Dr. James T. Ziegenfuss, Jr.

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Law, Medicine & Health Care: A Bibliography

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Facts On File Publications
New York, New York • Bicester, England

Law, Medicine & Health Care

Library of Congress Cataloging in Publication Data

Ziegenfuss, James T., Jr.
Law, medicine & health care.

Includes index.
1. Medical laws and legislation—United States—Bibliography. 2. Medical jurisprudence—United States—Bibliography. I. Title. II. Title: Law and medicine.
[DNLM: 1. Jurisprudence—United States—Bibliography. ZW 32.5 / AA1 Z66L]
KF3821.A1Z53 1983 016.34473'041 83-9013
ISBN 0-87196-828-2 016.34730441

Printed in United States of America

10 9 8 7 6 5 4 3 2 1

Toward further understanding of the linkage of law with medicine and health care, and health care and medicine with law—the systems' interrelations.

About the Author

James T. Ziegenfuss, Jr. is an organizational systems scientist working in the law, medicine and health care field. He holds a Ph.D. in social systems sciences from the Wharton School of the University of Pennsylvania and masters degrees in public administration from Pennsylvania State University and in psychology from Temple University. He has worked for ten years in organizational analysis, strategic and long-range planning and organizational development. His professional publications include two books (*Patients' Rights and Organizational Models* and *Patients' Rights and Professional Practice*) and more than thirty journal and conference articles. Dr. Ziegenfuss teaches in the graduate program in public administration at the Pennsylvania State University at Harrisburg. He is a member of the Academy of Management, the American Society of Law and Medicine and the American Psychological Association and is a consultant to various public and private organizations.

Preface

Represented in this collection of references and resources are some ten years of interest in the writings on law, medicine and health care. The book has been developed for several reasons. First, for interested practitioners and scholars it will greatly speed their searches for the history and current status of a wide range of topics in the field. Second, it is hoped that the collection will spur further work in the area. The relations between law and medicine and health care are now undergoing great change. In both practice and scholarship, there is a strong need for vigorous inspection of the existing positions and for the creation of new ones based in part on the work to date. Third, it is hoped that the growing network of persons interested in these topics will be aided by a listing identifying each other, which promotes mutual contact.

A fourth and important reason specifically of the first chapter is to introduce lawyers and health care professionals to the use of organizational and behavioral analysis. It is offered with a firm conviction of the usefulness of its contribution, and awareness of an already demonstrated wide range of applications. I have no doubt that the field will find many more uses and far greater acceptance in the next years.

Last, the book indirectly stems from and supports my own work on patients' rights and the interaction of law and professional health care practice. This listing was a part of the resources used for two previous books (see *Patients' Rights and Organizational Models,* 1983b, and *Patients Rights and Professional Practice,* 1983a). An awareness and understanding of a small part of this vast and growing literature was a prerequisite to these books and it contributes to my ongoing work in the area. To the extent that it helps others to gain an interest in and contribute to solutions of the patients' rights conflicts, it is all the more valuable to me personally.

I would like to thank several persons who have been involved in the design, development and preparation. Appreciation is extended to Mr. Edward Knappman at Facts On File, to Yvonne Harhigh for research assistance, to Wendy Kauffman for typing and to the people at Centennial Graphics—Dennis Beck and Peg Darlington—for assistance in manuscript preparation.

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CONTENTS

I. ORGANIZATIONAL & BEHAVIORAL ANALYSIS IN LAW, MEDICINE & HEALTH CARE

Organizational and behavioral analysis can be viewed as a new component of modern Law, Medicine and Health Care work. "Systems" related rather than legal in orientation, organizational and behavioral analysis can add considerable weight to compliance, negligence, malpractice and regulatory arguments. Attorneys and their firms as well as physicians that are becoming or currently are involved in Law and Health Care should consider this analytical contribution to be relevant to their interests.

The growth of governmental regulation has hardly gone unnoticed by the medical or the legal professions. In the 1980's, the medical-legal work has been and continues to be a growth industry. The new and expanding cadre of health care attorneys is testimony to this fact. But what exactly is the work area, and where are the relevant background materials?

First, the general areas of the law and health care work are those involving nearly every aspect of the medical and health care field. This book organizes the concerns into four major topic areas:

—Individual specialists and specialties
—Medical care organization
—Medical services and process
—Legal processes

Within each of these areas, the involvement of law occurs on a regular, *not* an occasional basis.

Each major subject area involves subsets such as: (a) separation of professionals under group practice, e.g., physicians, dentists, nurses, surgeons, etc.; (b) components of medical care organizations, e.g., administration, labor relations, insurance, finance, etc.; (c) medical services and process, e.g., admissions, medical treatments, medical records discharge; and (d) specific legal processes and disputes, e.g., legal representation, malpractice, legislation, etc. Conflicts that develop within these areas, as well as the prevention of those conflicts, comprise the domain of the law and health care field (domain is here considered to be the general work area or business problem that is of concern to a group of professionals or an organization, Trist, 1973).

This chapter is intended to illustrate the contribution of organizational and behavioral analyses to these areas. Since attorneys and physicians are involved in both specific patient litigation (individual case level work) and administrative/regulatory litigation (systems level work), examples will be provided for both. The former is individual casework while the latter is often identified with the area known as Administrative Law.

Before providing the two examples, a brief note on the involvement of behavioral science in law is warranted. The past few years in particular have found an increasing recognition of the contribution of behavioral science to many aspects of the legal practice. The contribution has been at the individual behavior level and at the organizational level. For example, behavioral scientists have conducted assessments of individuals in criminal trials (Roesch and Golding, 1980; Abt and Stuart, 1979) and have assisted in court processes and procedures such as jury selection (see, e.g., Brigham and Bothwell, 1983; Field, 1978; Deffenbacher & Loftus, 1982). More recently, their expertise has been recognized as involving a full range of functions, including assessment, treatment, education, research and consultation (Ziegenfuss, 1984). The literature on behavioral science and law has been expanding rapidly, even in sub-speciality areas such as forensic psychiatry/psychology (Ziegenfuss and Ziegenfuss, 1983).

While much of the work to date has been research-oriented, the applications for practice are emerging at a faster pace. As they are recognized and used, full field implementation will occur over the next ten years. This implementation will doubtless involve individual behavioral analyses and organizational analyses with considerable attention being paid to how individual behavior contributes to the workings of larger social systems, e.g. groups, organizational subunits and the organizations as a whole. The analysis of small and large systems, subsystems and wholes is clearly linked by the interactions of the systems themselves.

In order to understand the organizational and behavioral aspects of litigation—to analyze them at the organizational level even when they are person specific—there is a need for a conceptual view of organizations. While there are many ways to conceptualize organizations, the one used for the analysis will be

that of Kast and Rosenzweig (1979). They see organizations as composed of five subsystems: (1) goals and values; (2) technical; (3) structural; (4) psychosocial; and (5) managerial. These *are* the organization—their dynamic interaction produces the organization's behaviors.

The subsystems are defined as follows:

Goals and Values System: "The ends or desirable future of the organization with high relative worth and importance."

Technical System: "The knowledge required for the performance of tasks, including the techniques used in the transformation of inputs and outputs."

Structural System: "The ways in which the tasks of the organization are divided (differentiation) and coordinated (integration). In the formal sense, structure is set forth by organization charts, by position and job descriptions, and by rules and procedures."

Psychosocial System: "The individuals and groups in interaction. It consists of individual behavior and motivation, status and role relationships, group dynamics and influence systems. It is also affected by sentiments, values, attitudes, expectations and aspirations of the people in the organization."

Managerial System: "Spans the entire organization by relating the organization to its environment, setting the goals, developing comprehensive, strategic and operational plans, designing the structure, and establishing control processes."

In addition to these "internal" organizational systems, the organization is influenced by its environment which is composed of a wide range of influences, including the following (Kast and Rosenzweig, 1979):

—educational
—cultural
—technological
—economic
—political
—legal
—sociological
—demographic
—natural resource

These nine influences are "outside" the organization but affect its subsystems as a result of the constant transactions between the organization's parts and the environment. Both the organization's subsystems and the environment's influences can and do have an effect on the development and outcome of litigation.

These five subsystems comprise the organizations and are connected by the managerial subsystem which is the hub of the systems as indicated below:

The presence of both technical and social systems means the organization is sociotechnical (Trist, 1981; Susman, 1976). If litigation is considered to be in part an organizational problem, its effects will be felt in one or more of the subsystems. This can be demonstrated through case analysis.

This position—that conflicts and litigation are in part organizational systems problems—is one generally taken as necessary for analyzing all organization problems; i.e., every problem, including those resulting in litigation, are multiple systems-involved problems.

To inform managers and staff of the problem analysis procedure, the systems identified above are sometimes reduced to three—environment; organization structure/function; and human relations until users are accustomed to the methodology (Ziegenfuss, 1982). The use of the systems view and the contribution to litigation will be illustrated by the analysis of an individual patient's problem and a more general example of the current hospital regulatory problem (for reference to work in these areas see Chapter IV, Medical Care Organization and Chapter VI, Legal Processes).

CASE ONE: A PATIENT IN NEED

The first example, from an area in which the author has been working, concerns a case involving involuntary commitment and the level of medical treatment provided to a supposed mentally ill patient (*O'Connor* v. *Donaldson*, 422 U.S. 563, 1974). The patient, Kenneth Donaldson, was civilly committed as a mental patient in the Florida State Hospital at Chattahoochee in January, 1957. He was held against his will for 15 years. Throughout this time, Donaldson requested release, stating that he was not mentally ill nor was he dangerous to anyone. He also added that the hospital was not providing treatment. He brought suit against the hospital and the superintendent, stating that they had maliciously and intentionally deprived him of his constitutional liberty.

The evidence at trial indicated that Donaldson had not, to anyone's knowledge, been suicidal or dangerous. He was thought to have been able to earn a living on the outside, as he had done prior to his hospitalization. Additionally, his frequent requests for release were supported by responsible persons who would have helped him once he was out.

The evidence also showed that Donaldson's confinement was for custodial care that was lacking the programming needed to assist him with his illness. "Donaldson's requests for ground privileges, occupational training, and an opportunity to discuss his case with [Superintendent] O'Connor or other staff members were repeatedly denied." He was, in effect, confined against his will, apparently without sufficient justification and without services for nearly 15 years.

A brief analysis of some of the issues follows our concern for the organizational behavior aspects of this *individual* patient's case. First, the case raises the problem of the organization's basic purposes. Was the hospital organized and operated for custodial or for treatment purposes? Donaldson was confined *without* treatment. The organization as a whole appeared to be incapable of providing a full treatment regimen. The question of confinement and the hospital's goals also surfaced the problem of society's intentions. Does society want to provide confinement *and* treatment, or just protective custody?

Second, the case raised technical services questions. The initial commitment process was suspect because the rationale and justification for admission were found, on review, to be quite weak. Additionally, there was not an extensive formal treatment program. The hospital relied on "mileu therapy" as its mainstream treatment which, in this case, meant nothing more than having the patient live in the hospital environment.

Third, the hospital system's structure was totally oriented toward its protective position. There was not a sufficiently developed and organized treatment system. This was both a structural and a management deficiency. The trial pointed out an apparent lack of "team decision making" by the treatment staff.

Last, the human relations aspects of the case indicated that Donaldson received very little support in his struggle for freedom. The superintendent was particularly involved in a personal agenda that contributed to Donaldson's confinement. Against some suggestions from staff and offers of support from outsiders the Superintendent rejected release of the patient.

The case illustrates that there was a wide range of organizational and behavioral problems *in the hospital* which affected the *individual patient*. A summary of the list includes the following:

—Organizational *intended* purposes were not consistent with operating reality; e.g., treatment versus custody.
—The rationale for committing patients was misunderstood.
—Admission procedures and the need for detailed documentation of admitting rationale were deficient.
—The treatment regimen as a whole and programming for individual patients were deficient.
—The Superintendent's attitude toward patient confinement and his callous disregard for liberty interests contributed to a confinement-jail atmosphere.
—There were not sufficient organizational checks and balances to insure that the patient's liberty interests were protected; i.e., Donaldson was confined for 15 years during which he repeatedly sought his freedom.
—A personal conflict existed between the Superintendent, who controlled access to freedom, and the patient.

This brief list could be expanded with a more detailed analysis of the case and its impact.

In many ways, the case is a typical example of individual patient advocacy,

but to understand the context of the problem in which the patient is enmeshed, the organizational issues must be examined. The context of the case includes the organizational and social system developments which are those of the whole patients' rights movement.

Patients' rights issues, of which this case has been a leading one, have been receiving greater amounts of attention in recent years (Ziegenfuss, 1981). A current bibliography identified more than 400 references to the problem in the recent literature (Ziegenfuss and Ziegenfuss, 1980). This material must be examined and related to the case (for example by examining the literature identified in the Patients' Rights section in Chapter IV, Medical Care Organization).

Here the historical changes would support the plaintiff's position. The rights problems were defined when they first surfaced in the 1960's as individual problems for individual patients. Program issues began to surface in the early 1970's (see, e.g., Baltimore and Ziegenfuss, 1973) so that by a few years later, it was an organizational systems level problem (Stone, 1976) in need of organizational development (Lasky and Ziegenfuss, 1975; Ziegenfuss and Lasky, 1980). More recently, the whole patients' rights litigation problem is viewed as a combined one requiring: (1) behavioral changes from staff (Ziegenfuss, 1983a); (2) organization design/redesign (Ziegenfuss, 1983b); and (3) effective complaint mechanisms (Ziegenfuss, 1984). The perception of the problem as one of organization is considered now to be key (Ziegenfuss, 1983c). It goes without saying that this understanding of the problem should be represented in litigation responses *and* that the responses will be most effective when it is present.

The analysis as illustrated by this brief example is indicative of the work to be done in much of the law and health care practice. That is, there is a need to establish the organizational context in which the court conflict has developed. Are there goals issues; how does the intended purpose match actual operations; and was the behavior of individuals and groups consistent with professional practice guidelines?

This analysis of organization behavior occurs after the fact; that is, when conflict and/or impact has already developed. The range of the potential topics is quite large. Gray and Starke (1980) include the following and other issues in their classic text of organizational behavior issues:

—Motivation
  —Needs
  —Job Satisfaction
  —Compensation
—Behavior Modification
  —Reinforcement
  —Punishment
—Leadership
  —Characteristics
  —Approaches

—Organization Structure and Behavior
  —Centralization
  —Matrix
—Informal Organization
  —Status
  —Influence Systems
  —Resistance to Change
—Group Dynamics
  —Intergroup Behavior
  —Decision Making
  —Conflict
—Communication
  —Skills
  —Flow
  —Perceptions
—Organizational Conflict
  —Conflict and Competition
  —Interdependent Work Activities
—Organizational Development
  —Situations
  —Approaches
  —Effectiveness

The list illustrates the depth and scope of the issues to be addressed in both litigation and in the firm's business as a whole. Certainly the above topics can and often do become a central aspect of litigation. Analysis of these topics becomes a primary part of the legal process. Although there may be some experience required to see the connections between the list and cases of person-specific litigation, other types of legal practice involve the organizational analyses more directly.

A second area of legal practice is more preventive in orientation and directed toward establishing the most likely effects *before* they occur. Administrative and regulatory health law is also an expanding area of practice. Here the organization and behavior analytical contribution focuses more obviously on the administrative and organizational levels including technical services, organization structure, management processes and product/ services effects. In health care law as in other substantive areas, a primary part of this topic involves the government and its regulatory processes. Since changes in regulation and compliance with rules are key areas of legal analysis, Administrative Law is used for the next example.

CASE TWO: HOSPITALS

Prof. Kenneth Culp Davis has defined the work area of Administrative Law as "the law concerning the powers and procedures of administrative agencies,

including the law governing judicial review of administrative action. Administrative Law consists of constitutional law, statutory law, common law and agency-made law" (Davis, 1977). Administrative Law by this definition extends well beyond the regulatory systems of federal, state and local agencies. Impact analysis of governmental intervention through bureaucratic rules and regulations is a key component of legal practice. The focus of this example is the contribution of organizational analysis to the conflicting legal points confronting health and medical care organizations. (The literature in this area is identified in Chapter IV Medical Care Organization and Chapter VI Legal Processes.)

Hospitals too often learn the impact of new and revised regulations only after their implementation. From service and marketing processes to human relations and politics, regulatory impact is wide in scope and touches the depth of organizational actions. Frequently overlooked in the legal analysis of proposed or imposed regulations is an organizational behavior analysis of the effects of regulation on the hospitals and other health care organizations.

A prior organizational analysis has considerable potential to become an integral aspect of the legal regulatory practice. Its contribution is graphically demonstrated by an increasingly popular regulatory-deregulatory target—the health care industry. In particular, hospitals as the focal organizations in health care are bearing the brunt of governmental attention, particularly with regard to the new cost containment initiatives. By examining three organizational impact areas, the analysis illustrates how hospitals face organizational change with each new governmental rule. Additionally it demonstrates the utility of an organizational review for many types of business problems.

The Business Environment: Organizational Area 1. The Business Environment is comprised of those aspects outside the organization which affect its operating efficiency and effectiveness. In total, these aspects can be considered to include: education; technology, demographic and sociological characteristics of the population; economics; law; politics; natural resources; and the total culture of society (Kast and Rosenzweig, 1979). An increase in the regulation of any business or industry indicates changes in some or many of these environmental aspects. Since the environment in which an organization operates greatly affects its continuing viability, monitoring these changes is a vital necessity.

Hospital trustees and their corporate executive officers have recently encountered drastic environmental change. For example, new technologies are being developed which rapidly expand both the quality and quantity of medical care. Yet simultaneously, Americans have become aware of the considerable costs of health care in general. Citizens supported the legislation that developed regional health planning agencies whose task is to restrict and control (read "plan for") technological growth in the health field. The regulations developed by these planning agencies directly control the continuing technological growth capacity of a community hospital. It is important to note that these agencies are encouraged to utilize both organizational analysis and needs assessment in formulating their regulations.

How did the agencies come into existence? They were created because hosptals and their stakeholders (trustees, management, medical staffs) were not able to control the continuing expansion of services and technology. For example, as hospitals began to secure CT Scanners (Computer Assisted Axial Tomography Units for diagnostic assistance which pass x-rays through the body to construct cross-sectional x-ray images of it), the expense (often $750,000 to $1,500,000 each) became a point of contention in the cost reviews done by the planning agencies. First, the planners rejected development of some units. They next began to require shared services where possible. Hospitals in some cases are now using mobile CT units that travel from hospital to hospital. Others have developed a referral relationship that eliminates the need for several hospitals to each have their own individual units. However, the hospitals are usually very reluctant "developers" of these sharing mechanisms. Regulatory force and/or no alternatives are the stimuli. The situation with regard to new technologies and hardware is only indicative of the hospitals' changing business environment.

Hospitals, in their reviews of proposed regulations regarding new medical equipment and services, are confronted with an ambivalent environment. It is at once *supportive* of expansion and growth through advances in technology and *restrictive* of growth through limitations set by planning groups as to who can purchase equipment and who cannot. In this hospital example, if the environment had been successfully monitored, hospitals as a group might have responded to the pressures for cost control and regional cooperation with organizational changes before they were legislated. Local presentations of position statements, briefs and testimony on proposed regulations would put hospitals in stronger negotiating positions with community and governmental groups. Planning agencies include an analysis of environmental changes as well as possible alternative organizational responses to these changes. Hospitals and their legal representatives must present the hospital view. Thus organizational and behavioral analysis is involved with Administrative Law at one point as a contributor to the prevention of regulatory conflict through the identification of organizational choices (see Chapter III Individual Specialists and Specialties and Chapter IV Medical Care Organization for references to other organizational involvements and arrangements).

Organizational Structure/Function: Organization Area 2. The second area of regulatory impact involves the structures and functions of the organization. This area is composed of the traditionally recognized core processes and activities of any business or industry. Governmental regulation extends to the level of determining both the processes by which goods and services are produced and the types and qualities of the final products. Regulation of process always has the potential to alter the structure of the organization. Determination of the types and qualities of the final products also has the potential to alter the functions of the organization. Hospitals are confronted with both process and product regulation, creating the possibility of changes mandated without the organization's conscious recognition or consent. Consider the following example.