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primary concern is that the law not require that all types of limited health practitioners be accommodated in the hospital system without appropriate attention to the duties this may impose on physicians. Of course, if physicians desire to assume such duties necessary for protection of patients, I have no objection to such practitioners being accommodated.

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1. ACCREDITATION MANUAL FOR HOSPITALS 1983 (Joint Commission on Accreditation of Hospitals, Chicago)(1982) at 97.

In-House or Outside Counsel: The Debate Goes On

Dear Editors:

Max D. Brown, J.D., in his article, *In-House Law Offices: How Healthy are They?* in the October issue, re-initiated the debate on the question of when, if ever, should a hospital employ in-house counsel, as opposed to retaining outside counsel. The question has been a sensitive issue with hospitals and hospital attorneys since hospitals began to retain outside counsel in the early 1960s. In the early formation meetings of the American Society of Hospital Attorneys, hospital attorneys debated the question, and today, twenty years later, the debate goes on.

There is no clear answer to the question. Each hospital must evaluate its own needs and resources and make a decision that is in its best interest. Hospital attorneys should be careful not to become caught up in the debate; rather, they should study the issues and be prepared to discuss the question with their clients and point out the pros and cons of both arrangements. In considering the pros and cons, it would be helpful to review the emergence of the hospital attorney as a member of the hospital management team.

Prior to the involvement of the federal government in the health care delivery system through the Hill-Burton Program and the Medicare/Medicaid programs, most hospitals did not retain counsel. Traditionally, an attorney would serve on the hospital board and provide legal services free to the hospital. Originally, hospitals enjoyed charitable immunity and were not, therefore, involved extensively in malpractice litigation. Additionally, for many years, hospitals were not extensively involved with patients' rights and reimbursement issues. However, by the early 1970s, hospitals were facing myriad complex legal issues, and retained counsel became the rule. In the mid-1970s, many larger hospitals began to employ in-house counsel in addition to retaining outside counsel, and this trend has fanned the flames of the debate.

Let us review the arguments for and against in-house and outside counsel. Generally, the advocate of in-house attorneys believes that they tend to be sensitive to the hospital's daily needs and responsive to the entire hospital staff; in addition, they are believed to be cost-effective. Advocates of outside counsel praise their continuity of service and the level of their expertise; outside counsel may also provide objectivity because the counsel reports to the governing board, not the chief executive officer.

I would like to propose a compromise to provide the best of all worlds to hospitals. I recommend when a hospital determines that it should consider employing in-house counsel that it first request its outside counsel to designate one of its members as "hospital counsel" and that the member of the firm so designated be accessible and responsive to the needs of the hospital on a daily basis. The attorney will then become an important member of the hospital management team, will become more sensitive to all of the problems of the hospital, and can maintain a high level of expertise and provide continuity. Also, by sharing the cost of secretarial support, library and other support, the cost to the hospital should be less.

The designation of a member of a law firm as "hospital counsel" may not work in every case. It will, however, provide hospitals with an opportunity to review the benefits or liabilities of having "apparent in-house counsel," and it will enable law firms to reassess their efforts representing hospitals. Finally, it will give both an opportunity

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a) Labor Law

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b) Staff Privileges

Bernstein AH, *Words Can Hurt: Defamation in the Health Care Field*, HOSPITALS 56(21): 33-36 (November 1, 1982) [11-128].

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to review the costs and benefits of a hybrid arrangement before making a commitment involving long-standing financial commitments and quality of legal services issues. As an attorney whose firm is outside counsel to many hospitals, I encourage hospital attorneys to consider my recommendation before becoming overly sensitive to inquiries from their clients regarding the employment of in-house counsel and racing off to defend the retention of outside counsel.

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Role of Emergicenters

Dear Editors:

I write regarding the article, *Emergicenters and the Need for a Competitive Regulatory Approach*, published in your June 1982 issue. This article reflects many pre-existing and prevailing notions regarding the presumed beneficial effects of regulation. Your readers must first be reminded that health care is the most heavily regulated industry, yet is increasingly plagued with consumer dissatisfaction and uncertainty about quality.

The current regulation of emergency care does not guarantee adequate standards within hospital facilities.[1] There are vastly different "licensed" categories of hospital emergency rooms: Level I is the regional trauma center facility; Level II is a standard general hospital with a physician in the emergency room; Levels III and IV are hospital facilities with no physician in the emergency room, only available "on-call." Many "licensed" hospital emergency rooms in this country do not have an emergency physician available anywhere on the premises.

It must also be noted that the bulk of acute and emergent medical treatment is not rendered in hospitals, but rather in physicians' offices. Currently, there is no regulation regarding staffing, equipment, or credentialing of physicians' offices. Even though the majority of acutely ill people are seen initially in physicians' offices, only a third of these offices have even rudimentary laboratory equipment. Staffing is equally dismal. Less than 20 percent of offices are staffed by nurses or technicians.[2] It is a fact that outside of hospital emergency rooms, where the need is greatest, life-saving equipment will be found in ambulances and freestanding emergency centers, not in physicians' offices.

If regulators were concerned about the quality of emergency care rather than the economic impact of new competition, basic standards for equipment and staffing would be extended to all facilities that deliver emergency care. This includes physicians' offices, and "licensed," but falsely labeled, hospital emergency facilities. It is clear that proposed regulation is designed to erect barriers to entry and to discourage competition — not to increase quality of care.

The facility fee will not determine the viability of the freestanding emergency center as stated in the article. The facility fee is subsidization by third party and governmental payors. It is not generally required by freestanding facilities and in fact reflects inefficiency and lack of cost responsibility. Freestanding emergency centers generally charge fees competitive with physicians' offices. These facilities must be able to compete in the marketplace without the economic subsidy bearing the name "facility fee."

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Editors' Note

For more on the regulation and impact of emergicenters, see Zaremski, M.J., Fohrman, D.M., The Emergicenter: Has Its Time Arrived? *LAW, MEDICINE & HEALTH CARE 11(1):4 (February 1983).*