Chris Durham - PAD MAY 1972

ACTION KIT For Hospital Law

HOSPITALS LOSE THE WAR WITHOUT FIGHTING THE BATTLE . . .

H. E. W.'S Proposed Amendment of Hill-Burton

A serious and far-reaching setback for hospitals is H.E.W.'s decision of April 18th to issue proposed amendments to the Hill-Burton regulations. The new regulation would require all hospitals that have received Hill-Burton funds, and thus gave their assurance to provide a reasonable volume of free services to those unable to pay, henceforth to set this level of free services at 5% of operating costs and conform to a complicated Alice-in-Wonderland mechanism to demonstrate compliance.

The intent of the regulation is laudable. The terms of the regulation itself are unfair and the compliance procedure is either hopeless or a nightmare, depending upon how you look at it. It is going to increase patient and administrative costs and complexity, for which the hospitals will be blamed.

It is important that hospital leadership strongly urge alternatives to this proposed regulation — which should not have been issued at all. But it is likely that this war is already lost, because too few people ever saw the issues. Therefore, each hospital should begin to think about living with some form of the revised regulations.

How did things get to this point?

The Hill-Burton Act, 42 U.S.C., §291c, required that each applicant for Hill-Burton funds give an assurance that it would provide services for people who could not pay. The exact language is as follows:

(e) . . . Such [state plan] regulations may also require that before approval of an application is recommended . . . assurance shall be received by the state from the applicant that . . . (2) there shall be made available in the facility or portion thereof to be constructed or modernized a reasonable volume *[emphasis ours] of services to persons unable to pay therefor, but an exception shall be made if such a requirement be not feasible from a financial viewpoint.*

THE PRESENT REGULATION

H.E.W. issued a regulation, 42 C.F.R. §53.111, that explained the "assurance" requirement of the law. The exact words of this regulation are as follows:

Before an application for the construction of a hospital . . . is recommended by a State agency for approval, the State agency shall obtain assurances from the applicant that: . . . (b) The facility will furnish below cost or without charge a reasonable volume of services to persons unable to pay therefor. As used in this paragraph, 'Persons unable to pay therefor' includes persons who are otherwise self-supporting but are unable to pay the full cost of needed services. Such services may be paid for wholly or partly out of public funds or contributions of individuals and private and charitable organizations such as community chest or may be contributed at the expense of the facility itself. In determining what constitutes a reasonable volume of services to persons unable to pay therefor, there shall be considered conditions in the area to be served by the applicant, including the amount of such services that may be available otherwise than through the applicant. The requirements of assurance from the applicant may be waived if the applicant demonstrates to the satisfaction of the State agency, subject to subsequent approval by the Secretary, that to furnish such services is not feasible financially.

This regulation has remained the guideline for compliance with the statute up to the present.

SUITS TO FORCE COMPLIANCE

Within the last two years, several lawsuits have been brought against individual hospitals, contending that these hospitals which have received funds from the Hill-Burton program have not lived up to their assurance that they would furnish a reasonable

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Prison Health Care

Legal action to obtain hospital services for the poor has culminated in a number of suits filed against individual hospitals to contest their compliance with Hill-Burton, to which H.E.W. has responded with a proposed regulation which is the subject of this issue's main article.

These events should be seen as part of a general challenge to all institutions (including hospitals), using the courts and administrative action rather than the legislature, to force provision of benefits for the disadvantaged.

An interesting example is the recent case of *Hawthorne v The People of New York*, 328 NYS 2d 488(1971). Hawthorne, a prisoner at the correctional institution in Elmira, asked the court to compel the state to supply him with adequate medical care and to "cease and desist from subjecting the prisoner to cruel and unusual punishment by denying him a transfer to a correctional institution closer to New York City."

The prisoner alleged that he asked for reading glasses and replacement

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PHYSICIAN'S ASSISTANTS I

Physician's Assistants II - comprising the legal issues from the hospital's point of view and a recommended course of action, will be the June Insert.

A. WHO ARE THEY?

The latest entry into the field of providers of health care is the physician's assistant. What is he? -- as much a problem as a solution, at least from the point of view of the hospital. Just at the point when the courts are beginning to blanket hospitals with responsibility for the quality of care provided within their walls, regardless of whose hands actually delivered that care, a new category of health personnel is introduced which, by definition, is not within the direct control of the hospital.

1. WHERE HAVE THEY COME FROM?

The physician's assistant appeared on the scene because of the coming together of a number of unsolved, and quite conspicuous problems. These are the high cost of health care, the maldistribution of health care personnel, and the availability of a group of unutilized, partially trained providers of medical treatment who happen to be the objects of considerable public sympathy - the unemployed medical corpsmen among our veterans. These factors are readily combined into an equation of enormous political attractiveness. Put the corpsmen to work as assistants to physicians and thereby (1) extend medical coverage into geographic areas which do not at present have an adequate number of doctors and (2) realize the benefits of funds

already spent on their training instead of spending new funds on the training of more doctors and other medical personnel.

Unfortunately, the equation is balanced on some very shaky assumptions. One, that the skills and experience of the corpsman are those which are needed in the places where he will want to work, and, two, that he can work as an assistant to a physician and still, somehow, cover geographical areas in which physicians are lacking. But, be that as it may, the forces which produced him are real and powerful and the physician's assistant is, in fact, here. The next question is whether or not he can be used safely and effectively in the hospital now, and,if not, how his role can be restructured so that he can be in the near future?

2. WHERE DO THEY FIT AMONG THE HEALTH PROFESSIONALS?

Who is the physician's assistant vis-à-vis the other health professionals? As the title implies, he is not an independent specialist and must, therefore, always be considered with respect to the physician who is, after all, his link to the health care delivery system.

a. Doctors: The American Medical Association has determined to assume a leadership role in developing a national certification program for physician's assistants, and well they might. They would prefer legislation which permitted them to delegate certain specified procedures to qualified assistants, rather than that which would make it legal for the assistant

to practice medicine under the supervision of a physician.

It is an important distinction. The specification of procedures which the individual assistant is competent to perform lets the rest of the world know how to deal with him - patients, other health personnel, and provider institutions such as hospitals. It also has the advantage for the physician of making it more feasible to use the assistant outside of the physician's physical presence, and of limiting the physician's liability for the acts of the assistant when the scope of the assistant's competence has been made known to those who rely on it.

Certainly that approach is essential if it is intended that the physician's assistant be used in the hospital. And it is necessary that the physicians understand that if they wish to use their assistants in the hospital, they can only do so on conditions which are acceptable to the hospital. They would be wise, therefore, to consider this and seek the counsel of the hospital field in shaping legislation governing the use of assistants.

b. Nurses: Equally thorny is the problem posed by the relationship of the physician's assistant to the nurse. If the physician's assistant is generally thought of as working outside the hospital, it may not seem to be much of a problem. But once the assistant enters the hospital proper, the relationship will boil down (or over) to a simple but extremely tense question of "Who works for whom?" Professional nursing

is defined in the usual statute about as follows:

> ...the performance for compensation of any act in the care and counsel of the ill, injured or infirm, or in the maintenance of health or prevention of illness of others, or in the supervision and teaching of other personnel, or the administration of medications and treatments as prescribed by a licensed physician or dentist, requiring substantial specialized judgment and skill and based on knowledge and application of the principles of biological, physical and social science.

The nurse is someone educated and trained to perform, on her own, a number of tasks in the care and treatment of the ill. These tasks are performed as an employee of the hospital.

However, the hospital also makes the nurse available as an extra pair of hands, in effect, to the staff physician to carry out his explicit instructions in administering to a specific patient at his direction.

To the extent that they exist at all, statutes describing the physician's assistant characterize his activities as the rendering of medical services under the supervision of a physcian. This leaves everyone guessing as to whether he is an errand boy for the doctor, or a "quasi-doctor" himself. Most uncertain of all will be the nurse. In the absence of fixed educational and training requirements and independent responsibilities for the physician's assistant, she would probably tend toward placing him on the errand boy end of the scale. But the doctor, as well as the assistant, may think of him as a substitute for the doctor himself - with all the authority over the nurse which that implies. They might be left to work it

out among themselves in the doctor's office; in the hospital, it's a disaster.

Also inherent in the nurse/physician's assistant relationship is the male-female dichotomy and all that it entails in present society. Since the preponderance of nurses are women and the preponderance of physician's assistants are men, it is quite likely that work patterns and compensation schemes will reflect the traditional biases, and provoke all the new objections, unless care is taken in structuring the two professions. If the doctor employs a male assistant, he is likely to pay him on the basis of his being a man with a family to support; if a female, to pay her as a nurse. In any instance in which the assistant is actually employed by the hospital doing much the same type of work as the hospital nurse, the nurse is likely to demand equivalent compensation - and may very well be entitled to it under the Fair Labor Standards Act. Even where the statute is not strictly applicable, collective bargaining by the nurses could bring about the same result.

c. Others: Nurses, of course, are not the only allied health professionals challenged by the physician's assistant. Infringement on their field of activity is likely to produce pressure for further stratification of paraprofessionals by means of licensing and certification, a development which should send shivers up the spines of the hospitals. When the A.H.A. Board of Trustees called for a moratorium on licensure

of health professionals in 1969, they were already well aware of the limitations on career mobility and effective use of hospital personnel which result from state licensing statutes. Not only do they tend to establish a honeycomb of job slots which cannot be traversed by a hospital employee no matter how much additional skill he has acquired on the job. They also tend to establish a kind of group consciousness in which thwarted ambitions produce demands for higher salaries and more prestige. Hospitals already spend too much money on labor costs to want to encourage tendencies to increase them still further.

B. LEGISLATION.

To date, about twenty states have enacted legislation dealing with the physician's assistant. Several more have legislation pending. It is an area of great flux and cloudy outline.

1. EXEMPTION FROM THE MEDICAL PRACTICE ACTS

The laws thus far enacted are of two basic types: one simply exempts physician's assistants from the provisions of the medical practice act, the other type attempts to carve out a place for them. With respect to the former, the legislation of one state underscores the confusion inherent in the whole field: it exempts the assistant from the nursing practice act.

Exempting the physician's assistant from the medical practice act serves only to protect him - and at that, protects him only against penal sanctions by the state. It leaves everyone else, patient, physician and hospital, totally at risk in dealing with him. This approach embodies the classic American way of handling an emergent phenomenon - remove all of the obstacles in its way and let it develop "naturally". Unfortunately, this "hands off" attitude is singularly inappropriate in an area and a time where the risks, both medical and legal, are so great.

2. STATE "APPROVAL"

The other type of law attempts to give some shape to the field by requiring state approval of any one or more of the following: the training program, the supervising physician, and/or the assistant himself. But none of them has even attempted to answer the real question - what is the physician's assistant competent and allowed to do? The closest any has come, and it is only one state which has done so, is to require state approval of the job description of the physician's assistant. Interestingly, it is the same state which exempts from the nursing practice act, suggesting, perhaps, that it is at least sensitive to the real problems of putting the assistant to work.

3. LIMITATIONS ON THEIR USE

Some of the states have dealt with the more obvious aspects of where the assistant fits in the overall picture of medical practice by prohibiting him from performing acts in the areas of optometry, dentistry and/or chiropractic. New York has gone to the extreme of stating that assistants are not to perform any specific duties which are delegated by law to allied health professionals. This is an interesting reversal of the spectrum approach to health licensure: while theoretically a physician is qualified to perform any act within the scope of medical practice, he can delegate to his agent only the parts of medical practice not carved out for subspecialties. It also indicates the inevitable consequence of licensing all the subspecialties.

One of the other interesting features of the legislation passed in some states is the limitation on the number of physician's assistants per doctor. This could stem from an assumption that the assistant should not act outside the physical presence of his supervising physician. It could also reflect a belief that assistants will more than likely be males, and that males will have a stronger tendency to push beyond the scope of their competence in order to "get things done" than would females (nurses) and so must be controlled or it may be nothing more than an acknowledgment that since we do not yet know what a physician's assistant is, we had better not allow

any particular doctor to supervise too many.

C. THE ULTIMATE HAZARD: LIABILITY

The use of physician's assistants to provide medical services gives rise to potential liability on two counts. The first is in the possible violation of licensing statutes, the second is negligence.

1. VIOLATION OF STATUTES

In states which license, register or certify physician's assistants, failure to comply with the provisions of the statute will result in liability for the assistant, and the possibility of liability for the employing physician or hospital on the grounds of aiding and abetting the violation. The hospital might also be concerned about the possible loss of its own license for employing unlicensed personnel, although this seems unlikely. At present, only New York and West Virginia specifically authorize employment of physician's assistants by hospitals.

In states where there is no licensure for the assistant he is a layman, no more, no less, and both he and his employer run the risk of violating the medical and/or nursing practice acts unless he has been specifically exempted from their provisions. Again, employer liability is predicated on the aiding and abetting concept.

2. NEGLIGENCE

The more likely risk for all concerned is, of course, liability for negligence.

a. The Assistant Himself: Should a patient suffer harm as a result of an act of the assistant which did not meet the standard of care required in the performance of that act, the assistant will be liable for negligence and, in all likelihood, so will his employer - whether it be physician or hospital. If the profession has been recognized by certification or licensing, a standard of care for physician's assistants in the performance of their tasks will eventually evolve, and that is the standard to which they will be held.

One might add that one of the more alarming aspects of the lack of established standards for physician's assistants is the death of the locality rule. At an earlier time, the courts held that the standard of care to be applied to health professionals in negligence cases were the ordinary standards of care prevailing in their particular community. That rule has been changed, requiring professionals to meet the general standard of care of their peers. Given the fact that the role of the physician's assistant is nowhere defined, and that educational and training requirements are very varied, when they exist at all, establishing a standard of care against which to measure licensed physician's assistants will be an extremely difficult task.

Where the assistant is not licensed by the state, he is a layman and nothing more. Yet the standard of care applied will not be that of a layman. A number of cases already decided involving medical personnel indicate that a person performing a medical act is held to the standard of care of the professional performing the same act. In *Brown v Shyne*, 151 N.E. 197 (NY 1926), an unlicensed chiropractor was sued for causing paralysis by manipulation of the patient's spine. The court said, "The defendant in offering to treat the plaintiff held himself out as qualified to give treatment. He must meet the professional standards of skill and care prevailing among those who do offer treatment lawfully. If injury follows through failure to meet those standards, the plaintiff may recover."

In another case involving a chiropractor, *Whipple v Grandchamp*, 158 N.E. 270 (Mass.1928), the court said that manipulation of the spine was the practice of medicine and, despite the fact that the chiropractor had told the patient he was not practicing medicine, he was so doing in violation of the statute, and that negligence could properly be inferred.

More recently, a Louisiana court decided in *Thompson v Brent*, 245 SO.2d 751 (La.1971), that a doctor's office medical assistant was bound by the same standard of care as the physician in removing a cast with a Stryker saw. So if the physician's assistant is doing what is determined by court to

be a medical act he will be held to the standard of care of a physician.

If the physician's assistant performed an act customarily performed by any other health professional, such as a nurse, he would most likely be held to the standard of care applicable to nurses. *Barber v Reinking,* 411 P.2d 861 (Wash.1966), held that a practical nurse giving an injection would be held to the standard of a registered professional nurse because, by statute, only professional nurses could give injections.

Finally, with respect to the liability of the assistant himself, a recent case suggests that he might not be entitled to the same statute of limitations as would the professional in whose place he presumed to act, and thus the time he could be sued after the injury would be longer. *Simpson v Hubert,* 193 N.W.2d 68 (Mich.1971).

b. His Physician/Hospital Employer: Beyond the liability of the assistant lurks the possible liability of his employer, physician and/or hospital. Some of the states have dealt with the question of physician liability by statute. Utah provides that a physician shall supervise and direct the assistant and be liable for his acts and omissions. Washington holds the physician personally and professionally responsible for all acts of the assistant which constitute the practice of medicine. Florida attempts to limit liability to acts or omissions of the assistant while acting under the super-

vision and control of the physician, although it remains to be seen whether a court will permit such a limitation.

The usual rule, of course, is the doctrine of respondeat superior, which holds the employer liable for the acts of the employee where the employee is reasonably presumed by others to be acting for the employer. This doctrine would certainly apply to the physician for whom the assistant works, and might also apply to the hospital if, in fact, the hospital has employed him. Even if the physician's assistant is not the employee of the hospital, there is still a possibility of liability under this doctrine in any instance where the assistant is found to be acting on behalf of the hospital rather than the physician, and is thus considered a "borrowed servant".

c. The Hospital: Hospital liability for a negligent act of the physician's assistant that occurs within the hospital is a real and serious possibility even if it is clear from the facts that the assistant is acting for his physician employer and is not employed by the hospital. Such liability would be in addition to, not in replacement of liability by either the physician or the assistant himself. What we are speaking of here is corporate liability.

Following the precedent set in the famous *Darling* case, and those cases which have followed it, courts have been reasoning that patients look to the hospital for care, that they cannot be expected to inquire into the credentials of those

who minister to them in the hospital. Therefore, the hospital can be held responsible for the selection, supervision or working relationships of those who treat the patients, whether or not they are employees. These general rules would quite clearly be applicable to physician's assistants.

D. THE PROBLEM FOR THE HOSPITAL, GENERALLY.

The problem posed by the physician's assistant inside the hospital itself can be summed up by asking: Why is he there? If he is not an employee of the hospital, by what authority is he on the premises dispensing medical services, of whatever sort? There really is no answer.

He is not a physician, and is not a member of the medical staff. Therefore, he has been given no "right" to use the hospital in the care of patients. It is conceivable, of course, that he could be given some type of adjunct medical staff membership or clinical privilege,but to do so could give him a position in the hospital independent of his supervising physician and, at the very least, it raises the nurse-assistant problem squarely.

Medical staff membership and privileges are personal and non-delegable, privileges which the physician's assistant could not be given "through" his supervising doctor. And, to grant him privileges, however restricted, independently, is to consider him an independent operative in the hospital who has

been personally approved as to his qualifications by the hospital acting through its medical staff. In the absence of clearly established job descriptions, and, more important, educational standards, it is highly risky for the hospital to do this.

If he is not given certain privileges, and he is not a hospital employee, how is the hospital to exercise any control over him while he is on the premises? One method, of course, would be to limit his activity to the carrying out of explicit, direct orders given by his supervising physician within the physical presence of that physician. In that case, control over him is established and maintained by control over the physician. Unfortunately, however, that tends to make his presence entirely superfluous. Nurses and other employees are available to carry out the doctor's orders.

Can he be a conduit for conveying the doctor's direct orders to other hospital personnel? Residents? Interns? Nurses? Are they obliged to obey such orders? If they do, are they acting on behalf of the doctor who has issued the orders, or the hospital which pays them? What if they refuse? Each of these questions presents real legal problems.

Difficult as the questions are for the hospital when applied to the admitted private patients of the supervising physcian on the floor, they become even more so when the assistant is permitted to substitute for his physician-employer in the

emergency room.

In short, it is difficult at this point in their development to see either a legal or actual justification for permitting physician's assistants to act in hospitals as a substitute for their physician employers.

Yet, the hospital should be ready to try any innovation that promises better manpower utilization without risk to patient care. And the use of physician's assistants outside the hospital seems to have great merits.

What can be done?

Next month's Insert will explore the legal issues from the hospital's point of view and recommend a course of action.

-END OF PART ONE-