



Medical Malpractice Newsletter

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Illinois Good Samaritan Act Immunity: Evolving Concepts

The Parable of the Good Samaritan is a biblical story of a stranger who had been robbed, stripped and severely beaten. Many people passed by the man ignoring his plight. Ultimately, the Good Samaritan came to his assistance. For centuries the Good Samaritan has come to symbolize selfless volunteerism.

Illinois common law does not require individuals to volunteer medical assistance to persons in need of assistance in an emergency. In light of that, many states have passed Good Samaritan legislation to encourage emergency assistance and to immunize medical professionals from civil liability for volunteering such aid. In Illinois, the Good Samaritan Act is found at 745 ILCS 49/1 *et. seq.* The statute's stated purpose is to encourage persons to volunteer their time and talents to help others. It provides for broad civil immunities from claims of negligence, although not from willful and wanton misconduct.

The Good Samaritan Act provides civil immunities to a wide range of health care providers, including doctors, nurses, dentists, podiatrists, physical therapists, respiratory care practitioners, 911 operators, law enforcement officers, firemen, and even those who give emergency assistance to choking victims. The statute also provides that "without limitation the provisions of this Act shall be liberally construed to encourage persons to volunteer their time and talent."

Not unexpectedly, most of the case law interpreting the Good Samaritan Act concerns physicians. The Good Samaritan Act for Illinois physicians (Act) is found at 745 ILCS 49/25 and provides:

"Any person licensed under the Medical Practice Act of 1987 or any person licensed to practice the treatment of human ailments in any other state or territory of the United States who, in good faith, provides emergency care without fee to a person, shall not, as a result of his or her acts or omissions, except willful or wanton misconduct on the part of the person, in providing the care, be liable for civil damages." (emphasis added)

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Each issue of the *Medical Malpractice Newsletter* will showcase a few cases that have recently been handled by Hinshaw lawyers. We are pleased to report the following:

Thomas R. Mulroy, III & Diane E. Webster, attorneys in Hinshaw's Chicago office, recently tried a difficult medical malpractice case for a high-profile physician in Chicago. Plaintiff asked the jury for \$1.5 million. The jury deliberated for 36 minutes (a period which included the jury's lunchtime) before rendering a verdict in favor of the physician.

In *Knight vs. Van Matre Health HealthSouth Rehabilitation Hospital* (Winnebago County, Illinois), *Jeffrey S. Spears & Kelly J. Varsho*, attorneys in Hinshaw's Rockford, Illinois, office, prevailed on a motion to dismiss with prejudice under 735 ILCS 5/2-622. That statute provides that a plaintiff in a medical malpractice action must file a report from a reviewing health professional stating that there is a reasonable and meritorious cause for filing the action. It allows a plaintiff 90 days after filing the complaint to file the required report, where he or she was unable to obtain the report due to an impending expiration of the statute of limitations. Prior to 2005, courts regularly allowed additional extensions of time for "good cause." The 2005 amendments, however, added that "no additional 90-day extensions shall be granted . . ." In *Knight*, plaintiff invoked the 90-day grace period upon filing the complaint, but did not file the report within that timeframe. Immediately after the 90-days passed, Hinshaw filed a motion to dismiss with prejudice. Plaintiff consequently moved for an extension, and later filed her reviewing health professional report (without leave of court) on the date of the hearing on the motion to dismiss. Although plaintiff submitted an affidavit of "good cause" for an extension and tendered a proper report within 20 days of the 90-day due date, the trial court agreed with Hinshaw's argument that the courts no longer have authority to grant any further extensions. The court granted dismissal with prejudice on September 30, 2009. Plaintiff has appealed.

Michael E. O'Neill & Jeremy W. Willett, attorneys in Hinshaw's Schererville, Indiana, office, recently prevailed in two reported appeals. The first case, *Blaker v. Ronald Young, M.D. and Indianapolis Neurosurgical Group*,

The statute's wording leaves the answers to some questions unclear, including:

- May a physician cloak himself or herself with immunity after providing emergency care simply by not charging a fee?
- May a physician be immunized for providing emergency care even inside of a hospital?
- May a physician be immunized for emergency care even if he or she has a pre-existing duty to treat the patient?
- What if the physician does not charge a fee, but the hospital does?

Illinois case law has addressed these issues.

Case Law Analysis of the Act

Initial analysis of the application of the Good Samaritan Act encompasses the scope of three elements.

- Provides emergency care
- Without fee to a person
- In good faith

The Good Samaritan Act Applies Even Inside a Hospital

Johnson v. Matviuw, 176 Ill. App. 3d. 907 (1st Dist. 1988) involved a patient who was 37 weeks pregnant when she was admitted to a hospital for a work-up after she complained of numbness and pain in her lower right leg, hyperventilation, and chest pain. Four days later, the patient experienced respiratory and cardiac arrest, and a Code Blue was called. While attending to his own patient in the hospital, defendant physician was summoned by nurses calling down a hallway. The physician entered the patient's room and determined that she was in respiratory arrest. He intubated the patient and began cardiopulmonary resuscitation. The Code Blue team arrived 20 minutes before the patient's primary care physician arrived and assumed control of the Code Blue. The patient subsequently sued the physician and other doctors at the hospital.

The physician moved for summary judgment, relying upon the Good Samaritan Act. The patient argued that the Act was inapplicable because as a member of the hospital's medical staff, the physician had a pre-existing duty to provide care to the patient and unborn child, that a bill for his services was sent by the hospital, and that the Act applies only to emergencies arising outside of the hospital. In affirming summary judgment for the physician, the appellate court rejected the patient's arguments. There was no evidence that merely having staff privileges at the hospital created any legal duty for the physician to treat the patient. Also, the physician did not charge a fee for services (the only bill came from the hospital and reflected charges for drugs and supplies used during the emergency). In considering whether the Act applied inside a hospital, the appellate court looked to the Act's plain language. The Act included a discussion of the provision of emergency medical care, and made no limitation on whether the emergency care was provided inside or outside of a hospital. Finding the language unambiguous, the court declined to consider the Act's legislative history.

In *Somoye v. Klein*, 349 Ill. App. 3d. 209 (2nd Dist. 2004), the court considered the issue in the context of a defendant who had provided *emergency* medical care. (The court discussed a prior version of the statute, which provided that in order to be immunized by the Act the doctor must not have notice of the illness or injury.) Plaintiff patient received prenatal care at a family medical center by her family practice physician. The center had agreements with obstetricians at hospital to perform "on call" consulting services, including Caesarean section (C-section) deliveries, which were not to be performed by a family practitioner.

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At the time of the subject injury, defendant obstetrician was not the center's "on call" consultant. He was then in the labor and delivery section to deliver the baby of one of his own patients. The patient's physician asked the obstetrician for a hallway consult regarding the patient. The obstetrician recommended to the primary care physician that he hydrate the patient and determine the status of the fetus using an Oxytocin challenge test. The obstetrician was later asked for help in evaluating the patient's condition. He examined the patient and opined that the baby could not be delivered vaginally. The obstetrician contended that a C-Section was elective at that time and not an emergency procedure. However, he did volunteer to perform the C-section at the patient's attending physician's request, if no other obstetrician was available. After delivering his own patient's baby, the obstetrician performed a C-Section on the patient. The obstetrician charged no fee and received no compensation for his services.

The patient subsequently sued, alleging negligent delivery of her newborn. The obstetrician moved for summary judgment. The patient contended that the Act did not provide the obstetrician with immunity because he did not provide emergency care as defined in the Act. In affirming summary judgment for the obstetrician, the appellate court found the Act's language unambiguous. Given the purposes of the Act, the court ruled that whether an emergency situation exists it is to be resolved based upon the unforeseen, unexpected combination of circumstances presented, which required the need for immediate action, assistance or relief. The court held that even if there was no emergency under the Act, the patient's cause of action failed because she alleged that the obstetrician was negligent in failing to act promptly in the face of an emergency.

A Defendant Need Not Show the Absence of a Pre-Existing Duty to the Patient for the Good Samaritan Act to Apply

Neal v. Yang, 352 Ill. App. 3d. 820 (2nd Dist. 2004), involved an anesthesiologist, who answered an urgent call for help in resuscitating an unresponsive newborn. In opposing defendant anesthesiologist's motion for summary judgment plaintiff patient argued that the anesthesiologist was the on-call physician and obligated by contract to provide medical care to her. The patient contended that the anesthesiologist was therefore required to prove the absence of the pre-existing duty to render care. The anesthesiologist was an employee of a medical group, which had entered into a contract with a medical center for exclusive privileges to provide anesthesia services to the hospital's patients. The contract required at least one anesthesiologist to be in the hospital at all times and another anesthesiologist to be on call at all times. After the anesthesiologist went home in the afternoon, she was called back to the hospital to provide anesthesia for a different patient in labor. In a nearby labor and delivery room, the patient was having complications from a forceps delivery. The patient's obstetrician delivered a newborn without a heart rate or respirations. The anesthesiologist was immediately paged to respond as part of the neonatal resuscitation team. When the anesthesiologist arrived, she was the only physician involved in the Code Blue and was in charge until the baby was resuscitated and transferred to another hospital.

In affirming summary judgment for the anesthesiologist, the appellate court addressed the patient's argument that the anesthesiologist was not a volunteer because she was "on call" at the time of the subject incidents and so had a pre-existing duty to render care to plaintiff. Determining that the statute's language was unambiguous, the court found no requirement that a physician must prove the absence of a pre-existing duty to the patient for the Act to apply. Further, the court noted that in the Act's preamble there was no express requirement that a doctor be a "volunteer" for the Act to apply.

911 N.E.2d 648 (Marion County, Indiana), involved a patient who sued a surgeon and neurosurgical practice, alleging medical malpractice. The superior court, entered summary judgment in favor of defendants after plaintiff's experts only offered a hypothetical opinion on malpractice. On appeal, the appellate court held that expert witnesses' opinion that defendant violated the standard of care "if" he failed to identify a major blood vessel during patient's brain surgery failed to demonstrate a genuine issue of material fact on the question of breach. It also concluded that any error in the trial court's exclusion of the patient's supplemental evidence on the issue of proximate cause was harmless.

The second case, *Yedlowski v. Marvin Miller, M.D.*, ___ N.E.2d ___, 2009 WL3754021 (Marion County, Indiana), was a medical negligence action brought by the parents of 17-year-old patient who died during a hospital stay. Defendant was the patient's treating doctor in the hospital. The medical review panel issued a unanimous decision in favor of the doctor, who subsequently moved for summary judgment. Plaintiffs twice moved for enlargement of the time to respond, and obtained it. Hinshaw filed a motion to strike plaintiff's response to the motion for summary judgment as untimely. The superior court denied both the motion to strike and the doctor's motion for summary judgment. Holding that the superior court lacked discretion to grant the second and untimely request for enlargement of time to file the response to the motion for summary judgment, the appellate court reversed and remanded the case.

Dawn A. Sallerson of Hinshaw's Belleville, Illinois, office was successful in obtaining a dismissal with prejudice of a radiologist in a case involving an infant allegedly suffering and dying from respiratory distress due to an incorrectly sized and mal-positioned endotracheal tube. Additionally, Ms. Sallerson defended an action brought against a medical clinic wherein plaintiff alleged that after she was diagnosed with a phyllode tumor the employed surgeon failed to explain to her the available options for dealing with it. Plaintiff contended that had she known that she did not need a mastectomy, she would not have proceeded with the surgery for it and therefore would not have lost her breast. Ms. Sallerson was successful in obtaining summary judgment in favor of her client on the basis that plaintiff had failed to disclose in her bankruptcy proceedings that she held an action against the clinic for medical malpractice.

The Physician May Obtain an Economic Benefit From the Patient and Still Apply the Act, But the Physician Must Establish a Good Faith Decision Not to Charge a Fee for the Act to Apply

In *Estate of Heanue v. Edgcomb*, 355 Ill. App. 3d 645 (2nd Dist. 2005), two questions were raised: (1) does the Act apply to a physician whose medical group charged a fee to the plaintiff and as such received an incidental economic benefit?, and (2) must the physician establish that the decision not to bill was made in good faith.

Plaintiff in *Estate of Heanue* was in the recovery room after having a catheter inserted by a surgical partner of defendant. Observing that medication given to plaintiff was not working properly, the recovery room nurse attempted, unsuccessfully, to page the surgeon. She then contacted the surgeon's group. Defendant subsequently entered the recovery room and took over plaintiff's treatment.

Defendant filed a 735 ILCS 5/2-619 motion to dismiss pursuant to the Act. In support, defendant submitted his affidavit that he was a member of the medical group when he rendered emergency care to plaintiff, that plaintiff was not his patient, that he was asked to attend to her emergency needs, and that he did not charge a fee for the care he provided to her. Plaintiff argued that although defendant did not charge a fee, he belonged to the same medical group as plaintiff's surgeon and thus derived an economic benefit and was compensated for his care of plaintiff.

The appellate court considered the meaning of the word "fee" as used in the Act. The court determined that a fee is generated by and tied to the service performed. In rejecting plaintiff's argument, the court stated that the "legislature could have easily said that the immunity conferred by [the Act] is available to those who provide emergency care without deriving any economic benefit, but it did not. It specifically chose the term 'fee.'" The court refused to limit the scope of the Act by accepting plaintiff's argument. It held instead that the question of whether defendant derived some economic benefit from plaintiff's relationship with the medical group was not material to the Act's application.

The court also considered the "good faith" language in the Act. In the statute, "good faith" modifies both "provides emergency care" and "without fee." The court held that refraining from charging a fee simply to invoke the Act's protection would seem to violate the requirement that the doctor's actions be made in good faith. The court consequently reversed the order of dismissal to allow discovery on the issue of whether defendant's decision not to charge a fee was made in good faith.

Is the "Without Fee" Language in the Act Ambiguous?

In *Henslee v. Provena Hospital*, 373 F. Supp. 2d 802, 2005, a magistrate judge for the U.S. District Court for the Northern District of Illinois ruled against a physician's application of the Act. Finding the Act's language ambiguous, the magistrate judge considered the legislative history of the statute. The court ultimately arrived at a broader definition of the word "fee."

In *Henslee*, the patient suffered an anaphylactic reaction and experienced difficulty breathing. She was driven to an immediate care center, where defendant rushed out of the building to the parking lot to offer emergency treatment. Defendant intubated the patient and provided respirations while 911 was called and the patient was transported to hospital. The immediate care center was staffed by a health care management company, which employed defendant. The management company had a contract with a hospital to provide physicians for the immediate care center and the hospital emergency room. Defendant never billed patients directly, but instead was paid on a per diem basis. Therefore, no fee was billed to the patient by either defendant or his group.

The court attempted to resolve the question of state law as it thought the Illinois Supreme Court would. It conceded that in several appellate court decisions the Act's language was found to be clear and unambiguous. Nonetheless, the court found the term "without fee" to be ambiguous. It therefore considered legislative intent and focused on the Act's purpose of shielding *volunteers* from liability.

The court ruled that the legislative intent could not have been to create a situation where doctors could engineer immunity. The court queried, "If the legislature meant to create a provision wherein a doctor who is a paid employee at an immediate care center, on duty and bound to help anyone who comes through his doors could avoid liability by neglecting to bill a patient for those emergency services, the legislature would not have used the word 'volunteer.'" The court ruled that defendant was not a volunteer because he was paid *per diem* for his services. The court's definition of "fee" included both situations where *a physician is paid for professional services* and instances in which *a client pays a bill for those services*. The court rejected defendant's motion for summary judgment because he was paid a fee for his services.

Illinois Appellate Court Takes a Pass on Henslee's Approach

In *Muno v. Condell Memorial Medical Center*, 383 Ill. App. 3d 688 (2nd Dist. 2008), the appellate court rejected defendant's post-trial motion for judgment notwithstanding the verdict. The court held that the issue of whether or not a fee was billed in good faith was question of fact for the jury. The existence in *Muno* of at least an inference that the Act might have been a reason that no bill was sent

to plaintiffs was sufficient to support the jury's verdict. The court discussed *Henslee*, but did not rely on that case in arriving at its decision.

Similarly, summary judgment was reversed in *Hernandez v. Alexian Brothers Health System*, 384 Ill. App. 3d. 510 (1st Dist. 2008). There the court held that a genuine issue of material fact existed as to whether defendant had a good faith basis to not bill for his emergency services.

Plaintiff in *Alexian Brothers Health System* was undergoing a biopsy in radiology when she suffered a cardiac arrest. A Code Blue was called and the patient was wheeled to the emergency department. An overhead page went out for "any available cardiologist." Defendant cardiologist was on staff, but not officially "on call" at the time. He was then making rounds at the hospital and responded to the emergency call. Defendant's affidavit averred that neither he nor his practice billed plaintiff for defendant's emergency medical efforts on plaintiff's behalf. Plaintiff questioned defendant's good faith in not preparing a bill. The billing manager for defendant's practice testified in a deposition that this was the sole instance in which defendant did not charge a fee for the subject type of service. The court determined that a genuine issue of material fact was raised. The court did not address plaintiff's constitutional challenge to the statute as special legislation.

Another District Court Considers *Henslee* – Different Result

The most recent case discussing the Act's applicability, *Rodas v. Swedish American Health System*, 594 F. Supp. 2d 1033 (2009), involved a patient who sued obstetricians relating to the delivery of her deceased infant. Prenatal care was provided by a health care clinic. The patient, who had no primary care physician, was advised to go to a hospital for a delivery and that she would be provided a physician.

The clinic provided family practitioners at the hospital. It also had an agreement with a medical school, whereby the school's physicians would provide back up professional services to clinic patients on the labor and delivery floor. The clinic agreed to pay the school a set monthly fee regardless of the level of services provided, reserved the right to bill its patients after receiving documentation of services rendered from the school's physicians, and was entitled to keep the entirety of the proceeds. The school's physicians therefore did not directly bill clinic patients or receive additional compensation in the event they assisted with a clinic patient. Defendants, two of the school's physicians, were involved in the patient's care when they came to the assistance of a clinic physician. One of the defendant physicians was "on call" while the other was present in the unit and available to assist. When defendants were notified about the status of plaintiff's labor it was determined that a delivery should occur as soon as possible. There was testimony that the situation was an "emergency situation."

Contrary to the *Henslee* court, the *Rodas* court noted that "decisions of state appellate courts control, unless there are persuasive indications that the state supreme court would decide the issue differently." The *Rodas* court discussed the main issue as to whether defendants provided their services to plaintiff without fee. Illinois courts had found that a "fee" does not include situations in which the doctor only received some sort of indirect economic benefit for his or her services. In *Rodas*, the doctors provided services without fee, and no bill was ever sent or payment provided. The court distinguished *Henslee* because defendants in *Rodas* were paid an annual salary, not a *per diem* one, and the salary was the same, whether they were working on plaintiff's care or not. The court also found the statute's language unambiguous. Finally, the court rejected plaintiff's argument that in order for the good faith requirement to be met, the physician must act with nothing but pure altruistic intentions. "There is nothing in the statute or case law to support such a drastic reading of the good faith requirement and the court declines to impose one."

Where Do We Go from Here?

Generally, the issue of whether or not an emergency exists is straightforward, and courts have made it clear that the Act applies even where the physician obtains an indirect economic benefit from his or her services. Further, the Act may apply even in cases where the defendant has a pre-existing duty to treat the emergency patient.

However, the question of "good faith" in not submitting a bill or charging a fee will persist and continue to be a fact-specific and dispositive one. The only reported decision in which the Act's language was found to be ambiguous is a non-precedential U.S. District Court opinion which has not been adopted by any Illinois state court. Nonetheless, in the face of ongoing efforts at health care reform, and constantly changing insurance and billing requirements, the definition of "fee" for purposes of the Act is far from settled.

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Indiana's Good Samaritan Law

Indiana's Good Samaritan law is straightforward and has not been extensively examined by Indiana appellate courts. However, there are a few key issues with regard to it that pertain to health care professionals.

Ind. Code Section 34-30-12-1 provides immunity for "gratuitously rendered emergency care" when one comes across the "scene of an emergency or accident" or is "summoned to the scene of an emergency or accident and, in good faith, gratuitously renders emergency care at the scene." It has been revisited by the legislature several times in the past decade or so; primarily, the legislative changes include the addition of protections for the use of automatic external defibrillators (AED). In fact, the rule now specifically provides that anyone who uses an AED is immune from civil liability, and that "a licensed physician who gives medical direction in the use

of a defibrillator” is also immune. This latter category includes physicians who instruct the individuals who are providing emergency AED services. As a result, this is the only protected class that need not be at the scene of an emergency or accident for the act to apply to them. Indiana has otherwise limited the application of the Good Samaritan doctrine to those who are present at the scene of an accident.

A second section has been added to specifically address the use of cardiopulmonary resuscitation (CPR), even if not considered “medical care” under the initial statute. Under Ind. Code Section 34-30-12-2, any person who has completed a CPR course may administer CPR to a person “who is an apparent victim of acute cardiopulmonary insufficiency” without liability, except for acts of gross negligence or willful or wanton misconduct.

The statute does have some specific limitations. In *Steffey v. King et al.*, 614 N.E.2d 615 (Ind. Ct. App. 1993), the appellate court recognized that covering for another doctor while in a health care facility, regardless of the circumstances, was not acting as a Good Samaritan under the statute. This case involved a patient who was hospitalized for delivery of a child in a breech position. A first physician first examined her and was aware of the condition. While he was gone for a few minutes to do some paperwork, the patient began to spontaneously deliver. When the first physician could not be found, a second physician was called in to treat the patient. The second physician arrived in what she considered an emergency. The court, however, differentiated this situation from an “accident,” which the statute was intended to pertain to. As a result of the court’s holding, in Indiana, a physician who covers for another in what may be an emergency situation is not immune from liability for that reason alone under the statute.

While a logical result under the circumstances, it raises the question of why the court did not address whether such services were “gratuitous” or the issue of the “scene” of an accident. The statute now includes a specific subsection which indicates that it does not apply to treatment rendered at a health care facility by a health care provider, which renders such questions moot.

Steffey and the new statutory language are understandable, and health care providers providing services at a facility should not expect immunity under those circumstances. The decision in *Beckerman v. Gordon*, 614 N.E.2d 610 (Ind. Ct. App. 1993), the companion case to *Steffey*, is broader. In that case, a physician was called to the house of a patient of his associate. The patient had awoken with chest pains, and her husband called the physician, who lived only blocks

from the patient’s home, to see if he would make a house call in lieu of their going to the hospital. The physician agreed, and examined the patient. He advised the couple that the patient’s condition was not serious and prescribed pain and anti-nausea medication (and provided samples he had brought with him). The physician also advised the patient and her husband to call in an hour if the patient did not improve, and he scheduled a 9 a.m. appointment in his office. Approximately one hour later, the patient began gasping for air and choking. She was in full cardiac arrest when the physician returned and ultimately expired as a result of a blockage of a coronary artery.

In the ensuing case brought against him, the physician argued that he was not the patient’s physician and had been summoned to the scene of an emergency or accident. The court analyzed the terms “accident” and “emergency,” and concluded that the physician had been summoned not to an accident or emergency, but to a situation involving “circumstances of so pressing a character that some action needed to be taken.” This was not the sudden calamitous event contemplated by the statute. In short, the court rejected the characterization of the condition as an emergency.

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Federal Estate Tax Repeal Update

Unless Congress takes action, the federal estate tax will be automatically repealed in 2010. Although Congress has signaled that it does not intend to allow the repeal to occur, it is running out of time. With so much on its plate already, Congress will hard-pressed to resolve this issue by December 31. Because there may not be enough time to negotiate a permanent solution, the legislature may simply vote to extend the federal estate tax as applicable in 2009 for one more year. Under the current federal estate tax, \$3.5 million of value is exempt, and the maximum federal tax rate is 45 percent.

Of the options being considered, most seem to favor an exemption of at least \$3.5 million, which would be indexed for inflation, and a maximum rate somewhere between the capital gains rate and 45 percent. Stepped up basis would be retained. A repeal of the deduction for state estate taxes is being discussed. Given that some senators want a larger exemption and a significantly lower tax rate, it may be impossible to get this issue permanently resolved by year’s end. Hence, the possibility of a one-year extension. Updates will follow as warranted in future issues of this newsletter.

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