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Perspectives on clinical risk management

Nurse Practitioners and Physician Assistants Some Risk Management Concerns

Nurse practitioners (NPs) and physician assistants (PAs) are the named defendants in an increasing number of ProMutual Group's medical malpractice lawsuits. This increase may be attributable, at least in part, to the fact that there are more NPs and PAs practicing today than ever before. In 2003, there were over 111,000 practicing NPs in the United States. That number has been growing steadily since 1965, when the first NP program was started in Colorado in response to a shortage of primary care pediatricians.¹ It is estimated that by 2005, there will be as many NPs in this country as family physicians.² The 46,000 PAs in practice in 2003 represented a 110 percent increase over the corresponding figure for 1993.³

A review of ProMutual Group cases involving NPs and PAs reveals that the increase in lawsuits may also be attributable to clinical and administrative factors. Some, most notably inadequate follow-up, insufficient documentation, and lack of continuity of care, are applicable to all practices. Others are specific to practices involving NPs and PAs. They include:

- Absence of policies and procedures
- Absence of written practice guidelines
- Failure to refer to or collaborate with a physician
- Inadequate supervision on the part of the physician
- Assumption of too much responsibility

NPs and PAs can be a significant asset to the practices of which they are a part. Their success in a practice, however, cannot occur in a vacuum. It is dependent in large measure upon the professional relationship they have with their collaborating or supervising physician, the guidelines within which they work, and their willingness—and the physician's—to accept their limitations.

Physicians who appreciate the special strengths that NPs and PAs bring to a practice and build on them are likely to reap the benefits of greater efficiency, better communication, increased patient satisfaction and, by extension, fewer malpractice lawsuits. Those who consider NPs and PAs to be mere "physician extenders" may be more likely to become involved in malpractice litigation. In caring for more patients in less time and at lower cost than their physician colleagues, NPs and PAs can generate increased income for the practice. However, quantity as a goal in itself may lead to allegations such as "failure to diagnose," "negligence in prescribing a medication," and "failure to follow up," the very allegations that are at the heart of many malpractice cases involving physicians. "More" in the absence of "better" may also lead to patient dissatisfaction, the acknowledged reason for the filing of many medical malpractice lawsuits.

This issue of *Perspectives* examines some of the issues confronting physicians who share a supervisory or collaborative relationship with NPs and PAs in their office practice.



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Nurse Practitioners

Like certified nurse midwives (CNMs), nurse anesthetists (CRNAs), and clinical nurse specialists (CNSs), NPs are registered nurses with advanced education and training and licenses that enable them to practice in an expanded nursing role. As a group they are known as advanced practice nurses (APNs or APRNs). This article will focus only on NPs. Although some NPs who have been practicing for years were not prepared in a master’s program, a master’s degree is currently the entry level preparation required of all nurse practitioners.⁴ In addition, certification by a national accrediting body, for example, the American Nurses Credentialing Center, is necessary before an NP can practice.

Licensed in all states and the District of Columbia, NPs are authorized to practice with varying levels of physician participation in their practice. In all but five states, NPs’ scope of practice is defined solely by the state agency that licenses nurses. In 25 of those states, including Maine, New Hampshire, New Jersey, and Rhode Island, NPs practice independently, “with no statutory or regulatory requirement for physician collaboration, direction, or supervision.”⁵ In fourteen of those states, including Connecticut and Vermont, NPs are required to practice in a “collaborative relationship” with a physician. In six states, including Massachusetts, the relationship with the physician is defined as “supervision.” In the remaining five states, the scope of an NP’s practice is defined jointly by the respective states’ nursing and medical licensing boards.

The definitions of “collaboration” and “supervision” vary from state to state, with some state statutes identifying the responsibilities included in each.⁶ At the very least, both require a mutually agreed upon relationship between the NP and a physician who is educated, trained, or has experience in a field related to the NP’s work. The agreement is likely to address some or all of the following:

- Name of one physician in the collaborating or supervising role
- Need for policies and procedures
- Clinical coverage requirements for both the NP and the physician

- Practice guidelines
- Review of outcomes
- Method of quality assurance
- Scope of collaboration/supervision
- Situations requiring immediate communication with a physician
- Record keeping and periodic review
- Periodic visits to the practice site⁷

As a general rule, neither collaboration nor supervision requires the on-site presence of a physician. However, the collaborating or supervising physician or his/her designee should be available to the NP by telephone or to come in for consultation or referral. Physicians with specific questions about their role as collaborating or supervising physician are encouraged to contact their state nursing and/or medical licensing board.

Prescriptive authority, although a part of NP practice, is often considered apart from it. As this article is being written, NPs in 13 states, including Maine and New Hampshire, are authorized to prescribe medications, including controlled substances, independent of any physician involvement. In 34 states, including Connecticut, Massachusetts, New Jersey, Rhode Island, and Vermont, NPs may prescribe controlled substances but their prescriptive practice requires some degree of physician involvement. In four states, NPs are not authorized to prescribe controlled substances and must have physician involvement in other prescriptive practices.

All NPs who prescribe controlled substances need their own state registration and federal DEA numbers. Those who write prescriptions in states that require physician involvement will find that the requirements vary from state to state. In some, the NP will sign a prescription on a pad bearing the name of his/her supervising or collaborating physician. In others, the form must bear the NP’s own name, address, and telephone number and may, but need not, include the name and address of the supervising or collaborating physician. In some states, the NP has “the same privileges dispensing and administering drugs as physicians.”⁵ In others, the NP’s prescriptive practice must be

monitored on a regular basis by the supervising or collaborating physician. Expectations for the NP's prescriptive practice should be in compliance with state statutes and be well defined in the policies and procedures that are mutually agreed upon by the NP and the physician.

No NP should be denied the right to prescriptive authority as a condition of employment—unless he/she agrees in writing to that condition. A decision to withhold all or part of a right to full practice may lead to litigation.

NPs may do all that their education and license permit. At a minimum, that includes:^{4,8}

- Taking a history
- Performing a physical examination
- Ordering, performing, and interpreting laboratory and other diagnostic tests as needed
- Developing treatment plans
- Prescribing medications, treatments, and therapies for the management of chronic and common acute illnesses and injuries
- Making referrals
- Performing required follow-up
- Providing immunizations
- Evaluating the outcome of treatment plans
- Counseling patients on disease prevention⁸

Educated in the nursing model, NPs excel in health promotion and maintenance,⁹ preventive care, patient education, the facilitation of the patient's participation in his/her own care,⁴ and communication with both the patient and his/her family. Perhaps because of NPs' emphasis on education and communication, their patients have been found to be extremely compliant in taking medications, in keeping scheduled appointments, and in following recommended lifestyle changes.⁸

Physician Assistants

Physician assistants are trained in the medical model. Those who choose to enter a PA program typically hold a bachelor's degree and four or more years of health care experience.¹⁰ The average PA course itself is 111 weeks and includes classroom and laboratory instruction.¹¹

After graduating from an approved program, PAs must successfully complete a national certifying exam developed jointly

and offered by the National Commission on Certification of Physician Assistants (NCCPA) and the National Board of Medical Examiners.¹¹ All states require PAs to pass the NCCPA examination before granting them full licensure. PAs currently have prescriptive practices in 48 states, the District of Columbia, and Guam.^{12,13}

PAs, who are eligible for licensure in all 50 states, the District of Columbia, and Guam, do not practice independently. By definition, they must practice under the supervision of a licensed physician.^{10,14} The physician need not be physically present but either he/she or a delegate must be available for telephone consultation with the PA.

PAs work in almost all medical specialties, including surgery and emergency medicine. Some, such as anesthesiology, require additional education and passage of another certifying examination. The scope of a PA's clinical practice is dictated by his/her education and training, the physician's willingness and ability to supervise, and the employment criteria established by hospitals, medical offices, and the other institutions where a PA might work.

Risk Management Issues

The issues that involve NPs and PAs in litigation are not, as a rule, issues of education and licensure. They are, rather, issues of inadequate supervision, the absence or misuse of clinical guidelines, overdelegation, a failure to refer, and similar risk management issues. The following cases are representative examples:

Case 1: *A PA performed the annual physical examination of a 57-year-old*

A physician may be held directly or vicariously liable for an NP's or PA's work

male who presented without complaints. The medical history was significant for gout and hypertension, both successfully controlled with medication. Family history was remarkable for both parents having died of cancer (breast and prostate, respectively). The physical examination, which did not include a digital rectal examination (DRE), was normal. PSA was higher than one drawn at the last physical two years earlier, but within acceptable limits at 3.8. The following year, the PSA drawn by the same PA was 4.5. It was not until two years later, when the PSA reached 7.8, that the PA consulted the physician and notified the patient of the abnormality. The patient was subsequently diagnosed with metastatic prostate cancer.

Defense experts faulted the PA for a failure to:

- Include a DRE in the physical examination of a patient over 50 considered at particular risk because of family history
- Appreciate the significance of and consult with the physician about the gradually increasing PSA
- Communicate the test results to the patient
- Perform any follow-up

The physician was found to be at fault for his:

- Failure to supervise
- Failure to have policies addressing situations in which referral to or consultation with a physician was indicated

Case 2: *A 41-year-old female complained to her family nurse practitioner (FNP) of vaginal bleeding and abdominal pain. In each of six visits over a four-month period, and despite a worsening of symptoms, the FNP attributed the patient's symptoms to a variety of benign causes. The collaborating physician was never consulted. However, she cosigned the FNP's notes. She and the FNP were named as co-defendants in the malpractice suit filed by the patient's family after the patient succumbed to endometrial cancer.*

The FNP's failure to consult with or refer the patient to the physician was the primary issue identified by defense experts who reviewed the chart for the NP. The physician, on the other hand, was held liable for having signed notes she never read and for having inadequate practice policies in place for the NP.

Physicians are busier today than ever before. They are called upon to see more patients in less time, and are compensated differently than in an earlier age. Some physicians have seen the addition of an NP or PA to the staff as a solution. It may instead be a problem unless safeguards such as those described in the risk management suggestions section of this article are taken.

Vicarious Liability

There is little that is more likely to involve a physician in NP- or PA-focused litigation than what is considered or perceived to be inadequate supervision or collaboration. The role of collaborator/supervisor must not only be taken seriously; it must also meet the letter of the law.

As the employer of an NP or PA, a physician may be held directly or vicariously liable for the NP's or PA's work. The

greater concern of many physicians is vicarious liability, under which they may be held responsible for the negligent acts of a third party or employee.¹⁵ In the past, when physicians were considered "captain of the ship," they were likely to be held responsible for the actions of anyone they supervised.⁶ Today, it is more likely that either the doctrine of "respondeat superior" ("let the master answer") or the "borrowed servant rule" will be invoked and the physician found liable only for the actions of an employee whose work he/she controls¹⁶ or has a right to control, even if that right may not have been exercised in a particular situation.¹⁵

The "right to control" is not an absolute. Instead, the definition in any one situation may be decided by a court after consideration of such issues as the contractual agreements that exist between the two parties, the practice's policy and procedure manuals, the hiring and payment of the individual, the power to fire, supervisory requirements defined by the law, the testimony of experts, and the standard of care.¹⁵

Physicians are unlikely to avoid the responsibility and potential liability that may accompany the "right to control." Some may try by having no contractual agreement with an employed NP or PA, by failing to require adherence to a mutually created and/or agreed upon policy and procedure manual, or by hiring an NP as an independent contractor. (A PA cannot, by definition, be an independent contractor.) However, if there is a statutory or regulatory requirement for supervision/collaboration, the terms of that requirement must be met. As noted above, one of those terms is likely to be the creation of mutually agreed upon written policies and procedures that include, but are not limited to, the following:

- Protocols for the hiring, training, evaluation, supervision, monitoring and dismissal of employees¹⁵
- Definition of the scope of practice, ensuring that it exceeds neither the limits permitted by law nor the abilities and education of the NP(s) or PA(s) in a practice²

- Practice protocols identifying which patients are appropriate for an NP/PA visit only, which require collaboration, and which require referral

It is important to note that vicarious liability is most likely to become an issue for the physician when an adverse outcome results from actions that occur in the course of the work for which the NP or PA has been employed and/or is being paid. As a general rule, the physician is *not* vicariously liable for actions committed or omitted when the NP or PA is providing professional services outside the bounds of the employment contract, for example, moonlighting or working in a free clinic during off hours.

Direct Liability

The physician who sponsors or supervises an NP or PA who is *not* an employee is unlikely to be held vicariously responsible for the actions of that person. However, the physician *may* be held responsible for his/her own actions, specifically, those involving improper privileging (for example, of an unlicensed or incompetent person),¹⁷ improper delegation, inadequate supervision, or failure to monitor.

The physician who merely consults with a self-employed NP or PA is less likely than a colleague who employs an NP or PA to be held vicariously liable for the actions of that NP or PA.⁶⁹ However, direct liability may be imposed if an NP or PA bases a treatment plan on the erroneous advice of a consulting, collaborating, or supervising physician.

Direct liability may also be imposed upon any collaborating/supervising physician who:

- Hires an inadequately trained, unskilled, or unlicensed NP or PA,
- Fails to document the credentials of a newly hired NP or PA,
- Fails to adequately supervise/collaborate with or monitor an NP or PA,
- Fails to establish policies defining the NP's or PA's professional responsibilities,

- Fails to provide adequate training for an NP or PA in his/her employ,⁶
- Fails to respond to an NP's or PA's request for assistance or opinion,
- Is unavailable either in person or by telephone (or fails to delegate his/her responsibility for being available) to the NP or PA with whom he/she has a collaborating/supervising relationship,
- Incorrectly advises the NP or PA on a patient care issue,
- Causes a patient's injury by virtue of something he/she does or fails to do.⁶

Risk Management Suggestions

To minimize the risk of involvement in a claim or suit that arises because of the actions of an NP or PA, physicians would be well advised to take care in hiring, collaborating with or supervising, and respecting the professional abilities—and limits—of these professionals. ProMutual Group suggests consideration and, where possible, adoption of the following risk management guidelines.

- **Define whether the particular needs of the practice could best be met by an NP or PA** before hiring either. They are not interchangeable. The background, education, skills, and expectations of each are different.
- **Perform a credentialing check** on all NPs and PAs before hiring them into the practice. The credentialing process should include contacting all primary educational sources and prior employers, verifying completion of pharmacology courses required by some states for the granting of prescriptive privileges, and performing a criminal and background check.
- **Verify that competencies are current**—both at the time of hiring and at the time of annual reviews. Competencies may be assessed by chart review, direct observation, or regularly scheduled case meetings or conferences.
- **Consider closely monitoring the newly hired NP or PA** and expanding responsibilities only as his/her abilities become known.³

- **Take care to identify NPs and PAs to patients.** NPs and PAs should wear badges or nametags that clearly identify them, including their credentials. An explanation of the role of the NP or PA may be included in a practice brochure. Alternatively, notification concerning the fact that NPs and/or PAs are part of

tion or supervision. To the extent possible, try to make alternative coverage for a physician who does not agree to assume this responsibility.

- **Make sure that a physician who does not agree with the hiring/practice of an NP or PA is not asked to cover for the NP or PA.** He/she should also not

It is important not to mislead patients into believing that an NP or PA is a physician

the office staff may be posted in the waiting area. From a risk management perspective, it is important not to mislead patients into believing that an NP or PA is a physician.

- **Take care not to overdelegate.** Asking an NP or PA to assume more responsibility than is allowed by his/her license, education, and/or ability may become a point of entry into litigation for both the NP or PA and the physician.
- **Be familiar with all state requirements with respect to collaboration/supervision** and define in writing the mechanism for meeting them. Examples might include chart review and review of prescriptive practice.
- **Make sure that the collaborating or supervising physician shares the same medical specialty as the NP or PA.**
- **Define coverage agreements in writing.** An NP or PA should not provide coverage for a physician unless a collaborating or supervising physician is available during the coverage period. Likewise, any physician who covers for a collaborating or supervising physician should be both familiar and in agreement with the practice protocols that govern the work of the NP or PA.
- **Ensure that all actual or covering physicians serving in a collaborative or supervisory role agree with the practice protocols and are willing to assume occasional responsibility for collabora-**

tion or supervision. To the extent possible, try to make alternative coverage for a physician who does not agree to assume this responsibility.

- **Make sure that a collaborating or supervising physician is always available to the NP or PA,** at least by telephone. The responsibility for collaboration or supervision should be transferred or delegated to a willing physician who shares the NP's or PA's specialty if the primary collaborating/supervising physician is unavailable.

Although the law may not require the on-site presence of a physician, from a risk management perspective it is advisable for the practice to have a written policy concerning what steps should be taken when an immediate consultation with a physician is indicated and no physician is physically present.

- **Document any transfer or delegation of collaborative/supervisory authority.**
- **Restrict the number of NPs or PAs in collaborative or supervisory relationship.** There is no national standard concerning the number of NPs or PAs with whom a physician may be in a collaborative or supervisory relationship. Some states specify ratios ranging from 2:1 to 6:1 depending upon the medical specialty, the type of practice, and the role of the NP or PA. A 2002 review of ProMutual Group's closed cases indicated an increased risk of involvement in litigation for physicians sharing a collaborative or supervisory relationship with more

than two NPs or PAs. For this reason, it is our recommendation that one physician have a formal collaborative or supervisory relationship with no more than two NPs or PAs at the same time.

- **Create a written practice description** identifying
 - patient population
 - role of the NP or PA
 - mechanism for supervision or collaboration, for example, chart review, case conferences, or other¹⁰
- **Create a written job description** that includes
 - particular responsibilities of the NP or PA
 - types of patients he/she will be expected to handle
 - hours of work and work setting if the office has satellites
- **Develop mutually agreed-upon practice protocols**, keep one copy at each site in which the NP or PA works, and review and update annually or whenever new duties are added or a new NP or PA is hired. Protocols, which should be signed by both the NP or PA and collaborating/supervising physician, might describe:
 - types of patients that may be seen by NP or PA alone, those requiring collaborative care, and those needing referral
 - recommended number of times a patient may be seen by NP or PA for the same problem before consultation with or referral to physician is considered
 - protocol for follow-up on abnormal test results and missed appointments
 - documentation requirements
- **Consider developing clinical guidelines** for the management of common illnesses. Detailed protocols that deprive the NP or PA of the ability to use clinical judgment should not replace broad guidelines that can be individualized to particular patient needs. Guidelines should include, among others:
 - cancer screening guidelines

- need to consider the worst first and only after that is ruled out, consider a benign diagnosis
- **Monitor prescriptive practice.** In the absence of state mandates for such monitoring, the physician and NP or PA should define a mutually agreed upon system to ensure optimal prescriptive practice.
- **Perform periodic chart review.** Even if not required by statute or regulation, chart review is an excellent risk management and quality assurance tool.
- **Encourage open communication.** The NP or PA who feels threatened, demeaned, or intimidated by a physician is unlikely to ask for help when needed, a situation that may lead to litigation.
- **Chart all MD-NP/PA consultations.**
- **Review all notes before co-signing them.** A signature indicates assent. It should be given with care.
- **Make sure that every patient is seen by the physician at defined intervals.** This is particularly important if the physician is identified as the primary care provider. Experts in several ProMutual Group cases involving NPs and PAs faulted the physician for never having seen the patient.

The above suggestions should be interpreted as guidelines, not mandates. However, from a risk management perspective, it would be wise for practitioners to document their reason for deviating from these or any similar written guidelines in individual cases.

Conclusion

NPs and PAs are professionals in their own right. They can be a meaningful addition to the office practice that values their skills, builds on their strengths, and acknowledges their limitations. In considering them mere revenue enhancers, however, some practices push their employed NPs and PAs to accept too much responsibility and to work without the safety net of support that should be available to all professionals. NPs and PAs deserve more. So too do the medical practices that employ them and the patients who entrust themselves to their care.

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