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# New Developments in Health Care

*Harold L. Hirsch\**

This issue represents a potpourri of articles dealing with health care matters. Nevertheless, the articles do have a common theme: what's new in the various aspects of health care delivery and law.

Two of the articles deal with ensuring the quality of care patients receive by means of quality assurance. One aspect of quality assurance is minimizing, ideally even eliminating, patient injury. This is a form of risk management. Conceived a decade ago, the concept of "risk control" or "risk management" was believed to be the key element in the prevention of loss from adverse medical incidents. Risk management is the linchpin that links every quality assurance program with measurable outcomes necessary to determine overall effectiveness.

Risk management may be defined as a detection system designed to predict when the next person-failure will occur and to prevent it from happening. It is a program proposed to alleviate and control both patient injury and hospital liability problems. Effectiveness in risk management means successfully reducing patient injury by controlling exposures to risk. It also means reducing insurance costs by demonstrating the ability to identify potential loss in faulty health care planning and delivery, in addition to lowering claims frequency and severity.

A risk management program cannot eliminate every risk. Many patient care activities, even if performed in the most careful manner, are inherently risky and sometimes result in harm to the patient. Even when harm occurs, liability usually does not result if the patient was informed adequately of the risk and if he or she consented to the performance of the procedure. A risk management program can prevent liability by detecting carelessness before serious harm occurs. Experience shows that liability suits are often preceded by a clearly identifiable trail of substandard performance or behavioral aberration. If it is detected and corrected in time through a risk management program, serious harm to patients can be prevented.

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One of the focuses of risk management in striving for standards of reasonable care is to ensure that precautions will be taken to avert substantial harm. Imposing a legal responsibility to take precautions implies that the responsible party has the ability to implement the precautions. On the other hand, the precautions cannot be such that they involve too great a sacrifice of other respectable professional and legal interests. Given the present state of the law, attempts by health care providers to take necessary precautions may conflict with legal restraints.

The goal of risk management is two-fold: first, to improve safety in patient care; and second, to protect business assets by reducing the potential for loss. The achievement of these goals requires the dedication and cooperation of all professionals, from the smallest independent unit to the largest associations and organizations in the medical profession, in building a risk management program to which all must be committed. Such a program includes four basic steps:

- (1) Identifying all known risks;
- (2) Measuring and clarifying the potential impact of the known risks;
- (3) Developing a program to treat each risk; and
- (4) Establishing a system to monitor and control the results.

To be effective, such a program requires that a medi-alert network be established for rapid communication, evaluation, and dissemination of information from a central clearinghouse to health care providers in remote patient care settings.

As participants in risk management quality assurance programs, physicians are not strangers to review activity. The hospital medical staff traditionally has been charged with the responsibility for the quality of care rendered to hospital patients and with evaluating this care by determining whether diagnoses, courses of treatment, and results were warranted. Now, it is the primary responsibility of the board of trustees which has the responsibility and duty to establish appropriate rules and regulations. Physicians, however, have a collective responsibility for establishing standards and for taking appropriate action when substandard care is discovered. All of these activities are designed to identify and correct problems that prevent patients from receiving the best possible care. Many of the problems physicians identify in this review process can be traced to deficiencies in the facility, its equipment, or the way care is organized and delivered. Other problems, however, can be traced to "people failure" — to the fact that a physi-

cian or other health care provider lacks the knowledge, skill, or proper attitude necessary for optimal performance.

Doctors are people. Once that premise is accepted, it follows that doctors will make mistakes. Good medical judgment is a difficult thing to evaluate. Many bright physicians and other providers with excellent training and a good fund of medical knowledge cannot collate this knowledge into a workable quality system of patient care. How can one evaluate this immensely important flaw in a practicing physician? How can one develop remedial methods or weed out the uneducable ones in this category when evaluations from attending physicians focus only on the wealth of knowledge, the regular attendance, and the overwhelming interest? A good quality assurance and risk management program can accomplish this through quality assurance reviews and risk control measures.

Malpractice has been and is the bane of the health care provider's existence. There have been a variety of methods employed, particularly by the legislatures, to help relieve the malpractice crisis, but to no avail. Experience and studies have shown that the best way to curb malpractice is by prevention — prophylaxis beats malpractice. Over the last decade, the concept of quality assurance has been advocated to accomplish these purposes. To that end, programs of risk management have evolved with good results in improving the quality of patient care in conjunction with a decrease in patient injury and subsequent claims and malpractice lawsuits.

Physicians are not the only health care providers who are interested in the quality of care delivered. The state legislatures and Congress have been involved actively with the delivery of health care in the United States. The federal government has implemented two fundamentally different approaches for containing health care costs: competition and regulation. Under the Diagnostic Related Groups ("DRGs") for Medicare recipients, a prospective payment reimbursement system, the federal and state governments are revolutionizing the hospitals' financial, economic, and administrative functions and activities. Through the utilization of DRGs, Medicare reimbursement to hospitals is based on a predetermined, fixed payment governed primarily by the patient's diagnosis, rather than actual services needed or performed, or time spent in the hospital. Each patient is assigned to a DRG category on the basis of age, sex, discharge status, procedures, and diagnosis or diagnoses. The same reimbursement for an illness generally will be made whether the patient is hospitalized for seven days or for

fifteen days. Expansion of the DRG system to outpatient care is currently under consideration.

Another method of controlling the delivery of health care and its costs is through greater scrutiny and improved control over state licensure statutes and regulations. The licensing and regulatory boards have greater power and now require continuing education for re-licensure. Disciplinary statutes and licensing procedures have become the subjects of increasing litigation. Such proceedings reflect a desire on the part of the state and the public at large to improve health care and to reduce malpractice litigation by reducing health care practitioner malpractice. Re-examination of the physician on a continuing basis is an attempt by the state to reduce the risk of malpractice to the public and to improve care to the patient.

Malpractice litigation has resulted in an increase in hospital liability for the negligence of physicians, nurses, administrators, and other professionals who are expected to make judgments regarding the diagnosis and treatment of patients. The hospital may establish procedures and directives as to how non-physician employees are to perform their jobs and exercise their responsibilities. Potentially, the hospital could exercise essentially complete control over its employees if it is to be held accountable for their negligence. The recent discarding of the "captain of the ship" and "lent-borrowed servant" doctrines in many states is ample evidence of the trend toward finding hospitals liable for the negligent conduct of professionals associated with the hospital. This trend recognizes the reality of the modern hospital as an integrated medical service organization in which the participants have overlapping functions and responsibilities.

This trend of expanding hospital liability has further eroded the physician-hospital relationship. Hospital liability for negligent supervision and selection of medical staff members suggests that hospitals have sufficient discretion with regard to selection, limitation of privileges, and dismissal to enable them effectively to maintain staff quality. Hospitals should be capable of exercising this discretion, despite the existence of certain legal precedents that would seem to limit it. As a general rule, hospitals have a great deal of discretion with regard to selecting, monitoring, and supervising medical staff, as long as the authority is exercised in a reasonable manner and pursuant to procedural due process protection. In several recent cases, courts have held that hospitals must have a great amount of discretion in admitting physicians to staff mem-

bership because of potential liability. Supervision of attending physicians, even though they are independent contractors, places the hospital in a delicate situation. Hospitals are prohibited from exercising dictatorial control over the physician's practice of medicine in the hospital. The hospital, however, may maintain control over the quality of practice of these physicians through the medical staff quality review and evaluation procedures committee, which is responsible to the hospital's board of trustees.

Basic to American jurisprudence is the principle that although a health care provider is not an insurer or guarantor of results, the provider has a fiduciary relationship with the patient. The tort of medical negligence generally can be invoked only if the health care provider deviates from the accepted standard of care established by the provider's peers. This philosophy is changing. The law is subjecting health care providers to greater scrutiny and broader liability. One reason is that courts continually are confronted with technological and scientific developments that pose previously unthought-of issues of accountability for the health care provider. Another reason for the changing interpretation of the law is that public policy is changing.

The law generally is not static, rather it is highly dynamic. This is particularly true when it comes to health care law, because the role of health care has changed radically. Over the past twenty-five years, there literally has been a revolution in health care delivery and the law that governs it. To that end, courts have created a number of legal doctrines to implement this new philosophy. In addition, the courts have expanded old causes of action, as well as creating new theories. Concomitant with these expanded legal doctrines, the courts have extended the law of evidence and increased the scope of damages. One of the areas of change in the law of evidence is the access of the parties to demonstrative evidence and potential witnesses, such as treating physicians.

The courts are now declaring that physicians have a duty not only to their patients, but also to third parties who may be strangers. The physician has a duty to control or warn certain persons when his patient is dangerous to himself or others, even when the warning breaches the patient's right to privacy. The courts have ruled that when a duty of confidentiality conflicts with the public's need to know and when public safety and welfare are imperiled, confidentiality must yield to the public good. True privacy and confidentiality, except when there is danger to the public and to those immediately involved in the patient's care, require that no

one can expose the patient, his record, or a photograph for investigational or educational purposes without his express consent.

The law has imposed a duty on all physicians to be aware of changing concepts and new developments. Keeping up can be accomplished by reading current medical literature and attending scientific meetings or continuing education programs. It is not the physician's duty to implement new techniques merely because they are new; the technique's usefulness must reasonably be established. Nevertheless, a physician who is ignorant of recent developments that are known to and accepted by the profession may be liable if the use of an outmoded method results in harm to the patient.

When the attending physician knows that diagnostic consultation with another physician would benefit the patient, he has the duty to refer the patient to the specialist. Whether the physician's equipment or facilities are adequate or whether he has the requisite trained assistants are other determinants in referral or consultation considerations. If either or both of these necessities are unavailable, seeking appropriate medical consultation becomes mandatory.

Although the physician may be held liable for doing too little too late, there is another aspect to this medicolegal equation: the physician may be held liable for doing too much, and liability may be imposed for harm caused by overreacting. It may appear that the physician is damned if he does and damned if he does not, but in some instances he is best advised to do nothing. Such errors or mistakes in judgment are not negligence, but merely human frailty.

The legal doctrine of strict product liability — liability without established fault — has encompassed both the drug and the medical device industries, and now encompasses health care providers. Physicians are responsible for the safety and efficacy of the medications, materials, and devices that are used in the facility where care is rendered. Once a drug or device is distributed, it is incumbent on treating health care providers, in applying their professional judgment, to balance expected results against potential harmful effects. Using the information received from the manufacturer and other recognized medical sources, the health care provider is required to inform the patient of those reasonably foreseeable dangers inherent in the particular circumstances. In exercising this professional judgment, the physician may withhold information of the inherent dangers which, in his professional discretion, will jeopardize the patient if the patient acquires such knowledge in the particular circumstances.

Patients have a right not only to give "informed consent," but

also to indicate "informed refusal." The physician must issue a discrete warning as to perils, pitfalls, and potential harm of not complying with recommended diagnostic or therapeutic modalities. The health care provider must now, at least, "lead the patient to the water." In recent times, as the concept of patients' rights has evolved, the patient's wishes have become paramount. The patient's right to dignity is never more critical than when he or she is dying. The law recognizes that a competent patient may elect to refuse treatment when the treatment will merely prolong dying, that is, when death is inevitable. In the development of the right-to-die concept, courts have suggested that a competent adult who is terminally ill and whose death will occur by natural consequences in a fairly short time, has options as to the extent of care he or she will receive. If of lucid mind, the patient may refuse treatment. Even a patient who is not necessarily terminal has the right to reject life-saving therapy and invite his or her death.

Individual freedom of choice and control over one's life and body are personal prerogatives recognized by the judiciary. Courts generally accept the patient's directives and enforce them when they have been challenged. On rare occasions, for socioeconomic reasons, particularly when the public may incur responsibilities, the courts have rejected the patient's wishes and have imposed treatment. If the patient is incompetent, the next of kin may stand in the shoes of the patient and make the election. In anticipation of that situation, and in an effort to obviate the patient's uncertainties and the anxieties of the next of kin and health care providers, the law generally allows the competent person to impose his wishes at an earlier time. A number of states have codified this right by statute, which has been designated "natural death" or "living will" or by means of the "durable power of attorney."

The right of a patient to refuse treatment is so formidable that several health care providers have been sued for invasion of privacy by the patient's legal survivors for failure to heed the patient's request to discontinue treatment, even in jurisdictions without "right to die" statutes. If the patient is competent and asks for the cessation of life-support equipment (or in the case of an incompetent patient, the next of kin so requests), the physician should comply. If the physician feels uncomfortable with that decision, he should withdraw from the case after allowing the patient or next of kin an opportunity to select a new physician. In some states this is not possible, and treatment may not be discontinued for an incompetent patient without the approval of a proper court.

What of the right to end one's life by not taking nourishment, food, and water? Surely, if a competent but very ill person wishes to starve to death at home, no court could order him to eat. Even healthy young people are known to diet themselves to death. The matter takes on a different complexion when the patient is in a health care institution and demands not only that he be spared therapy, but that he not be fed. Do physicians and institutions have to stand aside and allow a patient to starve to death? Does it make a difference whether the patient is mortally ill, very old, or incapacitated? These questions have reached lower courts for the first time only recently and with mixed results, but the majority have accepted the right to refuse nourishment.