Legal Problems Facing Modern Hospitals

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SOME months ago an article in *Fortune* magazine called attention to the quality of medical and hospital care practiced today, by describing the treatment given to Charles II of England in 1685. "They drained a pint and a half of blood from his arm, and quickly followed with an emetic of herbs. Then they gave the King an enema compounded of rock salt, violets, beetroot, saffron, and cinnamon. When the King failed to improve, his head was shaved, and a blister raised on his scalp. Sneezing powders were administered; the King was fed forty drops of extract from a human skull. The King swallowed a costly bezoar stone—the gall-bladder stone of goats, said by Arab physicians to have great healing powers—and drank pearls dissolved in ammonia. As he weakened, the bleeding and the purging were stepped up. But the royal patient died."

The medical care that is available to us today is vastly different from that of 300 years ago, and much of it is given in our modern general hospitals. Today's voluntary general hospitals have evolved slowly since the Middle Ages from institutions one step above the charnel house to complex organizations devoted to the care of patients, education in the health professions, research in laboratory and clinical medicine and related sciences, and prevention of disease.

This transition from an introverted facility whose principal function was to receive passively the patients referred to them by practicing physicians, operating under the principles of "fee for service" and privileged patient-physician relationship, to a complex center looking outward into the community and actively engaged in programing health care services has focused attention on the philosophical and legal bases of the operation of hospitals in the public interest.

Hospitals are corporate bodies whose responsibilities are defined by the laws of the State. If they are nonprofit institutions they enjoy charitable tax-exempt status. They sign contracts with voluntary prepayment plans, nonprofit agencies like Blue Cross and commercial insurance plans, thereby introducing a third party into the hospital-patient relationship, a third party that compares in some respects to a public utility. They are eligible to receive large amounts of public money in outright grants or loans for capital funds, for patient care, for education of health personnel, and for research. Because of the increasing participation of government in support of these activities, the nonprofit and proprietary (for profit) hospitals as well as those which are organized as governmental agencies are increasingly subject to regulation by government.

Further, to an ever-increasing degree, the practicing physician is dependent on the institution as the locale for a major portion of his private practice, and therefore of his livelihood, and for his graduate and postgraduate education.

In such a climate, which invites controls, what are the major legal problems facing hospitals today? My assignment is to call attention to some specific problems faced by the administrator in the course of his daily work as he carries out the policies of the governing board rather than to give an overview of general problems by category. Here are 10 such problems.

1. Certain activities of hospitals are being attacked as the corporate practice of medicine. These include employment of physicians on

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salaries and contractual arrangements to supply consumer groups, banded together in prepaid insurance plans, with comprehensive health services.

The independent consumer health prepayment plans either employ their own physicians or contract with a health agency, such as a hospital, to supply medical and other services.

Organized medicine considers that closed-panel practices and contracts with organizations that are not controlled by physicians, to provide services of physicians, are unethical and even illegal. A basic economic problem is confused with and cloaked in terms of ethics or law. Sanctions may be imposed against the physicians concerned, such as social ostracism, denial of membership in medical societies, and discrimination against the members of closed-panel practices in their efforts to obtain privileges in hospitals. It may also mean legal action against participating hospitals and pressures on members of the governing board and the administration in the community on which the institution depends for philanthropic and other forms of support.

2. Hospital contracts based on straight salary arrangements with physician specialists in scarce categories (anesthesia, physical medicine, pathology, radiology) are condemned as illegal by the specialist societies. These specialist groups, whose members enjoy what amounts to exclusive privileges in the hospitals where they work, are even unhappy about percentage arrangements. They encourage lease arrangements, which I believe may in turn be illegal in some States. Because of this it is a rare hospital that is not engaged at regular intervals in painful negotiations with physician specialists.

3. A fairly new area of dispute concerns the permissible functions of nonphysicians. The problem arises, for example, when it becomes necessary for someone other than a physician to administer intravenous medications or transfusions. In a somewhat different vein, is the laboratory technologist or the X-ray technician practicing medicine in carrying out certain procedures?

4. As hospitals embark on new programs of patient care, new problems of legal liability arise.

General hospitals are being urged, for example, to develop psychiatric units for acutely ill, mentally disturbed patients. This raises a number of questions, and the general hospital administrator may not be familiar with the answers. Commitment and release procedures may be unknown, or the hospital personnel may be responsible for recognizing signs of serious disturbance which may prompt a patient to harm himself or others. Convalescing mentally ill patients may be allowed outside privileges as part of their treatment, or the rehabilitation patient who is being fitted for a prosthesis may have to visit the limbmaker.

Hospitals also are being urged to develop home care programs under which patients are treated for weeks, months, or even years in their homes by hospital-based teams of medical, nursing, social work, and other health-related personnel.

This extension of hospital activities into the community and specifically into the patient's home or foster home has opened a new possible area of liability for the hospital.

5. Two or three years ago the American Hospital Association began to urge its member hospitals to adopt formulary systems in which drugs are stocked and dispensed by their generic attributes rather than by their proprietary names. The reasons for this move are to reduce the need to maintain large and costly inventories of drugs, to lower the cost of individual drugs to the patient, and to reduce the chances for error in dispensing and administering drugs. A key feature of the formulary system is to obtain the consent of the physician to allow the hospital pharmacist to substitute a drug stocked under its generic name or even under another proprietary name if it is identical to that ordered by the physician under a proprietary name.

For a formulary system to be effective, the medical staff would have to agree on generic drugs that should be stocked or sometimes on which of several identical proprietary products should be carried in inventory. Then by medical staff resolution or by some permissive marking on the prescription blank, the pharmacist could substitute the identical drug unless there were specific instructions to the contrary.

This effort to reduce inventory, lower costs

of drugs to the individual patient, and lessen chances for error by simplifying the system has been disputed in various parts of the country by the organized drug industry and by medical groups as constituting a threat to physicians' unrestricted rights to practice medicine in the hospital. An acceptable statement of guiding principles on the operation of the hospital formulary system is still under discussion by the national organizations of hospitals, physicians, and pharmacists.

6. To an increasing degree hospitals are being held liable for the medical judgments and actions of the private physicians who are members of the attending staff. Hospitals in some States are requiring their staff members to carry adequate amounts of malpractice insurance as a condition for being accepted to and continuing to be reappointed to their medical staffs.

7. The hospital emergency service is growing and with it is an accompanying high risk of liability. This risk is enhanced when the hospital staffs its emergency facilities with unlicensed physicians or inadequately trained personnel or too few persons. A byproduct of this hesitation of the hospital to expose its personnel is the occasional adverse publicity sustained by a hospital when an injured person is left unattended in the vicinity while the police ambulance is called.

8. State and local tax assessors, ever seeking new sources of tax income, are looking to hospital real estate for revenues. They tend to condemn ancillary activities of hospitals chartered as charitable institutions, such as parking lots and garages, staff apartment buildings, and doctors' office buildings. Similarly, the Internal Revenue Service is engaged in an audit program that will review income unrelated to hospital services, such as doctors' offices, drugstores, cafeterias open to the public, coffee shops, gift shops, parking lots, and even vending machines. From these reviews it may be revealed that some nonprofit hospitals actually are being run for the private gain of certain individuals, and they will be denied their tax exemption.

9. During the last few years, hospitals in many metropolitan areas have been engaged in negotiations with labor unions that have organized their workers or have attempted to organize them. Hospitals have claimed that unions have no place in their organizations because of the nature of patient care and because the hospital is not engaged in interstate commerce. Nevertheless, hospitals in New York City, by statute, must now negotiate with the unions, and compulsory arbitration is provided for if it proves necessary. Laws providing for compulsory negotiation may spread to other metropolitan areas.

10. A recent development is the legal aspect of hospital planning, a development that is the outgrowth of a number of complex and interrelated factors, such as the high capital cost of hospital construction, the ever-increasing costs of continued maintenance, the duplication of facilities, the shortage of health manpower, the special needs of the metroplex and the rural areas, and the sources of financing.

In California areawide hospital planning is authorized by statute. In other parts of the country purely voluntary programs have been started as independent planning agencies or as arms of existing hospital associations. These voluntary programs are in their infancy, and they have not yet proved that they can succeed without legislative compulsion to control the location and numbers and types of hospital beds.

In this brief account I have indicated 10 areas where legal problems may arise in the operation of the complex institution we call the modern hospital, which is devoted to patient care, education in the health professions, medical and medical care organizational research, prevention of disease, and community service.

Obviously, this list is not complete nor is it static. It might include such additional evidence of the changing character of hospitals as their obligations when they receive money under the Hill-Burton Hospital Survey and Construction Act to admit and care for patients of all races and to accept on their staffs qualified physicians of all races; or the possibility of conflict of interest of a physician who has a financial interest in a proprietary hospital at the same time that he has staff privileges in a voluntary hospital; or the eligibility of an osteopathic physician to membership on a general hospital staff in a State where osteopathic

medicine is one of the legally recognized healing arts; or the denial of hospital staff privileges to physicians who engage in prepaid group practice; or the role of the State commissioner of insurance in directing how hospitals will use beds efficiently consonant with the requirements of good patient care; or the interpretation that residents are employees, to be covered by social security provisions, while interns are students and not so covered.

In the handling and solution of these legal problems, the public interest is paramount.

Community Mental Health Centers

Regulations under which States may apply for Federal funds to help build community mental health centers have been approved by Secretary of Health, Education, and Welfare Anthony J. Celebrezze.

The $150 million in Federal funds authorized in the Community Mental Health Centers Act of 1963 will be allotted to the States on a per capita income and population basis over the next 3 years to defray up to two-thirds of the construction costs of each such center. The National Institute of Mental Health and the Division of Hospital and Medical Facilities, Public Health Service, will jointly administer the program.

To qualify for Federal funds, a center must be a part of a program providing "at least the essential elements of comprehensive mental health service," defined in the regulations as inpatient and outpatient services and partial hospitalization (with emergency services provided 24 hours a day by one of the three services) together with consultation and education services to community agencies and professional personnel.

When the facility to be constructed contains only a portion of the essential elements and relies upon other community agencies to provide the rest, there must be written agreements to assure continuity of care. To achieve treatment for patients close to their homes, a basic goal of the program, the regulations limit the population to be served by a single program to from 75,000 to 200,000 persons (subject to waiver in exceptional cases) and require that the program be readily accessible to the population served.

Public or other nonprofit organizations can apply for funds through the State agency designated by the State Governor to administer the program. The State agency administering the center program is required to obtain assurance that the facility will be available without discrimination because of race, creed, or color, both to patients and for professional practice. The States will need to show that the centers and their treatment programs will be consistent with the long-range mental health planning now underway in all States. Coordination is also required with other related planning efforts, such as urban development, welfare service planning, and metropolitan and interstate planning.

General standards of construction and equipment, methods of administration and processing of applications, minimum standards of operations, and matters relating to fiscal accounting are prescribed in the regulations.

Copies of the regulations as printed in the Federal Register are available from the Publications and Reports Section, National Institute of Mental Health, Bethesda, Md.