the jury box and sat down, and the plaintiff's counsel started to question her. And never once mentioned the fact that she was pregnant.

So I seized the opportunity, because I knew that this would give her something to tell me about. And I said, "Ma'am, when's the baby due?"

And she paused, and everybody looked at her and kind of smiled. And she looked down at me and said, "Mr. Cooney, I'm not pregnant. I'm just fat." And you could have killed me right then, and I would have been thankful. But as things worked out, she was the forewoman of the jury and found in our favor. And called me afterwards and she said, "We felt, and I felt, that you were so humiliated by that stupid question that you asked that we couldn't do anything but find in your favor." And I'm sure that the lawyers' roles

don't pay that much, and it's really the clients' case. But that was an experience that taught me to keep my mouth shut a little bit more.

FRISCH: The other figure in this whole business is the rabbit. And I think that you ought to at least describe the circumstances of how you became acquainted with the rabbit.

COONEY: One day, early in the morning, well, it wasn't early, it was ten in the morning. I was standing in line, waiting to make a bank deposit. And right in front of me was a lawyer who I knew to be a defense lawyer. And he was drunk. And I said, "What in heaven's name are you doing this time of day being drunk?"

And he said, "Oh, Tom, I just lost a big case that I thought I would win, and I went out to drown my sorrows." And he said, "You have some experience. How do you handle losing cases that you expect to win?"

And I said, "Well, it's simple." And I thought he knew that I was putting him on, but he didn't. I said, "What you do is when the verdict comes in, tell your client 'we'll talk about it tomorrow.' Don't go back to the office. Go right to the liquor store and buy a half gallon of liquor. Go home. Don't kick the dog or say something mean to your wife or your children. Go downstairs behind the basement and set up the card table and two chairs. Get the black rabbit that you have for this particular occasion out of the cage. Bring him in, put him down. Pour him a drink. Pour yourself a drink. Tell the rabbit what a hell of a rabbit he is. And he'll reciprocate and tell you what a hell of a lawyer you are. And pretty soon you don't care about that verdict anymore. The only thing is, if you lose too much, it's very hard on rabbits."

Well I thought this fellow knew, halfway through, at least, that I was putting him on. And he didn't. And he thought I was giving him some sage advice. And to this day, I still get calls from lawyers that have lost cases, say, "Send the rabbit! Send the rabbit!"

Before you leave it, let me tell you another one about Judge King. He's a U.S. district judge, and a fine one. And our firm hired him when he was with the D.A.'s office. And the transition from criminal cases to civil cases sometime is a little bit hard because you can't treat everybody in a civil case like you do in a criminal case. And so our boss, Bill Morrison, finally came to me one day and said, "You take Mike King over and let him try the case, but you be there with him." Now Mike King had probably tried more cases than I had, because he'd been in the district attorney's office, and they try more cases.

But I went over with him. And he's a little bit younger than I am. And I said, "I'll sit in the back of the courtroom so I won't make you nervous. But you go ahead and try the case."

And the story as he tells it, everything was going quite well until the plaintiff put on their expert. And the question and answer thing was going back and forth. And then

suddenly from the back of the courtroom he heard, "He objects! He objects!" Then he turned around, it was me running up to the courtroom, the front of the courtroom, to tell the judge that he objected. And he said he would never return to court with me again. He never did.

FRISCH: You mentioned that health, that you started representing healthcare law, insurance companies or whatever, shortly after you started. Or was that later?

COONEY: We didn't get involved in defense of a high volume of health law. We had done some. In the early days, many physicians were bare, or like, for example, Dennis didn't have insurance. So they would pay us an annual retainer to defend their cases, no matter how many of them there may be. But in the '60s, Hugh Biggs' firm, and George Fraser, represented Oregon Auto in their malpractice cases. And we were general counsel for Oregon Auto. And in about 1965, Mayor vs. Dowsett came down. And that was the first time in Oregon that we heard of the doctrine of informed consent, and the first time that they applied the doctrine of *res ipsa loquitur* to a medical malpractice case. And it was after that, a few years later, that we started doing the sponsored program defense. And that's when I got involved in it. And that was in the late '60s.

FRISCH: When did you first become involved with the Oregon Medical Association?

COONEY: Probably in '71. '70 or '71, I was asked to become general counsel. Prior to that time, Bill Phillips' firm had been general counsel. And I had gotten to know some of the doctors through the medical malpractice work. And they decided they wanted us to become their general counsel.

FRISCH: Let's talk a little bit about the colorful figures, and then we can move on to the legal stuff. Let's start with lawyers. Who were the most memorable of the lawyers that you either worked with or tried cases with or against?

COONEY: Well, of course, the people that trained me, Bill Morrison and Walt Cosgrave and Howard Beebe were very, very good, bright lawyers. Bill Morrison was a strategist, and he could help you learn where the other side's weak point was. Walt Cosgrave was a dynamic personality that could take over a courtroom. Howard Beebe was the brains of the tort law area. Roy Shields was a member of that firm. And though he was not in the same department, he was a great teacher as far as ethics and professionalism, and a great, great lawyer.

As far as current day people that people would know, Judge Owen Panner was always, I always considered, very bright and very hardworking. His early days, he was a lawyer in Bend. And incidentally, a very, very, very high quality golfer. He almost turned professional when he was in college. Played for University of Oklahoma. Then he became judge on the bench, and is now senior judge. But he was a very, very bright man.

The other man that I always admired, even though he only had an eighth grade education, was my father. He was born in Limerick and went through only the eighth grade. And yet he had more street sense and good judgment than many people that I had known in my life. Some of the physicians that I had known were intellectually very bright. And I tried to remember at lunch the name of the surgeon up at Good Samaritan. His name was Matt, and he was chair of the surgery department. And he was a very bright, intelligent man. But I've always felt that with professionals, it doesn't matter how many rules of law that you know or how much medicine you know, if you don't have the good judgment as to how to apply it, it's useless. And I think that's really the reason patients or clients come to lawyers or doctors is to take advantage of their good judgment. And that's something that's hard to teach.

FRISCH: You've taught a number of lawyers, many of them still practicing around here. What are the essential qualities of an outstanding trial lawyer?

COONEY: Well, I think first of all you have to be able to not be afraid of standing up in front of people and talking. If you have that problem that is severe, maybe you're wasting your time going into a courtroom. Everybody has a certain amount of anxiety, because you're afraid you're going to make a mistake. Or in trial, the other lawyer's constantly trying to knock your head off and so you don't want that to happen, and so you have a certain amount of anxiety.

But one time my boss, Bill Morrison, came to me and said, "Tom, there's something that goes on in between opening statement and final argument." And he was trying to tell me that I was pretty good at opening statement and final argument, but I wasn't worth a darn when it came into how to do evidence and that kind of stuff. So much of the success of the lawyer that's going to be in the courtroom is preparation. And you don't have to be the most eloquent person in the world to be able to put forth a factual case in favor of your client, if you've prepared properly. And that's where the hard work is, and that's where the huge expense is.

And today it's kind of tragic, because when I was growing up, we tried a lot of cases. I can remember trying three jury trial cases to conclusion in one week. Now that's not a good thing to do, but I had to do it. But nowadays it's very, very difficult to find cases that a young lawyer can try and get experience. Because we look more now toward mediation and arbitration. So maybe we're kind of a dying breed. But there still are trials, but it's not like it used to be.

FRISCH: Probably the thing that struck me most about your teaching was the notion that you had to figure out what was important and what wasn't important. And also, how to communicate that effectively to a lay audience, very complex issues.

COONEY: As a young lawyer, you're kind of taught to have a vacuum cleaner mind. You suck up everything. And experience, then, tells you you have to discard 90 percent of what you sucked up and get down to the essentials and be able to know what is essential. And then once you do that, to be able to take that perhaps complex issue and

make that understandable to the jury. Not that you're talking down to the jury, not that you're talking up to the jury, but you're trying to make understandable a complex issue.

And one of the things that we notice with young lawyers as to whether they're going to make it or not in the world of litigation is do they have the ability to eventually sort out and know what is the key point in the case, or points, and narrow it down to that. And that's a hard thing for many young lawyers to do, because they're afraid to make a mistake. They're afraid that they'll miss something. And you can read a letter that they might draft. And it scatters. It's got everything in it. And if a person is pressed for time, you don't want to read all that stuff.

And then, coupled with that, you have to be able to stand up in the courtroom, and be able to communicate. And that's part of it.

FRISCH: Let's move onto some healthcare related things. First of all, describe the antitrust case in the '50s that the OMA and a number of other county medical societies won.

COONEY: This is a Kronenberg question. And he knows that I didn't start practicing law till '56, and that case predated me. But I did know of it, and I pulled it up and looked at it again and refreshed my memory from it. But in the '30s, when some forms of prepaid insurance started to come onto the scene, some doctors and some societies were opposed to that. And the ethical reason being that it detracted from the pure dedication of the physician to the patient, and there was a third party interjected. And so there was some opposition to that.

And where they got into difficulty was, it was alleged, at least, that the Multnomah County Medical Society and the state society were threatening to throw out of the organizations any doctor that participated in that. Well that, technically, is a boycott. And we probably know more about that now than we did in those days. So that threat resulted in complaints being made to the federal government, the U.S. Attorney's Office. But in 1941, I think it was, they stopped doing that. And in fact, they embraced Blue Cross/Blue Shield and the OPS, and helped create that.

But the feds didn't stop there. And they tried to prosecute them and filed a case trying to punish them for what they were doing, or threatening to do, in the '30s. And it went all the way to the Supreme Court, and the societies won all levels. And the court said, "No, we're not going to go back and punish them for something that may or may not have happened. And besides, they currently have changed, and they don't do that." So that ended favorably. But, the tragic thing is, I don't know what the legal expense was, but those are not cheap cases to defend.

And the other one that I do remember was in the '70s, I think, there was a big antitrust case by the chiropractors against some of the associations. I think it was filed in Chicago or New York. And at that time, there was an ethical rule that Oregon had, as

well as others, that said it was unethical to treat in conjunction with a chiropractic physician because they did not necessarily follow scientific procedures.

And so the lawsuit was filed back East, and the lawyers came out here to dig around in our records. And I spent some pretty worried times that we were going to get sucked into that litigation. But we were able to stay out of it, and the settlements were made. And eventually, that ethical rule was removed, because it was, in effect, a boycott of all medical doctors against chiropractors. Now it was never tested here in Oregon, but we were concerned about it. But we were able to avoid it.

FRISCH: Years later, but shortly after I came here, the Astoria Clinic case came into being. Could you talk a little bit about that and what impact did the eventual resolution of that case had on both peer review in Oregon and your views about how much deeper into the whole healthcare process lawyers got injected following that.

COONEY: The Astoria Clinic case was a case that I don't think many of us in the legal community thought would go very far, because peer review was always kind of considered an essential part of what doctors did. They were encouraged to do it. There was a rule that said that antitrust laws didn't apply to the quote unquote "learned professions," which medicine and law were supposed to be. But that had started to erode, and there were some cases that said that's not true.

So the Astoria Clinic case came along because Dr. Patrick had been a member of the Astoria Clinic, and had actually been offered a partnership. And for whatever reason, he chose not to, and went out and opened his own practice. And it was alleged that he or the clinic or the hospital, then, kind of went on a vendetta against him, claiming that they interfered with his practice, they tried to get his privileges at the hospital removed because he was competing with the clinic. And he went through part of the hospital fair hearing process and decided that the whole thing was a waste of time. And he and his lawyer, who happened to be Don Marmaduke, who's still practicing here in Portland, got up and walked out, and filed an antitrust case against the hospital and the clinic, the Astoria Clinic.

The hospital eventually settled out, and the case went to trial against the Astoria Clinic. And Tom Triplett tried the case, with Al Franski. And against Don Marmaduke. And to their surprise, the verdict came in in favor of Dr. Patrick. And if memory serves me correctly, it was around 900,000. And then under antitrust laws, if there's a violation, that's tripled. Plus, they are entitled to recover attorney's fees.

We got involved in the case after it was over, and represented some of the individual doctors against the insurance companies, trying to get them to pay the judgment on the theory that that activity was part of their peer review and their responsibilities, and was therefore covered on the policy. And that went on for a year or two. And it pretty well disseminated, or decimated, the Astoria Clinic. They broke up and the scattered. And Dr. Patrick was aggressive in trying to collect, and eventually left the

state and had a prosperous practice elsewhere. But the Astoria Clinic no longer existed, and the medical community there was in pretty tough shape for a while.

The fallout of that was that physicians were afraid thereafter to do peer review, because they frequently were reviewing a competitor. And they were afraid that if they did it, they would be subject to litigation. So the Wyden Act was enacted in 1986. It's called the Healthcare Quality Improvement Act of 1986. And that act gave certain immunities and protections to hospitals and physicians who served on those committees from tort liability and antitrust liability, so long as what they were doing was facially, at least, in the best interest of patient care. If it was done in bad faith, there was no immunity. So they were given that protection.

But a part of that act was the creation of the data bank. And that's where people that get disciplined at hospitals, or by licensing boards, or have malpractice settlements, get reported to the data bank and created a downside, so to speak, for doctors. Whereas on the good side, they were given immunity for peer review.

That's the law now. And maybe you hear stories of hospitals and medical staffs in some instances abusing that immunity. And the disruptive physician terminology has developed. And many physicians in fact are disruptive. But many are not. So it can be used to throw the physician off the staff. And if not watched carefully, it can be abused. But that's been the effect of it. It had a cooling off effect for a while, and now there's a cloak of immunity that surrounds that.

FRISCH: Well something that you were responsible for in terms of shaping state legislation was the giving the board of medical examiners the ability to assist hospitals by bringing an outside peer review. Could you talk a little bit about that?

COONEY: Yeah. What we tried to do before the Wyden Act became fully effective was to try and give some protection to hospitals to be able to do peer review, and not be faced with a Patrick type lawsuit. So there was an exception to antitrust violations and antitrust law that said if it was a state action investigation, it could not be an antitrust violation. So we created a statute that said a hospital and a doctor being reviewed could call upon the state board of medical examiners to appoint the reviewers from outside. And they could go in and do the investigation, and hopefully be able to avoid antitrust violations. That's still in the books. It's less significant now because of the Wyden Act and the immunities that that gives, but it's still used quite a bit.

FRISCH: You know, a footnote to the Patrick case is that Dr. Patrick and his wife died in an airplane crash in Pennsylvania on a cold and windy day.

COONEY: That's correct.

FRISCH: Apparently augured into the ground.

COONEY: It's kind of interesting that when that case was all over and done with and settled, and we were on the opposite side of Dr. Patrick, he came to us and asked him to help him with another matter, which we were able to do.

FRISCH: Interestingly enough, many people who followed this whole Astoria Clinic case say that that was the beginning of lawyers playing a more prominent role in the affairs of physicians. And in fact, the role of legal counsel in discussions of peer review activity was really brought to bear there, finally.

COONEY: I think that's true, because most of the time in prior years, lawyers were not involved in that. I can remember doing work with the licensing board, the Board of Medical Examiners, and I never went in with the doctor to appear. And as time went on, we changed our thinking on that. But the Patrick case was the beginning, I think, of lawyers being counseled, or being sought to give assistance to physicians in that area. On all sides of the fence. I don't think that was really the beginning of the problems we have in the tort field.

FRISCH: No.

COONEY: But I think it was the beginning where every, every doctor has a lawyer. And it's kind of sad that we have to be there, but that's where we are sometimes.

FRISCH: When I was working for you, the firm was doing an enormous amount of work with medical staffs around the state. And in fact, the Oregon Medical Association was working on model medical staff bylaws. That was a time, from my perspective, compared to now, where the medical staff was truly an independent organization, independent from the board. And I 'd like you to talk just a little bit the change in that perspective, and how you see that's impacted both quality of care and the tort field, and also the whole relationship between hospitals and physicians.

COONEY: Well you have to understand the structure legally of how a hospital and its staff is created. The hospital is a corporation, nonprofit corporation. And under the statute, the law requires that the hospital see that the medical staff is organized. And because of their superior knowledge and training, they are delegated the task of overseeing the quality of care and all things related to it for the patients that are, you know, admitted to that hospital. And it's supposedly a harmonious partnership type of situation.

In years past, I always felt that the medical staff was the center of power, because it had the knowledge. And the administration would be the overseer, but they were pretty much dependent upon what the medical staff advised them. This relationship was governed by the bylaws that would be passed by the hospital.

Well we learned that there were two sets of bylaws: the corporate bylaws of the corporation, which the medical staff had no input into; and the medical staff bylaws that the medical staff created in conjunction with the hospital. And sometimes, not always,

but sometimes they were in conflict. And so we felt that it was important that people pay some attention to what's in those bylaws, so they're not in conflict.

And we started looking at them and it became apparent that there was some tension between some medical staff, staffs, and some administrations. Kind of a control issue. And it was the hospital's facility, they're responsible for it, but they just needed the medical staff to make sure that things were done in the appropriate way.

Reviewing bylaws is about as exciting as reading a phone book.

FRISCH: Tell me about it.

COONEY: And it's really boring. And as a result, a lot of attention was not being paid to it. And this tension between the medical staff and the administration began to grow even more with the advent of managed care. And so the OMA started a program of putting together model bylaws. They weren't to be taken as absolutes, just it was the legal ideas of things that would benefit the staff. And we had them published for small hospitals and big hospitals.

And a case came out of the South, I think it was Alabama, that said if we do that type of thing, it could be considered a violation of the antitrust laws. About that time, I think it was the nurse practitioners became an issue in the legislature.

FRISCH: It was the CRNAs.

COONEY: CRNAs, okay. And the representatives of the National Nursing Board came out to visit with us and threatened litigation if we did not stop publishing medical staff bylaws. We looked into it and saw the case out of the South, and we felt that because those types of cases are so expensive to defend, it would be wiser to discontinue it. And it was discontinued.

And through the years, I have felt that the physicians have not paid as much attention to their medical staff bylaws, and through the years they have lost more and more autonomy, and more and more control with administration. And we do occasionally review medical staff bylaws at the request of the medical staff. And sometimes my advice has been, frankly, "Don't sign it. Don't do it. It gives too much authority. You give up too much." But that has happened, and now we're in a position, I think, where many of the administrations have more control because of the type of bylaws. And physicians find themselves now in a position where the rules that they're operating under may not give them the rights that they think they have. So I think that's been kind of the history of bylaws.

FRISCH: The Oregon Medical Association is coming up on its thirty-fifth anniversary of sponsoring the malpractice insurance for its members. Were you involved in the initial pieces of that? And can you tell us a little bit about how that program went before we got involved with CNA and a little bit after that, just the historical.

COONEY: Well the things that I remember during my time were that the Oregon Auto Insurance Company was the sponsored program for the OMA in the early years. And professional liability insurance was kind of an add-on. Kind of an afterthought.

FRISCH: To the auto policy?

COONEY: Well, to the auto policy or to an office premises policy. And they had a package. And some of the early cases, the one that I remember was a damaged baby case that Bruce Spalding tried. And it was only a fifty thousand dollar policy. Now I remember limits as low as five thousand dollars. I don't remember any of those being in litigation. Many doctors were bare, because it was not required by hospitals that you have insurance.

Oregon Auto was bought out by another company and decided to get out of the business. And the Hawaiian Insurance Company came in in around 1970 and took over for about two years, and then they got out of the business. And that's when CNA came in, in '71 or '72. And because we had been doing work for Oregon Auto, the OMA asked CNA that we would continue to do it. Well, CNA's primary law firm of choice was the Schwabe Williamson firm. So the compromise was, we shared it. And we did work with CNA until, I'm guessing, around 1981. And at that time, we were asked by the OMA to help negotiate the contracts for the sponsored program. And I felt uncomfortable being both lawyer for the OMA and lawyer for CNA, doing both, and so we discontinued representing CNA in their work, and continued on with other insurance companies.

FRISCH: Is this an unusual relationship compared to other kinds of insurance programs that are out there in the country?

COONEY: Yes, it is. Number one, just by its duration. But number two is I have never seen an insurance company before work in partnership as much as they do with the PCC committee of the OMA.

FRISCH: The PCC committee is what?

COONEY: The Professional Consultation Committee, which is the committee in the OMA that's supposed to kind of take charge of looking after insurance issues, as well as appeals from doctors on their malpractice case. And much of what's in the OMA/CNA insurance form is the result of hard fought negotiations between the PCC committee and CNA. And I don't know of any other professional liability carrier that has that relationship, where they try to negotiate what's going to be in their form. And this policy has some unique features in it that at one time or another were unique, and then have been copied by other professional liability carriers.

FRISCH: One of the things that I think is important for us to do today is to look at the history of the medical malpractice "crises," in quotes, in Oregon. We start in the early '70s, and then we have something in the mid '80s, and then of course arguably we

have something now. Would you start with that time? It's also important to note that a lot of the legislation that we refer to, the informed consent legislation, some having to do with peer review and others, all seemed to have come about in around 1974 or '75. Would you talk about that time? And what set the stage, and then some interesting things that would be useful.

COONEY: Well, I think it actually starts before that. Prior to the '60s, there was not very much action in the legal malpractice, or the medical malpractice field. And for that matter, in the legal malpractice field. They were expensive. Juries favored doctors. And it was just not a very active part of medicine. And I think one of the first cases that started to change that was the abolish–

[End Track One. Begin Track Two.]

COONEY: –ment of the charitable immunity doctrine for hospitals. And that was in '62 or '63. Prior to that time, hospitals had been immune if they made a mistake through their employees. Their employee was not, but the hospital was not liable for it. And so there was not much success in bringing a claim against an individual nurse. Because even though they may have been the (tort??) they usually didn't have insurance or any assets of note. But when that rule of charitable immunity was changed, then hospitals became a target and lawyers began to find out that they could successfully bring cases. Because hospitals were big and mistakes could be made there.

The next big area that I remember occurring that I think started the movement against doctors was in the Mayor versus Dowsett case, and that was in 1965. And that case, for the first time, talked about the doctrine of informed consent. And we had never really had a case that said that was necessary. It was kind of implied, but for the first time, we heard that. And also in that case, the court held that the doctor in a res ipsa loquitur could apply in med mal cases.

And so there were two kinds of res ipsa. One was if you amputated the wrong leg. That didn't take any expert testimony. And that's what res ipsa did was relieve the need for expert testimony. The violation was so bad it spoke for itself. That's what we call lay res ipsa.

But it also talked about expert res ipsa. And in that case, they said if the doctor testifies that this event ordinarily doesn't happen without negligence, that is testimony that invokes expert res ipsa, and can take the case to the jury. And that was really the big thing that they did. In the Dowsett case, the defendant doctor had admitted that this type of thing ordinarily didn't happen absent negligence.

FRISCH: That was the magic question we used to talk about.

COONEY: That's what we talked about, the magic question, and to be alert to that. And so that began. And those two doctrines, I think, kind of started the ball rolling. For a long time, many of us that dealt in this field felt that, what did you have to tell the

patient to get informed consent. And because physicians were held to standard of care issues, that we felt it was a standard of care issue. And therefore, what doctors normally told patients was what it was. And if they didn't tell them very much, that was a standard of care.

Well finally in '69, the Supreme Court came down and said, "Doctors, it's not a matter of standard of care. It's an absolute duty. And it must." So you had to explain the procedure, the viable alternatives, and the probably risks, material risks.

So then we had to start changing things. And we began to hear complaints from surgeons who would tell me, "Do you mean to say that that patient's about ready to die, and I have to go in and tell him that I'm going to operate on him and I might kill him? You think I'm going to do that, you're full of hops. And that's crazy, and it's bad patient care."

So we went to the legislature in '72 or '73, and created the informed consent requirement as it sits now. And that gives the patient the choice as to whether they want to listen to the risks and alternatives. They can say, "No, I don't want to listen to that." So that gave the patient a little bit more control, but it still was required of the doctor that it was a matter of practice, it was a matter that they had to do it.

SIMEK: We have to change tapes.

COONEY: Okay. I'm talking forever.

FRISCH: That's alright.

SIMEK: That's perfect, Tom.

[End Track Two. Begin Track Three.]

SIMEK: Okay, go ahead.

FRISCH: Today's date is June 15, 2005. We're here with Tom Cooney, Senior, OMA legal counsel. And this is our second tape on the history of legal medicine in Oregon. Would you comment on the change in comparative fault? This was all part of this early 1970s period. And a period we look back on as a period of crisis from the medical malpractice standpoint.

COONEY: It seems to me it was in '73 that we went from pure contributory negligence to comparative fault. And it was the rule until that time that if the patient themselves were in any way to blame, even one percent, they could recover nothing. And so the legislature adopted what we call comparative fault, which would allow the patient, the plaintiff to recover, even though they may have been at fault themselves. Originally they had to be less at fault than the doctor, so the doctor had to be a little bit more at fault than them, and then they could recover a pro rata of their damages.

The current law says they can recover down to 50/50, and they get 50 percent of their damage. So it's easier for the plaintiff to recover whether you have a case where there might be some fault involved.

That really didn't affect malpractice too much, because it wasn't very often that we raised the defense that the patient themselves did something wrong, because we were frankly afraid to blame the patient when the doctor was supposed to know everything. That changed as time went on. Current day, we do raise that. But it was a period of time when the plaintiff's lawyers became more active. Because now in a case that they would have turned down before because of some fault on the part of the plaintiff, they could recover. And so I think the adoption of comparative fault in about '73 was part of the increase in interest in lawsuits.

Finally, in '75, the first crisis hit. And several of the companies pulled out. And even CNA, who was the sponsored program had given notice that they would not continue in the future. And at that time we were writing occurrence policies only. And the thing that the insurance companies were complaining about was the long tail that would go out. So it wasn't much after that that the Oregon Supreme Court, or about that time, the Oregon Supreme Court, in fact, it was before that time, the Oregon Supreme Court came down and said the discovery rule applied in all injury cases, be they automobile, fall down, malpractice, no matter what. So that meant the patient had two years from the time they would discover it, no matter when. And that really drove the insurance companies crazy, and they couldn't predict how long out they had to carry reserves. And so they all decided to pull out. And that happened in '75.

And so in '75, the primary thing that was passed, although the package that the OMA put together was broader, the primary thing that passed was a shortening of the statute of limitations. Discovery rule was still used, but we adopted the two, five and ten rules, which was for adults two years from the time they knew or should have known of the injury, or, if they don't ever discover it, no more than five years from the event, which meant children were governed by that shorter limitation, not till eighteen. And then if there was misrepresentation, it could go out to ten years.

And that was some relief for the insurance companies, and it kind of encouraged them to come back in. And the problem of the long period of time they had to worry about reserve was shortened.

The other thing that was interesting was, this was all done in conference committee between the two houses. And the conference committee came out and spoke to myself and Dick Noble, who was representing the plaintiff's bar, said the conference committee wants to put a limitation on attorney's fees in malpractice cases. And I told the conference committee that we did not advocate that. That was not our agenda. And they say, "We don't care. We want it." And so they adopted the maximum attorney fee in the malpractice cases as one third.

And I believe, if memory serves me, that's when Dr. Roy Payne and I were down there. And we hastily wrote the statute that said that doctors would be required to carry a certain amount of insurance, and there would be a state fund created, and that the plaintiff could recover unlimited amounts of money. But whether they could collect it, they were limited to the insurance and the fund, and they would have to wait if there was not enough money for it. And because we all knew that that carried constitutional issues, we didn't want to lose all of our insurance protection, drop down to the barest limits and then find out it was unconstitutional.

So a declaratory judgment action was filed. And I think Dr. (Hagmeier?) was president at that time. And it went all the way to the Supreme Court. And the Supreme Court refused to give us an advice, saying that was an advisory opinion, and they wouldn't do it. And as a result, we were unable to ever go into that program because of our concerns about constitutional issues.

About the same time, the OMA authorized a study to see whether they could create their own self insurance company. Because around the country, physician insurance companies were starting to pop up. And we had a study and we looked at it, and I went to a couple of Chicago meetings. And we had it all ready to go. And as I remember, the House of Delegates decided not to go into it, and we didn't. And the fear was that those companies didn't last too long. And some of them didn't, but some of them have survived. And so the OMA did not create its own insurance company. But certain physicians came to the OMA and said, "Can we have the results of the studies that were done? And we want to create Northwest Physicians." And that was given to them, and they did create Northwest Physicians. And that is still a viable company in Oregon today.

FRISCH: When you say that you hurriedly put together some legislation, it was literally in Salem, writing it on paper?

COONEY: It was still one o'clock, two o'clock in the morning. It was tough to try to do that, try to anticipate all the pitfalls. And you had to get protection of the doctors. And it should have been something that could have been studied and developed over a long period of time, but we just didn't have it. And we were faced with all the doctors in Oregon being bare. So that was an attempt.

Excuse me, I'm going to interrupt here. I've got to change batteries in the microphone.

COONEY: Okay.

Stand by, Matt. You want to hit the stop tape there?

(?)

COONEY: Oh, maybe a year or two.

FRISCH: Well, things I want to talk about, I think, are–

Okay, you're on.

FRISCH: –terminations of pregnancy, the business about death, legislation to define death, and that whole sequence. And then the managed care sequence. And then maybe a little bit about the Board of Medical Examiners.

You're rolling.

FRISCH: Okay. Where were we?

COONEY: We talked about the shorter statute of limitations and attorney's fees.

FRISCH: Oh, right. Attorneys' fees. So when we talk about a crisis in '75, rates had gone up significantly.

COONEY: In '75, it wasn't as much a matter of rate as it was availability. There were no carriers that would write at any price. And it wasn't until we were able to change the statute of limitations that the carriers then changed their mind and said they'd come back. Because they didn't have to carry out this long reserve issue, because the statute was shorter.

FRISCH: And then we're into the mid '80s, and that legislation has all been in effect. Then what happens?

COONEY: Well, in '85, we started getting into costs again, and the insurance rates were going up. And now it wasn't a matter of just availability, it was a matter of affordability. And the premiums were getting really big, particularly for OB/GYNs and neurosurgeons, just as it is today.

And so the OMA tired in '85 to get some legislation through. And the governor's tort reform committee was appointed. And my partner, Mike Crew sat on that. And we put together a package of things, the most significant of which were caps on non economic damages. There were some limitations on punitive damages. There was a change in the burden of proof, higher level of proof, malicious conduct was required. And then, punitive damages, 50 percent of any recovery went to the state of Oregon. And all of those things passed. They were not limited to medical malpractice for constitutional reasons. It was thought that, pick out a specialty and not make it across the board, could violate equal protection. And therefore it was across the board. It was tort reform for all types of tort.

That resulted in a dramatic holding of premiums, and then eventually a huge decrease until the CENCO case came down and held a cap unconstitutional. Now the cap, earlier, had been held to be valid and constitutional if the patient died. Death claims. And

that was pretty easy to anticipate that, because at common law, there was no wrongful death claim. And if the patient died or the claimant died, that was the end of it. And wrongful death cases were created by the legislature, and therefore constitutionally could be changed by the legislature. So the cap as to wrongful death cases was thought to be, and ultimately was, upheld as constitutionally valid.

When the CENCO case came along, which was not a malpractice case, but a products liability case, where the patient survived with horrible injuries, the Oregon Supreme Court said the cap is no good because in common law, when the Oregon constitution was adopted, that cause of action existed, and our constitution preserved the right to jury trial, assessing the full amount of money was part of the jury trial, and therefore it could not be limited. And they held that the legislature had no authority. They couldn't do it if they wanted to. So the OMA tried twice to get constitutional amendments through that would allow a cap to take place. And the last go round just missed it in a very close race.

But that, then, when that cap was knocked out, it was a beginning of a rise in premiums until we're in the crisis state that we're in now. I don't think it was just that. I think managed care that had come along played a part. I think that changes in the way jurors are chosen had something to do with it. And I also think that Oregon is no longer as conservative as it once was. And you can see that today by the bank of your jurors. There are not many native Oregonians that are here that sit on juries. Not to bash non native Oregonians, but some are more liberal than others.

And so we've seen the rise in premiums. I think managed care did a lot to turn the public against the healthcare industry. And I think once the public began to understand that the way the system was working for a while was the doctor was getting compensated for not treating. That kind of outraged them. And it suddenly destroyed some of the trust that existed between the doctor and the patient. And the patient no longer chose the doctor; you had to be on the plan. And if you weren't on the plan, the patient couldn't go and they had to change. And the employer and the insurance company that were the ones that were really running the show, and it left out the doctor and the patient.

And so I think a lot of people resented that, and so it was more difficult to get a successful verdict. And it showed up very quickly in the smaller communities, where you always kind of thought that the jury would not find against the local doctor, but they have.

FRISCH: Well this issue of managed care, let's go back a few generations there and pick that theme up. Managed, Kaiser was here in the '50s, '60s. And how did this whole thing with managed care manifest itself in terms of the work that you were doing and your partners were doing?

COONEY: Well, Kaiser was always out there, and Kaiser, the Permanente Clinic was nothing more than a big clinic. But they had behind it an insurance plan that you had

to belong to to have access to the Permanente Clinic. It had some success, but not a great deal of success.

Some of the medical staffs began to think that it would be a good idea to imitate the Kaiser pattern. And the medical staff of XYZ hospital would group up and become a clinic. And they would serve that particular hospital. It would still be patients choosing their doctor, and patients either paying for the care themselves or through some health plan that would reimburse them or the doctor. And we had some come to us and say, could you create a giant partnership with XYZ hospital. And our response was always, "Yes, there's no problem. But you also assume the liability of anybody that's a partner. And you're a pretty good sized medical staff. Is that really what you want to do? Because now, as a partner, you have unlimited liability for the mistakes of someone else."

And that scared everybody out, and they wouldn't do that. And it was eventually, in about '85, maybe a little bit sooner than that, managed care became more of a force and more of a factor. And the OMA put together a program where we went around the state and told people that this was coming, and these were the things that we needed to watch for. And in fact, it did. And we've seen it go from managed care where the insurance company interjects itself into the healthcare decisions, and they may or may not be knowledgeable. It resulted in the OMA passing, or getting the legislature to pass, the patient protection act. To try to legislatively control some of the evils of managed care.

Now managed care has drifted away from this idea that the doctors get treated for, or paid for, non treatment. But they still have fee schedules or things of that sort that sometimes make it difficult, and sometimes make it difficult to get on the panels.

As a result, the current legislation effort is to consider the any willing provider rule being adopted as a matter of law, legislative law, in Oregon, in non-HMO settings, non-Kaiser types of settings, and applicable in PPOs. So that any physician that would agree to accept the fees and the peer review type of issues would be entitled to treat patients, and the patient would be able to have some choice, then, as to who they went to.

Now whether that will pass the legislature or not, I don't know. And I know that some physicians oppose that because they are already on the provider panel. And as you dilute the provider panel, you may do harm to the system. So it's kind of controversial.

FRISCH: This managed care evolution was so successful that actually it's worked to the physicians' disadvantage in terms of reimbursement rates. Because an awful lot of slop in the system got weeded out, and rates were established on the basis, compared to some of the stuff that was going on in other states in the country, rates for physicians' reimbursements were much lower, and remain that way. Are there some other manifestations of managed care in our system today that are causing concerns for physicians themselves?

COONEY: Well, I think the economic squeeze that physicians have felt due to loss of income, and therefore they are required of necessity to see more patients. And

thus increasing the risk that they might make a mistake, and thus increasing the risk that they could be subject to a lawsuit. And I think radiologists are faced with that. They have to read more films faster and quicker, and perhaps being exposed more to claims.

The other thing that occurred legislatively that kind of backfired a little bit on the OMA and all tort individuals, or companies that are sued, is the issue of several liability. Prior to '95, we had what we call joint and several liability, which meant that the plaintiff could sue three or four different defendants. And if they recovered a judgment against all, there was no assignment of percentage of fault, the plaintiff had the option to collect the whole thing from any one person. And that was thought to be unfair.

At the same time, there was the rule that if a settlement was made by one of those defendants, the settlement would not be shown to the jury. But at the end of the case, the amount that the plaintiff had received would be deducted from the judgment so that you didn't have to pay the whole thing.

When several liability was enacted in '95, legislature went along with the idea that you only pay for your own share. But when it came to what do you do with the defendant that settles out in the middle of the case, they said well you can't show the settlement, and you can't deduct the payment. And if you want the benefit of having the settling defendant's percentage of fault determined, you now, the remaining defendant, have to assert that that defendant was at fault, you have the burden of proof, and you have to ask the jury to assign a percentage of fault to the person that settled out. If you're successful and they assign a percentage of fault, then you only pay your share.

The downside is, if you don't undertake that task, let's say you've been working with the hospital and they settle out, all of a sudden now you have to decide can I turn around and call the kettle black. And most of the time, it's not done. So plaintiffs are in the position where they can get a double recovery. And that needs to be changed. And that was a bill in. I don't know whether it's going to pass or not.

FRISCH: You and your partner, Mike Crew, have spent a lot of years representing physicians in different kinds of arrangements. One of the areas that the firm has played a large role has been in the formation and the ongoing functioning of independence practice associations, or IPAs. Could you tell us a little bit about that and how that's impacted practice.

COONEY: The IPA was created to try and kind of level the playing field because the individual physician or the clinic didn't have the clout to battle with the carriers. And so for a large group of physicians to be able to group up and have any clout, it was prohibited by the antitrust laws unless there was a risk sharing. Which, in effect, made you a single entity, just like a PC or a partnership. And so IPAs were created, and they were supposed to have risk sharing. And there was how much risk did they have to share was 15 percent and now 20 percent. And they would have pools set aside that would be subject to the risk. And some would involve risk sharing with the hospital. And it was designed to give them more ability to negotiate. And to a certain extent, it was successful.

The thing that the IPA couldn't do, because they were so big, was say, "Okay, members, we're going to boycott. None of you may and be a part of this organization, refuse." You all independently have to make your own decision. And so that was kind of the weak spot that took away some of the negotiating power. Because if the plan didn't like what the IPA was doing, they could just go around and contact the individual doctors and say, "Take it or leave it."

But that's kind of how it came and why it came about. The IPAs are becoming less viable than they once were, and the plans have been kind of moving away from the idea that they can control, you get so much money per patient, and that's it. They're going back a little bit more toward the fee for service type of plan, where the patient has choice. But they limit the amount that will be paid, and the doctor has to accept that or not. They still have preapproval requirements and interjection into the doctor/patient relationship that is not well liked by the patients, and certainly not well liked by most physicians.

FRISCH: We still have a large number of younger physicians employed by various hospital systems in various communities around the state. That's in somewhat direct contrast to fifteen, twenty years ago, when most physicians were self employed small businesspeople. Talk a little bit about that.

COONEY: Well at one time, it was illegal in Oregon to have the corporate practice of medicine. And therefore, a hospital was not authorized to employ a physician to practice medicine. And that was removed from the books, and hospitals are not allowed to employ. They do, they have emergency room doctors, some are on contract, some are direct employees. They have pathologists, same thing. Radiologists, perhaps the same thing. And they have hospitalists who take over and are employed by the hospitals. And they actually have bought up certain clinics where the physicians, although a clinic, are really employees in the hospital.

That kind of followed the movement that we saw in law, where groups would join and become a mega law firm. And that happened to a certain extent with physicians. But as we in both professions did that, we found it was kind of like a marriage. And sometimes you didn't like the people that you were tied up with, or the employer was demanding to much of you. And so I think that spurt of growth that occurred is now falling apart, just like it did in the law profession, where maybe smaller is better, and compatibility is more an issue.

And the problem is, some contracts that people entered into that it's difficult to get out of. And I guess if I give one word of caution to my lawyers that review contracts for physicians of whatever kind, whether it's with a hospital or a plan or a private company or a clinic, you look first to how you get out of the thing. It's just like a divorce. And you have to look and see what will happen if it doesn't work out. And that has to be something that has to be spelled out.

FRISCH: Relationships between the hospital association and the medical association have always been determined, in large part, by the issues that were around. But there are a couple of figures you've passed on that I'd like you to just reflect upon briefly. One of them is Pete Fleischner, who was the exec for the hospital association a number of years ago. And also, Ray (Mansing?). Because I think both of those individuals characterized a certain collegiality that was effective in hospital/physician relationships. It may not be (?)

COONEY: Well, I think that's exactly right. There were times, for example, I can remember, when there was a dispute in the legislature about whether the hospital board of directors could unilaterally change the medical staff bylaws. And it was a very emotionally charged, hotly contested issue. And I had a telephone conference with Pete Fleischner and Ray (Mensing?), who at that time was employed by the hospital association. And we were able to work out a compromise that is on the books today. And there was not a lot of name calling or insulting or anything else that you get into. And there was a certain recognition that it was the hospital's hospital, but it also had a recognition that the hospital wasn't worth anything if they didn't have the knowledge and input of the medical staff. So those were put into position. And Ray (Mensing?) eventually left the hospital association and was up with our firm for a while before he died. And his knowledge of hospital protocols, particularly in Medicare, was invaluable. He knew that better than any of us.

And Fleischner was a very dynamic leader and I always thought had a good relationship with the medical association.

FRISCH: So did I. Let's talk a little bit about the evolution and emergence of legislation concerning definitions of death, how people made decisions for people who were incapable of making decisions, then the whole issue of living wills and pulling plugs and the whole thing.

COONEY: Medicine had been pretty much left alone as to how it handled dying. And eventually it became a significant medical/legal issue: What was death? And so a statute that was passed that gave a benchmark and a guideline as to this is what death amounts to. And that amounts to a signal of what you could do or not do as far as further treatment, or withholding treatment, things of that sort. And the judgments were all made by the family and the doctors. And it seemed to be working pretty well.

In '75, the first directive to physicians was promulgated. And I don't know whether it was a fear that physicians might not give proper care to dying patients or what, but it was felt that it was important that a written document be created that would come into play when the patient was terminal and was incapable of making their own decisions.

And I remember going to the legislature and advocating that they not touch it. That it should be left alone, let the physicians and the family decide what's to be done. And we were not successful. And the advance directive was the law that came forward.

And the right to life people were advocates of that type of legislation. And it became kind of a religious division in the legislature.

I remember being down there one time, testifying in front of a committee about something. And I felt a hand on my shoulder. And I turned around, and here was a man dressed in black with a Bible in his hand. And he said, "Forgive us, lord, the devil is among us." And he was talking about me. So it became a very charged emotional thing.

The next thing that occurred was the medical power of attorney. We always had powers of attorney, but they were always limited to business transactions. And so the power of attorney was created in which the attorney in fact, the designated individual, was authorized by the patient. That that person could make decisions for the patient when the patient could not. And that served for some time. And it had a life expectancy that expired automatically in seven years, where as the directive to physician had unlimited life, unless it was voided or canceled. So technically, a power of attorney now probably is no good, unless the patient was incompetent and remains incompetent to this day.

Then in '94, I think it was November of '94, the advanced directive became the only document that was recognized if it was executed after that date. And it had the patient's ability to say what they wanted, and it also had in it the patient's ability to appoint an attorney in fact to make decisions for them. The problem that we have found, number one, we don't know for sure whether there is some other common law right that exists, and whether that is the exclusive way to have you say that you don't want lifesaving procedures. I tend to think that as long as the patient– well, I don't tend to think, I know it's the law, that as long as the patient's competent, they can refuse or accept whatever they want. It's their choice.

It's only when they can't that you get into this kind of never never land. And there is still some lack of clarity as to whether, what we do if there's some disagreement between the advanced directive, where the patient says "I want this" and you have to say they give absolute authority to the power of attorney to do whatever they want. And does that mean that the power of attorney is limited by what the patient said, or does that mean truly that the power of attorney can do whatever they want. And we don't really have any cases that have come over that have decided this.

So doctors and hospitals have kind of struggled through it, and there hasn't been a lot of argument about it. My only advice is, be sure that if you're going to discontinue treatment that's likely to end in death, you don't have a big family split. Because that's where you're going to get the litigation. And if you have that situation, then you better have some consultation. And maybe there's an ethics committee in the hospital that can have input, so that in effect you're covering yourself in event of discord in the family.

FRISCH: We've taken another step, and other states have followed through in the sort of evolution we have. But we've gone farther. We've done what we refer to as physician-assisted suicide. How did you see the legal landscape during that whole

process? And what were some of the struggles that you had in advising physicians about this process?

COONEY: Well fortunately, the OMA, through its house of delegates, knew that this was politically charged. And they pretty much put it to a vote as to how the organization should come down on it. And they came down with such a split that they decided not to take a position on it. But it still ended up with the same group of people battling over the language of the statute. And there were those that were afraid of euthanasia, particularly for the elderly and the helpless. And people that didn't want their spouse necessarily to make the decision, because they might be in the process of going through a divorce, and it's a good time to get rid of old Joe. So it boiled down to a compromise, which frankly we didn't have much input into, as to the physician would be authorized upon the plaintiff's request and under appropriate circumstances, to give the patient a prescription to fill or not fill, if you wanted to, to have on hand an overdose that you could use if you wanted to die earlier than the natural causes.

This caused concern by some of the pharmacists because of personal beliefs or religious beliefs, didn't want to participate. And there was a question of whether they had to. And obviously they shouldn't have to. So it's been pretty much a voluntary program. This recent decision by the U.S. Supreme Court saying that medical marijuana is not a viable option, I think may come down to haunt us on whether doctors can issue the certificate, and whether doctors can issue an overdose of medication for an assisted suicide.

My advice to doctors right now is don't do either one. But I know that there's a lot of pressure, particularly for those that are dealing with very ill patients on both subject to maybe do it. But they do run the risk of the DEA coming after them.

FRISCH: One of the things that I was thinking about that was the physician aiding and abetting the patient in filing federal laws regarding not possessing or using marijuana. Is that–

COONEY: Yeah. I think that's a possibility. If they want to send a message, they'll make it a notoriety type of case and go after a physician on that theory.

FRISCH: The United States Supreme Court in Roe vs. Wade said that women have a constitutional right to decide about termination of pregnancy. Prior to that time, laws were on the books in various states that made termination of pregnancy a criminal act. Do you remember much about that in the times you were practicing before Roe vs. Wade?

COONEY: Yeah, there were. There were certain doctors that were known locally that would perform abortions. And they would periodically be charged with some criminal event. A lot of times, people were sent out of state, or it was undercover abortions. Some people were badly treated medically, and there were some pretty serious consequences. And so I think that abortion clinics became more acceptable, and abortion

became, for those that would accept it, more of a viable thing. And it would be in an environment where safety could be considered. But there was that period of time when abortion doctors were considered outlaws.

And I can remember some of the groups petitioning the state to find the names of doctors that were doing abortions on welfare. And being involved in trying to stop the revelation of their names to these groups, because it wasn't for anything usually other than to publicize them, and to picket and things of that sort.

FRISCH: One other issue that I think is a perfect metaphor for the relationship of physicians to Board of Medical Examiners, has been the whole evolution of the intractable pain, and treatment of intractable pain, and the board's involvement with that issue and physicians. Could you talk a little bit about how that all started, and where it went, and how it's ended up?

COONEY: Well, my involvement in it has been primarily through the licensing board. And the licensing board of Oregon has been pretty active in its belief that long term narcotics should not be prescribed, excluding terminally ill people. And that there are certain number of people that are drug seekers and drug users, and that the medications don't solve the problem. They just add to it and make it worse. And as a consequence, they sanctioned quite a few doctors for that. And there was a split in medical education as to whether certain patients, under appropriate circumstances, were, in fact, entitled to long term pain medication. And many doctors were afraid to prescribe, because they'd be afraid that they'd get in trouble. And pharmacies and worker's comp carriers and other health plans were turning doctors in.

And so it finally got to the point where legislation was considered in effect to put a slow down, so to speak, on the prosecution of medications that were used to control pain. And so the intractable pain act came into effect, and it was largely supported by lay people and some doctors that had been subject to sanctions. And there were certain requirements put in the bill, like California had a bill that was copied. And some of the leading doctors in the medical community disagreed strongly with the BME's position on using pain medication. So in effect, the intractable pain statute was passed with input on both sides of the fence, as well as the BME, that if you're going to do it, you have a contract with the patient, you have the appropriate warnings, you have to properly follow up and don't let the patient abuse the drugs and that type of thing. And if that's done, then the board, by law, has to leave you alone.

The problem that we have found is that 95 percent of the doctors don't understand the law or what it requires. And to this day, we'll go in with somebody and a board member will say, "Well, where's your contract? Where's your warning? Where's this?" And none of it's there. And it's simply because they don't know it.

FRISCH: The Medical Legal Handbook has been around forever and ever, and the OMA has produced this book. I remember when it used to be called *My Chair is Full of Cheerios.* This is actually a whole event that, or events that occurred around our

teaching loss prevention to physicians. Could you describe a little bit about your experience from the beginning of all that? And Tina Wright Rayburn and Tom Miller and some of the other people, and how the book got to be named.

COONEY: One of the things that we saw in defending malpractice cases, we'd go to the PAC committee, and the committee would review it. And we'd see time and time again, repeated mistakes that doctors were making. And so we decided to use the information that we garnered from the PAC reviews and the malpractice cases to go around the state informally and speak on these issues. And it was usually a dinner meeting after a county society, and everybody had had something to drink. And sometimes they were very meaningful, sometimes they were a lot of noise. And I remember going out to a Clackamas County group one time. And Dr. Billmeyer, Dan Billmeyer when he was alive, throwing a biscuit at me to encourage me to sit down and shut up. But I learned later on that was a form of endearment, and it was okay with Dan.

The name of the book started, I always said I was going to write a book about my life in court and Little League. So I started putting together notes of things that had happened. And one day I came home from work and I was tired and I sat in my chair where my daughter had been waiting for me, eating Cheerios. And I sat on them. And I jumped up and I said, "My God, my chair is full of Cheerios." And I thought that was a great title. So that was how the book was named.

But loss prevention has grown from those early years to the point now where we have *The Medical/Legal Handbook.* And I think that one of the big things that the OMA has done throughout the years is try to educate doctors through the loss prevention program on things that they do that can be harmful to the patient, and to try to find ways to correct them.

And I think now that what you're doing is expanding that to not only risk management, but to inspections, and the peer program, where doctors that might be deficient are upgraded, fills a whole much needed gap. And even though I'm the lawyer for the OMA, I applaud the OMA constantly for that. And it's not a way to cover up how to, it's the way to protect the patient from getting hurt. And I think that's very important.

And because the OMA is a group purchase entity, they can offer certain benefits that might be restricted by state law, all people who participate in the program *must* go to these peer review programs. Frequently they're on Saturday, and I know I would rather be out playing golf, and the doctor would, too. But very often, after it's all done and over with, they come up and say, "You know, it's better this time than it was that time." And you and Dr. Tom Miller and the whole crowd that does it are to be applauded.

I think the other big thing that people may not realize as part of the service of the OMA is their huge effort that they have made legislatively. And but for them, when I look through the history of malpractice cases and the law, I see the stamp of the OMA all over the stuff. And I don't know that the membership really realizes that.

FRISCH: No. And I think the whole guiding principle there was to make it better for physicians, and still be good for patients. And that whole ambulatory record certification program, and some of the other initiatives as well, all designed to try to reduce unnecessary duplication or confusion. And the result has been pretty amazing.

COONEY: And I think the service that the OMA provides has grown. I don't think it has shrunk. It has grown. And I think people need to realize that it's an important factor.

You know, one other thing I might want to just talk a little bit about that has, I think, changed. And that is the relationship between nurses and doctors in the hospital. maybe in the beginning the doctor was too godlike, and the nurse was maybe subservient in the eyes of the doctor. And perhaps there were instances where they were not treated well by doctors. But I have seen and experienced situations where it's kind of us against them now. And instead of being in a partnership, there are some instances where nurses, in effect, turn against doctors. And administrators use the nurses and the incident report to create a file to cause a physician to be labeled a disruptive physician.

And that shouldn't be. It should be a team effort. The arrogant, hostile, abusive doctor should be put in his place within the bounds of the hospital process. The nurses spend more time with the patient than the doctor does, and the doctor should listen. But they shouldn't be enemies. Because it hurts medicine. It hurts the doctor. It hurts the nurse. It hurts the hospital. and most of all, it's not good for the patient.

And I just have one true story that I, I won't identify who the person was. But I was in the hospital. and the patient and the patient's mother was questioning whether the doctor's advice on certain things was correct. And they should have asked the doctor about it, but they didn't. they asked the nurse. And the nurse, in effect, said, "You don't have to pay any attention to the doctor. You can do this, this, this and that." And I was appalled. Because all of a sudden, the patient was put in the middle of the doctor telling them one thing and the nurse, the other. And that should never have occurred. And I see more of that. and I see a distrust. And I would hope that there would be ways to solve that internally.

FRISCH: A lot of physicians today probably assume that the Oregon Health Sciences University and the Oregon Medical Association have enjoyed this close relationship. But the reality is that the medical school, years ago the medical school was fairly well isolated from the larger community. Can you talk a little bit about the evolution of that from your perspective?

COONEY: Well, what I remember about the medical school is there was a feeling by some of the practitioners there and perhaps some of the students that the doctors off the hill would dump bad cases on them that they had botched. And in defense of themselves, they would say such things as, "Who did this to you?" And make comments. Particularly the residents. And it kind of created a war between the off the hill/on the hill physicians. And it even was so bad that it sometimes affected referrals,

because doctors off the hill were afraid to refer because their treatment might get badmouthed.

There was some education spent on both sides of the table, trying to encourage a more collegial effort. And I think that has happened. And I think that some of that badmouthing has discontinued.

And I say that with a caveat, because I think managed care, particularly in the metropolitan area, has caused a rebirth of badmouthing. Because specialists and primary care physicians sometimes are at odds with each other. And that the specialists feel that they're being curb stoned by the primaries and not getting the referral that they should, or that they get the patient after it's too late and there are more complications. And the primaries are feeling that maybe the specialists through the years haven't treated them with the proper respect.

And the plaintiff's lawyers are very quick to know that. And they try to put that wedge in very early on. So I think badmouthing is something that we had tried to discourage, perhaps with a limited amount of success. But now it's coming back.

And the other thing that we were never able to curtain and stop completely was altering records. We've talked about that since day one. Converted defensible case into being undefensible because you doctored the record, you're not subject to trust anymore. And the message has always been "don't do it," but it still happens.

FRISCH: Well you're approaching fifty years in this business. I was just curious about what' brought you satisfaction working with physicians. What are some of the things that you've gotten out of it? You've given a great deal to everyone. What about for you?

COONEY: Well, the thing that you, I think if you take from the practice of law, and the thing that we talk to our young lawyers about. And every year we invited the law students into the office to talk to them. And I usually leave, because I want the younger lawyers to talk to the younger students. But I've always been one to advocate that no matter who you represent, you're helping somebody that needs help. And doctors, like anybody else, need help. Doctors may not believe this, but lawyers sometimes need help. And it's that satisfaction that you get, that can you help somebody. And that's what makes it interesting. But the combat and some of the infighting between lawyers is unpleasant sometimes. But the ultimate goal is, you're trying to help somebody.

FRISCH: There were a few things I'd like to ask, pursue a little bit farther.

Let's go ahead and change tapes.

[End Track Four. Begin Track Five]

Okay. Rolling on tape four.

FRISCH: This is tape four.

Excuse me, tape three.

FRISCH: Oh, you're right. You're right. This is an interview with Tom Cooney, general counsel of the Oregon Medical Association, June 15, 2005, at the OMA. The interviewer is Paul Frisch. This is the third tape.

Let's talk a little bit about how the doctor/patient relationship has changed over the past hundred years as a result of increasing medical/legal conflict, and where you see it going.

COONEY: Well, I think originally the doctor/patient relationship was one of trust by the patient, that they believed that the doctor could do no wrong. He was close to infallible, and yet the patients accepted that he was human and subject to human frailties. But it was kind of not the vogue, socially, to sue a doctor.

Gradually that changed as doctors would get sued more. And I think doctors, rather than patients, originally viewed the patient as a potential enemy because they might sue me.

And then along came managed care. And I think managed care did more to disrupt and interfere with the doctor/patient relationship, because it made doctors have to do things contrary, in their mind, to the best interest of the patients because of the control that the plans may have had for them. Some doctors didn't submit to that, but some did.

And patients, as they began to understand how managed care worked, and that the doctor maybe wasn't the sole person in charge, and that they could have their doctor removed by the plan anytime, it caused a distrust. And it's, doctor/patient relationship is still there, it's still pretty good, but it sure ain't the way it used to be. And I think we're kind of at a crossroads where in the future it's either going to continue to deteriorate, or patients and doctors are going to have to speak up as a group and say, "Hey, butt out, employer! Butt out, insurance company! Our decisions are our decisions; they're not yours."

And unless that happens, I don't see a restoration of the old doctor/patient relationship. Now I think doctors have to accept the fact that the patients nowadays are more intelligence, they're better educated. And the doctor can't just say, "This is what you've got to do," and they'll accept it. You have to explain it to them, because they want to know.

FRISCH: Comment also on the Internet and email.

COONEY: Well, I find myself guilty of it. I'll walk into my doctor's office and say, "I saw something advertised on this drug thing. What do you think?" And he thinks

my God, not only are you a lawyer and a pain in the neck, but you're also one of those guys that reads that stuff. But that's what we're faced with. And I have always felt that the drug companies would stop doing that eventually because they'd get sued for incomplete information. But you'll notice the last year or two, they're starting to mention the risks very quickly. Maybe the medical/legal issue with lawsuits against them may slow that down. I don't know.

But I think the doctor/patient relationship is no longer one of complete trust that it was at one time.

FRISCH: Well I think this whole business of being able, in the last year and a half, of being able to access your physician by email, and have a serious clinical conversation, if you will, is a real change in how it's done.

COONEY: It is a change. But I think the other thing that has to take place, I think the doctor has to be able to charge for phone calls and emails, just like lawyers do. Because it takes time.

FRISCH: Providence is actually reimbursing physicians for that.

COONEY: Well, they should. They should. Because they're giving medical advice, and it just takes the place of the face to face visitation. The danger to the doctor is that he's diagnosing without seeing the patient, if that's what happens.

FRISCH: I don't know if I ever knew there was a time when doctors and lawyers quote "got along." You can probably tell us better than I. But my question in that regard is, how have the relationships between doctors and lawyers evolved over time, and where do you see that professionalism going?

COONEY: You know, at one time, early in the practice, there was more respect and camaraderie between doctors and lawyers than there is now. They respected each other's job and role. There were some jerks on both sides of the fence, and everybody kind of knew it. But there were the Multnomah Medical Society used to put on a smoker for the doctors in the bar. And I played in golf tournaments where they were together. But that has changed. And there is such a rabid element on both sides of the fence that distrust one another, that I don't know that we will ever be able to return to that issue.

And Larry Wobrock is one of the leading plaintiff's lawyers in medical malpractice. And I've tried quite a few cases with Larry, but on the other side of him. And yet I look at him as one of the more graying, mature people. And I feel I can talk pretty openly with him. And we just know that there are certain issues between the professions that are rabid. And one is a cap. One is this limitation on attorneys' fees. And he says to me that, "You and I, Cooney and Wobrock, might sit down and figure out what's right. But we've got rabid people in the plaintiff's bar that won't buy what I say." And he said, "I'm sure you do, too." So I don't see the two professions voluntarily working things out. I would hope that they would, but I don't see it.

The other thing that I predict when it comes to what's going to happen with the malpractice scenario, I think all of the things that we are trying to do, be it cap, be it panels, be it disclosure of experts, statute of limitations, attorneys' fees, all are really patchwork things that are on the system. And the system, the jury trial system, is fine on certain types of cases. But it has gotten so big and so bad that it's interfering with the quality of care that the people are entitled to and deserve.

And I think that eventually, it may not be in my lifetime, but eventually, we're going to move to some form of a workers' compensation system for compensating people that sustain injuries as a result of medical care. And I know that's been talked about for some years, I know of the legal issues and the legal expense issues that go to it. But we have to go to that. And it won't cure things 100 percent, but it may allow people to get money without having to go through two or three years of litigation. It's not good for the client, it's not good for the patient, it's not good for the doctor. It's good for us, lawyers. And I just hope that we can find a way to compensate people that are harmed by the procedure, with or without fault. I think you have to do that to make it constitutionally valid. You're going to limit what they can recover. In order to do that limitation, you have to give back something, and that's to give them something without fault. And that's where the increased cost concerns come from, but that has to be actuarially studied.

FRISCH: Looking back on the Oregon Health Plan and its creation and implementation, from a legal perspective, was it and does it remain a rather radical idea? And how do you think we've managed the whole process of rationing care?

COONEY: Well, when it first came out, I'm kind of lapsing into a personal opinion now, not counsel for the OMA, but when it first came out, I didn't like the idea of rationing care for the poor. I thought they should be entitled to the same care that everybody else did. But as time went on, I became aware that we had limited assets. And it's better they get something than nothing. And that was my belief.

I do know from talking to doctors that sometimes these patients are the most difficult to handle, and cause more trouble. And that, as a result, doctors may say, "No, I'm not going to take Oregon Health Plan. Not only is it not financially feasible, some of the patients are a pain in the neck."

I think someday we're going to have to visit uniform healthcare for everybody. And it may be that it will be a limited tiered level, but it's better than nothing. And then you may have another layer on top of that that people can afford to pay for. I hate to see that. On the other hand, I'm appalled at the number of people that have no healthcare. And I think the Oregon Health Plan was a beginning. And I just don't think it has been managed well. I take my hat off to the managers of it, because it's a difficult task. But I think it's more than they're capable of handing, and I think we need some form of universal coverage.

FRISCH: Do you see any relationship between an experiment in universal coverage and some change in the tort system as fitting together effectively?

COONEY: I think that's a good possibility. I think that might be the tradeoff. What you have to do in order to change constitutionally protected rights like jury trial is you have to give something in exchange for it. And universal healthcare might be it. And you might be able to say, "Okay, you now have universal healthcare, but your ability to recover damages is capped at X amount of money. And therefore you get healthcare you would not otherwise have been able to afford, but you give up some of the ability to recover damages."

FRISCH: If you look ahead twenty, twenty-five years, what do you think we're going to be struggling with medically/legally? What kinds of issues?

COONEY: I don't think they're going to change that much. I think you're going to find the federal government sticking its nose in more often in regulating things with the whip rather than the carrot. And I think we're going to find that doctors are going to throw their hands up and say, "To heck with it. It's not worth it." Maybe in another political time, the government will realize that we have done a lot of damage to the doctor/patient relationship. I think there's a lot of distrust because of some bad doctors have created it. And there may be more licensing. I look for the days when the BME will not be confidential. It will be open and public, just like it is with lawyers. And I look for the day when a peer review in hospitals will be open and public. Maybe not as much as with the state agency, but I think it will be. And I think the idea of disclosure, of good hospitals versus bad hospitals, good doctors versus bad hospitals, will come. And it's going to be a painful time. But maybe it's better, and maybe it will bring up the quality of care, rather than bring it down. I don't know.

FRISCH: Did you feel that the passage of the apology bill, and the whole direction that (Jaco's?) taken with disclosure of error is something that will benefit the doctor/patient relationship.

COONEY: The apology issue will benefit the doctor/patient relationship, because many doctors have been afraid to say what is really in their heart, because it could be used against them in the courtroom. I was never a big advocate of that bill because most of the time it's not brought into the case. Because the plaintiff usually doesn't want it because it makes the doctor look like a good human being, and therefore they stay away from it.

Your non-experienced plaintiff's lawyers may try to do it. And if you do, you file a motion and limiting to protect that. but I think it takes something off the doctor's mind, that it's okay to say, "I'm sorry you had this complication."

What was your other issue?

FRISCH: The other question was, we've moved to this notion of mandated disclosure of error. Where do you think that's going?

COONEY: That is, I think, has yet to be seen how that's going to work. To me, it depends a lot how it's handled. If the doctor is kind of dumped on as the scapegoat, they have to tell the patient about every error that is made by a nurse, it could start World War Three. Because what will happen is, the doctors maybe get taken down in the lawsuit against the hospital. if it's meaningful disclosure for things that the patient really needs to know, then I think that's nothing more than the way it should have been already. And it eliminates some of this cover-up concern that patients may have. A lot of times when deposition, when I take the deposition of the plaintiff, I say, "Why'd you sue?"

They said, "I sued to find out what the hell happened to me." So honest and complete disclosure, I think, is important.

And I think the medical legal system has harmed doctors in hospitals because they are sometimes afraid to speak openly because the medical legal consequences. And I always say, "Practice medicine, not law."

FRISCH: In your role as a defense lawyer for physicians in medical malpractice cases, do you have a most interesting and a most difficult trial? Either one?

COONEY: I think of two. One was the group of cases up in Bend, which someday I hope to write a book about.

FRISCH: And he's been very open about it.

COONEY: Yes. And over seven hundred people were erroneously given more radiation than the doctor prescribed to treat cancer because of a miscalibration of the equipment. And the toughest thing was what do you disclose, if anything, to people who were dying? And when I was called about it, I conferred with a psychiatrist. I said, "Are we going to hurt these people more? Are we going to hurt them less?" And the advice I was given is don't disclose it, because these people are dying and you're going to make their death worse.

I went to Bend, and there was a dispute among the defendants as to whether there should be disclosure. I felt that the doctor was duty bound because of his relationship with the patient to tell them that. And I kind of admired the little nun that was the president of St. Charles Hospital. After listening to all this, she stood up and said, "There's no question that we will disclose. Now, gentlemen, let's move on to what are we going to disclose." And that was a significant task, because some of the people, even though they got more than was prescribed, still fell within the standard of care. And about 25 percent were outside. And so we had to hire radiation oncologist to evaluate what was given to see whether they were in or out. And of the seven hundred and some, about a hundred filed lawsuits. And there were some interesting characters. The poor doctor himself was all by himself up there, the only radiation oncologist. And the plaintiff's

lawyer was a legend over there, Roy Kilpatrick. And he brought in a lawyer named Johnson from Wisconsin. We called him Johnson from Wisconsin. And he'd had a lot of experience. And the physicist who'd made the mistake were defended by the Hoffman Hart firm, I think it was. I think CNA had them. And then the hospital was defended by Doris (?) lawyer from Eugene.

And about seven or eight or nine of those cases were tried and the plaintiff lost them all. And finally there was a small amount of money paid to cover costs, and they all went away. That was probably the hardest case.

The other one was the one involving informed consent.

FRISCH: Let me stop you for a minute. As I remember, the first case that you talked about, you could have tried eighty of the hundred and won eighty. But the moment you lost a case, it was the law of the case from that point forward.

COONEY: That's right. That's right.

FRISCH: So–

COONEY: We were afraid of that. And so what the plaintiff did was originally they went in, just said, "Well, you should have known there were complications." Well, that didn't fly, because there were always complications with radiation therapy. But then they finally woke up to the fact that the cases that were treated later on, you should have known that you had eighty patients that had complications. So in order to defend that case, we had to get all eighty charts, and to get an oncologist to review them as an expert witness to say that there was nothing unusual about this. And that's when we actually had to rent trucks to take up to the courtroom and have them up in the records there for the jury to see.

FRISCH: One other point about that case, the miscalibration, was it as simple as it was set to sea level and it should have been at the height?

COONEY: Yeah. Evidently that form of radiation equipment is calibrated according to atmospheric pressures. And Bend was at, I'm going to say 3700 feet, and it was calibrated as though it was at sea level. And that was the difference. But the sad thing was is when the physicist who did the calibration got off the airport at Redmond, it said elevation, in great big print, told them what elevation they were at, and they still did it.

And they were, Mark Wagner at the Hoffman Hart firm defended them, and did an excellent job. And they were able to convince the plaintiff to consolidate all hundred cases to be determined by the verdict in one case. And they were able to convince the jury that it was not negligence to make that mistake. So they were gone and out of the case. And that left the doctor and the hospital to defend themselves. And that's where we ended up trying, I think there were seven or eight of them who were tried.

FRISCH: How did the doctor make out?

COONEY: Well, just imagine being the only specialist in the community that does this. You're treating patients who have a terminal illness, usually. You're on call 24/7. You've got this dopey lawyer from Portland saying you've got a trial every other month for three years out, and I'm going to have to spend a week to ten days with you in the courtroom, plus depositions and preparation time. And how that physician was able to hold together, I'll never know, but he had a blessed wife who was a nurse, and she comforted him and got him through it. But I step back and think that I was not as sensitive to what he was going through. I was more concerned about winning the cases for him, the volume of them, and probably didn't do as good a job as I could have done in helping him through that.

FRISCH: You also made a long, a lifelong friend in your expert here in Portland.

COONEY: Oh, yeah, Dr. Goldman over at Emmanuel was a radiation oncologist who we were able to convince to be one of the reviewing doctors. And I think he regretted it because he never realized how many cases there were and how much time it would take, and that he'd have to testify in all those cases. And I've been to his house for dinner. And he jokingly refers to an addition to his house as the Cooney Room, because he says that I paid for that.

But periodically that group that handled those cases get together to kind of revisit.

FRISCH: So that was a significant one.

COONEY: Yeah.

FRISCH: And you said that probably the most difficult one was the Dowsett case.

COONEY: Well, I didn't try Dowsett . Dowsett was the first case, that was the predecessor firm to us. But it was after that case that we got involved in those cases. but I think the other case that was significant, and I probably did more to harm the status of the law on informed consent than anything else, even though we wrote the law, it was a case involving a device called an Angelchik device for repair of hiatal hernias.

FRISCH: (Arena vs. Gingrich?)

COONEY: That was the case. And I knew Mrs. (Arena?), because she'd been a neighbor of ours. And the doctor had talked to her about a surgical procedure. And then in between the time of that visit and the surgery had learned about the Angelchik device, which was a donut that went around the esophagus. And decided to use that, but forgot to discuss it with her. And so he installed it and the woman complained and had all kinds of trouble, psychological reactions. And it was removed by a physician who said that it

wasn't the device, but it was an overgrowth of the tissue surrounding the esophagus that had to be stitched no matter which procedure you used, and that's what caused the limitation. And when that was removed along with the Angelchik device, she had no further problems.

Now the issue was, we were clearly at fault for not having had informed consent, and we had to admit that. But the defense was that the same thing would have happened, because the Angelchik wasn't the cause of the problem. And the jury bought that. and the plaintiff appealed it, and we won in the Court of Appeals. But the plaintiff appealed it again to the Supreme Court. And the Supreme Court said oh, no, informed consent was an issue. And they adopted the subjective test on informed consent. And the majority of cases use the objective test. And the difference is, the doctor is entitled to believe that this person would act as an ordinarily competent person. Whereas the subjective test is the doctor has to guess and figure out what this person, individually because of their background, might want to know. And so Oregon has the minority rule, called the subjective test.

But that was a tough case, and it came out with some law that was against us. But it was interesting, and a hard fought case.

Other things?

Sometimes you get, sometimes doctors get really close to their patients that they defend, and I'm assuming from what you say that you got very close to a lot of your clients.

COONEY: I tried not to do that.

Could you go into that a little bit, Paul?

FRISCH: Yeah.

COONEY: Yeah, yeah, that's fine.

FRISCH: Go ahead.

COONEY: The question's been raised how close should you get to your client when you're going through a malpractice case. And I try not to become their pal and buddy, because I think that can cloud my judgment as to when I think I'm doing the right thing for them, and what I recommend to them. They need comfort, they need hand holding, because litigation is very stressful. And I encourage them to seek counseling if they're the type of person that would benefit from it. But I don't have any, many long term relationships with doctors that I've defended, other than the fact that many of the ones I go to for my own care, I've defended. I think it's a little bit unwise to establish lifelong friendships and still serve as the lawyer, because I think you can make mistakes

that way. Doesn't mean they're not friends, that doesn't mean that I don't care about them. Maybe it's just a professional line that you have to draw. Because sometimes you have to say things or make decisions with them that are not pleasant for them.

FRISCH: Of course the line that you draw doesn't extend to not playing golf with them.

COONEY: No, no.

FRISCH: You'll play golf with them.

COONEY: No, no, I'll cheat anybody on the golf course any time that I can. [laughter]

FRISCH: My other favorite story has nothing to do with this, is the young gentleman who was with him on one of his, wasn't it duck hunting trip? The kid from Burns? [laughs]

COONEY: Oh, we were over in Burns. I had a friend there, a lawyer named Pinky (Gronzo?). And he loved to kid me about being the lawyer from the city. And he took us chucker hunting. And he was kind of a pied piper, and he had a whole bunch of little kids that went with him. And so he assigned an eight year old boy to keep me from shooting myself in the foot. And his name was Howdy.

And we were going along looking for chuckers, and everybody was getting a shot off, and I wasn't getting anything. Finally I turned to the little boy and I said, "Howdy, how do I get a shot off on these birds?"

And he looked down and kicked the dirt and kind of hung his head. And he said, "Well, Mr. Cooney, you have to go a hell of a lot faster than you're going." And I thought that was pretty astute for an eight year old kid.

And when we roasted that lawyer, just before his death, Howdy came up and introduced me. He was an adult man, I recognized him. So it was kind of fun.

FRISCH: Was his name really Howdy? Or was that how he looked?

COONEY: Yeah, no, that was his real name, Howdy. And he still went by Howdy.

Let's see, there was one other that we were going to explore. And I had it a second ago.

COONEY: Rural-urban?

Yes.

FRISCH: Oh, I'm sorry. Let's do that one. Let's see, that is back over here. Tom, why don't you talk a little bit about how you see differences – medically, legally – between rural and urban practice?

COONEY: That has changed, too. But originally we thought that if we defended a rural doctor in his hometown, we had an advantage, because he probably delivered 50 percent of the population. And you tended to have more conservative juries in the smaller communities. There seemed to be more collegiality between doctors. They may not have all the fancy machines and the buildings and everything, but they were kind of a team. And you didn't get much badmouthing. The bigger the city, the less conservative the juries were. Doctors didn't know one another. There was a little bit more competition. And we would tend to lose a case in the urban city area where we might have won it in the rural area.

One of the things that has happened since CENCO is the collegiality seems to still be there among themselves. They don't have the same competition produced or invoked by managed care that we do here in the metropolitan or the valley area, so they still have collegiality. But what you don't have anymore is the juries that know these people well. A lot of influx of people from different states. Younger people that look more askance and more critically of medical care and treatment. And so the idea that one community or the other is more safe than the other as far as trying a malpractice case has diminished. I'd still rather try a case in Burns or Klamath Falls than I would in Multnomah County. But it's not as secure as it once was.

The quality of medicine sometimes is different. They don't have the same facilities, they don't have the same consultants, they don't have the same call coverage. And juries sometimes think that because we're board-certified specialists, we have to give the same care that you'd give in New York or in Portland. And that's a tough go. And the Board of Medical Examiners recently came down with a decision that said a doctor who can't provide the same quality of care, machines or specialists, that you could in Portland, shouldn't do the procedure down there, wherever you may be, and should refer the patient. Which was kind of surprising to me. Because it should be the patient's choice, whether they leave home and go to Portland, or whether they decide to make a decision to stay in Oregon.

So I think the lesson to be learned from that is the doctor needs to give the patient the option, that you can to go Portland, and you can get Dr. X, who does this day in and day out, whereas I do it twice a year, and then let them make the choice.

FRISCH: Thirty-three years ago, when I started law school, ours was, I believe, the first class at University of Oregon where there were more than a few women in the class. And you've practiced through this time period when it was a predominantly, law was predominantly a male profession, as was medicine. Can you comment, looking at both professions, can you comment about what impact more women in each profession has had?

COONEY: When you went to law school, that seems to me like last year.

FRISCH: I know.

COONEY: But when I went to law school in 1812, we had one woman in the class. And we started out with a hundred and six or seven of us, and twenty-nine graduated. And she was one of them, and she was number one in the class.

Nowadays, when I taught in the law school, there were more women than there are men. As far as the law profession, I think they have been given opportunities to grow and promote themselves. But I think part of the problem with the practice of law is that it's totally inconsistent with having a family. I have hired several females that were nurses, which were very helpful to me. But if I had to try a case in Bend, they couldn't leave their family to assist me, so I had to leave them at home.

So maybe the courtroom is not the first choice for some of them, because of the family situation. Some do it, and some do it very well. But I've always been concerned. Are they sacrificing something somewhere?

In the medical community, I find a lot of women. And many of them, because of this conflict with family, choose to work part time. And that's the way they adjust to it. And we can't really do that in a litigation section, because I can't say to the client, "Well, I'm sorry that trial is coming up. I'm going to be babysitting that day." So there has been substantial growth of part time women physicians. And I think they have accomplished a good thing there. I think some patients get annoyed that the doctor only works two or three days a week.

And I think the big change is in OB/GYN, gynecology. I think many women nowadays prefer a female doctor. And if I hear a complaint from male OB/GYNs that I'm a male and I can't find a job, more women are attracted to having a woman as their OB/GYN. So that's kind of what I see. And I see both professions having large numbers of women. And I see that there's plenty of opportunity for them in both fields.

If you're a bad lawyer, you're not going to do well, no matter whether you're male or female. And I think there's been enough emphasis now that there have surfaced good women in both professions that we now look at the quality of the skills that are presented rather than just the gender. So I think they've gained in that.

FRISCH: Well I think one other indication of how medicine has changed is we used to have three or four meetings, or five meetings a week, here at the association. And there's just not as much that goes on after hours anymore. And probably in part because medicine isn't the all consuming thing that it was for most folks.

COONEY: I think the generations have learned to put in perspective their career. Whereas maybe older generations didn't have that same focus. You were taught that the law is a demanding mistress, or that medicine is something that occupies your time seventy, eighty hours a week, and that's what you were taught to do.

I remember as a young lawyer having a young family finally declaring in my firm I was not going to work on Saturdays anymore, because I had a family. And that was a new, rebellious thing, and I was accused of all kinds of different things. But I said no, we're not going to do it. And we didn't. so I think the lawyer, or the professional, has to make the stand sometimes.

Tom just brought up another question in my mind. How had paraprofessionals affected the medical legal–

COONEY: And maybe mediation and arbitration.

FRISCH: Yeah, let's talk about those two things. And then let's call it a day.

COONEY: Yeah.

FRISCH: Tom, let's talk first about the use of paraprofessionals, or in medicine, we call them mid levels. In both professions, what have been the positives and the negatives?

COONEY: Originally, I was opposed to paralegals. I had been trained that a good legal secretary, for whom we did not charge their time, could do everything that I wanted a paralegal to do. And being old school, they had to take me kicking and fighting to the trough to use a paralegal. And I frankly don't see a lot of difference between what they do as a good paralegal as a long term private secretary. But they have more responsibility. They are allowed to make more independent judgments, and you can bill their time.

The key to using them effectively is supervision. Because they're going to have a tendency to want to go off on their own and practice law or practice medicine. And that's normal, that's human, and that's the way they think. And you need to constantly remind them that that's a lawyer decision, or that's a doctor decision. And you need to do it in a way that you don't come across as condescending and arrogant, that you're the only big shot in the office that knows what's going on.

And in this day, when financial issues are a big issue, a well supervised, well trained paralegal or medical assistant is invaluable. But it's the training, it's the supervision, because you are liable for them. And if they go off half cocked, you're stuck with them.

FRISCH: Lastly let's talk about mediation and arbitration. When I first came to work here at the OMA, Kaiser was heavily into a binding arbitration program, which they

subsequently abandoned. Could you talk a little bit about the differences between them, and what you see the advantages and disadvantages are?

COONEY: Mediation is simply a third party coming in to see if the parties themselves and their lawyers can reach a voluntary agreement. The mediator makes no decisions. He can't compel settlement. It's strictly a way to find if you can negotiate.

The arbitrator, on the other hand, takes the place of a judge and jury, and makes the decision. Just like you do in a courtroom. Arbitration was supposedly thought as the way to avoid skyrocket type verdicts. But what we found was as though it might have been a little bit quicker. You lost more cases at arbitration than you did at jury trials. So the expense came out to just about the same thing.

And I used to kid the lawyers. I served as a mediator for Kaiser sometimes. And I used to kid them. I said, "Well, you've gotten beat up in arbitration again. What do you think about arbitration?" And they eventually pulled it, and they don't use it anymore.

Mediation, on the other hand, I opposed originally because I thought lawyers, part of a lawyer's job was to be able to mediate the case, and negotiate with the other person. But as I went through it, I began to see that the mediator was a softener, sometimes between the aggressive, adversarial personalities of the lawyers, who could sometimes get in the way of what was best for the client. And so mediation became very successful and very popular. And I've changed my mind about it. I think sometimes it works.

The thing that people have to remember about mediation is you have the right to say yes or no. "I won't pay more than that." Say so. You're not going to get pushed. You can just say no. Or you're going to say, "I won't take that settlement. I want more." And you have your right to jury trial. And that's what people are afraid of mediation for, for some reason.

Arbitration, if I have a choice between jury trial and arbitration, I'll take the jury trial every time. Some people say that's because Irish blarney works better on juries than it does on arbitrators, but I don't believe it. Juries have a better sense of common justice than maybe the arbitrators do.

FRISCH: You know, I think the only reason that we'll get rid of the jury system is when we run out of Irishmen.

COONEY: [laughs] That's true. That's true.

Anything else?

SIMEK: That's great. Want to do a tail slate? Essentially the same thing that you read at the beginning.

FRISCH: Sure.

SIMEK: Go for it.

FRISCH: This has been an interview with Thomas E. Cooney, general counsel to the Oregon Medical Association. This interview took place on June 15, 2005, at the OMA in Portland, Oregon. The interviewer was Paul Frisch. Tom, thank you.

COONEY: Okay.

Thank you, thank you, thank you.

[End Session.]