

THE LEGAL DELEGATION OF MEDICAL RESPONSIBILITY: A COMPARATIVE FRAMEWORK

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ABSTRACT

Medical science has evolved toward greater specialization, with expertise being increasingly concentrated on ever-more specific subjects. As medical professionals are often unable to handle all related tasks on their own, when it comes to diagnosis, treatment, and especially surgery, such responsibilities have been delegated to third parties. This paper explores the legal issues surrounding delegation, particularly as they pertain to contracts. When physicians are obligated to fulfil a contract as a health care provider and when are they not? What kinds of practices and procedures may be delegated and to whom? This paper addresses those questions in a comparative context that includes legislative action in France, Egypt, Jordan, the United States, and Canada. Finally, this paper proposes a new and broader conceptualization of delegation within the medical field that focuses less on specific treatments and more on motivations and goals. The paper can help raise awareness about the legal aspect of delegation among researchers, practitioners, and policy makers, in order to facilitate health care delivery without legal complications.

Keywords: Delegation, Legislation, Liability, Medical Contract, Medical Assistants.

INTRODUCTION

The evolution of the medical profession has been characterized by specialization, which refers here expertise being concentrated on ever-more specific subjects or skills. Not surprisingly, most physicians cannot keep pace with specialization; they cannot provide patients with a full range of diagnosis and treatment. Therefore, it has become common for physicians to delegate portions of these duties to relevant medical staff and to do so within established parameters that are defined by specific terms and conditions. In today's world all professional services have their legal and contractual implications. There is a commitment, or a contractual responsibility, owed by a service provider to a client, much like the responsibility of a debtor to a creditor. This arrangement between the two parties tends to be stipulated by a written contract. Sometimes, a third party plays a role in arbitration of enforcement, especially when contractual responsibility is somehow in question or contested, which often calls attention to the issues of error, harm, and the possible causal relationship between error and harm.

Scenarios

This paper was motivated by need to resolve some of the legal issues raised above, and it becomes useful to describe three scenarios that involve a third party interfering with the provider-client relationship such that the provider fails to fulfil the commitment to the client. These three scenarios, described below, are labelled Scenarios 1, 2 and 3.

Scenario 1

A third party (with no relationship with the two parties in the contract) produces odd interference or an odd cause, voiding the contract and ending the provider's contractual responsibility (Helmy, 1984).

Scenario 2

A third party (usually in collaboration or collusion with one of the parties) produces non-odd interference or a non-odd cause, which neither affects the validity of the contract nor ends the provider's contractual responsibility.

Scenario 3

Provider who is somehow unable or unwilling to fulfil a contract delegates its full or partial execution to a third party.

This paper is not concerned with Scenario 1, but it is useful to describe a condition under which a contract cannot be fulfilled. An extreme but still relevant example might be that of a mayor of a city, who as a third party orders a home-quarantine lockdown for all of the city's residents, effectively ending all face-to-face contact between the provider and the client for the medically and contractually relevant term.

This paper is concerned with Scenario 2 only insofar as it yields Scenario 3, which is the topic of interest. Scenario 3 occur if a physician, as a medical provider, seeks the assistance of a third party (such as an associate, assistant, or nursing staff) to help fulfil the terms of the contract. Under this scenario, if that third party's actions lead to the contract's non-fulfilment, then the original physician, as the original provider, still remains contractually bound to fulfil the contract and make seek continued assistance. This process of using third parties to fulfil the contract is known as "*delegation*" in the medical field.

Delegation in a Comparative Context

Savatier et al. (1956), a French jurist, conceived of medicine practice as "*the act performed by a qualified person to heal others.*" Under that basic conceptualization, it is possible to offer both narrow and wide definitions. A narrow definition of medical practice, largely accepted by jurisprudence, runs as follows:

"... what is justified by treatment necessity, whoever the practitioner be, and it grants the in-charge actor (doctor) with the freedom to act upon a patient's body... the knowledge aspect that relates to the healing topic, disease mitigation, and prevention" (Al-Barghouthi, 2003).

A wide definition runs as follows:

"Any activity that concerns the human body or himself, where its nature and the how-to acting it, matches with the scientific principles and norms recognized, theoretically and practically in medicine science. And it is carried out by a legally authorized doctor with the intention of disclosure, diagnose and treat the disease to achieve recovery or to reduce the patients' pains or eliminate it, or prevent disease, or for the purpose of preserving individuals health, or achieving a social benefit, with the condition of the service recipient satisfaction"(Qaid, 1987).

Expectedly, different countries and their legislatures have come to define the medical profession and its practice in different ways. In France, for example, the French Medical Laws of 1892 limited the scope of practice and made it illegal for non-physicians to offer medical treatment or perform surgery (Renaut, 1999). This regulation was further defined by the Health Law of 1945 and extended to diagnosis.

In Egypt, the Medical Profession Practicing Law 1954 stipulated only those professionals designated by the Minister of Public Health could practice medicine, which included the areas of diagnosis, advice, treatment, sampling and testing, surgery, obstetrics and prescribing medication¹.

In Jordan, the Public Health Law No. 47 of 2008² clarified that all of what is normally considered medical practice (as mentioned above) is to come under the purview of the Council of Ministers, and this included “... *dentistry, pharmacy, nursing, anaesthesia, radiology, speech and hearing treatment, visual examination, eyeglasses erection, contact lens, clinical psychology, mental health, splints...*,” and any other practice deemed medical by the Council of Ministers, which also mandated that anyone advertising medical services and practicing in that capacity must obtain a license from the corresponding Ministry.

The efforts to regulate the profession in France, Egypt, and Jordan may be commendable, but these and other efforts lack a precise definition of medical practice. While there is a tendency over time to see more activity included under regulation, such as dentistry and radiology, it would have been more effective to include even more activity, and not necessarily remain so limited. Here, it is possible to mention the possibility that medical practice could include chiropractic treatment, massage, detoxification programs, and other practices often described as “*alternative medicine*.”

More clearly, none of these definitions found in France, Egypt, and Jordan and elsewhere have kept pace with developments in either mainstream or alternative medicine. Ideally, the definitions used in both jurisprudence and by legislatures should be sufficiently comprehensive so that they account for present and future changes. Definitions that are both broader and more precise also help the medical profession when it comes to each stage, and this includes education, training, consultation, diagnosis, treatment, surgery, recovery, and prevention. Better definitions also help to advance research and to avoid problems in the legal and insurance areas. In short, better definitions represent a win-win scenario in which everyone benefits.

In this paper, “*delegation*” is the process by which the original health care provider designates, assigns, or tasks a third party, the “*delegated*,” to carry out a specific activity. While legislatures in the Arab world have a long history of addressing this issue as it pertains to the medical field, it is somewhat newer to legislatures in the West. In Canada, for example, the first legislative mention of “*delegation*” was in the Regulated Health Professions Act (1991), which defined the term as follows:

“... *A mechanism that allows the delegated physician to perform a subjected activity to monitor, by granting this authorization to another person (whether in regular or other than that) that was not being independently delegated to perform the activity. It is not considered as a delegation process, if it is a permission to launch a monitored activity within the scope of professional practice for the other health specialist, and also it is not counted as a delegation, if it is referring the patient to some other doctor or specialist for care purpose*” (Mahmoud, 2016).

In most countries, delegation is part of General Law, with its basis and terms derived from Administrative Law. Administrative delegation is not statutory unless permitted by the

legislature, as a function of law or the constitution, and this is the first step in creating a specific specialization. Jurisprudence also tends to stipulate the general conditions of delegation such as if it is partial or full, that is, the extent to which responsibility is transferred to the third party. Here, delegation tends to run from top to bottom in terms of professional hierarchies, with recognized limits on how delegation may be amended or restored (Abdullah, 1986). However, delegation in civil proceedings differs to that under administrative law.

Crucially, three conditions must be adhered in the effort to fulfil a contractual responsibility:

1. The identification of a valid contract between the provider and the client.
2. The recognition that if there is a breach of contract, the provider is still accountable and must fulfil its terms.
3. The provider entrusts third party to fulfil the terms of the contract.

Medical Contracts: The Legal Basis for Delegation

In jurisprudence, a medical contract is regarded as a consensual contract, having been produced by mutual consent (Dagher, 2009). Such a contract is based on the patient's or client's selection of a physician, presumably for a combination of personal and professional qualities, both documented and reputed, in a process that involves a measure of trust (Savatier et al., 1956). Just as the patient has the right to decline entering into a contract, so too does the physician have the right to refuse it. However, if the physician accepts the contract then the physician also accepts the obligation to adhere to its terms of treatment and remains bound by that contract unless it can be fulfilled by a third party (Dagher, 2009).

The peculiarity of a medical contract, which makes it different from other contracts, is that it concerns the human body. As a result, there is a degree of unpredictability involved, owing to complex and fallible nature of human anatomy. Here, the "*do no harm*" principle of the Hippocratic Oath becomes important. The right to life and bodily integrity are both in the hands of the Creator.

Another consideration is that the relationship between the physician and the patient is unequal because the former is a professional with a high degree of knowledge and specialization, while the patient, despite education level, is likely to be unfamiliar with the details of diagnosis and treatment. Another source of inequality in this contractual relationship is that only one party, the patient, risks suffering from ineffective treatment or a physical or psychological relapse (Al-Khatib, 1989; Al-Hikma, 2014).

A medical contract is a continuous and dependent based on the essential element of time, given that the patient's first appointment to the doctor usually focuses on diagnosis, and given that most treatment is not immediate. Normally, a patient visits the doctor several times, with regular follow-up appointments after treatment, to monitor the original problem. Crucially, the physician is not permitted to abandon his patient and stop treatment, which would be considered as a breach of contract (Ashoush, 2007; Al-Tabakh, 2003).

Normally, there is nothing in a medical contract that prevents the physician from delegating certain tasks to qualified associates or assistants. The contract also remains valid if a third party oversees or manages its implementation. As long as the attending physician retains supervisory authority to issue instructions.

Delegation is an area whose legal framework differs across countries, but unfortunately most legislatures have not been sufficiently clear about this concept and its application. Many legislatures around the world, including those in France, Egypt, and Jordan, have created laws

that address delegation in implicit rather than explicit terms. Such laws provide some latitude for physicians delegating tasks to third parties. Consider, for example, the law in Egypt as passed in 2004 and detailed below.

1. Article (1/A) The Private Clinic: *“A facility owned or rented and managed by a doctor or dentist, where he may be assisted by one or more physicians, that are licensed to perform a similar profession.”*
2. Article (1/B) The Speciality Clinic: *“A common clinic, whereby more than one physician of different specializations act within it, and they are administrated jointly, where one of them is the technical director and in-charge for the clinic.”*
3. Article (1/D) The Specialized Medical Centre: *“The private hospital is a facility prepared to receive patients, for their check-up and treatment, provided that it is supervised and managed by a physician who is authorized to perform the profession.”*

Another example is furnished by Jordan, specifically by its Public Health Law No. (47) of 2008.

1. Article (19 paragraph c): *“The director or the authorized physician has the right to take samples”*.
2. Article (20 paragraph A): *“Must upon any physician who supervises or participates in treating an infected”, in addition to Article (27) that mentions: “The prosecutor or the authorized governmental doctor may take all necessary medical measures for the patient”*.

It is discerned from these statements that medical practice, both preventive and curative, can be delegated under licensed supervision and oversight.

The United States and Canada also offer examples. In the US, the 2005 Health Professions Law of Texas stated the following:

“A physician may delegate any medical duty to a properly qualified and properly trained person, acting under the supervision of a physician thereby performing by the standard methods, without violating any law. The wise physician within the scope of proper medical judgment considers him. It is required that the person to whom the duty was delegated did not announce to the public that he was authorized to medical performance, in the event that the commissioner is not a doctor.”

Here, the delegating physician remains responsible for the medical acts of the person performing the delegated medical acts. The same law stipulates the following:

“A person whom a physician delegates to perform Medical duty is not permitted to perform the medicine without a license”.

In the US, where medical practice is a state matter and not a federal matter, the 50 states have laws similar to Texas. As seen above, that law authorizes a physician to delegate a practice to a properly qualified, trained, and licensed person from a competent authority, with the physician remaining ultimately responsible for treatment outcomes, provided that this does not conflict with any other laws.

In Canada, a similar law is seen in its 1991 Controlled Medical Acts³. Licensed health professionals/physicians are authorized to perform 13 out of the 14 acts falling under regulation and those professionals may, in appropriate circumstances, delegate those acts to third parties who may or may not be members of a regulated health profession.

Forms of Delegation

Delegation can result from

1. Direct orders or
2. Medical directives and each one are normally seen as facilitating the effective health care.

The first source of delegation is a direct order, which takes place after establishing the relationship between the doctor and the patient, then it takes the form of a physician's instructions to a third party, involve just one patient, and can be issued orally (in person, by phone, or through video-conferencing) or in writing.

The second source of delegation is a medical directive, which, for a named patient and pertinent dates, must include sufficient detail about diagnosis and safe treatment, along with the patient's relevant medical record, an identification of the third party or parties authorized to implement the directive, and the signature and date of the physician authorizing responsibility.

Another important dimension of delegation in the medical field concerns the nature of the activity performed, without consideration of the person carrying it out. In France, this was confirmed by the French Council of State in the Rouzet decision of 1959⁴. According to this decision, the delegation of a specialization to a medical assistant still retains its defining quality; it remains as a medical activity regardless of the performer (Catherine, 1998).

Based on the observation above, three conditions emerge.

First Condition

A partial delegation and its alignment with the capabilities of the delegated party. German jurisprudence holds the following:

"... The physician may have the right to rely on his staff (whom he had trained and supervised carefully) in carrying out his duties properly, but he is not permitted to delegate to them his professional duties, and if he does that, then he will be directly responsible (personally) for his negligence in doing that and for all the acts of negligence or omission of his employees for carrying out all the erroneously done entrusted tasks".

Second Condition

The physician, as the delegating party, must supervise the implementation of the delegated procedures such that prevailing medical standards and practices are maintained. In France, the Ministry of Public Health, after consulting the National Academy of Physicians, divided delegated tasks into two kinds. First, there are simple tasks are dedicated to a third party by default, if the assistant is deemed competent. These tasks are further divided into

1. Daily tasks related to hygiene, monitoring vital signs, and keeping the physician informed, which are tasks often performed by nurses.
2. Simple therapeutic and nursing tasks such as preparing for surgery and taking blood samples, which are normally carried out without direct supervision (Hennan, 1987).

A second set of tasks is more complex and pertain to a third party's involvement in diagnosis and treatment, and this is also further divided into two parts:

1. Tasks requiring the physician's detailed instruction, and while there is no direct monitoring, the physician is accessible for immediate intervention if necessary (Al-Tabakh, 2003), and

2. Tasks requiring the physician's direct and on-site supervision (Al-Tabakh, 2003), and these are more delicate tasks such as anesthetizing a patient for surgery, providing him with blood while performing an operation, using X-rays and red rays and injecting risky medication (Savatier et al., 1956).

Third Condition

It is essential that the boundaries of delegation be precisely and clearly defined by the delegating physician, either in an oral or written fashion, in order to avoid misunderstanding and conflict.

Toward a New Conceptualization

As the case studies and examples above suggest, many legislatures have furnished definitions or laws in a way that catches-up, or tries to catch-up, to developments in the field. In other words, laws are passed, realities change, and new laws are needed. One reason is because legislatures have focuses on this or that practice or procedure, without considering the larger picture.

This paper offers a wider definition that may conceivable last for practical purposes. Delegation in medical practice may therefore refer to the following:

“A physician or medical professional assigning a procedure to a professional third party, recognized by the state as qualified, that involve a health and wellness when it comes to a patient's body, mind, or emotions.”

The first part of the definition is precise but not unlike other definitions of delegation. It is the second part that is more original and broader, able to accommodate future technological developments and increased specialization.

CONCLUSION

The medical profession can be identified by its exclusive responsibility over a patient's health, from diagnosis to treatment to follow-up. Due to the complexity of disorders and disease, and due to the increasing degree of specialization, it is not always possible for a physician, as a health care provider under contract, to administer a single diagnostic or treatment procedure (Qaid, 1987).

This paper has shown how France, Egypt, and Jordan have attempted to resolve the issues emerging from the new realities of the medical profession. Their legislatures have defined the scope of medical practice and described-implicitly or explicitly—those practices that may be delegated to third parties. Western legislatures such as those of the US and Canada have tended to be more explicit about delegation than other legislatures. This paper has also reviewed the various conditions pertaining to delegation.

This paper calls attention to the importance of research on the topic of delegation and to its greater appreciation on the part of legislatures, in order to further improve the quality of medical care.

ENDNOTE

1. Law No. (415) for the year 1954, in the matter of practicing the medical profession, published in the Egyptian facts on July 22, 1954, No. 58, this law was amended by the law's numbers: (491 of 1955, 319 of 1956 and 29 of 4665).
2. Jordanian Public Health Law, No. (47), of 2008, in the Official Newspaper, No. 4924, p. 3450, dated August 17, 2008.
3. Controlled Acts under the RHPA:

Regulated works under the RHPA Act have been briefly mentioned as follows:

1. Inform the individual or his/her representative of a diagnosis that identifies a disease as a disorder or as a cause of the individual's symptoms.
 2. Perform the procedure on the tissue under the dermis or under the mucous surface.
 3. Treating or repairing a broken bone or dislocation in the joint.
 4. Moving the spine joints beyond the normal physiological range of the individual.
 5. Providing drugs by injection or inhalation.
 6. Place a tool, a hand, or a finger until after the outer ear canal, until after the throat, until after the urethral opening, until after the opening of the vulva.
 7. Implementing or regulating the application of a form of energy determined by the executive regulations in the health professions law.
 8. Prescribing, dispensing, selling, or refining medications as defined in the Pharmacy and Drugs Act.
 9. Prescribing or dispensing medications for vision or eye problems, and prescribing or dispensing vision devices, lenses, or other eyeglasses.
 10. Description of one of the hearing aids for the hearing impaired person.
 11. Preparing or cutting out a prosthesis or orthodontic prosthesis.
 12. Managing work or conducting child deliveries.
 13. Taking an allergy test.
 14. Treatment by means of psychological therapy technique, and providing it through the therapeutic relationship, thought disorder, serious perception of the individual or mood disorder and emotional regulating.
4. French jurisprudence referred to this decision, indicated by: There is no need to focus on qualifying the medical act, on the quality of the person who performed the act, but on the nature of it.

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