Correspondence

Allied Health Professionals: A Further Look Needed?

Dear Editors:

While John Grad was faithful to the title of his article, *Allied Health Professionals and Hospital Privileges: An Introduction to the Issues*, published in the September issue, the subject needs further elaboration beyond "an introduction," in order to indicate properly the complexity of the subject. Having dealt frequently, and often at some length, with hospital administrators and medical staff leaders on the subject of hospital privileges for non-physician practitioners, I can say that while there is considerable opposition to granting privileges to such practitioners on competitive grounds, introducing them as independent, entrepreneurial practitioners within the hospital setting raises some substantial, and legitimate, questions.

I want to focus upon podiatrists and nurse-midwives, because I see both as "limited practitioners" who have been recognized, both by law (nurse-midwives in several states only) and consumer choice, and for whom certain quality of care arguments applicable to other limited practitioners who seek hospital privileges cannot be made. Many of the considerations raised by those who question the appropriateness of hospital privileges for such practitioners arise from the requirements imposed by the Joint Commission on Accreditation of Hospitals (JCAH) and certain state hospital regulatory agencies, which require supervision and the provision of complementary services by physicians and which can be construed as creating burdens on physicians that many, for noncompetitive reasons, are reluctant, even unwilling, to assume.

The *Accreditation Manual for Hospitals* states: "Admission of a podiatric patient shall be a dual responsibility of the podiatrist and a physician member of the medical staff. . . . Surgical procedures performed by podiatrists shall be under the overall supervision of the chief of surgery."[1] The *Manual* goes on to require as follows:

> Patients admitted to the hospital for podiatric care shall receive the same basic medical appraisal as patients admitted for other services. This includes having a physician who is either a member of the medical staff or approved by the medical staff perform an admission history and physical examination, and record the findings in the medical record. The podiatrist is responsible for that part of the history and physical examination that is related to podiatry. A physician member of the medical staff shall be responsible for the care of any medical problem that may be present on admission or that may arise during hospitalization of podiatric patients. The physician responsible for evaluating the general medical status of a podiatric patient shall determine, with consultation if necessary, the overall risk assessment and effect of the operation on the patient's health.[2]

It is readily apparent from the foregoing that the podiatrist cannot admit and care for the podiatric patient with the same degree of independent responsibility that is customary for physician members of the medical staff. The podiatrist lacks both the breadth and depth of training, and the legal authority of the physician. Furthermore, both the JCAH and state licensing agencies apparently ignore the question of payment by, or on behalf of, the patient for services rendered by physicians to the podiatric patient, for both specific services, such as the taking and recording of a history and the performance of physical examination, and maintaining oversight over the patient in order to be aware of such medical needs as may arise during the course of the hospital stay. A podiatric patient may have multiple problems; for example, a patient with diabetes or some other condition may well require some medical intervention for good quality patient care during the hospital stay for podiatric services.

I have noted that part of the physician reluctance regarding the question of granting hospital privileges stems from the physician's concern that if a podiatrist is granted privileges and is unable to find a physician willing to accept these responsibilities for the patient that the podiatrist seeks to admit, then the medical staff organization will be used to compel physicians to accept these responsibilities for podiatric patients. The typical response is along these lines:

> "I have nothing against podiatrists, but I don't want to be forced to assume a responsibility to a patient just because a podiatrist wants to admit his patient. Our freedom to not get involved may be compromised once we grant privileges to him. Besides, am I entitled to be paid, and will third party payors recognize my right to be paid, for the history, and the physical that I perform, as well as chart review and other activities during the patient's stay in the hospital?"

Physicians point out that, if the patient is under the care of an orthopedist for the services rendered by a podiatrist, no other physician automatically has to accept responsibility for the patient.

Issues of a similar nature arise with regard to hospital privileges for the nurse-midwives. I do not note similar specific provisions in the *Manual* concerning nurse-midwifery practice in hospitals; however, the very circumstances of nurse-midwifery practice in the hospital, which is limited to obstetrical care for normal labor and delivery, presupposes the availability of a qualified physician ready and willing to assume responsibility when the legal limits of the nurse-midwife's practice are reached. For example, even where nurse-midwives are legally permitted to practice, they lack the legal authority to select medications which may be necessary for their patients. This situation and others entail the intervention of physicians and, where no obstetrician on the medical staff has committed himself in advance to provide medical support when needed, a process to compel physician intervention might become necessary in order to fulfill the hospital's obligation to the patient. If a physician is required to

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https://doi.org/10.1111/j.1748-720X.1982.tb00791.x Published online by Cambridge University Press

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accept responsibility for the care of an obstetrical patient of the nurse-midwife, in order to provide services which may not be rendered by the nurse-midwife, the payment question arises also. Much of the difficulty one may anticipate in the context of hospital nurse-midwifery practice may be obviated when nurse-midwives and obstetricians are joined in a group practice.

It could be asserted that the JCAH, in its provisions dealing with podiatric practice in the hospital, is too rigid, and that the requirements for physician responsibility are unnecessary in the interest of providing an adequate level of patient care. If that is the case, then its requirements, and those of state hospital regulatory agencies which often copy JCAH requirements, should be modified. On the other hand, if requirements for physician involvement and responsibility are sound, there can be a serious burden placed upon the medical staff, on behalf of the hospital, to establish procedures which have the net effect of forcing physicians on the medical staff to associate themselves with podiatrists in the care of their patients even though that may be contrary to their personal desires. Again, medical staff members are not compelled to attend every patient that an orthopedist admits for the same procedures, and therefore the reluctance to grant privileges to podiatrists is understandable.

The proponents of independent, entrepreneurial practice for limited practitioners in hospitals need to address realistically the issue of providing the necessary physician supervision and/or responsibility. It is simplistic to assert that the negative position of physicians is solely the result of anti-competitive motivation. Physicians have a legitimate argument against being compelled to become associated in the care of patients who have selected limited practitioners, and they may be even less motivated by economics than are the limited practitioners, who seek the opportunity to practice in hospitals to generate additional income for themselves. It is also possible that, if the physician who is to assume responsibilities to make practice by the podiatrist possible in the hospital is to be compensated along with the podiatrist, the net cost to the patient and/or third party payor may be greater than if the patient were to receive the entire service from an orthopedist.

Finally, I would like to suggest that there are questions involving informed consent and the patient's role in selecting the responsible physician, which also require examination in the context of hospital privileges for limited practitioners.

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Professor of Health Law
Graduate School of Public Health
University of Pittsburgh
Pittsburgh, Pennsylvania

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2. *Id.* at 98.

Withholding Treatment

Dear Editors:

As author of the article, *Terminating Treatment for Newborns: A Theological Perspective*, which appeared in the June issue, I wish to comment upon the letters published in the Correspondence section in September.