

LAW AND MEDICINE

Reflections on a Metaphysical Misalliance

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This offering attempts to discuss from a broad perspective legal considerations respecting the delivery system, so-called, of health care. Although the writing started out to be specifically related to the group practice technique for rendering medical care, it became apparent that deeper, more compelling questions could be raised. This is without question a hazardous undertaking, for it involves much more than a mere recitation of the law—such as it is—affecting a particular method of delivering what has come to be known popularly as health care.

Even if it were possible to restrict the view of this enormously important topic to precise and technical legal considerations, we would find something close to the syncopated chaos that one associates with the Tower of Babel. In a slightly more modern pose the notions implicit in the term Bedlam also come to mind as we reflect on the cacophony that assaults us whenever the subject of law and medicine is discussed.

The broad perspective this offering takes will reveal even greater dissonance, if not madness. Yet the law has always been involved with health in one way or another. From earliest times the law—taking that to mean the disparate miscellany of statutes, judicial decisions and administrative regulations, rulings, pronouncements, orders and doctrines—has a posture that at once encourages, inhibits and is indifferent to health care.

Moreover, it will be found that throughout the centuries law has not been able to come to a working, practical definition of health or medicine, or, indeed, the scope of practice of the variety of practitioners who enhance it or purvey it, as the case may be. Such definitions as have been devised have been based, in part at least, on mysticism, magic, metaphysics and no small amount of self-serving protectionist sentimentality.

Whatever it was in the past, American law as it affects health matters is in transition. As the nation has become more aware of the vital importance of health in matters public and private, and as the many definitions of health have expanded, there is an increasing legal focus on the availability and adequacy of health services. This is true with respect to the broad areas of so-called public health such as protection against environmental pollution, surveillance of food processing, and drug control; it is equally true with respect to individual health care. The burgeoning concern of government and the public—for which read consumer—is comprehensive, relating not only to payment mechanisms but also to the quality of care provided. When we reduce the veritable Niagara of words concerning health care into a palatable distillate we will find that the public—growing in militancy and sophistication day by day—now demands a rationalized delivery system, unlimited access to that system, reasonable costs when the so-called system is used and high-quality care. We shall have more to say about these demands and the manner in which the law has responded to them in the past, how it now responds and how it may in the future respond.

For the moment it is enough to say that the group practice technique is regarded by some as an effective method of organizing health manpower and resources to provide high-quality care. The voluntary consumer-sponsored prepayment mechanism is one method of reasonably spreading the costs of such care. Taken together, the group practice technique and the prepayment mechanism are essential elements of the so-called health maintenance organization, which, its proponents suggest, can offer high-quality, comprehensive, rationalized care at rea-

sonable costs and on a national basis. That may very well be the case. But in the United States, at least, much of the law presently imposes barriers to the effective application of the group practice notion on a large-scale multistate basis. Moreover, different segments of what can be called "organized health" are for various reasons opposed to change. Other segments have their own agendas for change. It is clear that change will take place whether we like it or not.

Medicine, like society in general, has always suffered change badly. When one looks to the law as the mechanism for bringing about massive changes in an entrenched system, the process is likely to be quite difficult to say the least. It is not idle speculation to say that this is so with respect to the use of the legal system to bring about changes in the health care system because medicine *and* law have had such mystical origins, such metaphysical underpinnings, such secret and symbolic rituals and such economic overtones that the relationship of one to the other could not be anything but traumatic.

But the trauma now goes beyond the ancient and honorable ambivalent symbiosis between law and medicine. Indeed, medical care is only a part of a new definition of health care, and as we shall see, institutions are looked upon more and more as deliverers of care. So at last law and medicine may be even more intimately involved in a joint venture to monitor changes in the system. They may again become bedfellows in a new political arena. In a sense, then, bedfellows will make strange politics.

Can the legal system be employed as the mechanism to bring about changes that will rationalize health care, provide access, control costs and ensure high quality? We shall explore that possibility by reviewing what has happened in the past and by making a few guesses about the future. But first, it may be helpful to speculate why the law has become so interested of late.

JUDGE HOLMES' CONCEPT OF FELT NEEDS

For thirty years there sat upon the Supreme Court of the United States a tall, handsome gentleman, with a large handle-

bar mustache, a full head of white hair, sharp eyes and an alert, dignified manner. Prior to that he sat on the Supreme Judicial Court of the Commonwealth of Massachusetts for seventeen years, ending as Chief Justice. Early in his life, which spanned more than ninety years, Oliver Wendell Holmes, Jr. was made a lecturer on common law at the Lowell Institute in Boston. The lectures he gave there were converted into a book, *THE COMMON LAW*, a work of high erudition and extreme importance. In his book Justice Holmes put forth a definition of law that is most appropriate to our discussion:

The life of law has not been logic: It has been experience. The felt necessities of the time, the prevalent, moral and political theories, intuitions of public policy, avowed or unconscious, even the prejudices which judges share with their fellow men, have had a good deal more to do than the syllogism in determining the rules by which men should be governed. The substance of the law at any given time pretty nearly corresponds, as far as it goes, with what is then understood to be convenient; but its form and machinery, and the degree to which it is able to work out desired results, depends very much upon its past.

To a large degree the life of medicine has had the same experience. Medicine has grown and expanded according to the expressed desires of mankind to solve the mysteries of illness and disease. Over the years, disease, illness and sickness of various kinds have received special attention; great exertions of time and energy have been made and large infusions of dollars have been required to alleviate particular illnesses. Medicine responded to articulated felt needs.

Lawyers and physicians alike have learned from past experiences and have attempted to apply that knowledge to some currently felt necessity. Both law and medicine have long standing traditions. Both professions are challenged today as never before. This challenge comes precisely because more is expected of the two professions and the system is no longer controlled by them. The public demands that they respond to its needs—and they cannot.

Medicine, specifically, is facing a social and legal confrontation today such as it has never faced before in its long history. Its practitioners are, for any number of reasons, ill prepared to deal with these assaults. At the same time the public has grown in sophistication and now demands much more from them without giving in return what has been for a century at least a reverence almost akin to that which the laity formerly extended to the clergy. Today, however, the public views medicine in a light entirely different from that of just a short while ago. Attitudes of awe and respectful hope have changed across the nation; the general population now has high expectations and little patience with explanations that attempt to show why health care of the highest quality cannot be delivered right now and at reasonable cost.

We are, so the writers and editorialists inform us, in the midst of a health care crisis. It seems that every generation or so America rediscovers a "crisis." All the forces of society bewail the newly found old problem. This phenomenon can, perhaps, be described by the old French saying: "The more things change, the more they remain the same." Think, if you will, of the recurrent so-called racial crisis, of the economic crisis, of the environmental crisis or the educational crisis. They and the health care crisis are all of a piece. We have heard it all before. These recurrent crises symbolize the inability of the American political, economic and legal systems to deal lastingly and finally with human problems. It is perhaps the case that no social system *can* deal lastingly and finally with human problems.

Social change is occurring every day. Physical change goes on. Felt needs today are different from before and these changes have an impact on the demand for medical care. Indeed, the changing values of Americans have much to do with the demand for higher quality health care, and consequently the manner in which the law may be employed to achieve that end. This change in values is fundamental—and yet our responses to it may be the same in terms of the frame of reference with

which we formerly dealt with problems of this nature. That is, the attempt may be made to meet this felt need in the context of the notions implicit in the doctrine *laissez faire*, or in terms of true socialism. It is more likely the case that neither a policy of "hands off" nor total government control will suffice. What is needed is a creative reconciliation of the recognized health values of Americans that seek an improvement in the quantity and quality of health services within the context of a complex political system on the one hand—which still claims to adhere to notions of freedom of choice—and an economic system on the other, which still claims to rely on competition in the market place.

The system of values developed during the early industrialization phase of United States history no longer seems applicable to emerging institutional, group and individual patterns. A great many forces are intermeshing and working to hasten these shifts in values. They work at different paces and tempos for different people and they work differently from one place to another. Among these forces are growing national affluence, increasing societal complexity, increasing national insecurity and fear, heightened rates of change, exploding technology, upheavals in theology, the ascendancy of "youth values," strong demands from so-called minorities, new roles for business and government, wider accessibility of the mass media of communication, innovative use of collective action and confrontation and a heightened conviction among many Americans that the nation has not lived up to its promises and ideals explicit or implicit.

Under the circumstances, standards of what is important—i.e., what should have priority in a hierarchy of priorities—are changing. Even the upper-middle-class American finds that the attainment of status and material goals is so relatively easy that the quest for them no longer offers a challenge. So rather than face a lifetime of futility and senseless pursuit of things, people at almost every level of life are seeking different goals with which are associated higher values. Taken together these forces, events

and trends presage a time of rapid and fundamental shifts in the core values by which most Americans live. Moreover, in all areas of life these shifts augur new assaults on the established way of doing things, providing services and redressing grievances. The law, as Justice Holmes described it, is intimately involved in providing supportive mechanisms for the implementation and realization of the felt needs of society as they come to be expressed. Thus, the law is grappling with bringing about change.

National affluence, coupled with accessibility and the influence of the mass media, has an important additional impact: it facilitates the expression, dissemination and acceptance of personal, community and national values. In speaking of the values of Americans, we are referring to the basic and central values that people hold consciously or unconsciously. These are basic beliefs of people that are deeply held and difficult to analyze or rationalize. These basic values penetrate into every aspect of an individual, from his notion of beauty to his view of the meaning of life, to his private perception of his needs, to his desires for the future of himself, his family and his nation, to his personal preference for self-expression. Thus, a person's sense of health and his private notion of his health needs is intricately tied in with his values. It should also be stated that central values are not innate and immutable. They evolve, they grow, they change, they retract. Central values are influenced by actual or imagined experiences, they reflect upbringing, education, religious teaching, community attitudes, social and economic status, world events and a host of other factors. Nor are values found in isolation; rather, they can be said to form a molecular-like structure that defines a pattern and identifies a describable whole.

It can be seen that values tend to be generated by the basic needs that people have. Simply stated, needs dictate values by emphasizing what is most important. As the United States has moved from what might be called the frontier frame of reference—by which is meant not only the conquest of land but also

control of the economy under the idea of free enterprise as well as the notion of "survival of the fittest" as it applies to human relations—we have changed to a society that is more socially oriented, more organized, more institutionalized. As this has happened and as affluence has reached larger portions of the population the felt needs of the people have changed from that of basic survival in a competitive setting (some have called it a jungle) to sophisticated concerns for self growth and self actualization. This would seem to indicate that the individual in this day and in the years to come will be more concerned with personal well being and the well being of society. He will have a deep concern for the "quality of life" as much as life itself. He will seek and demand good health care and if he cannot find it within present social and legal frameworks he will develop approaches to make sure that it will come.

The law, it is suggested, will be and has been a vehicle to bring about change. It will reflect the current felt necessities of the times and it will bend to meet the current desires. But, as Justice Holmes further described, the prevalent moral and political theories, intuitions of public policy and even the prejudices that judges—and other lawmakers—share with their fellow beings will have considerable impact. Moreover, the changes that are effected by the law will still depend very much upon the way things were done in the past.

From earliest times the law has had an interest in the health of the community. From the times of Moses (and even before) to the latest pronouncement of the Supreme Court of the United States a major concern of the law giver was the public health. Indeed, the primary power of the state is the police power; pursuant to which it is the responsibility of government to provide for and to protect the health, safety, welfare and morals of the community. It is through the police power that state government, under our system, is active in the field of public health. The police power covers the person and the property of every individual and corporation in the state. It extends to the conduct of private matters as well as to business

affairs. The state, through its legislature may delegate some of its police power to its political subdivisions, such as counties and cities. It may grant powers to agencies within the executive branch of government. Thus, hospital, medical and nurse licensure boards are created and operate through the delegation of the state's police power.

The federal government also exercises control over health matters, but not through the police power, as one might expect. The federal government can only exercise the powers granted to it in the Constitution. Thus, federal control must be effected through a specific power that the federal government has been given. With narcotics, for example, control is established through the government's power to levy taxes. Under its power to regulate immigration and interstate commerce, the government authorizes physical examinations for aliens entering the country. Again, under its power to impose taxes, the federal government has attempted to provide for the medical needs of the elderly. The mechanism of social security taxation was used as the means to pay for the delivery of health care to that defined portion of the population.

Congress is now seriously considering several far-reaching proposals relating specifically to health care for Americans. The debate on health care is a major domestic issue and will be manifested in the political arena for years to come. Indeed, the health care issue will be raised in political campaigns at all levels. The public interest is focussed on health not only because of the rapid rise in the costs of care and the dichotomy between the promise of medicine and the fulfillment of that promise, but also because of the much more general agreement that good health care is a *right* of every American.

Now, when one speaks of rights in a legal context, immediate notions of correlative duties come to mind. If one has an entitlement then someone or something else has—or should have—an obligation to provide that entitlement. In the framework of American law—based as it is on the England Common Law—for every right there should be a remedy. Thus, rights, as they come

to be recognized and incorporated into the ever-expanding legal mosaic, will be enforced by the legal system one way or another.

At the state level we have witnessed in the past few decades modifications in the law that reflect the increasing demands of the public toward health generally and the delivery of health care on an individual basis. The changes reflect a trend away from a policy of protection of the health industry and the individuals or institutions who provide care to a philosophy of accountability. A few examples will illustrate the point.

In 1960 a majority of the states had a legal rule that protected charitable or nonprofit institutions, including hospitals, from liability for negligent harm inflicted on those who received their services. Of course, patients were included among those who could not successfully sue. Today the doctrine of charitable immunity has been almost completely overturned, by judicial decision or statute. The underlying rationale of the doctrine was that nonprofit hospitals and other charitable institutions had to be protected from financial loss for their carelessness even at the expense of the injured patient who came seeking aid at a time of vulnerable need.

Courts today are more likely than ever before to define and enforce notions of institutional responsibility for the health care activities that take place in hospitals. The long-recognized notion that actions of the private practitioner could not be controlled by lay boards or administrators has virtually come to an end. Today, it is almost universally agreed that the institution is responsible for everything that goes on within its walls including the delivery of medical care. The Darling case, is the most famous, but by no means the only, case to stand for that proposition. Moreover, courts are much more willing to intervene in disputes between private hospital and the private practitioner. Once they do so they invoke notions of fair play and equality, and apply them to what was legally construed as a private club, the activities of which the law had no power to modify.

Courts today have no hesitancy in defining rights of patients

and imposing duties on hospitals. Perhaps the best example of this recent trend is the manner in which the emergency departments of hospitals are viewed. It is traditional wisdom in American jurisprudence that the law does not require a person (or institution) to render assistance voluntarily in times of danger. But the cases on analysis have a different practical outcome. It may well be that hospitals now have a legal duty to provide some kind of emergency care to anyone who seeks it. More will be said on these points shortly.

These and other changes in the law as it relates to health care delivery have been wrought primarily through the judicial system. That is, the courts have been the primary change-agent and much of what has been mentioned by way of example is court-made law. Now the legislatures and the executive branches of government are beginning to stir. Moreover, nongovernmental organizations, such as the Joint Commission on Accreditation of Hospitals, have an important and growing influence on the definitions of the standards of hospitals and medical care.

These changes relate to this discussion because they affect the specific questions of access, cost and quality, which are the demands identified earlier. The idea that all Americans have a right to good health care includes as well the idea that the cost should be reasonable and manageable and, to some degree at least, predictable. It will mean very little if the right to care exists in a vacuum of impossible costs. Additionally, the right to care implies the responsibility of some part of society—government or the private sector, or both—to develop a means of financing such care of all Americans without regard to financial status. Implicit, also, in the discussions now going on is an understanding that not only are all Americans entitled as a matter of right to good health care but also that such care should be comprehensive and preventive not categorical and episodic.

Presently, there is a wide range of proposals for more effective and efficient systems for the delivery of health care. These include suggestions for financing the costs. Difficult as

these questions are they are not as troubling as the public policy questions that go to the fundamental relationship of law and medicine: How viable is the notion of "private enterprise" as it applies to health care? Is voluntarism effective, given the recognized needs of the public? Can political, social and economic ideologies allow for more government-owned or -sponsored health care systems? Can the law bring about such a massive social change?

Hopefully, we will come up with some answers to these questions. It is now time to look briefly at the way in which the law has so far dealt with the three problems: providing for more access, controlling costs and rationalizing medical and health practice so as to define quality.

THE PROBLEM OF OBTAINING ACCESS

It is generally acknowledged to be the prevailing rule that a hospital, whether public or private, is under no common law duty to provide health care to any and all persons who request such care. This is conventional wisdom. However, a few states have enacted statutes that expressly impose a duty on most hospitals to render medical care under certain circumstances. Other statutes that provide for public assistance or relief to the poor as well as those that authorize medical assistance payments to certain classes of diseased persons, may form the basis of a judicial determination that a hospital must offer services to those within the classification.

Of interest is a recent ruling by a federal district court that the provisions of the so-called Hill-Burton Act and its regulations are a legal basis for a private civil suit to compel hospitals to provide a reasonable volume of services to persons unable to pay for them. Moreover, several emergency room malpractice and negligence cases may, by inference, give rise to a legal duty to provide some kind of treatment to persons seeking assistance under certain circumstances.

One portion of the New York Public Health Law requires

every general hospital to admit with all convenient speed anyone in need of immediate hospitalization.¹ It also prohibits inquiry into the financial standing of the patient before admission. Another section of the same law provides for the revocation, suspension, limitation or annulment of a general hospital's operating certificate by the State Commission of Health or the New York City Health Services Administration, for the refusal by the hospital or its failure to admit or provide necessary emergency care treatment for an unidentified person brought to it in an unconscious, seriously ill or wounded condition.

The Illinois Public Health Law provides that every licensed hospital that provides general medical and surgical hospital services must provide a hospital emergency service and must furnish such hospital emergency services to any applicant who applies for the same in case of injury or acute medical condition where the likelihood exists that death or severe injury or serious illness will follow.² A penalty is imposed for violations of the provisions of the Act in the form of a fine that ranges from \$50 to \$200 for each offense.

A section of the California Health and Safety Code provides that emergency services and care must be provided to any person requesting such services or for whom such services are requested for any condition in which the person is in danger of loss of life or serious injury or illness at any hospital maintaining and operating an emergency department.³

The effect of these statutes would seem to be that in New York, California and Illinois the general public has a right, at least, to access to the institution for emergency treatment. What that treatment will be and how it shall be rendered are separate questions. But at least the statutes would seem to say that the institution must admit the person and provide some care.

Another interesting theory, which has met with judicial approval in one case at least, is one that provides that the language of the Hill-Burton Act and its regulations, which essentially require an assurance from the institution seeking funds that it will make available somewhere in the facility a

reasonable volume of services to persons unable to pay therefor. In a recent case from the Federal district court in New Orleans, Louisiana, several individuals sued to compel certain hospitals to provide a reasonable volume of services to persons unable to pay therefor.⁴ The defendants were ten hospitals in the area and the Director of the State Department of Hospitals. The theory of the plaintiffs case was that the Hill-Burton Act in setting forth the requirements of an assurance from hospitals to provide a reasonable volume of free care to those unable to pay therefor created a right that the consumer could enforce in the courts. The court agreed with that contention and provided that the plaintiffs could institute the private action under the federal act because they could be considered to be third-party beneficiaries of the contract between the state and the institution. The court also said that a right to sue could be implied from the terms of the Act. The language of the court is instructive.

It is unthinking that Congress, obviously concerned with people, would have left the Secretary with only the sanction of cutting off funds to the state. Moreover the private civil remedy is a method of policy enforcement long honored explicitly in statutes and by implication with the help of the courts. Congress more and more commits to individuals acting as a private attorney general, the effectuation of public rights to relief to individuals. In the case at bar, we hold that the Hill-Burton Act is designed, at least in part, to benefit persons unable to pay for medical services. Such people are not the sole beneficiaries of the act, but they certainly are the object of much of its concern. . . It is a matter of the clearest logic that the only real beneficiaries of a hospital program are the people who need or may need medical treatment. This includes people of all classes whether rich or poor. . . .

Other cases in different federal districts have dealt with this issue and decided in favor of the plaintiffs.⁵ The holdings in these cases are examples of the way in which some courts will respond to the felt needs of the public in relation to health care.

An interesting development has come from a line of cases

dealing with negligence in the emergency room. In these cases an analysis of the factual questions gives rise to a conclusion that a hospital may in fact be negligent if it fails to at least provide services that aid in the determination whether an emergency exists.

Perhaps the most famous and interesting case on this point is that of *Wilmington General Hospital vs. Manlove*.⁶ The facts of the case are interesting. In this case a four-month old child developed diarrhea. Next morning his parents consulted the family physician. He advised them that they should continue the medication he had prescribed. That same evening the mother took the baby's temperature and found that it was higher than normal. They called the physician again and he prescribed additional medication, which was delivered by a pharmacy. The child's condition remained the same and the physician continued to prescribe for the child. Several days after the initial contact with the physician the parents attempted to get in touch with him, but it was his day out of the office. They then carried their infant to the emergency ward of the Wilmington General Hospital.

The parents took the infant into the reception room of the emergency ward where they found a nurse on duty. They explained to the nurse what was wrong with the child, that is that he had not slept for two nights, had a continuously high temperature and that he had diarrhea. The father told the nurse that the child was under the care of the private physician and showed the nurse the medicine that had been prescribed. The nurse explained to the parents that the hospital could not give treatment because the child was under the care of a physician and there would be danger that the hospital's medication might conflict with that of the attending physician. The nurse did not examine the child, take his temperature, feel his forehead or look down his throat. The child was not in convulsion and was not coughing or crying. There was no particular area of body tenderness.

The nurse was unsuccessful in attempting to contact the

family physician, but she did suggest that the parents bring the baby back to the pediatric clinic on the next morning. The parents returned home. They did make an appointment by telephone to see the physician at eight o'clock in the evening. However, around three o'clock in the afternoon the child died of bronchial pneumonia.

The parents sued the hospital to recover damages for the wrongful death of their infant son. They charged that the hospital was negligent in failing to render emergency assistance, in failing to examine the baby, in refusing to advise the intern on duty about the child or permitting the parents to consult him. The trial court rendered judgment for the defendant hospital. On appeal the Supreme Court of Delaware found and held that there was at least a legal duty on the part of the hospital to render care in a situation where there was a frank emergency and the parents had relied upon the custom of the hospital to render aid in such cases. As the Court said:

We are of the opinion that liability on the part of the hospital may be predicated on the refusal of service to a patient in the case of an unmistakable emergency, if the patient has relied upon the well established custom of the hospital to render aid in such a case.

The Court however made the point that the facts as adduced in the trial did not clearly indicate one way or another whether there was in fact a frank emergency. Thus, the case was sent back to the trial for the development of the facts with respect to the frank emergency.

The Court did not indicate that the plaintiffs would automatically win. Indeed, it merely spelled out the proof that the plaintiffs had to make. This proof would have to come from expert medical testimony. As the Court said:

In the circumstances we think the case should go back for further proceedings. We should add, that if plaintiffs cannot adduce evidence showing some incompetency of the nurse, or some breach of duty or some negligence, his case must fail. Like the learned judge below, we sympathize with the parents in their loss of a child; but

this natural feeling does not permit us to find liability in the absence of satisfactory evidence.

A strong line of cases from other jurisdictions also follow the Wilmington equation.⁷ Among these cases are some that involve not only the failure to render assistance as the applicants entered the institution. Some of these cases also impose liability or deal with the question of liability after the hospital received the applicant for emergency services and held him for some period of time and *then* denied aid. The cases also deal with the factual situations where the hospital exercised some control, gave some aid and then released the patient.

Although it is not suggested that the law is presently well fixed on this question, substantial legal support may be cited for the idea that an institution offering health services to the public cannot deny those services unjustifiably. What will be justified will depend on the facts and circumstances of any particular case, but clearly an arbitrary rejection will be looked upon with disfavor.

Does the same rule apply to groups of physicians organized to provide emergency services to the public? It is too early to say with any assurance how the courts will deal with this question. It can be stated that as more and more physicians join together to form group practice partnerships or corporations and as they work within the framework of the emerging health maintenance organization, so-called, that the rules of law applicable to the hospital as it is known today will apply to the new health maintenance organization. There can be no question about that. The case law, at least, will look for past solutions to adjust new conflicts.

Thus, this quick analysis indicates that the law has changed from a posture that imposed no duty requiring the hospital to do anything for anyone they did not choose to serve, to a rule today where at least some effort must be made on the part of the hospital to provide an initial determination that emergency care is or is not needed. This essentially is what is commonly

known as the triage. Although it is not appropriate to discuss that notion here it is instructive to indicate the language of the new standards of the Joint Commission on Accreditation with respect to emergency services. The interpretation to the first standard on Emergency Services provides in part as follows: "The hospital must have some procedure whereby the ill or injured person can be assessed, and either treated or referred to an appropriate facility as indicated."

The notion that every hospital seeking accreditation must make at least the assessment is one that comes directly from the Manlove case. It is also important to note that the "Conditions of Participation in Medicare" has similar language.

On the question of access, then, we can see a clear implication in statutes, cases and regulations or standards that requires the institution to provide an opportunity to receive care and the rendition of some kind of treatment. The law moved in when the need was expressed.



THE PROBLEM OF SPIRALING COSTS

The health industry is the third largest in the nation. It employs more than three million people. It accounted for more than seven per cent of the gross national product in fiscal 1969-70; that came to more than \$67 billion. The federal government pays almost one third of the total health cost: \$21 billion in fiscal 1971. Without doubt the cost of health care is spiraling upward at a rate that is at once shocking and frightening. Everyone recognizes the problem but real solutions are hard to devise.

The problem of providing satisfactory medical service to all the people of the United States at costs which they can meet is a pressing one. At the present time, many persons do not receive service which is adequate either in quantity or quality, and the costs of service are inequitably distributed. The result is a tremendous amount of preventable physical pain and mental anguish, needless deaths, economic inefficiency and social waste. Furthermore, these

conditions are largely unnecessary. The United States has the economic resources, the organizing ability and the technical experience to solve this problem.

This statement could have been made last week. In point of fact it is taken from the final report of the Committee on the Costs of Medical Care, dated October 31, 1932. The more things change, the more they remain the same.

It is becoming more and more apparent that the legal—that is, governmental—involvement through Medicare, Medicaid and other consumption programs that funnel funds into the present system, helps to fuel the inflation of the costs of health care. Indeed, the system itself, which has a built-in bias toward hospitalization, exacerbates the cost problem.

It is likewise clear that the major governmental force in this area of concern is the national government. Undoubtedly more federal funds will be required to modify and improve the health care system. But those funds may be difficult to obtain given the increasing demands on the federal budget. The states, of course, are in no position at all to make a significant impact on health care costs. It can be said that governmental efforts at controlling costs have been at best counterproductive. When state or federal agencies attempt to curtail benefit payments and investment in facilities to moderate costs they cause a denial of care to the consumer and increase the impact on the purveyors of care. Some 20 per cent of the population is without any health insurance at all; those who have basic insurance may nonetheless experience a catastrophic expense at the onset of lingering serious illness. When insurance or federal benefit payments run out physicians and hospitals are left with uncollectible bills for service already rendered. Today the law permits (indeed, encourages) a mind-boggling assortment of institutions, individuals and entities to offer health care. A complementary and equally bewildering set of government-sponsored programs managed by busy ant colonies of agencies supports these efforts on the local, regional, state and national levels.

The public can do little to influence the public agencies in health matters. Most people who attempt to confront the so-called bureaucracy end up frustrated and angry. Indeed, given the recent trend toward community representation it is probably the case that the consuming public has more access to the policy-makers of the private health institution than to the public or governmental system.

We have yet to see a workable system. It may well be that, given our form of government and our political, social, economic and philosophical frames of reference, we shall never achieve a workable health care system that universally and routinely provides all needed services to the people. It is also conceivable that the alteration of present methods of payment will have little effect on the solution of the equally bewildering unsolved problems involved in raising health standards around the nation. Nor can it be said that solving the cost problem will automatically lead to an increase in quality of care.

It is the case, then, that the legal system has had little positive effect on the cost problem. Indeed, it is responsible in part for the problem. The group practice technique coupled with the prepayment mechanism may be one way to moderate costs. But this will be true, only with a concomitant emphasis on preventive health care, along with rational programs for better utilization of present manpower, more equitable distribution of services, manpower and facilities and use of ambulatory care as opposed to institutional care. As has been indicated there is at the present time a heavy bias in favor of institutionalization. How far the legal system goes in controlling costs will also depend precisely on how high it values such principles as fee-for-service for practitioners and voluntary pluralism and competition that characterizes the health care system today. That question is fundamental.

THE ENFORCEMENT OF QUALITY

There is an accelerating awareness—exemplified in part by the emergency room cases, but manifested in other areas of the

law as well—of the importance of medical care delivered in an institutional setting. It may be useful to place this trend in historical perspective. Changes in law as they affect the physician and the hospital have come about because of the change in the institution and the practitioners. The hospital in its early period was primarily a custodial institution. This was the case up to the first decade of this century. From then until after World War II the hospital was a workshop for the physician. The impact of Hill-Burton and other federal and state construction, expansion and up-grading programs has brought us to the point where, today, the hospital is the primary center for health care. The metamorphosis has been remarkable: from pesthouse for the unclean and undesirable to almshouse for the impoverished or improvident to comprehensive health care center. Just a moment ago in terms of man's recorded history, the hospital was the place where society forced its unwanted to go to die or to languish in unrelenting misery and where only the most dedicated physician practiced his craft. Today, it is the place where everyone goes at the slightest twinge of pain; and what is more, it is the place where physicians practice medicine. The way the law views the hospital and health care is a reflection of changing community views.

Another social trend also has had substantial influence on the manner in which the law now views health care. This might be called the quest for uniformity or equality. The notion—for good or ill—is now quite prevalent that wherever we go in the land we should be able to receive the same kind and quality of service. In a sense this has had a detrimental effect on the unique qualities of some areas of the nation. Think, of the ribbons of concrete, neon and plastic sameness that assault the environment north, east, south and west. But from another point of view the quest has had salutary—if traumatic—consequences. Criminal law, civil rights, consumer protection and voting rights are just a few of the areas in which one or more of the lawmaking branches of government have sought to introduce uniformity of treatment.

In our area of concern—health care—the same notion is at work. It is seen in Medicare and revisions in the welfare system; in regional medical programs and in comprehensive health planning. It is seen also in the recent trend to impose institutional accountability for the quality of care rendered and to remove parochial definitions of quality.

Any number of judicial decisions highlight this important trend. Perhaps the best case to illustrate the increasing focus on institutional responsibility is the famous Darling case. Every so often in the law a case is handed down that has importance beyond the specific, limited holding of the court. Darling vs. Charleston Community Memorial Hospital⁸ is such a case.

The Darling case and its progeny will affect the way in which we look at the operation of hospitals and the persons who perform services within hospitals. In that case, an 18-year-old college student broke his leg playing football. He was taken to the emergency room of the Charleston Community Memorial Hospital on a Saturday afternoon. A cast was applied at the time by the general practitioner who was serving his rotation in the emergency room. Because of an unfortunate complicated series of acts and omissions, the youth's leg had to be amputated 20 cm below the knee. The medical record was clear that there was carelessness on the part of the physician. Indeed, he settled the suit without going to trial. The case before the Illinois Supreme Court was an appeal by the hospital from a jury verdict imposing liability in the amount of \$150,000. The court reviewed the evidence and made several important findings and conclusions.

On the issue of the liability of the hospital's employees, the court found that the nurses were careless in providing skilled nursing care to the patient. They should have looked in upon the boy and ministered to his needs more often than they did. Expert nursing testimony at the trial established the standard of care for nurses in situations of this nature. Moreover, the court said that the hospital could be found liable for the failure of the nurses to call to someone's attention the fact that

the patient was receiving inadequate care from the physician.

What the Darling case says on this point is that the employer—the hospital—continues to be responsible for the acts of its employees and, most importantly, the employees are held to higher standards of care than ever before. The rule of *respondeat superior*, which is the traditional legal requirement that the master be held responsible for the acts of his servants, is most relevant to this discussion. The rule is the same, but the context in which it is invoked and applied has changed. For example, nurses today are expected to know more, and they are charged by the law with duties that require them to do more than ever before.

Thus, one aspect of the Darling case is that as more and more procedures are performed under the aegis of the hospital, and as more and more activities are subject to hospital routine, control and management, the institution will be held responsible. This is so, notwithstanding the fact that the procedure may have been done at the behest of or under the supervision of a physician. In short, the notion of the “borrowed servant” is dying.

The Darling court also dealt with the question of corporate negligence. This is a fast-growing aspect of hospital law. Today, it is almost universally acknowledged that a corporation can, in fact, employ a physician who will practice his profession, although as an employee of a hospital. It is clear that individual physicians or groups of physicians employed by a health care institution will not only be responsible for their own acts but also the institution will likewise be responsible for the acts of those physicians. But another aspect comes from the Darling case. Because the hospital is required by law to render health services and because the hospital, as an institution, is responsible for the quality of care rendered, it has a responsibility to see to it that the care rendered is of quality. That means that the institution must oversee by some mechanism the medical and health care delivered on its premises. It is responsible. Darling tells us that the institution can be liable for its failure

to enforce its own rules, which require that a private practitioner obtain a consultation in certain cases. The language of the court is instructive:

As to consultation, there is no dispute that the hospital failed to review Dr. Alexander's work or require a consultation; the only issue is whether its failure to do so was negligence. On the evidence before it the jury could reasonably have found that it was.

Even the most casual look at the state regulations, at the Standards of the Joint Commission on Accreditation of Hospitals, and at the regulations promulgated by the federal government from various agencies, will show that requirements on hospitals affect the delivery of care by physicians.

Although it is not suggested that private physicians are now considered to be employees of the hospital, the point is nevertheless that more and more the general public looks to the institution as the place where medicine is practiced. The institution is responsible for the selection of physicians to carry out the delivery of medical care within the hospital. The board of trustees has power to decide who shall practice medicine in its walls. That power must be exercised fairly, but with that limitation, it exists. Courts have recognized the power and correlative responsibility of the hospital in this regard. Here is what the Illinois Supreme Court said in a case that occurred some seven years before the Darling case:

Liability might well be made to fall upon the hospital if their personnel or equipment were permitted to be subject to control of one lacking in some of the necessary professional skills. Under such circumstances it is only logical that the institution have the right to safeguard its interest and the public interest as well by exercising direction in the makeup of the medical staff. We conclude, therefore, that the board is vested with regulated discretion in the appointment and reappointment of doctors to the staff, in the exercise of which they have the power to refuse membership on the grounds of both clinical incompetence or failure to abide by reasonable rules, or both.

The court, in *Dayan vs. Wood River Township Hospital*, was dealing with a case involving a recommendation by the medical staff to the board that a physician not be reappointed.⁹ Specific reasons were given, and the physician had an opportunity to dispute the grounds at a full and fair hearing. The court upheld the action of the board in following the recommendation of the medical staff.

Both the hospital and the physician are held to higher standards of care today. The *Darling* case also held that the standard of care by which hospital activities are measured could include pertinent regulations of the state licensing agency, the standards of the Joint Commission on the Accreditation of Hospitals and the hospital's own rules and regulations, as well as evidence of the community practice.

With reference to physicians, the standard of care is growing, too. Again, the rule has not changed; the application has changed. The court said in an early case from Pennsylvania:

The law has no allowance in quackery. It demands qualification in the profession practiced—not extraordinary skill such as belongs only to a few men of rare genius and endowment, but that degree which ordinarily characterizes the profession. And in judging of this degree of skill, in a given case, regard is to be had to the advanced state of the profession at the time. Discoveries in the natural sciences for the last half-century have exerted a sensible influence on all the learned professions, but especially on that of medicine, whose circle of truth has been relatively much enlarged. And besides, there has been a positive progress in that profession resulting from the studies, the experiments, and the diversified practice of its professors. The patient is entitled to the benefit of these increased lights. The physician or surgeon who assumes to exercise the healing art, is bound to be up to the improvements of the day. The standard of ordinary skill is on the advance; and he who would not be found wanting, must apply himself with all diligence to the most accredited sources of knowledge.

In 1853 Judge Woodward, of the Pennsylvania Supreme Court, wrote that opinion in *McCandless vs. McWha*.¹⁰ Interest-

ingly enough, that language accurately sets forth the rule to be applied today. What has been changed over the years is the standard of medical practice. The accomplishments of the present decade show that medicine indeed is more and more a science. As that wide expanse of knowledge grows, the law will expect the physician—specialist or general practitioner—to meet the higher standard that follows higher knowledge.

It has been noted that the life of law has not been logic, nor has it been consistent. This is especially true of health matters although it applies to law generally. The law expresses itself through the governmental agencies. Felt needs are recognized as men and women meet in the legislatures, in the courts and in the executive branches of government to attempt to solve the problems that arise. Certainly, in our system of government, comprising fifty separate independent states and a separate federal system, it is possible for each of the states to take a somewhat different view or position on any particular matter. Compound this with the further division of government into three separate and ostensibly coequal branches, and it will be seen that a necessary amount of inconsistency and confusion exists in the growth of the law. But the law is constantly reforming itself, modifying itself and being changed. The nation is growing, and its communications are becoming more and more sophisticated. The current trend, noted earlier, is toward standardization or uniformity. The way we travel, the houses we live in, the food we eat and all aspects of our life, including health, are standardized. Some effort at standardization is being made by the Joint Commission on Accreditation of Hospitals. A similar attempt is being made by the Department of Health, Education and Welfare, with its "Conditions of Participation in Medicare." It is seen in the courts and the acceptance by some courts, at least, of the notion that physicians should be aware of the current state of the art of their particular specialties wherever they practice. The courts are beginning to apply a national standard to the practice of medicine. Two cases point this out.

In *Brune vs. Belinkoff*¹¹ the Massachusetts Supreme Judicial Court held, in effect, that a physician specializing in anesthesiology in New Bedford, Massachusetts, could be held to the standard of practice enunciated by physicians in Boston for the amount of medication to be given to a patient after a particular procedure. The court overturned a rule it had pronounced 80 years earlier, which essentially held that a physician would be measured by the standard of practice on his local community.

Eighty years later, the plaintiff in *Brune vs. Belinkoff* contended that the distinctions based on geography are no longer valid in view of modern developments in transportation, communication and medical education, all of which tend to promote a certain degree of standardization within the profession. The court after reviewing the cases at some length agreed:

We are of the opinion that the locality rule of *Small vs. Howard* which measures a physician's conduct by the standards of other doctors in similar communities is unsuited to present day conditions. The time has come when the medical profession should no longer be balkanized by the application of varying geographic standards in malpractice cases. . . . The present case affords a good illustration of the inappropriateness of the locality rule to existing conditions. The defendant was a specialist practicing in New Bedford, a city of 100,000, which is slightly more than fifty miles from Boston, one of the medical centers of the nation, if not the world. This is a far cry from the country doctor in *Small vs. Howard* who eighty years ago was called upon to perform difficult surgery.

A recent case from Michigan also points out a change in the rule applicable to specialists to make them duty bound to apply the degree of skill possessed by the reasonably prudent specialists practicing that specialty, taking into account the state of the art. The case was *Naccarato vs. Grob*.¹² The plaintiff in this case brought suit against two Detroit-area pediatricians claiming that they were liable for malpractice in failing to make a timely diagnosis of phenylketonuria (PKU). The jury brought in a verdict for the plaintiff, which was overturned by the trial court. On appeal, the question was whether the trial court was

correct in setting aside the jury verdict on the grounds that two of the plaintiff's expert witnesses were not competent to testify because they were not from the Detroit area. Without their testimony the trial judge thought the verdict could not stand. The two expert witnesses were world-renowned experts on PKU. They did not express competence to testify about their familiarity with the practice of Detroit-area specialists. They did testify to the dissemination of knowledge of PKU throughout the nation and the standard of care that should have been employed by physicians in communities similar to Detroit, where large medical centers were located. They also testified that board-certified pediatricians in evaluating a mentally retarded child would have included a test for PKU.

The issue before the Supreme Court of Michigan was whether the trial court was correct in rejecting the testimony of experts who were not familiar with the practice of Detroit-area board-certified pediatricians. The court held that the trial court was in error. Essentially, the Supreme Court of Michigan held that the specialist in an urban setting is measured by a national standard:

The reliance of the public upon the skills of a specialist and the wealth and sources of his knowledge are not limited to the geographic area in which he practices. Rather his knowledge is a specialty. He specializes so that he may keep abreast. Any other standard for a specialist would negate the fundamental expectations and purpose of a specialty. The standard of care for a specialist should be that of a reasonable specialist practicing medicine in the light of present day scientific knowledge. Therefore, geographical conditions or circumstances control neither the standard of a specialist's care nor competence of an expert's testimony.

We can generalize from the cases that signal demise of the locality rule. It is clear that expert witnesses will be easier to obtain, and they—at least the specialists—will come from various parts of the country. There is growing judicial recognition that the standard for the general practitioner should also be raised. The standard itself is continuing to be raised as more and more

knowledge becomes available and as training in new techniques and skill becomes available in postgraduate courses for physicians. It is interesting that one of the Joint Commission standards relating to medical staff is a standard on continuing education. Hospital-based practice grows increasingly important precisely because the educative nature of the peer-review process will itself give rise to a dissemination of information and a transfer of experience and training that is so vital to the continuing competence of medical practitioners today. Finally, the public today has more access to the technical information about medicine. Patients are more sophisticated about it, and they know that they should receive quality care no matter where they reside in the nation.

One can predict that the law, whether through the courts in malpractice and negligence litigation, or through public and private agencies by means of administrative regulations, will have very much to say specifically about the measurement of quality. However, it can also be predicted that the impact of these pronouncements will not be evenly felt across the country. Nevertheless, the standard of care will rise and as a consequence so will the measurement of quality of care.

SUMMARY AND CONCLUSIONS

Can the legal system bring about a planned, comprehensive health care program that meets the currently felt and specifically articulated needs for access, reasonable costs and quality? The answer, in the judgment of this writer, is probably not. Our system and our philosophy cannot tolerate such an intrusion. Moreover, the division of powers is too complex in the health care field among executive agencies and legislative bodies, among the profitmaking and nonprofit institutions, among the professional individuals and their organizations, among medical schools and schools of public health, among the manufacturers and suppliers of equipment and health commodities, among the public and private insurers. Focusing on the fed-

eral government for a moment, we see a fragmentation—a balkanization—of the executive branch that is reflected in the Congress itself. The attempt to bring about an orderly, coordinated, orchestrated system must inevitably impinge on special interests that abound at every level. Consolidations will be necessary, but the special interests will be loath to relinquish what has come to be thought of as long held and cherished. Federal activity will inevitably conflict with the multiplicity of private interests and with state administrative mechanisms.

Yet, fundamental changes will be wrought in the delivery system brought about primarily by the insuring-manufacturing-supplying sectors of the health care industry. In the years to come these sectors will have more influence, more power, more effective impact on final decisions by government than any organized (or unorganized) consumer groups. It is likely to be the case that the health industrialists will also wield more influence than organized medicine, the schools of medicine and public health and the hospitals combined.

This potential turn of events does not elicit a great deal of concern. Indeed it has become somewhat fashionable to look to the profit system (and profit-oriented health industry) to point the way out of the crisis and lead us into a promised land of service, efficiency, reasonable cost, quality and profit. This viewpoint would have us believe that all the health care institutions need is a solid dose of hard-headed business management thinking with infusions of profit motive. It can be a compelling argument especially to the law givers who probably are accustomed to working with business and industry to solve essentially social problems. This in fact involves more mysticism and leaps of faith but of a different variety. We are quite used to masking our particular brands of magic in statistics and seemingly logical equations.

And thus we come back to where we began. The law has a most important role to play in health care. Whatever position the law takes will be important. The decision to adopt a “hands-off” policy is just as important a decision as the one to

get involved. The law—again defining that to include the diverse collection of statutes, judicial decisions and administrative pronouncements of all kinds—will be influenced by the felt needs of the times. But felt needs are one thing and responding to them is quite another.

It is one thing to articulate a social plan and design the improvement on paper, it is quite another to implement it and make it work. We have learned in race relations, environmental pollution, urban affairs and in a number of other areas of social, economic and political concern, that the law can point to change, but it alone is rarely capable of transforming entrenched institutions, systems and mythologies that act as operational hypotheses for action.

We conclude that the law will continue to play an important role in health care. The influence of the law will in fact grow. But it will still maintain a posture that at once supports, inhibits and is indifferent to health care needs.

REFERENCES

- ¹ New York Public Health Law, Article 28, sections 2800 through 2805.
- ² Illinois Public Health Law, Ill. Stat. Ann., Chap. 111½. Sec. 86 through 87.
- ³ California Health and Safety Code. Sec. 1407.5.
- ⁴ *Cook v Ochsner Foundation Hospital*, 319 F.Supp. 603 (E.D.La. 1970).
- ⁵ See *Euresti v Stenner*, 327 F.Supp. 111 (D.C. Colo. 1971), rev'd U.S. Ct. App. 10th Cir. No. 71-1393 (Mar. 28, 1972).
- ⁶ 174 A 2d 135 (Del. 1961).
- ⁷ See *O'Neill v Montefiore Hospital*, 202 N.Y. Supp. 2d 436, (N.Y. App. 1960); *New Biloxi Hospital v Frazier*, 146 So. 2d 882, (Miss. 1962); *Methodist Hospital v Ball*, 362 S.W. 2d 475 (Tenn. 1961); *Bourgeois v Dade County*, 99 So. 2d 575, (Fla. 1957); *Barcia v Society of New York Hospital*, 241 N.Y. Supp. 2d 373 (N.Y. Trial Ct. 1963).
- ⁸ 211 N.E. 2d 263 (Ill. 1965).
- ⁹ 152 N.E. 2d 205 (Ill. 1958).
- ¹⁰ 22 Pa 261 (1853).
- ¹¹ 235 N.E. 2d 793 (Mass. 1968).
- ¹² 180 N.W. 2d 788 (Mich. 1970).