Outside Europe

Who runs the hospitals?

WOODBURY PERKINS

The answer to this question in the United States was quite easy 15 years ago. It was the medical staff. They set policy for implementation of hospital management by the hospital administrator.

Progressively since 1965, however, this simple system has become very complex because of a variety of new forces and counter-forces. Thus, at the moment, there is no simple answer.

It seems appropriate to focus comments on these various forces that are changing the hospital industry and the delivery of health care in the United States.

For a basis of understanding, there are roughly 7000 hospitals in the United States. About 6000 of these (or 86%) are acute, general care, short-stay hospitals, most of which are privately owned and operated. Forty-seven per cent of these have under 100 beds and another 36% have between 100 and 300 beds. It is about this group of privately owned and operated hospitals that I will speak. The other, roughly 1000, hospitals are special, such as those operated by the Federal Government, or hospitals limited to long-term care, or limited to certain types of diseases, such as tuberculosis or psychiatric illnesses. Thus, to pin down the topic, my remarks address the question of who runs the privately owned and operated hospitals.

Another item of importance is that in the United States system, any licensed doctor, regardless of specialty, is eligible to admit patients to a hospital once the doctor has applied for and been appointed to the medical staff.

Medicare Program

The change from a simple to a complex system was precipitated by several events starting in 1965. One was the passage of Amendments to the Social Security Act, which initiated the Medicare Program of federally funded hospital care for those aged 65 and over. This program, which is still in existence, has had a major impact on the operation of hospitals, as well as the delivery of health care to elderly American citizens. Changes in the control of the flow of money for health care services under Medicare have created a major new direction and set of problems from those which existed before 1965.

To have a government pay for both hospital and doctor has provided increased accessibility of care for senior citizens but, on the other hand, has allowed the development of bureaucratic mismanagement, excesses of service, underpayment, etc, etc, which we, in this country, need not detail to you from Great Britain. In 1966, when the Medicare Program began, about 25%

of the patients in hospitals were eligible by virtue of being 65 or older. In the past 15 years that per cent of patients now covered by Medicare has nearly doubled to 48% of the patients in hospitals. This rise results from several factors, such as the American public is living longer, new technology has ameliorated many of the degenerative diseases most prevalent in the elderly, and new surgical techniques, such as cataract implants and cardiac surgery for coronary artery disease, have been developed. Under the Medicare system, a bill for services is submitted to the Federal Government or its agent by the hospital for its services, and by the patient for physician services. Each bill, based on a published reimbursement formula, is paid directly to the sender. In the sense that he who pays the piper calls the tune, Medicare is obviously controlling more and more of the hospital activities as more and more patients become eligible for Medicare. The system is getting out of hand both financially and politically. The costs to the American taxpayer have become exorbitant, and in the past three years have been rising 4% a year. Changes will have to be made and, presumably, will result as the government changes the formula by which it reimburses both hospitals and doctors. The current formula for reimbursement is based on predetermined costs of service. The definition of those costs is determined by the government and, thereby, the flow of money to hospital and doctors is under its control. All government has to do is change the formula of allowable services for which it will pay. Already we see reimbursement being less and less of the actual costs and of the total bill. More subtly, government can influence hospital use for non-emergency conditions by limiting allowable admissions, duration of stay, or use of equipment or procedures through the activities of its funded agencies, such as the PSRO (Professional Standard Review Organisation), the local HSA (Health Service Agency), or an HMO (Health Maintenance Organisation).

Legal decisions

A second significant force that impacts on hospital management has been the actions emanating from legal decisions in the United States court system. Because of the vast increases in public funding for health care delivery just discussed, there has emerged a growing degree of public awareness, expectation, and demand for health and medical services. The consumer voice in the management of public funds and in the methods of delivering health care has been loud. With an increasing part of the gross national product going to delivering health care, and a large part of this being paid by Federal and State money, there have been an ever-increasing number of problems resulting in litigation. Court decisions have thus been a significant force in changing attitudes and actions. There has resulted a legal basis for what we do.

Some of the celebrated litigation has resulted in sharper definitions of the responsibilities of hospitals (both private and public), as well as of the responsibilities of doctors using the

Paper presented at the BMA Clinical Meeting at San Diego, California, on 21 October 1981.

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hospitals. The quality of care being delivered by both hospitals and doctors is within the public interest. The hallmark case of *Darling v the Charleston Community Memorial Hospital* in 1965 established that the institution, through its voluntary governing board, has the duty to establish a mechanism for evaluating the quality of care being rendered in the institution, and the responsibility to take actions to avoid unreasonable risks of harm to a patient. Thus a hospital is considered to deliver a public service whether it is private or non-private. This responsibility means that an individual doctor using hospital facilities cannot simply do what he wants to do, but must conform to some sort of institutional standards of quality performance.

Thus we see focused the fact that the voluntary board of trustees or board of directors of the hospital is the legally responsible body to run the hospital. In a subsequent 1973 case, *Gonzales v Nork*, the courts further defined the relation between the hospital board's corporate duty to assure quality care in the institution and the duty of the individual doctors of the medical staff functioning within the hospital structure. The individual doctor's duty was not eliminated because of the responsibility of the board, the courts declared, because the board delegated patient-care matters to the medical staff. Thus the medical staff functions as a special agent of the board, not as an independent contractor. As such, the medical staff, as a group as well as individually, is subject to legal liability for what goes on in the hospital regarding patients. Resulting from these and other court decisions, the incidence of malpractice suits against hospitals and individual doctors has increased considerably and, naturally, malpractice insurance premiums for both hospitals and individual doctors have skyrocketed. In this sense some consider the insurance industry runs the hospitals.

One result of these legal dictates has been the development within each hospital of quality control devices designed to avoid and minimise clinical misadventures that invite litigation. In that the patients are obviously taken care of by the medical staff, it is the doctors who are deeply concerned in quality assurance activities with the backing of the board of directors or board of trustees.

Care control

A word about the concepts and techniques of controlling the quality of care is appropriate. Five standards relative to the activities of medical staff have been enunciated by the Joint Commission on Accreditation of Hospitals. The Joint Commission is an independent, free-standing body, which voluntarily sets standards by which hospitals throughout the United States are accredited. Most hospitals want to be accredited because such is an indication in each community that the hospital is up-to-date, is adhering to high quality standards of patient care, and has passed a detailed external examination of cleanliness and proficiency. In addition, coincidentally, only the accredited hospital is eligible to receive Federal funds through the Medicare Program for patient services.

The five standards are:

(1) The medical staff shall assure that each member is qualified for membership, and shall strive to maintain the optimal level of professional performance... through the appointment-reappointment procedure, the specific delineation of clinical privileges, and the periodic indepth reappraisal of each member of staff. This means that the initial application of a doctor to participate on a medical staff is critically reviewed and that the procedural privileges requested are also judged by peers. Each member of the medical staff must reapply annually or biannually for continued medical staff privileges at which time the performance of each doctor is reviewed by his associates.

(2) The medical staff shall be organised to accomplish its required functions. This means that there must be an organisation of the medical staff that includes officers, committees, and a system of promotion or discipline.

(3) The medical staff shall develop and adopt bylaws, rules, and regulations to establish a framework of self-government and a means of accountability to the governing board.

(4) Within this framework, "The medical staff shall provide mechanisms for the regular review, evaluation, and monitoring of medical staff practice and functions. Such mechanisms shall be designed to maintain high professional standards of care." These functions include the review of tissue removed at surgery, the review of the pharmacy and therapeutic activities within the hospital, a review of the medical records, the use of blood, the use of antibiotics, all deaths, etc.

(5) The medical staff shall participate in a programme of continuing education.

With these five guidelines, the medical staff is exercising its responsibility for overseeing the care of patients within the hospital.

Growing force of unionism

Finally, in considering who runs the hospitals, attention must be paid to the growing force of unionism among hospital employees, including professionals. As in the case of the other forces that have arisen within the past 15 years, the same may be said about the activities of organised labour in the health care industry. In 1970 only about 9% of hospital employees were represented by unions. By the end of the 1970s, however, more than 20% of hospital workers were represented by labour organisations. To put this into perspective, hospital employment of full-time equivalent personnel increased from 2 600 000 in 1970 to 3 300 000 by the end of 1978. Thus the increase in the number of organised hospital employees is far more dramatic than the basic percentage figures would indicate. The purpose of a labour union movement is to improve working conditions, improve salaries, and bargain collectively for other benefits. The force and threat is the ability to strike and thus reduce hospital activities to a minimal level during negotiations. Successful union activities increase the costs of operating the hospital. Particularly disturbing is the growing trend of unionisation among nurses because of the immediate impact on the daily delivery of patient care. Additionally, there is a shortage of nurses in the United States and thus their bargaining position collectively is enhanced. What is particularly troublesome is the growing pressures to link independent unions, such as that of the American Nurses Association with the National Education Association. Another example is the plan of the American Federation of Teachers to expand their enrolment to include nurses and other health professionals, including doctors. Some knowledgeable members of the hospital industry believe that with the number of hospital workers increasing at an average annual rate of about 5.5%, hospital personnel are a targeted group by organised labour for expanding union control within this decade.

By way of conclusion, I must return to the initial question. Is it the Federal Government who, indirectly, runs the hospital by controlling a large segment of the flow of money for services rendered; or is it the lawyers, the judges, and the insurance industry who exercise control of hospital activities through threats of litigation and court decisions? Or perhaps it is the medical staff who run the hospital in having responded to inroads from both the Federal Government and the courts by enforcing, as a body of doctors, stringent self-management rules and regulations concerning the care of patients in the hospital. Or, can it be that the hospital industry is becoming controlled by the unionisation of employees with power to strike tied to demands for higher pay and changes in working conditions?

Certainly, all of these forces are at work in this country and each exercises a component of control. Technically, and in fact, the legally constituted board of trustees or board of directors are the body that run the hospital. They are legally and fiscally responsible for the operation of the institution. Their work, however, must be to co-ordinate joint co-operative actions

between the medical staff, the hospital administration, and the loyal hospital employees. It seems to me that we in the United States are in a state of transition from the good old days when the doctor simply admitted and took care of his patient in the hospital according to the individual needs. We are now trying to co-ordinate and balance all of these several forces. Paradoxically, the central motivation seems to be to reduce the rising costs of medical care but, in so doing, the establishment of new agencies and regulations has only added to the mounting costs. In essence, the adversaries appear to be the private sector v

government control. At the present time, it is the private sector that run the hospitals in each community by joint co-operative actions between the voluntary board of trustees, the medical staff, and the hospital employees. In my opinion the future is optimistic in that this balance of power will prevail. Certainly, it is the tenor of our country at the present time to encourage private sector, voluntary management, and control of the hospital industry, as well as other industries.

(Accepted 3 November 1981)

Personal Paper

As you like it: 1911-81

CONSTANCE VON KUENSSBERG

Today I am 70, and Jaques's seven ages stretch behind, a penetrable vista. No lean and slippered pantaloons, but rather a fat and well-booted granny enjoying the garden: it is a place for review of the living, the sick, and the dying known in a life born to middle-class good fortune in a northern city.

1915 . . .

Early personal memories dredge up hideous nightmares of nights, and intermittent bouts of fierce earache. The family doctor believed that pain was good for the character, like beating boys, which has induced a permanent fear of it. He put it all down to the condition of the bowels, and vaccinated one with something like a blunt butter fork, the scars of which are carried still.

Babies were often carried by staid elderly nurses dressed in navy blue cylinders, with small velvet bonnets and long streamers. The infants were often veiled, as if under a meat cover. When asked why, Nurse said, "To keep the dust off, dear"! The street standard lamps bore notices saying "Please do not spit on the pavement" and the trams had "MOH Says Spitting Spreads Disease." One would meet men with peg legs, women with the shrivelled, dragging limbs of polio, children with deformities. One met funerals of solid worth—a black hearse with shiny carvings along the ridges and glass sides, with a man resplendent in a top hat sitting aloft. According to one's bank account, two or four horses, a black plume on each head harness, pulled this magnificently, their chests flecked with foam from the bearing rein.

The bowels were the obsession of the early century. Have you? Haven't you? and an inspection. One of the earliest memories is straining on a pot, with a sugar-topped biscuit on one side for a Good Girl, and, on the other, a glass of horrible, steaming liquorice mixture, for a Bad Girl. How one envied friends their Gregory's, or lovely syrup of figs. Stasis for over two days earned castor oil, neat, in a rinsed tumbler: not rinsed in hot water, but tepid, so the oil flowed slow-ow-ly. This appalling draught

continued to be compulsory, immediately antenatally, well into the 1940s.

Apart from ears and throats, nursery diseases stretched from the fevers of measles and chickenpox to the horrors of whooping cough. Children stayed wee and white for months after this, going into spasms with any stimulation and being sent for healthy walks round the gas works—large, wet, and windy beside an icy sea, which was supposed to induce cure. Having measles and jaundice simultaneously, my red face and orange eyeballs were concealed in the nursery behind a carbolic sheet hung in the door, only penetrated by Nannie and a kindly vicar. Everything infected had to be burnt, so I could not even hug my teddy; a dreary time to be 5 years old.

These years were those of the first world war. The memory is still carbon-clear of the centre pages of the national press, black with the names of those lost in the major battles of the Somme and Passchendaele. We lived in a school house of 30 boys, and in the four years 38 lost their lives, many of them straight from the classroom and rugby pitch. The whole air stank of death and darkness. My father reacted as to the death of sons, so one bore one's own troubles.

1918 . . .

School friends often went off sick, mostly with colds, coughs, blains, and sore throats and ears. Tannin throat paint on a tickly brush, salt or Condyl's fluid gargles, warmed oil or onion in the ears, oil of cloves in an aching tooth; one learnt about pain and had to convalesce from it—no quick route through chemotherapy and sedatives. Many of all ages bore neck scars from glands that had swollen and burst, or been lanced, and a tonsillectomy on the drawingroom table left the back of the throat like an aching cavern if you breathed through an open mouth. Several contemporaries had large concavities behind their ears from infected mastoids. Some girls disappeared and died, probably from adolescent tuberculosis, while others developed erythema nodosum or toxæmias leading to bacterial endocarditis and nephritis. Later, in the 'thirties, one saw many of these young things in the wards. Often they were ravishingly beautiful, with flushed skins, sparkling eyes, panting breath, and, so the local lore went, often with burningly brilliant red hair. The symptoms signed their death warrant. Infections went through the whole process then: tumor, rubor, calor, rigor, crisis, and