

Nickles P, Tucker G, Brown M, *FTC Wants to Supervise Hospital Buys*, MODERN HEALTHCARE 12(10): 150-53 (October 1982) [11-023].

*American Medical Association vs. Federal Trade Commission*, CONNECTICUT MEDICINE 46(11): 673-75 (November 1982) [11-136].

*Federal Trade Commission Issues Final Order Against American Medical Association*, CONNECTICUT MEDICINE 46(10): 601-03 (October 1982) [11-100].

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.<sup>1</sup> There are vastly different "licensed" categories of hospital emer-

## Hospices

Werner PT, *Hospice Care—An Alternative*, JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA 71(10): 693-95 (October 1982) [11-105].

## Hospital Law

Goldberg BA, *The Duty of Hospitals and Hospital Medical Staff to Regulate the Quality of Patient Care: A Legal Perspective*, PACIFIC LAW JOURNAL 14(1): 55-78 (October 1982).

Kardon RD, *Hospital Liability for "Concessionaires or Franchisers,"* MEDICAL TRIAL TECHNIQUE QUARTERLY 29(1): 108-13 (Summer 1982) [11-231].

gency 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.<sup>2</sup> 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

## a) Labor Law

Horty JF, *Truth's a Strong Weapon in Firing Worker*, MODERN HEALTHCARE 13(1): 136 (January 1983) [11-249].

## b) Staff Privileges

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

Horty JF, *Critical M.D.'s Bid for Privileges Fail*, MODERN HEALTHCARE 12(11): 120 (November 1982) [11-151].

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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## References

1. *Recommendations of the Conference on the Guidelines for the Categorizations of Hospital Emergency Capabilities* (American Medical Association, Chicago) (1981).
2. Weiner, J.D., *The Baltimore City Primary Care Study: An Analysis of Office-Based Primary Care* (Baltimore City Medical Society, Baltimore) (1981).

## 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 & HEALTHCARE 11(1):4 (February 1983).*