Thus, since a "life lease" creates an estate in real property, the instrument is entitled to be recorded if it meets all the requirements of the recording statute. The requirements for the recordation of instruments are set forth in 1937 PA 103, § 1, MCLA 565.201; MSA 26.1221. As stated therein, an instrument must be acknowledged if it is to be accepted for recording. Therefore, it is my opinion that a "life lease" document must be acknowledged in order to be recorded.

FRANK J. KELLEY,
Attorney General.

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PHYSICIANS

HOSPITALS

DRUG ABUSE: Treatment of drug abusers.

DRUG ABUSE: Confidentiality of drug abuse program information.

By statute in Michigan, physicians need not treat drug abusers for drug related illness.

While Michigan law does not require doctors or hospitals to treat drug abusers for their drug related diseases, federal law, with respect to hospitals, commands this action in emergency circumstances and a hospital's failure to meet the aforesaid federal mandate could place its federal aid in jeopardy.

The Federal Comprehensive Drug Abuse Prevention and Control Act of 1970 allows the Secretary of Health, Education and Welfare and the Attorney General of the United States to accord confidentiality to drug abuse programs they deem to be research and rules have been adopted pursuant thereto.

The Federal Drug Abuse Office and Treatment Act of 1972 makes records of drug abuse prevention functions conducted, funded or assisted by the federal government confidential, subject only to (1) patient consent, (2) certain administrative and medical limitations or (3) an order by a competent United States District Court authorizing disclosure with appropriate safeguards.

Under state law, confidentiality attaches to any communication concerning the identity of patients or research subjects involved in drug abuse.

Opinion No. 4797 February 26, 1975.

J. Irvin Nichols, Administrator
Office of Substance Abuse Services
1019 Trowbridge Road
East Lansing, Michigan 48823

I have been requested to respond to questions dealing with two major issues: (1) Whether medical personnel are legally required to treat minors

who suffer from drug related illnesses, and (2) whether the fact of their illness and its treatment must be reported to the authorities.

Before addressing these questions, it may be helpful to note that agencies established to help solve the problems of drug abuse in our society operate in a variety of ways. Some agencies act as a clearinghouse by referring inquiries to specialists; others operate their own research treatment or rehabilitation efforts. However, effective utilization of any of these facilities would require an individual seeking help to come forward and admit that he or she is or has been engaged in conduct that may be criminal even though the admission is made in a good faith attempt to end that behavior. If this information is available to those who enforce the criminal laws, most drug abusers would be deterred from seeking medical assistance. Thus, an important method of dealing with problems of drug abuse might well be frustrated by the very law enforcement agencies that seek to control it. Both federal and state officials recognize the inherent conflict between the two legitimate societal objectives of law enforcement and drug abuse treatment, and both of these governmental levels have enacted laws to encourage treatment and research into causes of drug abuse by providing a measure of confidentiality.

Addressing the first question, there is no requirement of Michigan law that compels a physician to treat one suffering from drug abuse. It has been a long standing ethic of the medical profession, with legal acquiesence, that a doctor may refuse to treat any person, and neither the Michigan Medical Practice Act, 1973 PA 185; MCLA 338.1801 *et seq;* MSA 14.542(1) *et seq,* nor any other statute imposes any penalty or liability for such refusal. As stated in 70 CJS, Physicians and Surgeons, § 48b, p 959:

> "A physician is not bound to render professional services to everyone who applies, and may refuse to respond to the call of a patient unable to compensate him; and he is therefore not liable for arbitrarily refusing to respond to a call or render treatment, even though he is the only physician available."

As to hospitals, it will first be noted that the statutes provide for the establishment of public hospitals in a variety of forms. Cities, townships and villages can join together to establish hospitals for their areas. 1945 PA 47; MCLA 331.1 *et seq;* MSA 5.2456(1) *et seq.* These hospitals are to be run by a hospital board with authority to adopt by-laws, rules and policies governing the operation and professional work of the hospital. MCLA 331.6; MSA 5.2456(6). A county may also, with voter approval, establish a hospital. 1913 PA 350; MCLA 331.151 *et seq;* MSA 14.1131 *et seq.* Again, however, the hospital board has wide latitude in establishing an admission policy.

Also, counties with population of over 100,000 may establish hospitals:

> ". . . for the treatment of persons suffering from contagious and infectious diseases and for the treatment of indigent persons suffering from any physical ailment or impairment, and may contain a psychiatric ward for mentally ill patients, both non-indigent and indigent, . . ." 1945 PA 109, § 2; MCLA 331.202; MSA 14.1150(2)

> "If the facilities of the hospital or institution will permit, the board of trustees, in its discretion, may accept other persons afflicted with contagious or infectious diseases and other indigent persons suffering from any physical ailment or impairment, . . . upon such terms and conditions as may be fixed by the board of supervisors of the county." 1945 PA 109, § 7; MCLA 331.207; MSA 14.1150(7)

In counties with over one million population, the county may establish ". . . a county general hospital . . ." 1945 PA 109, § 12a; MCLA 331.212a; MSA 14.1150(12a)

In each case, however, the hospital board is authorized to adopt rules governing the operation and professional work of the hospital and, as there is no affirmative requirement that hospitals treat drug abusers, Michigan law does not impose this requirement upon them.

Federal law, on the other hand, explicitly requires hospital treatment of drug abusers in emergency situations. Section 407 of the Drug Abuse Office and Treatment Act of 1972, 86 Stat 78; 21 USC 1174, states that:

> "(a) Drug abusers who are suffering from *emergency medical conditions* shall not be refused admission or treatment, solely because of their drug abuse or drug dependence, by *any* private or public general hospital which receives support in *any* form from *any* program supported in whole or in part by funds appropriated to *any* Federal department or agency.

and

> "(b) . . . If the Secretary determines that a hospital has violated subsection (a) of this section and such violation continues after an opportunity has been afforded for compliance, the Secretary is authorized to suspend or revoke, after opportunity for a hearing, all or part of *any* support of *any* kind received by such hospital from *any* program administered by the Secretary. . . ." (emphasis added)

As the extent of federal aid to hospitals is virtually all-inclusive, the threat of the loss of federal funds emphasizes the determination of Congress that drug abusers be given medical help.

I therefore conclude, in answer to the first inquiry, that, while Michigan law does not require doctors or hospitals to treat drug abusers for their drug related diseases, federal law, with respect to hospitals, commands this action in emergency circumstances and a hospital's failure to meet the aforesaid federal mandate could place its federal aid in jeopardy.

As to your second question, in addition to the Michigan statutes, there are two federal statutes involving the right of privacy of persons treated for drug abuse. The first is the Comprehensive Drug Abuse Prevention and Control Act of 1970, 84 Stat 1242; 21 USC 801 *et seq* (hereinafter called "the 1970 Act"). This act has two confidentiality provisions. Under each, the right to retain confidentiality of information may be granted to those "persons engaged in research on the use and effect of drugs," [84 Stat 1241; 42 USC 242a(a)] by the Secretary of Health, Education and Welfare, and to "persons engaged in research," [84 Stat 1271; 21 USC 872(c)], by the United States Attorney General. The sections giving the

Secretary of Health, Education and Welfare and the United States Attorney General power to confer this immunity state:

> "The Secretary may authorize persons engaged in research on the use and effect of drugs to protect the privacy of individuals who are the subject of such research by withholding from all persons not connected with the conduct of such research the names or other identifying characteristics of such individuals. *Persons so authorized to protect the privacy of such individuals may not be compelled in any Federal, State, or local civil, criminal, administrative, legislative, or other proceedings to identify such individuals.*" 84 Stat 1241; 42 USC 242a(a) (emphasis added)

> "The Attorney General may authorize persons engaged in research to withhold the names and other identifying characteristics of persons who are the subjects of such research. *Persons who obtain this authorization may not be compelled in any Federal, State, or local civil, criminal, administrative, legislative, or other proceeding to identify the subjects of research for which such authorization was obtained.*" 84 Stat 1271; 21 USC 872(c) (emphasis added)

The Drug Abuse Office and Treatment Act of 1972, 86 Stat 66; 21 USC 1101 et seq (hereinafter called "the 1972 Act"),[1] provides a more limited form of confidentiality. Section 408(a) states that:

> "Records . . . which are maintained in connection with the performance of any drug abuse prevention function authorized or assisted under any provision of this Act or any Act amended by this Act shall be confidential . . ." 86 Stat 79; 21 USC 1175(a)

The definitional terms used in section 408 are:

> "(a) The definitions set forth in this section apply for the purposes of this Act.
>
> "(b) The term 'drug abuse prevention function' means any program or activity relating to drug abuse education, training, treatment, rehabilitation, or research, and includes any such function even when performed by an organization whose primary mission is in the field of drug traffic prevention functions, or is unrelated to drugs. . . ." 86 Stat 67; 21 USC 1103

In addition, the phrase "drug abuse prevention" used in the 1972 Act was clarified and expanded in a series of "interpretive regulations" issued by the President's Special Action Office for Drug Abuse Prevention created by this act. It is there stated:

> "(d) The term 'drug abuse prevention function authorized or assisted under any provision of the Act or any act amended by the Act' means any drug abuse prevention function—

[1] In *People* v *Newman*, 32 NY2d 379 (1973), the court ruled that section 408 of the Drug Abuse Office and Treatment Act of 1972, 86 Stat 79; 21 USC 1175(a), did not repeal or modify section 3(a) of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 84 Stat 1241; 42 USC 242a, subd [a].

"(1) Which is conducted in whole or in part by any department, agency, or instrumentality of the United States, or

"(2) For the lawful conduct of which in whole or part any license, permit, or other authorization is required to be granted by any department or agency of the United States." 21 CFR 401.01; 37 Fed Reg 24637 (1972)

Thus, the confidentiality provided for in the 1972 Act runs, not only to any continuing pattern of conduct aimed at the drug abuse problem which is conducted or assisted by the federal government, but also to conduct which requires the federal government to license.

However, neither the 1970 nor the 1972 federal acts were intended to exclude state action that would make the research and treatment of drug abuse confidential. Neither act expressly forbids state activity in this area. To the contrary, the 1970 Act specifically states in section 708:

"No provision of this subchapter [which includes both immunity provisions cited] shall be construed as indicating an intent on the part of the Congress to occupy the field in which that provision operates, including criminal penalties, to the exclusion of any State law on the same subject matter which would otherwise be within the authority of the State, unless there is a positive conflict between that provision of this subchapter and that State law so that the two cannot consistently stand together." 84 Stat 1284; 21 USC 903

Although the 1972 Act is not as explicit, it is my opinion that the language of the act does not indicate any intent of Congress to supersede state action.

The 1972 Act, section 408, contains the following confidentiality provision:

"(a) Disclosure authorization. Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any drug abuse prevention function authorized or assisted under any provision of this Act or any Act amended by this Act shall be confidential and may be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

"(b) Purposes and circumstances of disclosure affecting consenting or nonconsenting patient.

"(1) If the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives his written consent, the content of such record may be disclosed

"(A) to medical personnel for the purpose of diagnosis or treatment of the patient, and

"(B) to governmental personnel for the purpose of obtaining benefits to which the patient is entitled.

"(2) If the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, does not give his written consent, the content of such record may be disclosed as follows:

"(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

"(B) To qualified personnel for the purpose of conducting scientific research, management or financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

"(C) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

"(c) Prohibition against use of record in making criminal charges or investigation of patient. Except as authorized by a court order granted under subsection (b)(2)(C) of this section, no record referred to in subsection (a) of this section may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

"(d) Continuing prohibition against disclosure irrespective of status as patient. The prohibitions of this section continue to apply to records concerning any individual who has been a patient, irrespective of whether or when he ceases to be a patient.

"(e) Penalties for first and subsequent offenses. Except as authorized under subsection (b) of this section, any person who discloses the contents of any record referred to in subsection (a) of this section shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense." 86 Stat 79; 21 USC 1175

The basic premise of the 1972 Act is that records pertaining to drug abuse efforts are to be confidential, subject only to those exceptions contained therein. Those exceptions are found in subsection (b), and are divided into two categories, namely, disclosures with the patient's consent, and disclosures without the patient's consent. Subsection (b)(2)(C) allows a competent court to compel disclosure, and it sets forth the factors to be considered by the court in making this decision and directs the safeguarding of any information so released. Subsections (c) and (d) also contain provisions concerning the use of this information in a criminal proceeding against a drug abuse patient, and extends the confidentiality beyond the time during which an individual is a patient.

Since section 408 has become law, a series of problems has arisen in its implementation. To assist in resolving these problems, the Special Action Office for Drug Abuse Prevention promulgated its "interpretive regulations" to clarify section 408, 21 CFR 401; 37 Fed Reg 24636 (1972).

The introductory recital to these regulations begins by amplifying the Congressional intent:

"The rationale underlying the policy of section 408 is simple and compelling. . . . If society is to make significant progress in the struggle against drug abuse, it is imperative that all unnecessary impediments to voluntary treatment be removed. There is clear agreement among drug abuse treatment program operators that their ability to assure patients and prospective patients of anonymity is essential to the success of their programs. The identification of a person as a patient of a general practitioner or hospital clinic is not ordinarily of great significance, but the identification of a person as an enrollee in a narcotic treatment program can, in and of itself, have profoundly adverse consequences.

"It was in recognition of these considerations, among others, that Congress enacted section 408 of Public Law 92-255 (21 U.S.C. 1175). It must be emphasized that the operation of this section in no way creates a sanctuary for criminals. The enrollment of an addict in a treatment program takes away nothing, immunizes nothing, that would be available to law enforcement authorities if the program did not exist or the addict did not enroll in it. The only effect of his enrollment is to diminish the likelihood of his continued criminal conduct, and if the price of this is to isolate the records generated by the enrollment itself, this is a small price indeed in the light of the social benefits. [37 Fed Reg 24636]

"* * *

". . . Both the positioning of this authority in the bill . . . and the explicit crossreference in section 408(a) of the final Act make clear the congressional intent that section 408(b)(2)(C) operate as a mechanism for the relief of the 408(a) strictures and not as an affirmative grant of jurisdiction to authorize disclosures prohibited by other provisions of law, whether Federal or State. . . . [21 CFR 401.61; 37 Fed Reg 24638]

"* * *

"(a) It is abundantly clear that section 408(b)(2)(C) was *not* intended to confer jurisdiction on any court to compel disclosure of any information, but solely to *authorize* such disclosure. An order or provision of an order based on some other authority, or a subpena, or other appropriate legal process, is *required* to compel disclosure. To illustrate, if a person who maintains records subject to section 408(a) of the Act is merely requested, or is even served with a subpena, to disclose information contained therein which is a type whose disclosure is not authorized under section 408 of the Act or any of the foregoing provisions of this part, he must refuse such a request unless, and until, an order is issued under section 408(b)(2)(C). *Such an order could authorize, but could not, of its own force, require disclosure.* If there were no subpena or other compulsory process, the custodian of the records would have the discretion as to whether to disclose the information sought unless and

until disclosure were ordered by means of appropriate legal process, the authority for which would have to be found in some source other than section 408 of the Act. . . ." 21 CFR 401.62; 37 Fed Reg 24638-24639 (emphasis added)

Therefore, the production of section 408(a) records can be authorized only by court order under section 408(b)(2)(C), and then only when that order is accompanied by subpoena or other compulsory process.

As to state law, the Substance Abuse Services Act, 1973 PA 56; MCLA 325.711 *et seq;* MSA 18.1031(11) *et seq,* creates an Office of Substance Abuse Service within the Department of Public Health to coordinate efforts of substance abuse control. The act also provides for an advisory commission [MCLA 325.717; MSA 18.1031(17)], or county or regional coordinating agencies [MCLA 325.719; MSA 18.1031(19)], and the licensure of all "substance abuse service programs" [MCLA 325.720; MSA 18.1031(20)].

Of particular interest to this inquiry is the fact that the act attempts to assure confidentiality for these programs. Section 18 states:

"(1) Records of the identity, diagnosis, prognosis, or treatment of any individual which are maintained in connection with the performance of any licensed substance abuse treatment-rehabilitation or prevention service authorized or assisted under this act are confidential and may be disclosed only for the purposes and under the circumstances expressly authorized under this section.

"(2) If the individual, with respect to whom any given record referred to in this section is maintained, gives his written consent, the content of the record may be disclosed to medical personnel for the purpose of diagnosis or treatment of the person, or to governmental personnel for the purpose of obtaining benefits to which the person is entitled.

"(3) If the person with respect to whom any given record referred to in this section is maintained, does not give his written consent, the content of the record may only be disclosed as follows:

"(a) To medical personnel to the extent necessary to meet bona fide medical emergency.

"(b) To qualified personnel for the purpose of conducting scientific statistical research, financial audits, or program evaluation, but the personnel shall not identify, directly or indirectly, any individual person in any report of the research audit, or evaluation or otherwise disclose identities in any manner.

"(c) Upon application, a court of proper jurisdiction may order the disclosure of whether a specific person is in treatment with an agency. In all other respects the confidentiality shall be the same as the physician-patient relationship as provided by law." MCLA 325.728; MSA 18.1031(28)

As with the federal act, 1973 PA 56, *supra,* § 18 extends its policy of confidentiality to agencies licensed under the act and records of "identity, diagnosis, prognosis or treatment," and safeguards them by limiting their

release and setting differing standards depending on whether the patient has consented. The standards of 1973 PA 56, *supra,* § 18 are made to apply to "any licensed substance abuse treatment-rehabilitation or prevention service" that is authorized or assisted under the act. 1973 PA 56, *supra,* § 2(g) and (h) define these terms in the following manner:

> "(g) 'Substance abuse treatment-rehabilitation service' means the providing of an identifiable treatment plan including *but not limited to* any of the following therapeutic techniques for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs:
>
> "(i) Chemotherapy which is the use of any drug in the direct treatment of substance abuse.
>
> "(ii) Counseling which is the act of giving advice, opinion, or instruction in directing the judgment or conduct of the person as applied to the problems of existing or former substance abuse.
>
> "(iii) Rehabilitation which is the act of restoring a person to a state of health or useful activity through vocational or educational training, therapy, and guidance.
>
> "(h) 'Substance abuse prevention services' means the providing of identifiable services including *but not limited to*:
>
> "(i) The providing of public education and referral services to substance abusers, their families, or the general public.
>
> "(ii) The providing of crisis intervention counseling services for current potential, and former substance abusers." MCLA 325.712; MSA 18.1031(12)

Also, 1973 PA 56, subsections 10(2) and (5), *supra,* require licensure of any such service except those which receive no funding from the public or are nonprofit and tax exempt in nature.

Although the Substance Abuse Services Act, 1973 PA 56, *supra,* § 18 embodies much of the policy of the federal statutes, 1973 PA 56, *supra,* § 18(3)(c) affects a major departure through its application of the physician-patient privilege to the area of drug abuse records. Unlike section 408 of the 1972 federal act, 1973 PA 56, § 18(3)(c), *supra,* allows a court to order only the disclosure of whether a given person is being treated. This assumes that the name of the person in question is known and requires the revelation of nothing more than the fact of his treatment. Thus, unless there is patient consent, the records covered in 1973 PA 56, § 18, *supra,* can be revealed only to medical personnel in actual medical emergencies, for statistical research or for program audits or evaluation, and then without the disclosure of any identity information. In every other situation where there is no patient consent, "the confidentiality shall be the same as the physician-patient relationship." MCLA 325.728; MSA 18.1031(28)

In Michigan, this privilege is defined by statute as follows:

> "No person duly authorized to practice medicine or surgery shall be allowed to disclose *any information which he may have acquired in attending any patient in his professional character, and which infor-*

> *mation was necessary to enable him to prescribe for such patient as a physician, or to do any act for him as a surgeon:* Provided, however, That in case such patient shall bring an action against any defendant to recover for any personal injuries, or for any malpractice, if such plaintiff shall produce any physician as a witness in his own behalf, who has treated him for such injury, or for any disease or condition, with reference to which such malpractice is alleged, he shall be deemed to have waived the privilege hereinbefore provided for, as to any or all other physicians, who may have treated him for such injuries, disease or condition: Provided further, That after the decease of such patient, in a contest upon the question of admitting the will of such patient to probate, the heirs at law of such patient, whether proponents or contestants of his will, shall be deemed to be personal representatives of such deceased patient for the purpose of waiving the privilege hereinbefore created." 1961 PA 236, § 2157; MCLA 600.2157; MSA 27A.2157 (emphasis added)

In addition, section 54(3) of the Controlled Substances Act, 1971 PA 196; MCLA 335.354; MSA 18.1070(54), provides:

> "A practitioner engaged in professional practice or research is not required or compelled to furnish the name or identity of a patient or research subject to the practitioner's licensing agency, nor may he be compelled in any state or local civil, criminal, administrative, legislative or other proceeding to furnish the name or identity of an individual that the practitioner is obligated to keep confidential."

This covers both the researcher and the doctor who, in his own practice, works to treat drug abuse with about as wide immunity as a state can confer. Moreover, this provision is self-operating.

It must be noted, however, that 1954 PA 60; MCLA 335.201 *et seq;* MSA 18.1131 *et seq,* requires the reporting of "drug addicts" and "drug users" to the county health officer by physicians or hospitals. A "drug user" is defined in 1954 PA 60, *supra,* § 2(1) thereof as:

> ". . . any person who habitually uses any habit-forming narcotic drugs so as to endanger the public morals, health, safety, or welfare, or who is so far addicted to the use of such habit-forming narcotic drugs as to have lost the power of self-control with reference to his addiction." MCLA 335.202(1); MSA 18.1132(1)

And 1954 PA 60, *supra,* § 4 states:

> "Every practicing physician in the state who shall examine any person and find that such person is addicted to the use of narcotic drugs shall make a report thereof to the health officer of the county, city, township or district in which such person is a resident, or to the state health Commissioner when there is no local health officer." MCLA 335.204; MSA 18.1134

This requirement, however, must be construed as having been repealed by implication as a result of the subsequent enactment of the federal and state laws cited above.

In addition, section 58(4) of the Controlled Substances Act, 1971 PA 196, provides:

> "The administrator[2] may authorize persons engaged in research on the use and effects of controlled substances to withhold the names and other identifying characteristics of individuals who are the subjects of the research. Persons who obtain this authorization are not compelled in any civil, criminal, administrative, legislative or other proceeding to identify the individuals who are the subjects of research for which the authorization was obtained." MCLA 335.358; MSA 18.1070(58)

Thus, it is clear that the federal and the state laws provide for drug abuse confidentiality and it is evident that the Michigan legislature has augmented the protection afforded by the federal law through enactment of 1973 PA 56, § 18, *supra*, and 1971 PA 196, § 54(3), *supra*.

It must be noted, however, that in granting their respective forms of immunity and confidentiality, these laws[3] make reference only to the records and the documentation of drug abuse functions. They avoid any direct mention of nonwritten avenues by which information may be disclosed; nevertheless, any dissemination of identification of a drug abuser or information concerning his or her drug problem frustrates the legislative objective. I am therefore of the opinion that these laws grant confidentiality to oral communications as well as written records.

FRANK J. KELLEY,
Attorney General.

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[2] Defined as "the state board of pharmacy or its designated or established authority." 1971 PA 196, § 3(2); MCLA 335.303(2); MSA 18.1070(3)(2).

[3] The 1972 federal act speaks only of "records" in section 408, making frequent use of terms like "such record," and "any given record." 86 Stat 79; 21 USC 1175 The Michigan law, in section 18 of 1973 PA 56, goes no farther, stating only that "records . . . are confidential." MCLA 325.728; MSA 18.1031(28) And although it could be contended that use of physician-patient privilege in section 18(3)(c) extends the confidentiality to many of the forms of information not specifically documentary in nature, I do not believe that this proposition can stand, nor can section 18(3)(c) of 1973 PA 56 be read in such a broad light.