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SYMPOSIUM: CURRENT DEVELOPMENTS IN HEALTH LAW

The Changing Perception of the Hospital: A Prescription for Survival

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Hospitals in this country have traditionally been viewed as providing some of the most basic services to a community. A community, while it may have had certain industries, certain stores, certain other things, had, if it was a mature community, a fire department, a police department, a school, and very often, a hospital. These latter four services were perceived as permanent, a quality which was not readily associated with ordinary businesses. However, at least with respect to hospitals, permanence can no longer be taken for granted.

Hospitals have begun to feel the pressures of the changing na-

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ture of our economy, the changing lifestyles of our people, and changes in medical and hospital care itself. The hospital is changing today as rapidly as any other facet of American life. It is no longer appropriate to think of the hospital as a permanent fixture in the community—simply a *place* to go if care was needed. Rather, it must be viewed in a much more dynamic way, as a *thing*, with a collective, changing life of its own. This requires an almost subliminal change in the way in which physicians, trustees, management and the public at large think of the hospital corporation. Unfortunately, long after reality would indicate otherwise, the idea that the hospital is just a place is often central to the thinking of those vital to its survival.

Although change has occurred with increasing rapidity in recent years, the transformation of the hospital did not occur overnight. Prior to World War II, the hospital primarily existed as a place where extremely sick or severely injured people could be kept comfortable; little could be done for them except to let nature take its course. However, the military uses of hospitals in World War II changed the hospital.

Shortly following the end of the war, the first major federal program aimed at rebuilding and modernizing hospitals was instituted: the Hill-Burton program.[1] This program provided federal financial assistance in the form of loans and grants for construction and renovation of hospitals throughout the country. One of the requirements for receipt of Hill-Burton funds in individual states was the adoption of a comprehensive system of hospital licensure regulation.[2] Even though largely concerned with construction and safety standards, these licensure laws were built on the premise that hospitals as *institutions* had specific duties and responsibilities with respect to their patients and the public at large. They were no longer only *places* where doctors sent their patients.

During the 1950s and 1960s, fundamental changes in the law of negligence as it applied to health care facilities underscored the concept of institutional responsibility. Prior to this time, the courts recognized what was known as the "charitable immunity doctrine," which held that all charitable organizations, including hospitals, were immune from liability except in certain extreme situations. However, by the late 1960s, courts in virtually every jurisdiction

1. Hospital Survey and Construction Act of 1946, Pub. L. No. 79-725, 60 Stat. 1040 (codified as amended at 42 U.S.C. §§ 291-291o-1 (1982)).

2. 42 U.S.C. § 291c (1982).

had rejected this doctrine.[3] This development substantially increased the potential liability of nonprofit community hospitals as corporations.

The demise of charitable immunity coincided with the emergence of the doctrine of hospital corporate liability. While a handful of judicial decisions had previously recognized that hospitals had some institutional responsibility toward their patients,[4] the case of *Darling v. Charleston Community Hospital*,[5] and those that followed, made it clear that hospitals had an independent corporate responsibility to patients to monitor the quality of medical care rendered by physicians appointed to their medical staffs.[6]

Perhaps the most fundamental change to affect the health care field since World War II was the passage of the Medicare and Medicaid programs,[7] a conscious decision on the part of American society to underwrite care for the elderly and the poor. Because the elderly and the poor have historically required the greatest amount

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3. Heimbuch v. Resident & Directors of Georgetown College, 251 F. Supp. 614 (D.D.C. 1966); Ray v. Tucson Medical Center, 72 Ariz. 22, 230 P.2d 220 (1951); Malloy v. Fong, 37 Cal. 2d 356, 232 P.2d 241 (1951); Bell v. The Presbytery of Boise, 91 Idaho 374, 421 P.2d 745 (1966); Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966); Harris v. The Young Women's Christian Ass'n of Terra Haute, 250 Ind. 491, 237 N.E.2d 242 (1968); Haynes v. Presbyterian Hosp. Ass'n, 241 Iowa 1269, 45 N.W.2d 151 (1950); Noel v. Menninger Found., 175 Kan. 751, 267 P.2d 934 (1954); Mullikin v. Jewish Hosp. Ass'n of Louisville, 348 S.W.2d 930 (Ky. 1961); Garlington v. Kingsley, 289 So. 2d 88 (La. 1974); Colby v. Carney Hosp., 356 Mass. 527, 254 N.E.2d 407 (1969); Parker v. Port Huron Hosp., 361 Mich. 1, 105 N.W.2d 1 (1960); Abernathy v. Sisters of St. Mary's, 446 S.W.2d 599 (Mo. 1969); Myers v. Drozda, 180 Neb. 183, 141 N.W.2d 852 (1966); Collopy v. Newark Eye & Ear Infirmary, 27 N.J. 29, 141 A.2d 276 (1958); Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957); Avellone v. St. John's Hosp., 165 Ohio St. 467, 135 N.E.2d 410 (1956); Hungerford v. Portland Sanitarium & Benevolent Ass'n, 235 Or. 412, 384 P.2d 1009 (1963); Flagiello v. Pennsylvania Hosp., 417 Pa. 486, 208 A.2d 193 (1965); Villarreal v. Santa Rosa Medical Center, 443 S.W.2d 622 (Tex. Civ. App. 1969); Purcell v. Mary Washington Hosp. Ass'n, Inc., 217 Va. 776, 232 S.E.2d 902 (1977); Friend v. Cove Methodist Church, Inc., 65 Wash. 174, 396 P.2d 546 (1964); Adkins v. St. Francis Hosp., 149 W. Va. 705, 143 S.E.2d 154 (1965); Kojis v. Doctors Hosp., 12 Wis. 2d 367, 107 N.W.2d 292 (1961).

4. *See, e.g.*, Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957).

5. 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966).

6. *See, e.g.*, Ludlam, *The Impact of the Darling Decision upon the Practice of Medicine and Hospitals*, 11 FORUM 756 (1976); Moore, *Medical Staff-Corporate Accountability*, 43 INS. COUNSEL J. 110 (1976); Springer, *The Darling Case: Ten Years Later*, HOSPITAL MED. STAFF 1 (June 1975); Comment, *The Hospital and the Staff Physician—An Expanding Duty of Care*, 7 CREIGHTON L. REV. 249 (1974); Comment, *The Hospital-Physician Relationship: Hospital Responsibility for Malpractice of Physicians*, 50 WASH. L. REV. 385 (1975).

7. Social Security Act, Pub. L. No. 89-97, 79 Stat. 285 (codified as amended at 42 U.S.C. §§ 1395-1395zz (1982 & Supp. I 1983) (Medicare) and 42 U.S.C. §§ 1396-1396zz (1982 & Supp. I 1983) (Medicaid)).

of health care services, the industry realized tremendous growth. With certainty of payment, both providers of care and the firms that supplied them with goods and services became big businesses almost overnight.

Other trends in society during the 1960s had a profound influence on the health care field. One example is the civil rights movement. Prior to the civil rights movement, many hospitals in the South had segregationist policies with respect to accommodation of patients and medical staff appointment. A number of judicial decisions beginning in the early 1960s struck down these restrictions.[8] Most importantly with regard to medical staff appointment, the legal theories of due process upon which those cases were based formed the groundwork for suits by other physicians who were denied medical staff appointment for reasons totally unrelated to racial segregation. As a result, the previously collegial and benign relationship between certain physicians and hospitals often assumed adversarial and legalistic overtones. The feminist and consumer movements of the 1960s and 1970s influenced the health care field in more intangible ways. Female nurses and physicians became less willing to accept without question male authority in the health care field; patients, more aware of their rights as consumers, placed even more demands upon hospitals and physicians.

By the mid-1970s, the health care industry was again faced with fundamental change and upheaval, this time due to the application of the antitrust laws. In the case of *Hospital Building Company v. Trustees of Rex Hospital*,[9] the United States Supreme Court for the first time recognized that hospitals were engaged in interstate commerce and thereby subject to the Sherman Act. With the concurrent demise of the "learned profession" exemption to the antitrust laws one year earlier,[10] doctors were no longer shielded from antitrust scrutiny. As a result of these developments, hospitals and other health care providers have, for the last ten years, been faced with an explosion of suits alleging antitrust violations, as well as increased scrutiny from regulatory agencies, such as the Federal Trade Commission, charged with enforcement of those laws. In addition, more recent antitrust cases, such as *Jefferson Parish Hos-*

8. *See, e.g.*, Cypress v. Newport News General and Non-Sectarian Hosp. Ass'n, 375 F.2d 648 (4th Cir. 1967); Simkins v. Moses H. Cone Memorial Hosp., 323 F.2d 959 (4th Cir. 1963), *cert. denied*, 376 U.S. 938 (1964).

9. 425 U.S. 738 (1976), *reh'g denied*, 104 S. Ct. 512 (1983).

10. *See* Goldfarb v. Virginia State Bar, 421 U.S. 773, *reh'g denied*, 423 U.S. 886 (1975).

pital District No. 1 v. Hyde,[11] have made it clear that health care providers will be treated like any other business and accorded no special status simply because they are involved in health care.

It is important to note that, in one of these antitrust cases,[12] the Supreme Court recognized that hospitals had developed into something more than way stations for the ill and injured:

> Some hospitals, indeed, truly have become centers for the "delivery" of health care. The nonprofit hospital no longer is a receiving facility only for the bedridden, the surgical patient, and the critical emergency. It has become a place where the community is readily inclined to turn, and —because of increasing costs, physician specialization, shortage of general practitioners, and other factors—is often compelled to turn, whenever a medical problem of import presents itself. The emergency room has become a facility for all who need it and it no longer is restricted to cases previously authorized by members of the staff. And patients that not long ago required bed care are often now treated on an ambulatory and outpatient basis.[13]

The passage of the Tax Equity and Fiscal Responsibility Act of 1982[14] (TEFRA) and the provisions therein aimed at "reforming" the Medicare program represents still another stage in the dramatic transformation of the hospital environment. As a result of that law, as well as subsequent changes to the Social Security Act adopted in 1983,[15] the Medicare reimbursement system was changed from one that reimbursed hospitals on the basis of the costs they incurred in providing services, to a system of "prospective payment" based on a number of artificially derived price formulas known as diagnostic related groups or "DRGs." Many private third party payors quickly followed suit with similar programs.

Under prospective payment (PPS), hospitals receive no more than the predetermined DRG amount from the Medicare program, regardless of the actual costs involved. This program places responsibility for fiscal decisions clearly on the shoulders of the institution rather than the government. The result of PPS is a health care environment that is highly competitive, but one which operates within a framework of a government administered price struc-

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11. 104 S. Ct. 1551 (1984).

12. Abbott Laboratories v. Portland Retail Druggists Ass'n, 425 U.S. 1 (1975).

13. *Id.* at 11.

14. Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, 96 Stat. 324 (codified as amended in scattered sections of 26 U.S.C.).

15. Social Security Act, Pub. L. No. 89-97, 79 Stat. 285 (codified as amended at 42 U.S.C. § 1320b-5 (1982)). The regulations promulgated pursuant to this statute may be found at 42 C.F.R. §§ 405.470-405.477 (1983).

ture. In short, as with many other businesses, health care has become a combination of regulation and competition.

Among the other changes wrought by TEFRA has been the new "Competitive Medical Plan" program for Medicare beneficiaries authorized by section 114 of the Act.[16] This program allows health maintenance organizations (HMOs), hospital health plans (HHPs), and competitive medical plans (CMPs) to provide care to Medicare beneficiaries in return for fixed payments from the government. Under the program's implementing regulations,[17] HMOs, HHPs and CMPs assume responsibility for administering to all the health needs of Medicare beneficiaries in their service areas. This program, coupled with increased pressure from the business community to keep its group health costs down, has resulted in an explosion of alternative delivery systems for all segments of the population. These systems are now vying with traditional providers and payors for center stage in the health care market and control of the health care dollar.

Another significant development we are witnessing today is a renewed attempt to control the quality of medical care on the part of state licensing bodies. Licensing of professionals was originally designed to negate charges that frauds and charlatans were practicing medicine and other healing arts on the basis of very minimal credentials. Shortly after the turn of the century, a whole panoply of licensing requirements for physicians and others in the health care field were adopted by states in response to this perception. By the 1960s, however, the licensing of health care professionals that had once been considered so innovative would be viewed as a mere formality predicate to entry into the profession. There was virtually no *continuing* evaluation of the competence of health care professions by state licensing boards. Instead, that burden was and continues to be almost completely assumed by the hospitals which grant physicians clinical privileges.

Court decisions in the 1960s and 1970s placed much of the responsibility for ongoing credentialling and for the quality of physician practice on hospitals.[18] While this largely remains true today, state licensing boards have been revived in the sense of requiring hospitals to come forward and report to state medical licensing boards actions they have taken with respect to medical staff ap-

16. 42 U.S.C. § 1395mm.
17. 50 Fed. Reg. 1314 (1985) (to be codified at 42 C.F.R. § 417).
18. *See supra* note 6.

pointment and clinical privileges.[19] Thus far, however, action on the part of state boards in response to such reports *remains* more potential than actual.

This development may, nevertheless, have two effects on hospitals in the future. One is that the state licensing boards will take a larger role in the disciplinary regulation of physicians and others. The second, almost as a corollary to the first, is that the hospital will take a lesser role. The mere fact that a hospital must report disciplinary actions to a state board may tie the hands of the hospital process politically until the need for taking action becomes so great that the only thing that can be done is to terminate the individual's ability to practice in the hospital. The tension between the need to report and the need of the hospital to evaluate and act independently has not in any way been alleviated. What this development does signal is a change in the perception of society as to the need for examining the continuing abilities of the individuals who practice the healing arts within institutions. To a large degree, this perception has focused on the key institution in the health care environment—the hospital.

Thus, as can be seen from this brief discussion, a number of trends and developments have come together that lead to one inescapable conclusion: the modern hospital is much more than just a place. Today, a hospital provides numerous services that are not traditional in nature and that do not take place in the traditional hospital building, although they may take place nearby. Significant change began when physicians' offices were grouped at one location, perhaps a hospital medical building, or a group practice

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19. *See, e.g.*, ALA. CODE § 34-24-59, -360 and -361 (1985); ALASKA STAT. § 08.64.336 (1984); ARIZ. REV. STAT. ANN. § 32-1451 (1985 Supp.); ARK. STAT. ANN. § 72-634 and -637 (1979); CAL. BUS. & PROF. CODE § 805 (West Supp. 1986); COLO. REV. STAT. § 12-36-117 to -118 (1985); CONN. GEN. STAT. ANN. § 20-13(c)-(e) (West Supp. 1985); DEL. CODE ANN. tit. 24 § 1728 and 1731 (1981); D.C. CODE ANN. § 32-1308 and § 2-1326 (1985 Supp.); FLA. STAT. ANN. § 458.331 (West 1981); GA. CODE ANN. § 31-7-8 (1985); HAW. REV. STAT. § 663-1.7 (1976); IDAHO CODE § 54-1831 (1979); ILL. STAT. ANN. ch. 111 §4437 (Smith-Hurd Supp. 1985); IOWA CODE ANN. § 258A (West Supp. 1985); KAN. STAT. ANN. § 65-28 (1980); KY. REV. STAT. ANN. § 311.595 (Baldwin 1985); ME. REV. STAT. ANN. tit. 24 § 2504 (1985 Supp.); MD. HEALTH OCC. CODE ANN. § 14-504 (1981); MASS. GEN. LAWS ANN. ch. 111 § 53B (West 1983); MINN. STAT. ANN. § 147.23 (West Supp. 1985); MISS. CODE ANN. § 73-25-81 (1985 Supp.); NEV. REV. STAT. § 630.012 (1979); N.H. REV. STAT. ANN. § 329.17 (1984); N.J. STAT. ANN. § 24:21-39 (West Supp. 1985); N.M. STAT. ANN. § 61-6-14 (1981); N.Y. PUB. HEALTH LAW § 230(11) (McKinney 1983); N.C. GEN. STAT. § 90-14 (1981); OHIO REV. CODE ANN. § 4731.22 (Page Supp. 1984); OR. REV. STAT. § 677.415 (1983); R.I. GEN. LAWS § 5-37.1 (1980 Supp.); TENN. CODE ANN. § 68-11-218 (1983); TEX. REV. CIV. STAT. ANN. art. 4495b § 5.06 (Vernon Supp. 1986); UTAH CODE ANN. § 58-12-43 (1985 Supp.); VT. STAT. ANN. tit. 26 § 1362 (1985 Supp.); VA. CODE § 54-317 (1982); W. VA. CODE § 30-3-14 (1985 Supp.).

clinic. This movement brought physicians closer to the hospital as an institution. This development was also a change in the outlook of the traditional hospital that was not concerned with where its physicians or patients were located. The recent emphasis on home health, durable medical equipment, and "wellness" programs, partially the result of changing fiscal realities, underscores this change from the traditional organization and operation of the hospital. How many hospitals in this country were involved in these types of activities ten years ago? A very, very small percentage. Today, nearly all are.

Long term care is also being integrated into the hospital's organizational structure—not just to take up unused bed capacity within the hospital, but also because of the changing mission of the hospital. In addition, alcohol, drug abuse, and rehabilitation programs of various kinds are becoming organizationally, and at times, physically part of the hospital structure. All of these changes represent a considerable departure from the traditional role of the hospital as simply an acute care, inpatient facility. The role is broadening and deepening as hospital corporations follow a strategy of integrating all kinds of patient care under one organization—an organization with a history and a mission of providing quality care.

Nevertheless, the perception of what hospitals are is changing much more slowly than the reality. Many still see hospitals only as acute inpatient facilities where heroic things are done to maintain life or to solve medical problems. One reason for this is that this is what the physicians have traditionally wanted a hospital to provide. It is also what most physicians are trained to do. It is this perception that has driven hospital trustees to push for higher and higher technology medicine in the form of increasingly complex and expensive facilities and equipment. By and large, the physician component of the hospital (the medical staff) has not been particularly friendly to the idea that the hospital ought to vertically integrate the whole range of health care services. Many are content with the role of the hospital as an acute, inpatient, high-tech interventionist center.

For better or worse, this role will not continue. It will be altered, not just because third parties won't pay for as much inpatient care as they did in the past, but also because our whole method of treatment is changing from an acute care mode to one that is more all encompassing. Hospitals are either going to narrow their revenue base to a point where they cannot sustain themselves, or they

are going to have to find new revenue sources and provide and integrate new services that were not provided or integrated in the past.

Obviously, the financial constraints currently facing the field bear heavily upon this evolution. Hospitals are receiving less and less from Medicare relative to the increasing costs of providing that care. Employers are increasingly unwilling to accept cost shifting. Governmental subsidies for the care of the poor, the elderly, and others who run out of funds are constantly shrinking. Moreover, alternative delivery systems, such as HMOs, are growing to the point of being able to demand potentially crippling discounts from hospitals.

These financial trends, however, are neither the only, nor perhaps even the prime, factors that are changing the role of the hospital. The role of the hospital is also changing due to the changing perception of medicine by society in general. While many prefer to view hospitals as unchanging, and enjoy the comfort of thinking that they will always be there in their traditional role, the reality is that hospitals are changing at a rapid rate—and changing more rapidly every year. It is doubtful that the health care field will return to a stable environment in our lifetime.

The success of hospitals and other health care providers in the 1990s and beyond is going to depend largely on the adaptability of their management, governance and medical staff structure. Unfortunately, the management, governance and medical staff structure of most hospitals today is by and large ill- equipped to deal with change. It is far too often that of a stable, unchanging business. Decisions can be arrived at only through a slow, deliberate process of reaching consensus. Business risks are not encouraged, in spite of the fact that a certain amount of risk is inherent in a rapidly changing business environment. A board of 25 or 35 trustees that takes upon itself active management responsibilities of an institution that are far greater than would be the case in a commercial business, or a board beholden to a large and potentially volatile medical staff, is singularly ill-equipped to deal with the kind of atmosphere that faces the field today.

A medical staff that is organized as a practicing democracy concerned primarily with "self government" and that tends to center around protection of the economic status quo (which is peculiarly defined as meaning that very little gets done), is also ill-equipped to deal with an environment that is constantly changing. The hospital medical staff is an institution that has long been employed to

prevent action, rather than facilitate it.

The ability of hospitals to survive and prosper as independent voluntary community centers of care in the upcoming years will hinge upon their ability to structure themselves for survival. They must be run in a way that reflects the increasing competition to provide services that meet the needs of their communities. This must be coupled with a governance, medical staff and management structure that gives them as good a chance of surviving as any large corporation. The biggest problem facing hospitals is not one of resources. It is the hospital's perception of itself. Unless this perception changes to reflect a rapidly changing reality, and unless those charged with running the hospital begin to treat it as a *thing*, rather than just a *place*, the concept of a private, voluntary health care system in this country may well become a mere historical footnote.