MEDICAL CARE

Current Problems in Medical Care

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CURRENT problems in medical care may be defined along several axes of classification. One could consider the financing of medical care, examining questions of tax support, insurance, philanthropy, and private purchasing of service. On the other hand, one could consider the technical provision of medical care, examining the issues associated with hospitals, physicians, dentists, nursing service, drugs, physiotherapy, and so on.

Another approach might be in terms of disease entities, examining the special features of medical care for acute infectious disease, crippling conditions, mental illness, tuberculosis, blindness, or maternity. Still another approach could focus on population categories for which special medical care programs have been developed, such as the indigent, veterans, industrial workers, school children, or aged retired persons.

To get a grip of this many-faceted field of medical care, I sought a central feature which might explain, albeit in an oversimplified way, the basis for difficulties in this field. If we understand the underlying reason for problems in the day-to-day provision of medical care, we can probably approach more intelligently the legal framework associated with them. We can understand better perhaps the ways that laws define the intricate interpersonal relationships in medical care, the ways that medical care arrangements must be shaped to be consistent with the law, or, indeed, the way that the law should sometimes be changed to adjust to the medical care needs of the population.

The central feature that I think helps to explain current problems in medical care is the gradual and steady evolution of the task of diagnosis and treatment of the sick from an individual to a social responsibility. This development is evident in the several systems of collective financing that have helped to make medical care more economically accessible at the time of need, a collectivization that has occurred through governmental and voluntary efforts alike; indeed, more through the latter than the former. This development is seen also in the growing technical organization of health services through increasingly complex teams of personnel in an expanding variety of facilities, both for bed care and ambulatory care of the sick. The development of social responsibility is seen also in the never-ending organization of social or community programs for special diseases or special population groups, combining in those programs a collective or societal approach, both with respect to the financing and the provision of medical care. (I am not discussing the tasks of preventing disease and promoting health, which are indeed even more collectivized than those for diagnosis and treatment.)

All these developments in the way people receive medical care and the way health workers provide it constitute a shift of the responsibility from the individual to the group. The group may be of many different kinds, of many different jurisdictional levels (neighborhood, city, county, State, region, or nation), and with varied scopes of authority. But it is a shift of relationships from those characterized by a one-to-one exchange between a patient and doctor to a much more complex arrangement. It is not only third parties that enter the relationship between patient and doctor, but there are fourth, fifth, and sixth parties as well.

These complex relationships are illustrated

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by the ostensibly simple case of a truckdriver's wife, Mrs. Jones, who develops an abdominal pain and sees Dr. Smith at a nearby group practice clinic. The doctor makes a diagnosis of acute appendicitis, and has Mrs. Jones admitted to a hospital for an appendectomy. Dr. Smith's bill and the hospital bill are paid by Mr. Jones' health insurance, obtained through his membership in a local unit of the Teamsters Union. In this process of relatively simple medical care, a variety of State and Federal laws have come into play, as follows:

1. Dr. Smith has been licensed to practice medicine by the State government, through a medical practice act.

2. The group practice clinic has been established under the laws of a business partnership; it is not incorporated because this is not authorized for medical service by State law.

3. The hospital is licensed under the State public health legislation.

4. The drugs provided to Mrs. Jones in the hospital have been produced under the surveillance of Federal food and drug control legislation.

5. The student nurses who serve Mrs. Jones are being trained under legal regulations of the State department of education.

6. The insurance company that ultimately pays the hospital and doctor's bills is supervised by the State department of insurance.

7. Mr. Jones' memership in the health insurance plan is by way of a Health and Welfare Trust Fund, the administration of which is governed by the provisions of the Federal Taft-Hartley Act.

8. Since Mrs. Jones is also employed as a waitress, she is covered by the State disability insurance law, which pays her certain cash benefits during the time of her illness and convalescence.

If Mrs. Jones' illness had been an abdominal condition caused possibly by some accident in the restaurant where she works, a legal action under workmen's compensation law might have ensued.

If she were the wife of an unemployed truckdriver, whose insurance had lapsed, her medical care might have been obtained under State and local social welfare legislation.

If the appendectomy had not been performed in time, and Mrs. Jones suffered a rupture with peritonitis, possibly a malpractice action would have been taken, and other laws would have come into play.

Aside from these speculations, in connection with each of the eight sets of laws actually operative in this case, there are serious problems that perhaps reflect the gap between the laws we have today and the full implications of the social responsibility that has developed in modern medical care. Just a few words on this basic point:

The State licensure law that defines Dr. Smith's privileges and duties is theoretically designed to protect the public, but it does nothing to ascertain that Dr. Smith, who was licensed 30 years ago, is qualified to perform surgery by current standards. There are, indeed, voluntary certifications of such competence, but Dr. Smith might or might not have them.

The partnership laws governing the group practice clinic define certain business obligations, but they say nothing about the professional standards of the physicians, technicians, clerks, and others who work in such a clinic.

The hospital licensure law that authorizes the hospital to exist defines certain minimal standards of construction and safety, but says nothing, for example, about the operation of a blood bank that might be lifesaving in a surgical case, like that of Mrs. Jones.

The drugs given to Mrs. Jones have been supervised as to their safety by Federal law, but there are no real controls with respect to their medical effectiveness or their costs.

The student nurses in the hospital are being trained in a school coming under some supervision of the State department of education, but the teaching standards are allowed to fall much below those that are demanded in colleges and universities.

The State insurance legislation, supervising the company which carries Mr. Jones' health insurance, ascertains that adequate financial reserves are kept, but does nothing to examine the premiums charged for the insurance protection despite the alarming rise in the costs of medical care. It likewise is unconcerned with the economy or efficiency of the hospital where its subscriber's money is being spent.

The Health and Welfare Trust Fund that collects the insurance premiums, and actually pays claims (seeking reimbursement later from the insurance company), does nothing to assure a proper quality of medical care for its beneficiaries. The Federal law is designed to prevent corruption in the management of these moneys, but stipulates nothing about the wisdom with which they are spent for health service.

Finally, the State disability insurance law arranges for Mrs. Jones to receive cash benefits, but does nothing to assure that she receives proper medical care, so that she can return to working fitness as quickly as possible.

Thus, the many laws defining the social relationships of modern medical care tend to enforce a certain measure of social responsibility over these relationships. They protect the individual patient in many ways and define some of the obligations of the providers of medical service, as well as the third, fourth, and other parties involved. But they do not go nearly so far as our social and professional conscience in the field of health services has developed.

In some specific fields, the laws have even inhibited the implementation of widely accepted social concepts. In workmen's compensation laws, for example, the effect of having cash awards depend on the extent of physical disability may actually discourage the injured worker from cooperating in a rehabilitation process. Under the State insurance laws, there may be provisions that retard the development of sound health insurance programs, simply because the language was written originally to favor one sponsorship group over another. The medical practice acts may operate to restrict admission of needed doctors into a State in order to reduce professional competition, rather than to maintain technical standards.

The laws, of course, cannot be expected to evolve faster than public demand. In many fields, such as hospital accreditation or medical specialty certification, voluntary actions have been effective in imposing some collective influence more promptly than the power of law. But there are many shortcomings in private initiative in the health services. All around us we see situations, such as those cited briefly, where wide consensus among students of the problem points to deficiencies. Laws are continually being changed, of course, to correct these recognized deficiencies, sometimes by legislative action and sometimes by court decision on constitutionality. An important recent decision by the New Jersey Supreme Court, for example, declared unconstitutional a law which for some 20 years had obstructed the organization of prepaid medical care plans under consumer sponsorship. In the intervening years before the law adjusts to socially recognized needs, many people can suffer.

In a word, the problems in medical care today follow from the steady expansion of a sense of social responsibility about its financing and provision. These social relationships are being increasingly defined and controlled by law, but not at the same rate as the development of social concern. Some persons, of course, are anxious about the expansion of law with its implied restrictions on individual freedom, but the clear lesson of history has been the increasing protection of individual freedom from disease, and from fraud, quackery, and corruption, by the enactment of democratic laws. More important, laws have helped us to establish minimum standards of performance, which protect quality not only for the sophisticated few, but for everyone.

The social organization of medical care toward improvement in its quality and availability to the population is proceeding constantly. There are bound to be lags in the adjustment of laws to these changing social demands and expectations. We must look to lawyers, with an understanding of health objectives, for help in bringing about these adjustments.