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# A Study on Legal and Ethical Issues Surrounding Health Practitioner Pro Bono Services

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## Abstract

The purpose of this paper is to explore the legal and ethical implications of *pro bono* health care services in the United States and abroad. The research regarding volunteer or pro bono health services has focused mainly on physician involvement in volunteer medical services, or pro bono health services, with research showing only 39% of physicians, compared to 30% of general public, taking part in volunteer services to patients and the community (Grande, D, and Armstrong, K, 2007). Historically, pro bono services were derived from the Canons of Professional Ethics in 1908 and evolved into the Model Code of Professional Responsibility in 1969 and finally the Model Rules of Professional Conduct in 1983. The World Health Organization developed the Commission on the Social Determinants of Health in 2005, which include the following goals: (1) Improving living conditions (2) Addressing the inequitable distribution of power, money, and resources, and (3) Measuring and understanding the related problems (WHO, 2008). In the final report, the four areas of concern included socioeconomic factors, patient health care accessibility, health care rationing, and patient advocacy. Pro bono health services are one method of addressing the health care accessibility and socioeconomic factors surrounding the current dilemma in health care.

Key Words: pro bono, ethics, world health organization, universal health care

### **A Study on Legal and Ethical Issues Surrounding Health Practitioner Pro Bono Services**

The purpose of this paper is to explore the legal and ethical implications of *pro bono* health care services in the United States and abroad. The research regarding volunteer or pro bono health services has focused mainly on physician involvement in volunteer medical services, or pro bono health services, with research showing only 39% of physicians, compared to 30% of general public, taking part in volunteer services to patients and the community (Grande, D, and Armstrong, K, 2007). Historically, pro bono services were derived from the Canons of Professional Ethics in 1908 and evolved into the Model Code of Professional Responsibility in 1969 and finally the Model Rules of Professional Conduct in 1983 (Scott , 243). The World Health Organization developed the Commission on the Social Determinants of Health in 2005, which include the following goals: (1) Improving living conditions (2) Addressing the inequitable distribution of power, money, and resources, and (3) Measuring and understanding the related problems (WHO, 2008). In the final report, the four areas of concern included socioeconomic factors, patient health care accessibility, health care rationing, and patient advocacy (WHO, 2008). Pro bono health services are one method of addressing the health care accessibility and socioeconomic factors surrounding the current dilemma in health care.

In the early 1990's lawmakers feared the tort liability would discourage volunteers from providing medical services for the community that needed it most, those who were socio-economically disadvantaged. This led to the enactment of the Volunteer Health Practitioners Act of 1997 (Horwitz and Meade, 2009). Only one case of opposition to this Volunteer Health Practitioners Act is noted in the literature. It is the case of Andrew Popper (1998), who adamantly opposed the legislation, citing the disfavor done to the most vulnerable population in favor of the majority and protection of the powerful. Very few cases of volunteers being sued for negligence are listed in the courts and literature. One such case

involved a young man who was lifted onto a stretcher and taken down a mountain by a group of volunteer medical staff. He sued the staff suggesting they caused his quadriplegia, but he did not continue on with the case (Weber, 1991). Perhaps much of the perception of “public fear” regarding volunteer service has stemmed from the litigious culture in which we live, coupled with a health care system that does not allow access to all citizens, but is quick to place legal injunctions on those who volunteer to close the gap in health care services.

Most of the research on legality of volunteer medical services emphasizes emergency medical relief and the issues arising from health care workers who are not employed by a specific agency to perform volunteer work and may find the fear of civil liability charges to be prohibitive (Hodge, 2007). The Uniform Emergency Volunteer Health Practitioners Act of 2006 was developed primarily for emergency situations and disaster relief (UEVHPA, 2006). The act does not provide protection for health care providers during non-emergency, non disaster relief situations, however, it does set the stage for specific states to use as a reference when considering non-emergency health care volunteer work and the issues related to civil liability and malpractice insurance, which arose in the early 1980s (Vine, 2006).

*“This act (1) establishes a system for the use of volunteer health practitioners capable of functioning autonomously even when routine methods of communication are disrupted, (2) provides reasonable safeguards to assure that health practitioners are appropriately licensed and regulated to protect the public’s health, and (3) allows states to regulate, direct and restrict the scope and extent of services provided by volunteer health practitioners to promote disaster recovery operations.” (UEVHPA, 2006).*

This ESARVHP, emergency systems for the advance registration of volunteer health professionals, was designed to assist in establishing coordination among health care professionals across states in the state of an “emergency”. However, the term “emergency” was not well defined; liability for health care providers who respond to a volunteer emergency situation is not well defined, and issues related to injury compensation to the volunteer was not addressed (Hodge, Gable, and Calves, 2005).

There are several legal penalties a health care practitioner could be implicated in aside from criminal law suits and regarding patient care, three common lawsuits in healthcare include: torts, negligence, and malpractice law suits (Pozger, 148-151). Research shows little correlation between medical malpractice law suits and quality of health care. However, some research has hinted at a link between poor communication of the health practitioner being linked with increase in malpractice law suits (Lester & Smith, 1993). Historically, the following English cases set the precedent for America in the early 1800s for civil liability immunity, even though they were overruled by *Mersey Docks and Harbour Board Trustees v. Gibbs* (1866) later: *A Duncan v. Findlater* (1839), *Feoffees of Heriot's Hospital v. Ross* (1846), and *Holliday v. Parish of St. Leonard* (1861) (Martinez, 2003). In 2007, two new sections were voted in for the UEVHPA that added two options for civil liability protection for health practitioner volunteers and a section for workman's compensation for volunteers who are injured on the job (Centers for Law and the Public's Health, 2008). The options for civil liability include "clear immunity" for volunteers during emergency and the other option supports the existing Volunteer Protection Act (Centers for Law and Public's Health, 2008).

The Volunteer Protection Act, 111, Statute 218, which was signed into law in 1997 by the Clinton administration, protects nonprofit organizations from lawsuits filed against their health care practitioner volunteers for claims of bodily harm which do not include "gross negligence" (NPCC, 1998). However, the provider act also allows states to request "proof of financial resources to provide relief to patients who are injured due to the volunteer's services", which can be interpreted as requiring general liability insurance for volunteer health care providers (NPCC, 1998). Accordingly, the health care practitioner is not considered liable if the following criteria are met: (1) The volunteer acts within their scope of practice (2) Volunteer is properly licensed (3) Volunteer is not guilty of gross negligence, willful criminal acts, or reckless misconduct (4) and the volunteer does not harm

the individual by using a vehicle that requires an operating license by the state (Runquist and Zybach, 2001; Public Law 105-19, 1997). Some fear that immunity from civil liability breeds a group of “careless or reckless” volunteers, while others state the fear we should be focusing on is the fear of losing volunteer services in a time of dire need for a health care system that does not provide services to the most vulnerable populations (Horwitz and Meade, 2009).

Research conducted by Frank et al (2003) reported 71% of women physician participation in pro bono work, with the youngest women the least likely to volunteer and the African American physicians the most likely to volunteer their services. Original data collected by Horwitz and Meade (2009) suggests a nine percent increase in medical volunteers in states where immunity was provided. States with high immunity include Kansas, Alabama, Colorado, District of Columbia, Idaho, Iowa, Minnesota, Montana, Nevada, Rhode Island, Texas, Utah, and Wisconsin. No immunity states include but are not limited to Florida, Alaska, New York, Ohio, and Oregon (Horwitz and Meade, 2009).

Research regarding physical therapist pro bono services is surprisingly lacking. The American Physical Therapy Association goal of autonomous practice, direct access, provided by “doctors of physical therapy” by 2020 must also realize the responsibilities connected to aspirations of a profession striving for a place within the current health care system. As a direct access provider, the physical therapist, supported by the APTA Vision 2020, along with all component members, has a social responsibility to promote pro bono health services. Promotion of pro bono services by the APTA and individual direct access physical therapists provides evidence to other professions that the PT is seeking direct access for reasons other than financial gain that would benefit the dying health care system and reach patients who currently do not have access to health care.

One of the major ethical dilemmas a health care service profession has today is to provide equitable care to all peoples without discrimination due to socio-economic status in the society. Forty-seven million people in the United States are uninsured, which predisposes this population to decreased access to healthcare services (Scott, 242). Healthcare in the USA is considered a privilege, not a basic right. This policy has produced a large sector of socioeconomically disadvantaged people living in the USA who do not qualify for health services and for the most part cannot afford access to healthcare. This policy of health care privilege, closely tied to rationing of health care services, directly opposes the concept of distributive justice.

The Emergency Medical Treatment and Active Labor Act of 1986 directly addressed this inequality in treatment at least at the “emergency medicine” level, but failed to provide for patient services beyond the emergency room situation (Pozger, 185). Autonomy and respect of the individual, nonmaleficence, and beneficence are all breached when access to care is denied to a population and voluntary provider services are discouraged due to fear of litigation and lack of legal support for health provider pro bono services. The American Physical Therapy Association’s Code of Ethics for the Physical Therapist and Physical Therapist Assistant directs physical therapist practice to include autonomy and respect of the patient, equitable care, nondiscriminatory practice, and beneficence for all patient care (Pozger, 253). Another ethical consideration of health care providers is the concept of equity, which means equal distribution of rights to all individuals and could also be understood as equal protection of rights. Although pro bono health service work would improve the equity of patient care, the concept of protection for non-profit organizations and volunteers has been deemed inequitable by some, as it leaves the patient with little litigious power in the case of harm done to the patient under the care of the volunteer and charitable organization (Martinez, 2003).

Some research suggests a proactive approach to training volunteers as a means of preemptive reduction of harm to patients involved in voluntary services rendered by a volunteer health care provider. Suggested minimum standards of protection for volunteer medical services staff includes: licensure reciprocity in emergency medical situations, civil liability protection, and worker's compensation benefits (Hodge, Gable, and Calves, 2005). In Kansas, the Charitable Provider Act was established in 1991, and provided exemption from all civil liability claims against volunteer health care providers in the event of a lawsuit (KS 75-6120). Law suits against health care providers who volunteer their services in Kansas are defended by the Attorney General's office and funded by the Kansas Tort Claims fund even when malpractice or professional liability insurance is also provided. Although this law is in effect, only physicians, ARNPs, and Physician Assistants are not required by their practice act to hold malpractice insurance when volunteering. Other health care providers, including physical therapists, occupational therapists, and other health practitioners must provide evidence of malpractice insurance. This apparent discrepancy among the protective charity provider act law and the professional practice act law, which requires malpractice insurance for every "active member", may serve to discourage therapists and other allied health professionals from volunteering medical treatments to patients in need.

### **Summary**

Pro bono service by health care practitioners is an ethical responsibility for medical professionals who desire to provide equitable care, distribute justice among patients, and promote beneficence and nondiscriminatory practice among all Americans. In the past, health care practitioners have been hesitant to volunteer services due to a litigious culture. Because of this fear, the Volunteer Protection Act was passed in 1997 to encourage health care practitioners to volunteer and provided a limited form of immunity for non-profit organizations and the volunteer medical staff. The current struggle for volunteer medical

staff resides in the interpretation of individual state charity provider acts, professional practice acts, and malpractice insurance requirements among professions.

**Editorial Note: The opinions expressed by authors represent those of the authors and do not reflect the opinions of the editorial staff of The Online Journal of Health Ethics.**

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