Survey of Hospital Law

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IT WILL COME as no surprise to those who operate hospitals to say that the law which affects hospitals has been changing and the legal aspects of the operation of a hospital increasingly occupy the time of the hospital administrator and members of the governing board. But for those who do not deal with hospitals daily, it might be useful to put this development in historical perspective.

Changes in the law as it affects hospitals have been accelerated by two things. First is the continuing change in the hospital itself from a predominantly custodial institution during the 19th century and the first 15 years of this century, into "the doctor's workshop" through World War II, and now into a community health center. Thus, much of the change in hospital law is a reflection of the change in the hospital as an institution and an organization as well as a reflection of the changing way the community views the hospital.

In addition, hospital law has been affected by changes in our legal system. Suits against hospitals have increased as personal injury litigation in other fields has increased. These suits against hospitals are but a facet of the problem of personal injury litigation. Also, increasing governmental interest in all areas of society and specifically in health organizations has resulted in regulation of the hospital by both Federal and State agencies.

It is my hope to focus attention on several issues which reflect both changes in the hospital as a health organization and changes in the applicable law. I will specifically deal with legal problems involving the governing board, the medical staff, consents to medical and surgical treatment, medical records, and negligent acts.

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Governing Board

The only logical starting point for any consideration of hospital law is the legal structure of the hospital organization. Hospitals, whether organized as governmental entities or as private corporations, receive their authority from the State. This authority exists by virtue of statutes which create either specific authority for a certain hospital or general authority to charter corporations for business, charitable, or specifically hospital purposes.

In any event, the legal responsibility for the operation of the hospital is vested in a governing body of the institution. This body may be denominated a board of trustees, a governing board, a board of directors, or by various other names. It can consist of an individual or a group. But in every State it is the legally constituted body to operate the hospital. In this paper the governing body will be referred to by the term "governing board" and will be assumed to consist of a group of individuals. Only the governing board has the power to determine who shall administer the hospital, who shall practice medicine in it, and who shall be admitted as a patient. Only the governing board has the right to set standards and promulgate rules and regulations for the hospital. With this power goes the responsibility of seeing that the hospital discharges the purpose and function for which it was chartered.

Members of the governing board of a hospital have a general duty of supervision and man-

agement which they must discharge by virtue of their membership on the board. This duty is inherent in the hospital governing board whether the hospital is a charitable corporation, a profitmaking corporation, or a governmental agency.

Members of the governing board have a duty to exercise reasonable care and skill in managing the hospital's affairs and to act at all times in good faith and with complete loyalty to the institution. This duty of due care and loyalty requires that any individual who accepts membership on a hospital governing board must personally fulfill the functions of a board member. Service on the board is a personal duty; it cannot be fulfilled by proxy or a representative. The board member must attend meetings and participate in the consideration of matters within the province of the board, giving them his full attention and best judgment. If he finds it impossible to attend a reasonable number of board meetings, he should resign. Each board member assumes full legal responsibility for any decisions made by the board which he did not oppose. And in all situations involving the hospital he must put his duty as a member of the board above personal gain or privilege.

Members of the governing board have a specific duty to use reasonable care and skill in managing hospital property. Hospital property includes both tangible property, such as the physical plant, and intangible property, such as mortgages and debts for hospital services. Hospital property must be protected from injury, destruction, and loss.

One basic protection for tangible property is adequate insurance against fire and other risks. The utility of insurance in providing against risks of fire and other disasters is so widely accepted that failure by the board to carry adequate insurance might well be construed as failure to carry out the general duty to protect hospital property. A similar duty may exist to protect the hospital from risk of loss because of negligence or malpractice by its employees. Hospitals in those States where the rule of charitable immunity does not protect them risk dissipation of tangible and intangible assets by judgments for negligence in the same manner as from fire and other disasters.

The governing board has a duty to pay all taxes and to satisfy all other liens upon hospital property in order to protect hospital assets. If the corporation is qualified for a tax exemption, the board must treat this exemption as an asset of the corporation to be preserved and protected as any other asset. The hospital's attorney should advise the governing board as to whether a contemplated activity could jeopardize this tax-exempt status. The board must then weigh this information in determining its course of conduct.

The board must also enforce any rights to which the hospital is entitled. This includes the collection of just claims for hospital services using legal process where justified. Accounts receivable are assets of the institution and should be collected unless it is determined that the patient has no funds for their payment. It is immaterial that the hospital is organized as a charitable corporation. It should give charitable service only when the patient does not have sufficient funds to pay the costs of his care.

In addition to the general duty of members of the hospital governing board to supervise and manage the hospital corporation, specific duties are imposed which prohibit or restrict certain transactions and activities by governing boards. The first area is "self-dealing." "Self-dealing" can be defined as a situation in which a corporation contracts or otherwise deals with business in which a member of the hospital board has an interest. Legal rules concerning "self-dealing" have evolved for obvious reasons: When an outside entity contracts with a hospital governing board having a member with an interest in that outside entity, the possibility is always present that undue profit may occur because of the dual relationship of the board member.

With regard to business corporations, the rule has generally been that a contract between a corporation and a firm in which a director has an interest is, at most, voidable. This means that the contract can be canceled at the request of the corporation. Such contracts are legally binding, however, if the interested director abstained from speaking or voting for the contract and made a true disclosure of all the facts respecting his interest in the outside entity.

Cases involving transactions between charitable hospital corporations and their board members generally state that a fair transaction, when accompanied by a full disclosure of the board member's dual position, will be permitted to stand. Statutory provisions in some States, however, specifically forbid "self-dealing" transactions. In Wyoming a statute forbids any officer of a hospital corporation to enter into any contract with the corporation during his term of office.

"Self-dealing" is recognized by the courts to carry risk to any institution which engages in it. The risk is, of course, that the institution may receive less than its full value for the items which it has purchased or contracted to buy. Sometimes, however, the most advantageous contract for the hospital is with a company in which one of its directors is interested. A rule denying this kind of opportunity places an unfair burden upon the hospital. It may also make it impossible for the hospital to recruit board members with the kind of talent and background ordinarily sought. Thus, so long as it is understood that the board member has a dual responsibility and a dual interest, there is no reason why the hospital cannot negotiate a fair contract with him or his company. The touchstone is full disclosure by the director, full knowledge by the board that the individual has two responsibilities, and nonparticipation by the board member in the discussion or voting on the awarding of the contract.

Another duty of board members is to invest hospital assets prudently. Rules for such investment will depend upon the statutes in the State in which the hospital is located. Investments which may be prudent for a business corporation could be imprudent for a charitable corporation. Also, statutes prescribing investment standards for trustees may be applied to certain assets of a charitable corporation which are of a trust nature. In most States, provisions of both the business and nonprofit corporation statutes either forbid loans to officers and board members or create liability on the part of board members and officers making or assenting to such a loan. It is difficult to think of the situations which justify lending hospital assets to members of the governing board.

General rules forbid compensation to board members of a business corporation unless authorized by statute, the corporate charter, or the bylaws. Generally, compensation to board members is proper for services performed in addition to the normal duties of office. As a matter of practice, the charter or bylaws of business corporations often provide compensation for board members.

The rules relating to compensation of board members of a charitable hospital are the same as for a business corporation in the absence of a specific statutory provision forbidding compensation. While compensation is permissible in most States if it is provided in hospital charter or bylaws, many hospital authorities consider it both unwise and unnecessary. On the other hand, compensation of persons giving additional service to the hospital is proper even though such persons are members of the hospital board. Thus the administrator, if a board member, should be compensated for his services as administrator. The same rules should apply to the hospital attorney or to the medical director.

The basic management functions of the governing board might be summarized as including: (*a*) selection of corporate officers and agents, (*b*) general control over the compensation of such agents, (*c*) fixing policy, (*d*) delegation of authority to the administrator and his subordinates, and (*e*) supervision and vigilance over the welfare of the whole hospital corporation.

Selection of corporate officers and agents is a relatively direct duty. It requires that the board elect its officers and appoint such committees as are necessary to discharge the function of the board. Also, the board must select an administrator for the hospital, set his compensation, and perhaps approve the compensation of others in hospital administration.

But more important is the authority of the board to fix policies or rules for the hospital. This authority may be exercised by the board through the promulgation of rules and regulations for the conduct of the hospital, or it may be delegated in part. This delegation may be broad or narrow as the board sees fit, but the board is not required by law to delegate any of its authority. To operate the hospital most efficiently, it is necessary that much of the

board's authority be delegated to the administrator, to the medical staff, and to officers and committees of the board.

It must be emphasized that there is a limit to the power of the board to delegate authority. The authority to delegate is implied by the business necessity of managing the corporation. There is a crucial difference between delegation of authority and abdication of authority by the board. A delegation of authority is, by definition, limited in time, scope, or purpose. What constitutes permissible delegation and what constitutes abdication is, of course, a question of fact.

The board may permit the formulation of rules and regulations by the administrator or his subordinates or by committees in the hospital, subject to review and approval by the board. The power may be delegated to the medical staff to promulgate rules and regulations for its own conduct subject to the approval of the board. Policies made in this way, which do not contravene either applicable statutes or the hospital's charter or its bylaws, bind the hospital upon approval of the board and will be effective in determining the rights of hospital patients, employees, and professional staff.

It must be borne in mind, however, that since the governing board is under no obligation to delegate its management functions, any delegation of the function of making policy is subject to revocation at any time. Since there is no obligation to delegate, there is no obligation to continue a delegation once made. Thus, the board has the right to revoke any power given the administrator or the medical staff to make rules and regulations.

Perhaps the most important specific management duties peculiar to hospitals include: (*a*) determining hospital policies in accordance with community health needs, (*b*) maintaining proper professional standards in the hospital, (*c*) assuming general responsibility for adequate patient care throughout the institution, and (*d*) providing for adequate financing of hospital operation and expansion.

Determining hospital policy with respect to community health needs is one of the most important functions of the governing board. This duty requires that the board continually consider the relationship of the hospital to the total health needs of the community. This is a real and continuing responsibility which will grow as the hospital becomes more and more central to the community health program. Equally important is the duty that the board provide satisfactory patient care. It is only through the fulfillment of this duty that the basic purpose of the hospital will be fulfilled. The elements of this duty are varied and extend from the purchase of the most suitable equipment for patient treatment, subject to the hospital's financial ability, to the hiring of a competent administrator and employees and the selection and general supervision of competent physicians. It should be stated as a corollary that this duty applies equally to both proprietary, charitable, and governmental hospitals. Licensing laws and regulations impose the same standards on both proprietary and charitable hospitals and the same requirement of due care applies.

Medical Staff

The duty of the governing board to exercise due care so as to provide satisfactory patient care implies a duty to select members of the medical staff and to specify the privileges within the hospital to be granted staff members. This duty is legally vested in the governing board. No other group, either within or without the hospital, has the legal duty to select the medical staff or supervise the quality of medical care within the hospital. This duty may be delegated to a properly organized medical staff, but it can never be abdicated.

To the extent that selection of the medical staff requires determination of the professional competency of the individual under consideration, the matter should be delegated to a duly constituted committee of the medical staff for recommendations. This enables the board to utilize the training of the staff to determine technical questions of professional skill. The recommendations of such a committee are not lightly disturbed. The governing board may fail in its duty of due care and diligence if it capriciously disregards the studied recommendation of a medical staff in areas of their special competence.

As a corollary to selecting competent members of the medical staff, the board has a duty

to see that proper professional standards are maintained in the hospital. This requires general supervision of the quality of medicine practiced in the hospital. The appointment of a physician whose practice falls below minimum levels of competency usually is not renewed. As an alternative, the board must restrict the privileges of a physician whose qualifications do not permit him to exercise unlimited privileges, so that he undertakes only such acts as he is capable of without risk to patients. The board may delegate to duly authorized committees in the medical staff the task of assessing continuing competency and of making recommendations, but the legal responsibility and the power to curtail or end medical staff privileges are powers of the board alone.

As a general rule, staff privileges of doctors who practice in public hospitals are more likely to be protected by the courts than are privileges of those who practice in voluntary hospitals. Thus a physician cannot be arbitrarily, capriciously, discriminatorily, or unreasonably denied the use of the facilities of a public hospital for the treatment of his patients. But where public hospitals have excluded physicians for failure to keep the records imposed by hospital regulations and have provided procedures for notice and hearing before withdrawing the right to use the hospital facilities, courts have upheld such action.

With respect to public hospitals, the courts have attempted to place a large measure of authority and control on the governing board as a result of their duty and responsibility to operate the hospital. Nevertheless, the courts are concerned with protecting patients and physicians using such facilities from the improper exercise of such authority. By insisting that board actions be procedurally fair, that is, that there be proper notice and hearing and that the rules formulated to govern the hospital be subject to a test of reasonableness, the courts are attempting to serve the interests of the community as a whole. In public hospitals the courts have upheld standards directed toward a high quality of medical care. These standards often take the form of regulations setting certain criteria for surgical or other privileges. Or the board may refuse to permit the use of hospital facilities by a certain class of practitioner. Since a denial of surgical or other privileges must be based upon hospital rules and regulations, challenging the restriction of privileges often is decided by the reasonableness of the procedural regulations.

The courts are increasingly recognizing that difficult and complex surgical or medical procedures may necessitate advanced training or experience beyond that necessary to become licensed. Thus, reasonableness of the rules and regulations restricting privileges depends on how fairly they provide a determination for the fitness of physicians for full surgical or other privileges.

Permission to practice medicine in a charitable or nonprofit hospital has traditionally been a privilege given by the hospital. The courts have established no right of a physician to practice in such a nonprofit or proprietary hospital and have frequently stated their unwillingness to interfere with the governing board's internal management of the hospital. The authority of the governing board in this regard includes initial granting of staff privileges and any subsequent determination of the duration of such privileges.

Refusal to recognize any substantive right to practice medicine in a nonprofit hospital sharply limits the area in which a court will intervene to protect a physician. Only the legal doctrine that any private organization must follow its own internal rules constitutes a basis for court intervention. Thus specific provisions for hearing or for remedying the constitution, bylaws, or rules of the hospital must be complied with before action can be taken to restrict, suspend, or revoke privileges enjoyed by a member of the medical staff. To require a hospital to abide by its own rules does not reduce the authority of the governing board, since only the board can initially enact rules to determine who may practice in the hospital and to set the limits of such privilege.

The uniform judicial position is that a decision on appointment of a physician to the medical staff of the hospital rests solely with the governing board. This principle has been adhered to in the face of numerous attempts to establish a substantive right to appointment. In recent cases, however, the courts have taken the position that the hospital board cannot

abdicate its responsibilities to set standards by vesting such responsibility in the county medical society or any outside group. Since nongovernmental hospitals have the right to refuse medical staff privileges to a physician, it is not surprising that the courts have found that such hospitals have a similar right to withdraw privileges. Of course, as they do when examining a refusal of staff privileges, the courts pay close attention to the procedural steps taken by the hospital to withdraw or limit privileges in order to be certain that the hospital's own constitution and bylaws are followed. Thus the hospital must be certain that it follows its own internal rules when altering the staff privileges of a physician. It might be stated parenthetically that, since a physician has no right to practice in a nongovernmental hospital, it is not surprising that osteopaths and other practitioners have been unable to establish such a right.

The pressure on hospitals for staff privileges and the pressure within the hospitals for available beds or for higher medical practice standards will result in continuing litigation of medical staff privileges. It is likely that the law will continue to evolve toward more protection for the individual physician's right to practice in a hospital. This protection will probably continue to be a procedural, not a substantive, one.

Thus hospital rules will be carefully scrutinized to be certain that the physician has been fairly treated and that the hospital rules have been followed. But most courts are not likely to substitute their judgment for that of the hospital with respect to the physician's actual qualifications and conduct.

A hospital normally satisfies itself that any medical staff disciplinary action has been motivated by substantive reasons, depending on the quality of medical care given by the physician or his suitability as a staff member, based on his acceptance and obedience of the reasonable rules and regulations of the hospital. Disciplinary action against a member of the hospital medical staff is one of the most acrimonious controversies a hospital can have, as it can divide the hospital staff and the governing board. Therefore, the hospital usually moves with care to provide evidence of fairness in the treatment of the physician involved as well as with firmness in upholding the standards of the institution.

Negligence

Generally, negligence for which a hospital may be liable is of two types: One is liability for the negligence of individual employees under the doctrine of respondeat superior; the other is liability under theory of corporate negligence. Liability is imposed under respondeat superior in cases where the hospital is held liable for the negligence of its employees. The theory of corporate negligence is used to impose liability upon the hospital in situations where it has failed to fulfill a duty owed to anyone coming in contact with it.

The courts traditionally have held that the hospital is not liable for the negligence or malpractice of a staff physician engaged in the treatment of his private patients in the hospital. In reaching this position, the courts generally emphasize that there is a private contract for medical treatment between the patient and the physician and that there is no right in the hospital to control the physical conduct of the physician while he is treating his patient. Imposing liability upon a hospital for the act of a staff physician would indicate that the jury found that the hospital was controlling, or had a right to control, the physical professional acts of staff physicians. In actual practice such control is seldom exercised.

In a California case involving an anesthesiologist and a patient paralyzed as a result of a spinal anesthetic, however, the hospital was held liable under a doctrine of "ostensible" agency (*1*). In that case the negligent physician was one of six anesthesiologists on the hospital's staff. He gave anesthetics at no other hospital, and all drugs, supplies, and equipment used by him were supplied by the hospital. The anesthetist billed the patient for the anesthetic he gave and had a regular rotating "on call" duty at the hospital. The court held that the jury should be permitted to determine whether the anesthesiologist was the "ostensible" agent of the hospital. Permitting the jury to consider whether an apparent or ostensible agency exists for the purpose of fixing liability upon the hospital under respondeat

superior may greatly extend the area of possible hospital liability. Under this theory there are many circumstances where courts or juries might find the relationship between physician and hospital such that the public would believe that the physician was acting as the hospital's agent, thus making the hospital liable for his negligent acts.

While the courts have generally held that a hospital is not liable for the negligence or malpractice of a staff physician, the same cannot be said for residents. It is usual for hospitals to be held liable for negligence or malpractice of residents in the treatment of the patient in the hospital.

A resident pursues a course of advanced medical education in the hospital under the direction of a staff physician or a particular hospital department. In addition to his educational responsibilities he is paid by the hospital to perform certain routine duties. As such he is clearly a hospital employee. Generally speaking, there is no contractual relationship between the resident and the patients for whom he performs services. He acts as an agent and servant of the hospital and is not the private physician of the patient. The absence of this contractual relationship and the fact that the resident is a paid employee of the hospital has generally led the courts to apply respondeat superior, to establish hospital responsibility, without discussing the element of control of the resident's physical acts.

In a 1962 Colorado case the court refused to draw any distinction between the status of a resident and a staff physician and held that, because statutory law in Colorado forbids hospitals to practice medicine, a hospital could not be liable for the negligence of a surgical resident (*2*). In this Colorado case the lack of a right of the hospital to physically control the acts of the resident was deemed crucial. Certainly, in any situation where there is a contractual relationship between the resident and the patient—a relationship outside the routine duties of employment—which constitutes the private practice of medicine, he is most likely an independent contractor, and the hospital is not responsible for his negligence. Another instance where no hospital liability may arise is where the resident performs acts under the direct physical supervision of a staff physician. In such situations the physician may be deemed to have the right to control the acts of the resident. Of course, control in all instances is a question of fact.

Interns are medical school graduates who are not yet licensed to practice medicine but are employed by hospitals to perform certain duties while they are gaining the additional medical education and experience required as a prerequisite of medical licensure. A resident is a licensed physician and thus can perform certain acts as an independent contractor. This, of course, is not true of an intern. His duties must be performed under supervision of the hospital's staff physicians. Interns cannot legally contract with patients to provide medical treatment. Thus the hospital is generally liable for the negligence of an intern under the doctrine of respondeat superior. However, in certain instances it is possible that the right to control the intern's physical actions might impose liability upon the staff physician supervising the intern rather than upon the hospital.

Externs, medical students who have not completed their formal medical school education, stand in the same position as interns in the hospital. Here, however, the hospital has a distinct duty to limit the actions of these students to routine and minor acts under the direct and actual physical supervision of staff physicians. No special dispensation has been granted to such students to practice medicine under general supervision, as is the case with interns. Therefore, the hospital has the specific duty to prevent actions by externs which might result in negligence and for which they are not qualified or licensed to perform.

Negligence is often imposed upon the hospital when patients are injured by negligent acts or omissions of a nurse, but the relationships between the nurse and the hospital, the patient's physician, and the patient often vary. Therefore, the right to control acts of the nurse is normally determinative of whether the hospital or physician is liable or whether liability is placed upon the nurse alone.

In dealing with negligence of nurses and other operating room personnel, the courts frequently state that the physician is in sole command in the operating room, with the right to control

all personnel present, and that consequently the physician, not the hospital, is liable. All acts of nurses in the operating room, however, are not the responsibility of the surgeon. For example, negligence of an operating room nurse in making an improper sponge count has caused liability to be imposed upon the hospital (*3*). In that instance the court stated that the certain duties of operating room nurses, such as the sponge count, do not involve professional skill or decision on the part of the physician. The physician relies upon the nurse and inquires of her as to the removal of sponges. The nurse, therefore, remains the employee of the hospital and under the control of the hospital for the purpose of the sponge count.

Other acts of nurses, if negligent, can result in the imposition of liability upon the hospital. Cases have involved the application of overheated hot water bottles, the administration of an enema of too high a temperature, injection of an incorrect medication, failure to support a patient properly, and failure to warn the patient of danger when lowering his bed. Such negligent acts or omissions by nurses will generally cause the hospital to be liable. In the performance of such duties the nurse is considered to be the employee and under the control of the hospital. It should be noted that a nurse's negligent failure to act, as well as her negligent act, may be the basis of hospital liability.

The hospital may also be held liable for acts of hospital technicians and other employees. In all instances it is a failure to use care, skill, and experience that places liability upon the hospital as well as upon the individual concerned.

Hospital liability may also occur in situations where no employee is directly responsible for the injury. For example, a hospital may incur liability to a patient injured as a result of the use of dangerous, faulty, or improper equipment. This liability attaches to the hospital directly. Liability for the use of defective equipment must rest upon a finding that the defect in the piece of apparatus was the approximate cause of the injury for which damages are sought. In order to prove liability the plaintiff must establish a connection between the alleged failure to supply safe equipment and the injuries which resulted.

However, supplying equipment which does not embody the latest improvements or innovations does not necessarily constitute supplying defective equipment. Thus use of an old-model incubator which did not have all modern improvements was not considered negligence by the Georgia court, since the incubator was reasonably suited for its intended use and customarily used in similar circumstances by other hospitals in the area (*4*).

Liability can occur for the misuse of equipment as well as for the use of defective equipment. Thus when a heating lamp shattered and caused hot fragments to fall upon a patient's back, the court indicated that the hospital could be held liable (*5*). Applying a heating pad for too long a time upon a patient's body also resulted in liability.

Any equipment in the hospital can become defective and capable of causing harm to persons coming in contact with it. What must be shown is that the hospital knew or should reasonably have known that the equipment was defective or was being used improperly. When this is the case, hospital liability will follow even though it has been proved that the employee using such equipment was negligent in its use.

Consents

Before hospital care is given or before any medical or surgical procedure is undertaken, consent to such care and treatment must be obtained from the patient or someone authorized to consent for him. This legal rule, simple only on the surface, is the basis for increasing concern of hospitals and physicians with the question of liability under the law of assault and battery.

If authorization from a patient is not obtained before treatment, except in an emergency or a situation which gives rise to an implied consent, a trespass (a battery) is committed to the person, for which the nonconsenting patient may recover damages. Thus a touching of the person without consent can result in liability. There is little question but that the hospital would be held liable under respondeat superior for any act of an employee which results in an unauthorized touching while the employee is discharging his hospital duties.

It should be noted that there is considerable difference between a battery and a negligent act, both of which are civil wrongs and both of which can cause an injury for which a patient can recover damages. A negligent act is one whose results are unintentional, while a battery is an act whose results are intentional. Negligence betokens carelessness, a failure to use that degree of care that the law requires to be used under the circumstances. It is the carelessness which causes the injury. A battery is an intentional unauthorized touching. Consequently, it is of no importance that the act (perhaps unauthorized surgery) was done with great care and actually improved the state of health of the patient. The fact that it was unauthorized makes it a battery.

The way in which the hospital, its employees, and members of its medical staff may be protected from such liability is by receiving the consent of the patient to medical or surgical treatment. This consent may be obtained in several ways. It may be an explicit consent, either oral or written. An oral consent is legally just as binding as a written one, but it is more difficult to prove. Written consents are preferable because they furnish evidence at a later date as to consent to the procedure.

Or consent may be manifested by a voluntary submission. A voluntary submission occurs under circumstances where it is apparent that the person involved has submitted voluntarily to the touching and its consequences. Thus if a person presents himself in an emergency room for treatment of an open wound, generally a voluntary submission can be found even though no explicit consent is given.

In other situations the necessity for consent may be obviated by the emergency nature of the situation. In an emergency no consent is required in order to treat a patient. However, an emergency does not justify treatment when a patient refuses to consent. In all cases involving adults who are rational, refusal of consent or the withdrawal of a previously given consent must be respected, since an adult has the right to determine whether he will submit to medical treatment. In some instances consent may be implied from a previous consent. Thus, often, consent for an extension or an alteration of an operative procedure is implied from a previous consent to that procedure. Usually, this is the case where, after opening the patient, the surgeon finds that he must of necessity extend his surgery into areas not previously contemplated or he must entirely alter the surgery. In such instances consent is generally implied and the physician's act does not constitute a battery except in those instances where it would not adversely affect the patient's life or health to end the operation, close the patient, and ask his consent for an additional operation.

Of course, a consent to a specific operation does not constitute consent to a totally unrelated one. Although what is meant by "unrelated" will be determined by the facts of each case, certainly the consent to an operation upon one ear does not constitute a consent to an operation on the other. Also, a consent will not cover a surgeon who has misrepresented either the results, the necessity, or the danger of the operation.

One of the most important requirements is that the consent be an informed one; that is, the patient must understand in general terms the nature and consequences of the act to which he is consenting. This precludes the acceptance of a consent drafted in such general terms that the patient in effect merely gives his physician the right to do anything which he feels is in the best interest of the patient and will secure his recovery. Obviously, determining the extent to which the patient must be informed raises questions. Must the patient understand all the nature and consequences of the proposed procedure? What risks must be explained to him and what possibilities, rather than probabilities, must be dealt with before a consent by the patient may be considered to be sufficiently informed? While this area will continue to be one of considerable litigation, certain rules are apparent. The consent form which procures the patient's consent in general terms should not be used in a surgical operation or in any other procedure where the risk to the patient is great. In those instances the consent form should be one which spells out to some degree at least the information upon which the patient is basing his consent. When this is done, there is less likelihood that the consent will be held invalid.

Medical Records

Medical records are an integral and essential part of hospital care, designed to hold all the data necessary to treatment of the patients. As a consequence, the form, substance, and accuracy of the medical record is increasingly regulated both by State agencies and by such nongovernmental bodies as the Joint Commission on Accreditation of Hospitals.

One essential point should be made. Because medical records are used in court proceedings, they are often discussed as if they were primarily a legal document. Medical records are maintained in hospitals for use in treatment of the patient while in the hospital and to provide information about previous illnesses when the patient is admitted to a hospital at a later date. The purpose of a medical record is to aid patient care, not to provide a record for use in a court of law. Thus the legal aspects of medical records should be seen in their proper perspective, as subordinate to the medical purpose of the record.

While the medical record should be accurate, clear, and complete so it can be used in court, the legal aspects of a medical record should not control its existence and utility. Generally, requirements concerning medical records are found in hospital licensing rules and regulations. Licensing regulations dealing with medical records can be divided into three groups. Some States detail the information required; others specify the broad areas of information required but do not deal with the record in detail; and others simply state that the medical record shall be adequate, accurate, and complete. The regulations may also set out standards for the maintenance, handling, filing, and retention of medical records.

Needless to say, the hospital must conform to the minimum requirements of the licensing regulations in its State. Should any litigation concerning the completeness and accuracy of the medical record occur, a failure to satisfy regulatory requirements could well be used as evidence to show negligence on the part of the hospital.

Since the medical record is maintained primarily for the use of the hospital and the medical staff in providing better care of the patient, the length of time a medical record is retained should be judged primarily on this basis. The period for retaining records, however, cannot be decided on the basis of administrative and medical utility alone. In several States, licensing and other regulations provide a specific length of time all records must be retained. In other States, specific provisions apply only to certain records, such as X-rays. Regulations in several States provide that the medical record must be kept permanently, and some require that the records be kept until the statutes of limitation upon a contract or personal injury action have expired. In several States, by regulation, it is provided that records cannot be destroyed without approval of the regulating agency.

The question of retention of records should be determined after considering all factors concerned, including whether microfilming is practical, whether there is sufficient storage space, and whether future medical or research need for such records are anticipated. All these factors should be considered as well as the utility of having the record available in the event of a suit by a patient against a hospital or third party. Generally speaking, when a record ceases to be medically useful, its retention for legal purposes alone is not justified unless required by statute or regulation. Up to the present time there has been no instance where a hospital has been held liable for failing to retain hospital records.

Hospital licensing regulations requiring that medical records be accurate and complete impose a duty upon the attending physician as well as on the hospital; consequently, the regulations should be read as creating a dual responsibility. There is little doubt that hospitals have the legal power to require, through hospital regulations, that members of the medical staff complete records on their patients within a reasonable time after discharge. To enforce this requirement the board has the power to set a penalty which can range from temporary withdrawal of admission privileges to revocation of medical staff membership. The courts will not interfere with such disciplinary action if the rule is reasonable.

The test of reasonableness is that the regulation be one which physicians in the hospital other than the physician involved find it possible to obey. If this is so, the courts generally

will not prove sympathetic to a plea by a physician that he finds a specific rule unreasonable. In order for a rule to be valid and binding upon a specific physician, however, it must be a hospital rule to which he has agreed as a condition of being given medical staff privileges.

Most hospital licensing agencies have the legal power to revoke licensure where there is a failure to maintain medical records with the accuracy and completeness necessary to meet minimum standards of the regulations. In addition, hospitals may be held liable for a breach of the duty to maintain accurate records. In a Washington case the hospital was held liable for an attending nurse's failure to observe certain symptoms and record them on the patient's chart (*6*). Thus liability can exist where the hospital record is not complete or where inaccuracies or a lack of information in the record injures the patient. The patient's suit is considerably simplified when the hospital's conduct results in a medical record which does not meet minimum licensing standards in that State. When this is the case, the patient need go no further to show that the hospital failed to use due care.

When the hospital is asked to disclose information contained in a patient's medical record, several problems can occur. The hospital's duty with respect to disclosure of information in court is clear. It must obey any lawful subpoena or other requirement of the court to produce the medical record or the information contained in it. More difficult is the problem when disclosure of the information outside of court is asked.

The starting point for considering out-of-court disclosure is that the medical record belongs to the hospital. It is not the property of the physician; it is not the property of the patient. In Kansas, Missouri, North Carolina, Pennsylvania, and South Carolina, this requirement is stated in the licensing regulations (*7*). In those States medical records are the property of the hospital and cannot be removed from the premises except by court order. While the attending physician has a clear medical interest in the record, he has no legal right to prevent disclosure of information in the record by the hospital.

The medical record is a peculiar type of property. The physical pieces of paper belong to the hospital. The hospital may restrict the removal of the record from its premises, except when under court order to bring the record to a hearing. The patient, however, has an interest in the contents of the record and can examine it, although the patient may have to go to court to enforce this privilege. In all States where this type of case has arisen, judicial decisions have upheld this right.

Although the patient has a right to examine his medical record and the physician may not deny this right, the hospital can reasonably define conditions under which it will permit examination and copying by the patient or his agents. The hospital has a legal right to demand that examination of the medical record occur at a reasonable time and place and after reasonable notice to the hospital. It may also require that a reasonable fee be paid for this privilege.

When the hospital or the attending physician feels that there is an adequate reason, concerning the medical well-being of the patient, for refusing to allow him to see his record, they in effect shift this responsibility to the court. Ordinarily, no adverse legal consequences will arise if the hospital refuses to allow a patient to see his record and requires that he get a court order permitting him to see it. If such order is obtained, the hospital must comply with it. No hospital has been required to pay damages based on refusal to allow the patient to see his record. The possibility of such damages is remote so long as the refusal of the hospital to let the patient or his agent see the medical record is based on the hospital's determination that seeing the record would not be in the best medical interest of the patient.

Generally, the law affecting hospitals has developed along commonsense lines and in the best interests of the hospital while protecting the legitimate interests of patient and physician. Those with the responsibility for regulating hospitals have a duty to continue this development along rational lines.

REFERENCES

(*1*) *Seneris* v. *Haas*, 45 Cal. 2d 811, 291 P. 2d 915 (1955).

(*2*) *Moon* v. *Mercy Hospital*, — Colo. —, 373 P. 2d 944 (1962).

(3) *Rural Educational Association* v. *Bush*, 298 S.W. 2d 761 (Tenn. Ct. App., 1956).
(4) *Emory University* v. *Porter*, 103 Ga. App. 752, 120 S.E. 2d 668 (1962).
(5) *Richards* v. *Grace-New Haven Community Hospital*, 137 Conn. 508, 79A. 2d 353 (1951).
(6) *Hansch* v. *Hackett*, 190 Wash. 97, 66 P. 2d 1129 (1937); *Larrimore* v. *Homeopathic Hospital Association of Delaware*, — Del. —, 181 A. 2d 573 (1962).
(7) Kansas State Board of Health: Hospital regulations, sec. E, 1; Division of Health of Missouri: Hospital licensing regulations; North Carolina Medical Care Commission: Rules and regulations for hospital licensure in North Carolina; Pennsylvania Department of Public Welfare: Rules and regulations for hospitals; South Carolina State Board of Health: Minimum standards for licensing in South Carolina hospitals and institutional general infirmaries.

Law, a Tool for Scientific and Social Ends

Although the rule of law may be regarded as an end in itself, we are here examining legal standards and procedures as tools to achieve utilitarian ends derived from science and from the broader demands of social policy. The law performs such functions for public health agencies in three general areas.

1. Technical standards are expressed as law either in legislation or by administrative regulations in sanitation, water pollution, food and drug protection, environmental and occupational health, the regulation of medical practice, and the like.

2. Legislation is frequently used to express and define functional relationships affecting public health activities. For example, such relationships are expressly made subject to determination by State law in the new Federal programs for assistance in construction of locally based facilities for the mentally ill and the mentally retarded.

Functional relationships are also often determined by implication of statutes which were intended for other purposes, as with laws defining procedures for the commitment of mentally ill patients. In this example, present procedures in California tend to contradict the stated public policy that the community should be the first line of activity in the provision of public mental health services.

Functional relationships between the State of California and local government are now being shifted in the direction of a congruent pattern of local operation under State supervision with State financial support. In all publicly operated medical and social services, this pattern seems to be developing in a consistent and desirable way with no express declaration of policy having been made.

3. Legislative enactments are a conspicuous method of announcing major shifts in social policy. Such shifts can occur in a glacial, evolutionary way through occasional piecemeal statutory changes as in the developments which in California have put approximately one-quarter of the total medical care function under public auspices. Shifts in policy can also center about expressly stated issues, such as that between the public assistance (Kerr-Mills) and prepaid insurance (King-Anderson) approaches to medical care.

In State legislation, at least, the processes by which legislative programs evolve and are acted upon are sufficiently loose to make it quite feasible for alert and active professionals to have major impact on legislation. Major legislative action has been initiated in this way in several instances in California.—*Summary of remarks by Winslow Christian, LL.B., at the dinner session of the Institute on Public Health Law, December 13, 1963. At the time of this address, Mr. Christian was administrator, California Health and Welfare Agency. He is now executive secretary to the Governor of California.*