HEALTH SYSTEMS AGENCIES

A Civil Rights Forum

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INTRODUCTION

In 1932, the Committee on the Costs of Medical Care published a report, *Medical Care for the American People.* One of the major recommendations was as follows: "The Committee recommends that the study, evaluation, and coordination of medical services be considered important functions for every state, and local community, that agencies be formed to exercise these functions, and that the coordination of rural with urban services receive special attention." A similar recommendation was made in 1966 in another important report, *Health Is a Community Affair,* sponsored by the American Public Health Association and the National Health Council.

These recommendations, as well as other efforts that had taken place, resulted in two pieces of legislation. In November 1966, the Comprehensive Health Planning and Service Act, (P.L. 89-749, Partnership for Health Act), was signed into law. This law, which was in effect for almost a decade, established regional health planning agencies as legitimate entities in the health care system along with hospitals, physicians, medical schools, third party payors, government, and other key actors including a growing consumer movement.

While the intent behind P.L. 89-749 was good, several weaknesses in the law prompted the drafting of improved legislation. These changes were to provide more authority to regional health planning agencies and to consolidate under one agency the three programs of Comprehensive Health Planning, Regional Medical Programs and Health Delivery Systems Programs. This new concept emerged as the National Health Planning and Resource Development Act of 1974 (P.L. 93-641).

The purpose and priorities of this Act include promoting and helping to assure health care containment, assisting in regional development of primary care services for medically under-served populations.

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development of multi-institutional systems and medical group practices, coordinating regional development of programs for training of para-professionals, general promotion of quality of care, encouragement of health promotion and illness prevention, and development of effective methods of educating the general public to health care issues.

A subcurrent which often pervades health care availability and the needs in health care services, particularly in urban areas, is the matter of services to minority groups. Obviously, this matter is being addressed in most communities by many agencies and professional groups in both the public and private health care sectors. However, there are some well-known disparities in health care service availability in minority health status statistics. We will not completely address these disparities in health status until questions of civil rights are resolved, and this is the focus of this article.

FORUMS FOR CIVIL RIGHTS DEBATE

While civil rights lacks the high profile it had during the 1960s, assurance of civil rights nonetheless constitutes an important concern that pervades all areas of public policy making. This is certainly true of health planning. In fact, there are several interacting forums that may be set into action at any moment, given the planning or implementation issue under consideration.

For many issues and in many instances, an HSA itself should and must assume a leadership role — by its internal action and by its influence externally. It, in turn, may involve other entities in the civil rights issue. In this sense, an HSA is a cutting edge which can prompt debate, through several forms — government, news media, elected public officials and the public itself. Involvement of these is discussed below.

Government. Government at any level may concern itself with a civil rights issue that is HSA-related. In regard to health care at the federal level, the Office for Civil Rights (OCR), an integral component of the Department of Health, Education, and Welfare (DHEW), is a primary civil rights forum. The Office for Civil Rights is responsible for the administration, enforcement, and implementation of DHEW's policies implementing the mandates of various civil rights laws applicable to DHEW programs, including Title VI (non-discrimination in federally-assisted programs), Title VII (non-discrimination in employment), Title IX of the education amendment to 1972 (non-discrimination in federally-assisted educational programs), §799A and 845 of the Comprehensive Health Manpower and Nurse Training Act of 1971 (non-discrimination in federally-assisted health training and educational programs), §504 of the Rehabilitation Act of 1973 (non-discrimination against the handicapped), and Executive Order 11246 (non-discrimination in affirmative action for federal contractors).

Ten regional offices of DHEW contain OCR components. Each OCR office is staffed to deal with civil rights complaints related to health planning matters. The jurisdiction of OCR is quite vast, considering the numerous non-discrimination laws which OCR administers. In short, OCR is the "civil rights" policeman for DHEW.

The U.S. Department of Justice also has vast jurisdiction in the civil rights field. This responsibility is delegated primarily to the Civil Rights Division which is responsible for enforcing all federal civil rights laws which prohibit discrimination.

At the state level, a possible civil rights link between an HSA and a state is through the capital expenditure review process. This might be Certificate of Need or some other program which statutorily requires HSA involvement in civil rights issues.

Locally, larger municipalities commonly have offices dealing with civil rights issues. These offices might ask an HSA to become directly involved in a civil rights issue arising in a health planning context or follow-up on its own initiative on such an issue.

News Media. The news media can have significant impact through the power of publicity and pursuasion on civil rights issues. Factors affecting the way an issue is presented, if at all, include an HSA's technical expertise in analyzing issues, working relations with the media, the political orientations of the media, and the effectiveness of various segments of the community to persuade the media.

A leveling element in this uncertain mix is the advantage to all parties of the media assigning knowledgeable and interested reporters to cover health issues. This leads to a professional approach by which reporters and analysts develop expertise in the subject matter as well as experience that provides continuity of viewpoint and a broader measure for accurate reporting. Aside from the reporting itself, simply the presence of the media can affect the context in which decisions are made.

Elected Officials. Elected officials at all levels have been involved with HSAs. The type of appeals to them are as varied as the help they can provide and vice versa. Clear-

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ly, the relationship can be positive or negative and may come through individuals or be organizationally based upon a Council of Governments, informal coalitions, etc. The involvement of elected officials represents part of the HSA constituency. A challenge for HSAs is to identify common goals elected officials and the agency share, and to develop these relationships over a period of time rather than relying on a crisis to bring the two together.

Public At Large. This forum is, in a sense, the "culture" in which an HSA operates. Its theoretical dimensions are infinite, although in fact the mobilization of forces around civil rights issues will likely occur when citizen activist groups or a concerned person intervenes in HSA processes such as planning, project review, public issues involvement, etc. A more amorphous force not to be discounted is "public opinion" which may be the catalyst to more focused activities.

HSA Itself. An HSA is a highly complex organization. This is in part attributable to the fluid and diverse membership which constitutes the volunteer element of an HSA, as well as the HSA process itself which promotes public access and impact on its functions (e.g., planning, project review, public involvement, and coordination among other organizational entities).

Due to its membership matrix and organizational process, countless opportunities exist for an HSA to involve itself in civil rights issues. An HSA is in and of itself a forum. The issues may come forward out of technically oriented functions such as project review or planning, or come forward out of a more socio-political context such as the public involvement function. Further, potential HSA involvement in civil rights issues gives additional impetus to the need for HSAs to recruit and employ qualified minority group staff.

Rationales used for HSA involvement in civil rights issues will vary from legal and regulatory to ethical and moral, with the Board of Directors being the final arbiter. Perhaps the key point is that this forum requires not only that the HSA provide the opportunity to raise issues, but that it also be given the required tools to resolve them.

In summary, an HSA is a center of gravity for the debate of civil rights issues related to health. These forums do not exist in isolation but rather interact to produce knowledge, information, opinions, attitudes, policies, and ultimately actions in response to issues.

LEGAL CONSIDERATIONS: P.L. 93-641/Title VI

There are many civil rights statutes and regulations enacted by federal, state, and local authorities. Not unlike private business corporations, many of these laws are applicable to an HSA and its internal affairs. However, it is an open question whether, in interacting with provider-institutions, an HSA has the legal authority to enforce the civil rights laws as to those external entities.

BOEHRINGER INGELHEIM DEDICATES NEW RESEARCH FACILITY. *Dedication ceremonies of the Boehringer Ingelheim Ltd. new Research and Development Center were recently held in Ridgefield, Conn. Among the guests were (L to R) Danbury Mayor Donald W. Boughton and Connecticut Governor Ella Grasso, shown here with Dr. Harvey S. Sadow, president of Boehringer Ingelheim. Over 200 guests from around the world attended ceremonies at the 188-acre pharmaceutical complex.*

HSAs, being "statutory creatures" brought into existence by P.L. 93-641 and the National Health Planning and Resources Development Act of 1974 ("the Act"), are limited in their powers. A critical issue to be resolved is whether an HSA has the power to enforce the civil rights laws and, if so, the source of that power.

The Act, being the "charter" of the HSA's powers, is the first law which should be examined. It does not directly empower or require an HSA to delve into the matter of civil rights vis-a-vis external entities. It has, however, been argued that the following language in the Act, specifying the health planning priorities established by Congress, gives rise to such an obligation: "The provision of primary care services for medically underserved populations, especially those which are located in rural or medically depressed areas [deserves priority consideration]." This language is ambiguous, however, for it mandates only that an HSA consider whether a "medically underserved population" exists and, secondly, whether a health planning decision would diminish or increase the availability of primary care services to such a population if it exists. While a "medically underserved" population in certain inner-city areas may be predominently a minority group population, the terms "medically underserved" and "economically depressed" do not in all instances coincide with the usual definition of minority groups. In other words, the focus of the Act in health planning is upon medically underserved populations. The Act does not authorize an HSA to exercise any further powers if that population is coincidentally a minority group population.

A second statute, also a possible source of authority for an HSA to enforce the civil rights laws, is Title VI, which in connection with implementing DHEW regulations (45 C.F.R. §80.1 *et seq.*), contains the following broad prohibition: "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance." Further, the DHEW regulations implementing Title VI require that a recipient, in determining the benefits to be provided under a federally-assisted program or the persons to be served, not utilize criteria or methods which have a discriminatory effect as to that program.

The argument asserted is that an HSA, as a recipient of federal assistance under the Act and regulations, has the obligation not only to insure that its own operation comports with Title VI, but also that other recipients of federal funds involved in the

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health planning process (i.e., providers) also comply with that law. While an HSA's obligation to "police" itself under Title VI is clear, it is ambiguous in the absence of any established legal precedent that Title VI enables an HSA to police others.

The problem under Title VI is illustrated by the following example: Hospital, Inc. files a Certificate of Need application with an HSA to add 100 beds. It is known that Hospital, Inc., which receives Medicare reimbursement funds, refuses to admit, treat, or employ minorities. The hospital is, however, not located in an area with any medically-underserved population.

In the context of the Hospital, Inc. situation, given the existence of discrimination at the institution, may an HSA deny the Certificate of Need application for that reason alone? Considering that the HSA receives federal funds under P.L. 93-641, while Hospital, Inc. receives its federal monies under the Medicare program, the nexus contemplated by the DHEW regulations appears to be absent. If the HSA recommends the Certificate of Need to the state authority, this action will not have any discriminatory impact upon the administration of the Act, which is the source of the HSA's funds. Thus, it is questionable, given the absence of controlling precedent, whether Title VI or its regulations can be enforced by the HSA vis-a-vis Hospital, Inc.

It is an inescapable conclusion that HSAs, if they are to play a meaningful role in the enforcement of Title VI or any other civil rights statute, must have the unambiguous statutory power to do so. Present statutes and regulations do not clearly prescribe such a role for HSAs. This being the case, their authority might be challenged if they attempt to enforce the civil rights responsibilities of other entities.

CONCLUSION AND RECOMMENDATIONS

It is a reality that HSAs are a civil rights forum where persuasion and argument range from legal and planning rationales to ethical and moral imperatives. Whichever forum is a vehicle by which an HSA assumes civil rights responsibilities, it is imperative that the agency performs competently. The present laws do not provide the support and direction needed by HSAs to enforce the civil rights responsibilities of others.

Assuming that Congress intended HSAs to be a civil rights forum, that intent should be clarified and legislation passed which give HSAs the clear power to enforce the civil rights responsibilities of others while performing health planning duties. Further, that intent must be evidenced by a funding commitment to assure that HSAs are "well-armed" to perform their assigned duties in the civil rights arena.

SEDATIVES & HYPNOTICS

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BARBITURATES

Barbiturates are still the most commonly found drugs in the bloodstream of patients who have died by suicide. They are also the most commonly found drug, other than methadone, in the urines of methadone maintenance patients. They are abused, overused and readily available, both legally and illegally. Their use should probably be limited to (1) control of seizures — both recurrent and status epilepticus; (2) induction of anesthesia; (3) reduction of intracranial pressure and (4) treatment of withdrawal from drug dependence.

The symptoms of withdrawal from barbiturates include delirium, convulsions, status epilepticus and loss of temperature regulating mechanism (hyperthermia).

Treatment for withdrawal from barbiturates should be initiated using phenobarbital. The patient is given a dose of 200 mg P.O. and re-evaluated in 30 minutes to one hour. If the withdrawal symptoms have not abated during this time, one-half the dose should be repeated every hour until symptomatology abates. If seizures occur, the patient should be started on diphenyl hydantoin in addition to intravenous barbiturates.

Inadvertant injection of a barbiturate is a calamity. The solution is extremely alkaline and causes sclerosis of the small arteries of the periphery (usually the hand). This condition should be treated as follows: Meperidine for pain; Heparin — every six hours for four to six days; Low Molecular Weight Dextran — 500ml daily for five days (if a transfusion of blood is anticipated, adequate blood should be drawn for type and cross-match, as Dextran will interfere with proper cross-matching); Dexamethasone — at least 12 mg daily; elevation of the involved part and physiotherapy when tolerated (surgery is a last resort).

Long Acting Barbiturates: Phenobarbital and Methbarbital. The diagnostic clues are very few. The patient may present with coma, respiratory depression and hypotension. Leukocytosis is usually present. "Barb Burns" are large bullae present on the extremities. I have never seen these.

The half-life of these drugs is very long; phenobarbital — 96 hours, and methbarbital — 108 hours. Sixty to eighty percent of

The real clearance of these drugs can be markedly enhanced with alkaline diuresis. Fluid intake parenterally should be limited to 250cc per hour. In large studies, the morbidity and mortality escalate if the fluids are increased beyond this point. Blood pH must be limited to less than 7.55, since there is no increased excretion above this pH. In addition, with pH above 7.55 there is serious interference with the oxygen disassociation curve.

Intermediate Barbiturates — Seco, Amo, and Pentobarbital. As with the long acting barbiturates, the diagnostic clues of intermediate barbiturates are few. Though not common, cyclic coma can occur as the metabolic products are hypnotic. In addition, there are rare instances of "Barb Burns." The half-life of secobarbital is 24 hours, and the half-life of pentobarbital is 36 hours. The blood level will drop 10mg per ml every 10 hours. These drugs are cleared through the liver.

The treatment of the patient not in coma is ipecac, emesis, charcoal and cathartic. If the patient is in coma, extra-corporeal hemoperfusion extracts a fair amount of drug. The patient should be dialyzed only if he is in severe acid-base imbalance or severe electrolyte or fluid imblance. Alkaline diuresis has a small effect but not enough to warrant the increased morbidity with this technique.

CHLORAL HYDRATE

This drug is infrequently encountered at Charity Hospital. The diagnostic clues are pinpoint pupils, rapid onset of coma (knock-out drops, Mickey Finn) and gastrointestinal bleeding. The half-life of this drug is short. It is metabolised in the liver to trichlorethanol, which is the active metabolite.

If the patient is not in coma, the prephenobarbital is metabolized by the liver, and the remainder is excreted unchanged. Seventy to 90 percent of methbarbital is excreted unchanged.

The treatment, if the patient is not in coma, is ipecac emesis followed by charcoal. Cathartic should then be administered. If the patient is in coma, gastric lavage should be performed after the patient has been intubated. Extra-corporeal charcoal hemoperfusion is very effective, although it is expensive and time consuming. Moreover, thrombocytopenia is a complication of this therapy.