

Mid-level Practitioner Liability

Preventive Action and Loss Reduction Plan

Table of Contents

Introduction	2
Defining Mid-level Practitioners	3
Physician Assistant (PA)	3
Advanced Practice Registered Nurse (APRN)	3
Nurse Practitioner (NP)	3
Certified Nurse-Midwife (CNM)	4
Certified Registered Nurse Anesthetist (CRNA)	4
Clinical Nurse Specialist (CNS)	4
Anesthesiologist Assistant (AA)	4
Understanding Theories of Liability	4
Direct Liability	4
Agency	4
Vicarious Liability	4
<i>Respondeat Superior</i>	5
Collaboration and Supervision	5
Unprofessional Conduct	5
Negligent Credentialing	5
Negligence	5
Case Summary No. 1	6
Mid-level Practitioner Closed Claims Data Analysis	7
Primary Misadventures (Allegations) with Risk Management Findings	10
Failure to Diagnose and Delay in Diagnosis	10
Failure and Delay in Obtaining Specialty Consultation or Referral	10
Inadequate Evaluation and Physical Exam	10
Case Summary No. 2	11
Exposure to Disciplinary Action	12
Mid-level Practitioners in Private Practice	12
Common Mid-level Practitioner Type and Scope	13
Physician Assistant	13
Nurse Practitioner	13
U.S. Nurse Practitioner Workforce 2013	14
Liability Concerns	15
Employment Concerns	15
Policy and Procedure Manuals	16
Position Descriptions	16
Risk Management and Patient Safety Checklist	18
Frequently Asked Questions	19

Introduction

Since the advent of managed care, the number of mid-level practitioners (MLPs) and non-physician practitioners has been growing at a rapid pace. This group of healthcare professionals is also described as “physician extenders” and “allied health providers.” MLPs can be found in a wide variety of specialty areas and clinical settings, including hospitals, outpatient clinics, and rural community centers. The MLP group is composed of many different MLPs, such as nurse midwives, nurse practitioners, physician assistants, and nurse anesthetists. Currently, the two most prevalent categories of MLPs are nurse practitioners (NPs) and physician assistants (PAs). Data from the Centers for Medicare & Medicaid Services (CMS) show that the number of practicing MLPs continues to grow each year.

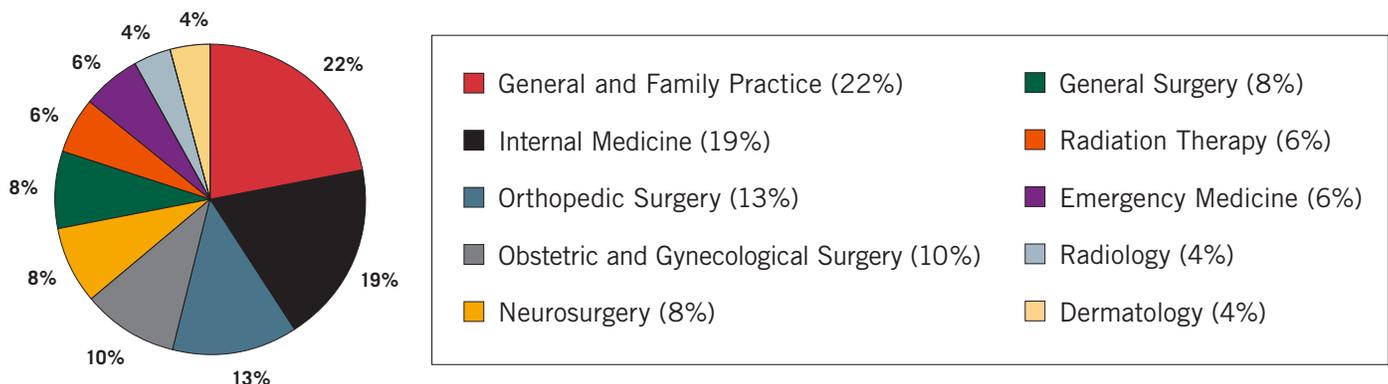
The American Academy of Physician Assistants (AAPA) estimates that there were over 83,000 PAs in clinical practice in 2010. The American Academy of Nurse Practitioners (AANP) indicated that, during that same time period, there were over 155,000 NPs actively practicing in the U.S.

Today, the MLP is an important and integral member of the healthcare team, assisting physicians in providing a wide range of healthcare services. For instance, an MLP can obtain and record health histories, perform physical assessments, order diagnostic tests, and prescribe medications for patients. This has resulted in time savings for physicians, as well as cost savings.

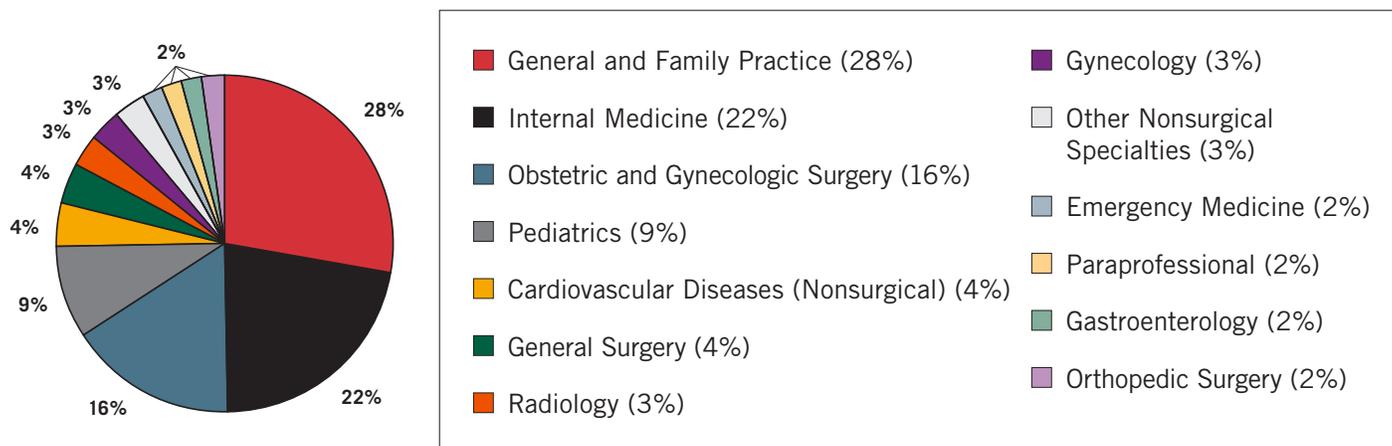
However, in tandem with the increasing number of practicing MLPs is the increased frequency of medical malpractice claims against physicians that are attributed to the acts or omissions of MLPs. Under various theories of tort liability, discussed later in this booklet, not only can a physician be held directly responsible for his or her acts or omissions, but also for the acts of MLPs working with him or her. In fact, the most recent data from the PIAA reveal that the average indemnity paid on behalf of PAs is \$321,991. The average indemnity paid on behalf of NPs is \$309,405. One of the primary reasons for the increased liability exposure for physicians and physician practices is that the general prevailing state rule specifies that the hiring physician or practice is responsible for supervising the MLP. However, the level of supervision required, as well as scope of practice, remains regulated by the individual state in which the MLP is licensed.

The distribution of medical malpractice claims, by MLP and by medical specialty, is shown in these charts.

Physician Assistant Malpractice Claims by Medical Specialty (2001–2010)



Advanced Practice Registered Nurse Malpractice Claims by Medical Specialty (2001–2010)



Implementing effective risk management measures will help ensure that the benefit of using MLPs is not at the expense of increased liability exposure and malpractice claims. This booklet will address liability risk issues for physicians and medical practices in hiring and working with MLPs. It will include recommended preventive actions and patient safety and loss reduction strategies.

Defining Mid-level Practitioners

An MLP may be referred to as a “physician extender” or “allied health provider.” The MLP group is broad and includes various provider types, such as:

■ Physician Assistant (PA)

A PA is a licensed and highly skilled healthcare professional trained to provide patient evaluation, education, and healthcare services. PAs must complete an accredited training program. Preferably, the program should be accredited by the American Medical Association. In addition to state certification, PAs must also be certified by the National Commission on Certification of Physician Assistants. Many states require that PAs have training in the specialty within which they practice. PAs can usually prescribe medications according to formulary guidelines. Additionally, many states require PAs to complete an advanced pharmacology course and/or specific training for prescribing controlled substances. When selecting an appropriate PA candidate, a physician should match the PA’s training with the medical specialty in which the PA will practice. The supervising physician must also adhere to the state’s maximum PA-to-physician ratio and supervisory requirements.

■ Advanced Practice Registered Nurse (APRN)

The term “advanced practice registered nurse” includes RNs who have completed advanced education and certification to practice as one of the following MLPs: nurse practitioners (NP), certified nurse-midwives (CNM), certified registered nurse anesthetists (CRNA), and clinical nurse specialists (CNS). Here are specific descriptions:

– Nurse Practitioner (NP)

NPs are registered nurses with a Master of Science degree and training in their area of specialty. Their scope is defined by the state’s board of nursing. Unlike the PA, who practices under “supervising physician” capacity, the NP generally practices using “standardized procedures.” Check your state board of nursing for required elements of practice. While an NP can furnish medications, many states require advanced pharmacology courses in order to meet established regulations.

- **Certified Nurse-Midwife (CNM)**
CNMs function in two areas: antenatal and postnatal. They are found in health departments and clinics, providing gynecological services and prenatal care for uncomplicated obstetrical patients. Private obstetricians use their services for seeing the uncomplicated patient through the entire obstetrical experience, including delivery and conducting routine gynecological exams. CNMs are RNs who have specialized training obtained either through certification or Master of Science programs.
- **Certified Registered Nurse Anesthetist (CRNA)**
A CRNA is a registered nurse with special formalized training in delivering anesthesia. While some states continue to require supervision of CRNAs by a qualified licensed physician, a federal “opt-out” program has been adopted by several states in accordance with federal law. Check federal guidelines and your state board of nursing for supervision requirements within your state of practice. National certification and recertification is a requirement for a CRNA. The ratio of CRNAs to supervising physician is often defined by state licensing regulations, as well as the underwriting guidelines of most professional liability carriers.
- **Clinical Nurse Specialist (CNS)**
A CNS is a registered nurse who specializes, through focused training, in one particular area of patient care. They are most often found in the hospital setting, performing patient or staff education and overseeing particular physician/departmental protocols. Their scope of practice is largely well defined by their state board of nursing.
- **Anesthesiologist Assistant (AA)**
An AA is a graduate of an accredited AA program who works under the direction of a licensed anesthesiologist to implement anesthesia care plans, in addition to the delivery and maintenance of quality anesthesia care and monitoring. The AA may assist an anesthesiologist in developing and implementing an anesthesia plan of care for a patient within the framework of a written practice protocol between the supervising anesthesiologist and the AA.

Understanding Theories of Liability

Because of the potential for increased liability exposure with MLP use, physicians and MLPs should be aware of the various theories of liability that could affect their practice. An essential risk management strategy is to instill in MLPs that they should provide care and treatment only within the scope of practice and that they should be comfortable consulting with the supervising physicians on complex cases.

- **Direct Liability**
A physician or MLP can be held directly liable for his or her acts or omissions. This can occur when the individual renders care that deviates from the acceptable standard of care and causes harm or injury to the patient. This is based on a theory of negligence, the most common theory of liability in a medical malpractice action. There are four elements of a negligence cause of action: duty, breach in the standard of care, causation, and harm and damages to the claimant.
- **Agency**
Agency is the theory of liability that is used to link the negligent acts of the MLP to the physician. This is because the MLP, as an employee, is said to be an agent of the physician or employer. This theory can come into play even when the MLP is classified as an independent contractor. If it appears to the public that there is an agency relationship between the two individuals, then it might be reasonable to assume that the MLP is acting as an agent of the physician. In most states, MLPs are required to have some level of physician supervision; therefore, it would be difficult for a physician to avoid liability simply by classifying the MLP as an independent contractor.
- **Vicarious Liability**
Vicarious liability is a legal theory used to make one person liable for the negligent acts or torts of another person because of some relationship between them. Such is often the case with employers who are held vicariously liable for the negligence of their employees. The employer does not need to be directly involved in an allegedly negligent act under this theory. Thus, physicians and their practices can be held directly liable for their own acts and vicariously liable for their employees’

acts. This is also referred to as a theory of imputed negligence. An example is when an MLP misses a diagnosis, resulting in patient harm. Although the MLP may be the direct caregiver and the one responsible for the error, his or her employer—the supervising physician—can be held vicariously liable. The intent of this imputation of fault is to ensure that the injured party has a right to full recovery from the entity or provider directing the employee's actions.

- **Respondeat Superior**

The common law doctrine of *respondeat superior* is invoked to hold an individual liable for the acts of their agents. Under this theory, a physician can be held liable for the negligent acts of his or her employees that happen during the course of employment. This can occur even when the physician did not personally treat the patient. This theory is often used to hold physicians liable for acts of an MLP. The liability could arise from the physician being an employer of the MLP or from the physician's responsibility to supervise the MLP.

- **Collaboration and Supervision**

An allegation of negligent supervision can arise when a physician allows the MLP to function beyond the scope of the license or when the MLP does not receive adequate supervision for services rendered to patients. However, the definition of what constitutes appropriate "collaboration" and "supervision" of an MLP can vary greatly from state to state. In addition, each medical professional can be regulated by a different regulatory body. PAs are generally regulated by the state medical board and NPs are regulated by the state nursing board. It is imperative that physicians and their MLPs be thoroughly familiar with and remain current on the prevailing state law. Some considerations for physicians and MLPs, when determining the roles and responsibilities of the MLP in the practice, include the number of MLPs the physician can legally supervise, the medical record review and documentation criteria, obtaining and maintaining prescriptive privileges, criteria for when the MLP needs to consult with the supervising physician, and whether there are any requirements for written delegation agreements or written protocols between the physician and MLP. In California, the physician can demonstrate the appropriate supervision by examining the patient after the PA, by reviewing and countersigning every medical record within 30 days, or by auditing at least 5 percent of the records the physician considers to be greater risks.

- **Unprofessional Conduct**

A physician can also be subjected to a review or investigation by the state medical board if he or she fails to properly supervise an MLP or allows the MLP to practice outside the scope of the license. The state medical board can issue an accusation charging the physician with unprofessional conduct or with aiding in the unauthorized practice of medicine. Physicians need to be aware that a medical malpractice action can trigger a medical board review, or the review can be initiated separately.

- **Negligent Credentialing**

Physicians are responsible for ensuring that their staff members are qualified and properly licensed. This means it is imperative to do a thorough prescreening of the MLP's background and references, as well as a direct verification of the MLP's licensure status. Further recommendations to consider in hiring and credentialing an MLP can be found in the section on employment concerns in this booklet.

- **Negligence**

Medical malpractice claims that are attributed to the negligence of an MLP are frequently made against the MLP's employer, which in many cases is the supervising physician. Frequently, the malpractice insurance coverage for an MLP is written under the physician's medical malpractice policy or that of the employer (commonly the professional association or corporation). However, the variety of state-specific reporting requirements results in a lack of uniformity for assessing the inherent liability exposures attributed exclusively to the use of MLPs.

Case Summary No. 1

A 53-year-old married female underwent a laparoscopic cholecystectomy, which was performed without incident by the insured general surgeon. The surgeon saw the patient three days post-op, noting that she was doing well and had no complaints other than the expected incisional pain. The patient was next seen at five days post-op by the surgeon's PA. The PA noted an obvious infection at the umbilical surgical wound. He obtained a culture (which later proved to be *Klebsiella*) and started the patient on Levaquin, an antibiotic. The patient returned four days later and was reevaluated by the surgeon, who noted that the wound still looked infected, with the presence of drainage. The surgeon felt that the patient had cellulitis, continued the antibiotic, and advised her to return if needed. A week later the patient returned and was seen by the PA. She complained of recent onset of nausea, vomiting, and diarrhea and had a temperature of 103 degrees. Although the PA noted that the wound still appeared infected, because the patient's abdomen was not tender and no masses were felt, he diagnosed the patient as having a "superficial wound infection" and "gastroenteritis." The PA told the patient to continue the Levaquin and prescribed Phenergan for the nausea and vomiting. Three days later, the patient was admitted through the ER with an acute abdomen. She underwent exploratory surgery and was diagnosed with an intrahepatic abscess. The patient then developed disseminated intravascular coagulopathy, continued to deteriorate, and expired several days later. Suit was filed against the insured, the PA, and the insured's medical practice. The primary issue of negligence was the failure to diagnose and treat the intrahepatic abscess. Defense experts could not support the PA's failure to properly assess the patient when she presented with obvious clinical signs of infection. The PA was criticized for failing to consult with the surgeon. The surgeon, who signed off on the PA's medical management of the patient, was held vicariously liable for the acts of the PA and directly negligent for his inadequate supervision of the PA. Consequently, the case necessitated settlement.

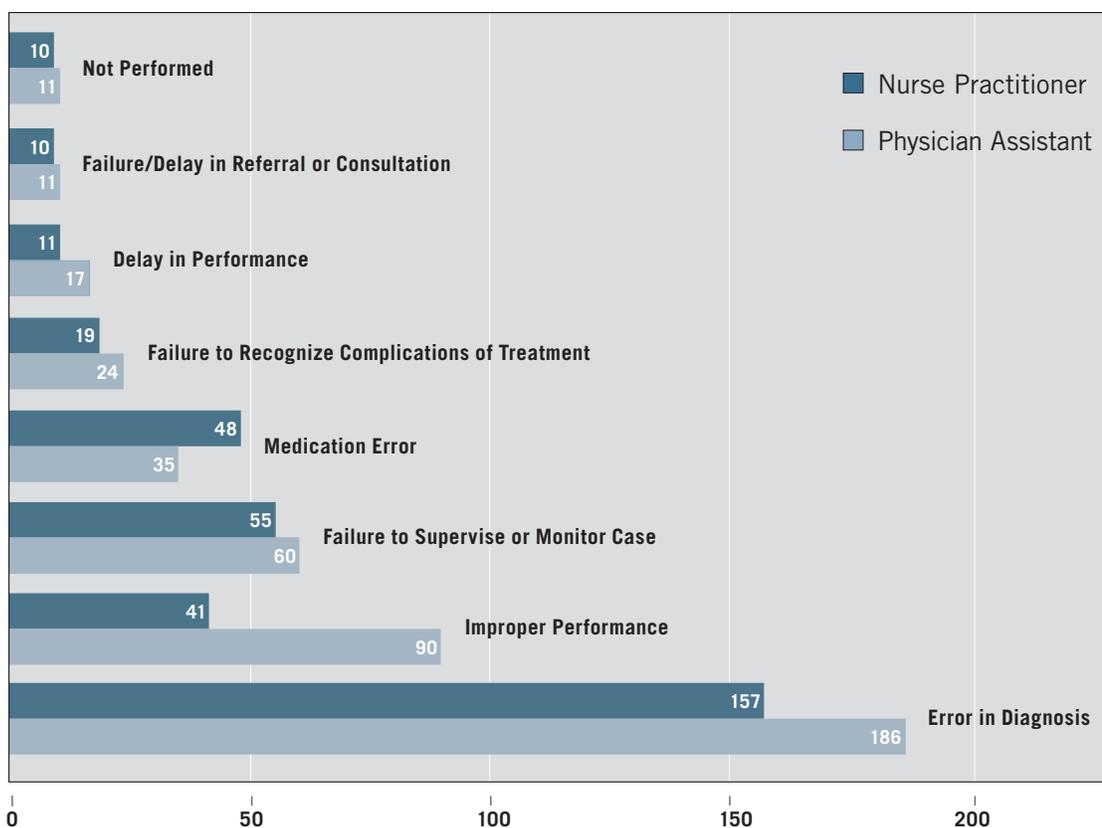
Mid-level Practitioner Closed Claims Data Analysis

According to closed claims data compiled by the PIAA for the 10-year period of 2001 through 2010, 28.4 percent of closed medical malpractice claims involving PAs and NPs resulted in indemnity payments. The average indemnity paid during this time period for both PAs and NPs was \$317,558, with PAs at \$321,991 and NPs at \$309,405. In most cases, the indemnity payment is made on behalf of the MLP by the supervising physician’s policy or that of the practice’s professional association.

The most prevalent misadventure (allegation) for both PAs and NPs was error in diagnosis. The indemnity paid for this allegation (for PAs and NPs combined) averaged \$329,841. The other misadventures for both PAs and NPs are shown in these charts.

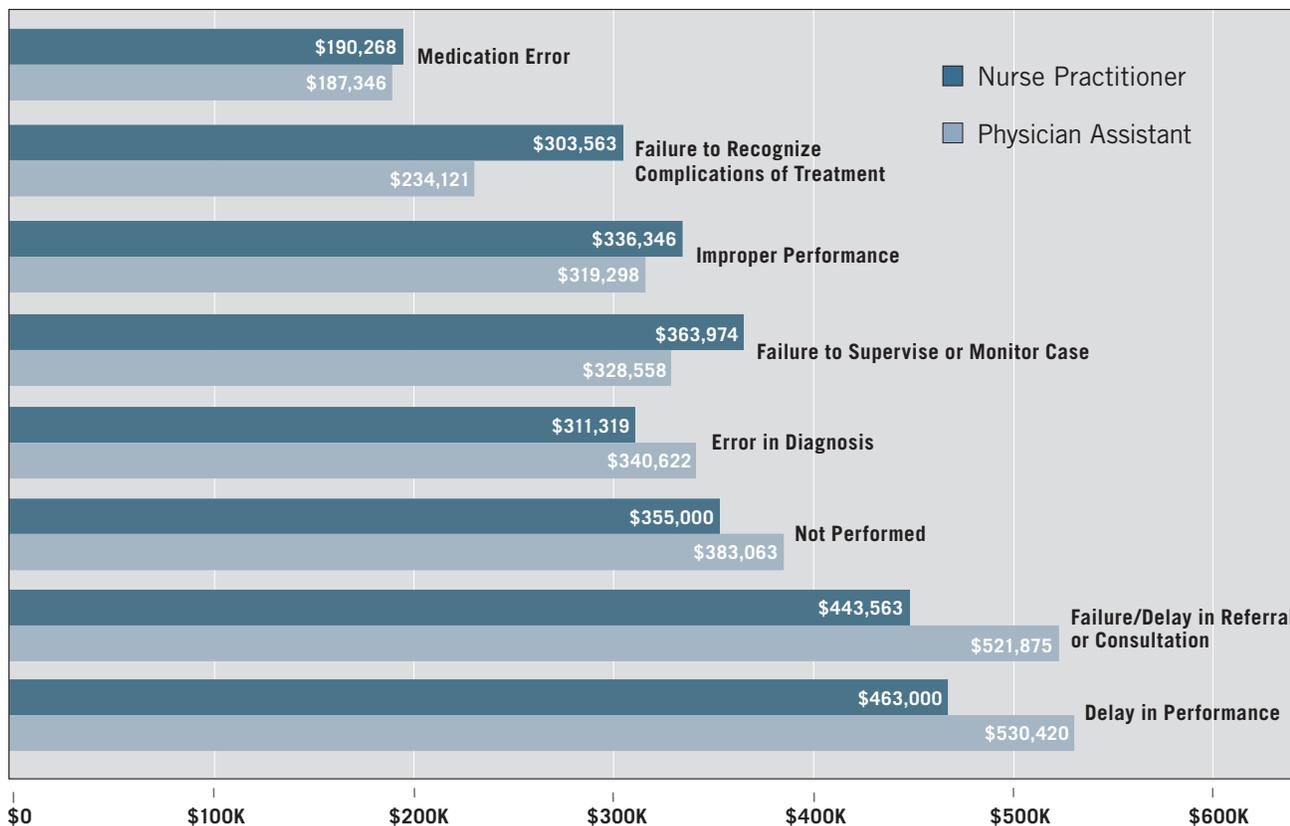
Most Prevalent Misadventures (2001–2010)

Number of Closed Claims



Most Prevalent Misadventures (2001–2010)

Average Indemnity Paid



Most Prevalent Procedures and Conditions (2001–2010)

Most Prevalent Medical Conditions: Physician Assistant

- Injury to multiple body parts.
- Symptoms involving abdomen and pelvis.
- Displacement of intervertebral disc.
- Coronary atherosclerosis.
- Fracture of tibia or fibula.
- Back disorders, including lumbago and sciatica.
- Fracture of vertebral column.
- Chest pain.
- Pregnancy.

Most Prevalent Medical Conditions: Nurse Practitioner

- Diabetes.
- Symptoms involving abdomen and pelvis.
- Breast neoplasm.

- Chronic pain.
- Hypertension.
- Coronary atherosclerosis.
- Back disorders.
- Acute myocardial infarction.
- Brain-damaged infant.

Most Prevalent Procedures: Physician Assistant

- Diagnostic interview, evaluation, or consultation.
- Prescribing medication.
- General physical examination.
- Operative procedures on joint structures, excluding spinal fusion.
- Injections and vaccinations.
- Miscellaneous manual examinations and nonoperative procedures.
- Diagnostic radiologic procedures, excluding CAT scan and contrast material.
- Operative procedures on the skin, excluding skin grafts.

Most Prevalent Procedures: Nurse Practitioner

- Diagnostic radiologic procedures, excluding CAT scan and contrast material.
- Injections and vaccinations.
- Prescribing medication.
- Microscopic examinations.
- Diagnostic interview, evaluation, or consultation.
- General physical examination.
- Cesarean section deliveries.
- Miscellaneous manual examinations and nonoperative procedures.
- Diagnostic procedures involving cardiac and circulatory functions.

Primary Misadventures (Allegations) with Risk Management Findings

Failure to Diagnose and Delay in Diagnosis

A primary allegation associated with failure to diagnose and delay in diagnosis is lack of physician supervision and the failure of the MLP to consult with the physician when needed. Risk management findings include misinterpretation of information provided by the patient to the MLP and an MLP's level of experience with diagnosing and managing a particular patient's condition.

An MLP is required to consult with his or her supervising physician when unsure of a diagnosis or plan of care. Liability exposure is reduced when the MLP follows established protocols for this global regulatory requirement in such situations.

The importance of documenting the patient's clinical symptoms with specificity cannot be overstated. Successfully defending failure to diagnose and delay in diagnosis claims often depends on supporting the MLP's clinical rationale in the face of otherwise silent clinical symptomology.

Failure and Delay in Obtaining Specialty Consultation or Referral

A primary allegation associated with failure and delay in obtaining a specialty consultation or referral is the MLP independently managing a complication that is beyond his or her expertise, skillset, and scope of practice. Risk management findings include overconfidence in skillset, lack of communication between the MLP and supervising physician, and patient compliance issues. Physicians and MLPs have a legal and ethical obligation to refer a patient to a specialist or order a specific diagnostic test when indicated, based on the patient's presenting signs and symptoms. To further reduce exposure to liability, all uncertain diagnoses or courses of diagnostic treatment to determine a diagnosis must be communicated to the supervising physician, while considering a specialty referral when indicated. Documentation is, again, key to successfully defending a claim. Chronology would include initial work-up, internal consultation if indicated, specialty referral submission if indicated, and, finally, a documented plan of care based on referral findings.

Inadequate Evaluation and Physical Exam

A primary allegation associated with failure to perform an adequate patient assessment or exam is the MLP relying on previous medical record history and other sources to conclude a diagnosis, rather than performing a comprehensive exam. Risk management findings include communication issues associated with not conducting an interview with the patient, which leads to inadequate knowledge of current medications, illnesses, and any changes that may be contributing to a patient's signs and symptoms. This, in turn, leads to an inappropriate plan of care. To reduce liability exposure in this area, the MLP must perform a thorough physical exam, including a review of medical history and current complaints communicated by the patient. Documenting complete findings will reduce exposure to liability, while ensuring continuity of care and recall of the assessment when needed.

Case Summary No. 2

A 59-year-old female underwent redo coronary bypass grafting surgery times four, including a left internal mammary artery graft, by the insured cardiothoracic surgeon. Prior medical history was significant for a coronary artery bypass graft 12 years prior and well-controlled type II diabetes. Surgery was performed uneventfully. Noteworthy is the fact that the WBC was 11.8 preoperatively and was 13.9 four days later, prior to discharge. When the patient was next seen, the physician noted that although the patient reported feeling well, she complained of lightheadedness. The sternal wound was noted to be healing well, and the balance of the exam was unremarkable. The patient's spouse subsequently testified that his wife complained of neck and shoulder pain during the visit, called the physician's office two days later, and spoke to a PA, who advised to increase the patient's pain medication. The patient's spouse also testified that he then contacted the physician three days later, was again directed to the PA, and reported a continued complaint of pain. Although the medical record had no documentation of either phone call, the plaintiff produced evidence that a prescription for pain medication had, in fact, been called in by the PA. The following day, the patient herself called and spoke to the PA, indicating that she was experiencing chest pain with movement and deep breathing, and she was instructed to report to the ER for evaluation. The ER physician noted that the patient was taking Darvocet for chest pain. An EKG was unremarkable. WBC was 14.8. The patient was prescribed Ultram and discharged with a diagnosis of "chest wall pain." The ER physician testified that he spoke with the physician's PA; however, no documentation of that call was found in either the hospital record or the patient's chart. The following day, the patient again phoned the physician and spoke to another PA with a complaint of neck and shoulder pain. The patient testified that the PA instructed her to continue taking the pain medication prescribed by the ER. Because of continuing severe neck pain and spasm, the patient sought care from a chiropractor, who noted a reddened, swollen area at the incision site and directed the patient to contact the insured. That evening, the patient called the physician, was directed to a PA, and described her symptoms. Instructions were given to continue the pain meds. Although the PA acknowledged the phone call, she had not documented the call. The patient's spouse testified that the following day he called the physician five times, demanding that the patient be seen, before being given an appointment. Upon arrival, the patient was evaluated by a PA, who summoned a physician in the group to examine the incision. The physician admitted the patient, where she ultimately experienced diminished sensation below the diaphragm and underwent surgery for a ventral epidural abscess. Unfortunately, the patient was rendered an incomplete C6 quadriplegic.

A suit was filed against the physician, the physician's three PAs, and the physician's medical group practice, alleging that a delay in diagnosis of the sternal wound infection resulted in progression to an epidural abscess and subsequent quadriplegia.

Exposure to Disciplinary Action

Each state board of medicine and state nursing board has jurisdiction for managing the disciplinary actions of licensed MLPs. Since all states require a supervising physician for the PA, both the physician and PA are often the subject of discipline when lack of supervision is discovered. For advanced practice nurses, many states require the use of standardized procedures. Similar to the PA, if such procedures are not followed, disciplinary action can be taken by both the respective state board of nursing and the respective medical board. Criminal acts and quality-of-care concerns are examples of what could lead to an investigation by state licensing boards. In many states, a licensed individual who is found guilty of a crime committed outside of work, such as driving while intoxicated, can still be subject to disciplinary action by a licensing board. Quality-of-care issues or drug diversion may warrant notification by an employer to a licensing board. This may result in suspension of a license, followed by revocation if there is not apparent evidence of an MLP's competency to perform duties or completion of a specified drug diversion program. Each state board, as well as many professional associations, has code of ethics language that all licensees are obliged to follow. When MLPs perform acts that are not consistent with these codes of ethics, state boards may become involved to investigate concerns. Check your state board and professional designation websites to learn more about disciplinary actions, codes of ethics, and how to maintain a professional scope while avoiding any inquiries by your respective board.

Mid-level Practitioners in Private Practice

Like any other business decision, hiring an MLP requires advance planning. Consider the volume of your practice, patient demographics, patient expectations and acceptance, and managed care/payer reimbursement, which may be less for MLP services. MLPs frequently spend more time talking with patients. They generally provide greater detail on follow-up care, provide specific care instructions, and are able to answer patients' questions under less rigid time constraints than a physician.

Typically, MLPs are trained to perform 20 to 60 percent of the tasks formerly considered to be a physician's domain. Increasingly, group practices offer patients the option of seeing an MLP immediately versus waiting for an appointment with a physician. Numerous studies indicate that the majority of primary care office visits can be, and increasingly are, adequately handled by MLPs. Although the majority of MLPs are employed in group practices, increasing numbers of solo practitioners are using MLPs. The benefits of using MLPs include:

- Lower operating overhead and other economic benefits.
- Faster patient access to healthcare.
- Increased physician time and focus for more difficult medical cases.
- Improved patient education.
- Increased medical record documentation.
- Broader cross-coverage and after-hours on-call coverage.
- Enhanced patient satisfaction.

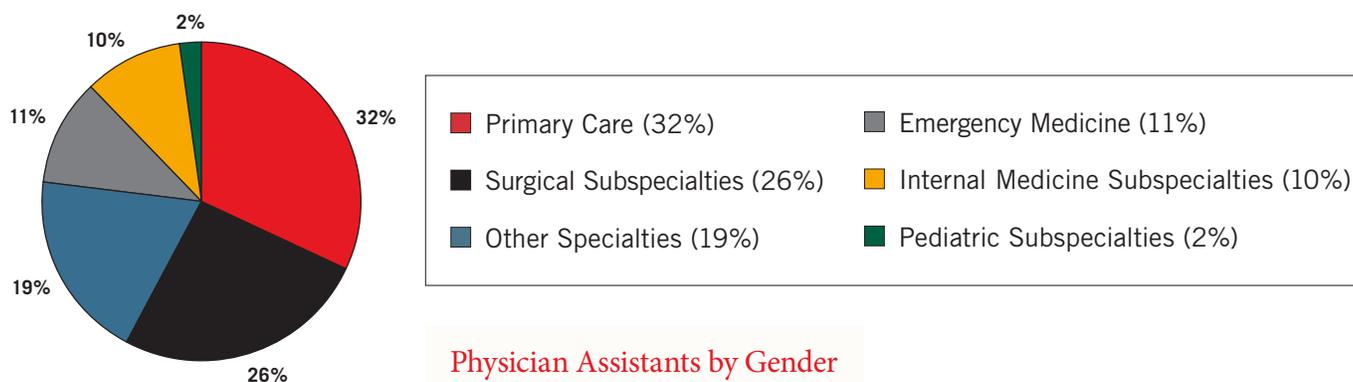
Common Mid-level Practitioner Type and Scope

Physician Assistant

Approximately 82 percent of PAs work in one clinical setting. Eighteen percent work in two or more clinical positions concurrently. Forty-eight percent of PAs are employed by a single or multi-specialty group practice, while 32 percent are employed by a hospital. Fifty-two percent of all PAs perform invasive procedures. The median amount of time the supervising physician is on site was 55 percent. The AAPA published the following data in its 2013 AAPA Census Report:

- PA median age: 37 years.
- Percentage of PAs in clinical practice: 95.7 percent.
- Median number of years in clinical practice: 12 years.

Physician Assistants by Primary Specialties



Physician Assistants by Gender

Male: 33% Female: 67%

Nurse Practitioner

NPs are used in many private practice settings. According to the AANP, the largest percentage of NPs are engaged in providing primary care. Overall, 69.5 percent of NPs see three or more patients per hour. NPs assess and manage both medical and nursing problems. Subject to individual state regulatory guidelines, NPs take patient histories, conduct physical examinations, order, supervise, perform and interpret diagnostic and laboratory testing, prescribe pharmacological agents, and render treatment.

U.S. Nurse Practitioner Workforce 2013

- 95.1 percent of NPs have graduate degrees.
- 96.8 percent of NPs maintain national certification.
- 44.8 percent of NPs hold hospital privileges, and 15 percent have long-term care privileges.
- The average NP is 50 years old and has been in practice for 11.7 years.

There are more than 192,000 NPs practicing in the U.S.:

- There were more than 14,000 new NPs who completed their academic programs in 2011–2012.
- Almost 50 percent are family nurse practitioners. Almost 100 percent of the NPs prescribe medications, averaging 19 prescriptions per day.
- NPs hold prescriptive privileges in all 50 states and the District of Columbia, with controlled substances privileges in 49 states.

NP Population Distribution (Mean Years of Practice and Mean Age) by Specialty

Population	Percent of NPs (%)	Years of Practice	Age
Acute Care	6.3	7.7	46
Adult	18.9	11.6	50
Family	48.9	12.8	49
Gerontological	3.0	11.6	53
Neonatal	2.1	12.2	49
Oncology	1.0	7.7	48
Pediatric	8.3	12.4	49
Psych/Mental Health	3.2	9.1	54
Women's Health	8.1	15.5	53

Sources:

AANP National NP Database, 2013.

Fang D, Li Y, Bednash GD. *2012-2013 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing*. Washington DC: AACN.

2012 AANP Sample Survey.

2010 AANP National Practice Site Survey.

Additional information is available at www.aanp.org.

Liability Concerns

Most malpractice claims attributed to MLPs can be traced to clinical and administrative factors that are easily identified and remedied:

- Assumption of too much responsibility.
- Inadequate physician supervision.
- Absence of written protocols.
- Deviation from written protocols.
- Failure and delay in seeking referral or physician collaboration.

Consequently, there are precautions that the employing physician should take. Ensure that your MLPs are not providing services beyond their capabilities or those not permitted by law. Monitor the practitioner's work closely at first until you achieve a comfort level with his or her abilities, and monitor at regular intervals thereafter to ensure continued quality performance. Monitoring enables detection of misdiagnoses, delays in diagnoses, improper orders, or any other issues requiring attention. MLPs are the agents of their employers—their malpractice reflects directly on the supervising physician.

Employment Concerns

Using MLPs can be a great relief on the caseload and the expenses of running a practice. However, to avoid increasing the liability exposure for the practice, physicians need to know who they are hiring. This requires a proper screening and verification of the credentials of all prospective employees, including MLPs. The goal of the practice should be to hire well-trained and qualified individuals. To ensure that this occurs, the physician or group should independently verify all licensures and credentials, contact references, and conduct additional background inquiries. Proactively managing these and other employment-related issues can help ensure the protection of the public from harm caused by unqualified staff and decrease liability exposure for the practice. A detailed background review, original source verification, and ongoing competency training and evaluation can also help to prevent hiring an individual with fraudulent credentials.

Employment considerations for physicians hiring MLPs include:

- Verify the applicant's credentials and prior experience as thoroughly as you would a physician's. Verify qualifications with original sources.
- Obtain authorization to conduct credit, reference, and police background checks.
- Use a skills checklist to determine what might require additional training.
- Obtain hospital privileges, if needed, but don't rely solely on the hospital's credentialing process.
- Develop written guidelines for examinations, treatment, delegation, supervision, chart review, and consulting with the supervising physician.
- Educate other members of your staff and on-call physicians about the MLP's role and limits.
- Be thoroughly familiar with the state statutory requirements, limitations, and licensing guidelines that affect the particular practitioner you are hiring, especially those regarding your responsibility for supervision.
- Insist that all employees and your MLPs wear a name badge in 24-point font so that patients will not be misled about each staff member's role.
- Use patient satisfaction surveys to determine your patients' satisfaction with the care and services at the practice, including care provided by MLPs.
- Obtain insurance coverage for all MLPs under your employ.
- Notify your professional liability carrier of any changes to scope of practice or employment status for your MLPs.

Policy and Procedure Manuals

Policy and procedure manuals can be valuable reference tools for physicians and MLPs. These manuals can be written for both the clinical and administrative aspects of your practice. Properly written, manuals can encourage consistency and adherence in clinical practice guidelines. Poorly drafted and outdated policy and procedure manuals, on the other hand, can increase liability exposure for your practice. Moreover, the failure to adhere to written policies and guidelines can also increase liability exposure and undermine the defense of a malpractice claim.

Physicians and MLPs need to keep certain guidelines in mind when developing policy and procedure manuals for their practices, including:

- Protocols should address clinical procedures with specificity.
- Policies and procedures should be succinct and easily understood by all staff, and the manual should be reviewed and updated as needed, but at least annually.
- Avoid protocols that may create unrealistic standards for the practice.
- Collect and archive all old policies to avoid faulty reference.
- Date revisions to policies and procedures as they are made.
- Retain all material for at least seven years.
- Provide education and require that staff members read and acknowledge newly enacted procedures.
- Educate and review current policies and procedures with all new staff.
- Protocols adopted from reference materials should also be updated.

Position Descriptions

Position descriptions are another useful tool for ensuring that employees and MLPs are practicing within practice guidelines. Descriptions can also serve the purpose of meeting state statutory guidelines. For instance, in California, a delegation of service agreements and written guidelines is required for all PAs employed at the practice. These written guidelines memorialize the scope of practice for the PA, specify the role and responsibilities of the MLP and the supervising physician, and clarify supervision guidelines. NPs with prescriptive privileges must have written standardized policies and procedures. Some states provide sample agreements for physicians to use.

When drafting position descriptions:

- Specify the number of MLPs a physician can supervise, based on state regulations and the number of MLPs the provider feels comfortable supervising.

Sample: The MLPs are supervised by licensed physicians. All care is rendered in accordance with the guidelines set forth by the State Medical Board and applicable law. *[Specify number of MLPs the physician can supervise]*

- Clearly define the duties and responsibilities of the MLP, including minimum knowledge, clinical skills, and abilities required for the job.

Sample: The MLP may diagnose, treat, and manage acute and chronic medical problems of patients in a primary care setting, including interviewing clients, obtaining and recording health histories, performing physical assessments, ordering appropriate diagnostic tests, diagnosing health problems, managing the healthcare of those clients for which he/she has been educated, providing health teaching and counseling, initiating referrals, and maintaining health records. Medications prescribed to patients are prescribed as outlined in the prescribing protocols, and physician supervision is provided in accordance with applicable law for MLPs.

- Clearly identify consultation guidelines—when the MLP must seek guidance from the supervising physician.

Sample: The physician will be consulted for the following conditions: *[List medical conditions or clinical situations]*

- Identify the license or certification required by statute or regulation.
Sample: Certification of approval from the State Board of Medicine, and, if a nurse practitioner, licensure from the State Board of Nursing.
- Identify mandatory certifications and continuing education requirements.
Sample: Fulfills mandatory educational requirements annually *[list requirements]*, which include, but are not limited to, The Joint Commission and other institutionally required education, BLS and ACLS, or appropriate certification related to specialty. CME hours, as required by specific extender national certification.
- Clearly list drug therapies that the MLP may prescribe, initiate, monitor, alter, or order.
- Specify the supervising physician's duties.
Sample: The physician shall provide general supervision for routine healthcare and management of common health problems and provide consultation and/or accept referrals for complex health problems. The physician shall be available by telephone or by other communication device when not physically available on the premises. If the physician is not available, his/her associate, *[Name of Physician, MD/DO, License# 999999]* *[or other description of designated doctor(s) or groups]*, will serve as backup for consultation, collaboration, and/or referral purposes.
- Include the signature of the MLP and supervising provider.
Sample: All parties to this agreement share equally in the responsibility for reviewing treatment protocols, as needed, and no less than annually.

Risk Management and Patient Safety Checklist

- Check a candidate's credentials and licensure status carefully before employment.
- Verify that a candidate's licensing and certification requirements are current.
- Obtain authorization to conduct credentialing and background verification for a candidate.
- Use a skills checklist to assess a candidate's clinical skills prior to employment.
- Ensure that newly hired MLPs undergo orientation to the practice.
- Periodically test competency and document performance evaluations.
- Obtain MLP hospital privileges, when required.
- When required, notify managed care plans of MLP participation in patient care.
- Promptly notify insurance carriers of MLP staffing changes.
- Maintain copies of professional liability insurance coverage.
- Obtain and review state licensing board guideline requirements periodically.
- Remain current on and comply with MLP licensure requirements, scope of practice, and supervisory limitations.
- Develop written job description(s).
- Develop written guidelines and protocols that specify the MLP's responsibilities relative to examinations, assessments, diagnoses, treatment, prescriptive privileges, and administrative functions.
- Delineate in written guidelines and protocols how often the physician must see the patient and under what circumstances the supervising physician must personally assess the patient.
- Clarify the type and extent of physician supervision required.
- Ensure that the physician can perform all procedures assigned to the MLP.
- Establish criteria for periodic review and evaluation of MLP medical record documentation.
- Monitor an MLP's prescription practices and maintain a current copy of the DEA certificate.
- Document all communications between the physician and MLP.
- Consider providing disclosure language in patient authorizations and/or consent forms indicating that treatment will be rendered by MLPs under your supervision.
- Ensure that all staff members and other physicians in the practice understand the MLP role and limitations.
- Instruct all MLPs to consult with a physician whenever they are in doubt about the treatment of a patient.
- When used, keep clinical guidelines up to date.
- Develop an employee handbook.
- Have employees acknowledge employment policies and procedures and confidentiality statements.
- Conduct annual performance evaluations for all MLPs and staff.
- Require that each staff member and MLP wear a name badge delineating his or her title.
- Determine patient satisfaction with the MLP care provided.
- Determine patient satisfaction with the practice overall.
- Foster open communication among all staff members in your office.
- Ensure that all staff members project a professional demeanor.
- Assure patients that they will be seen by a physician when they or the doctor feel it necessary.
- Encourage and promote continuing education among MLPs and all staff.
- Include patient safety and patient satisfaction in evaluation criteria.
- Ensure the staff schedule includes time off, vacations, and equitable workload.
- Promote an environment in which staff can report errors without fear of reprisal.
- Implement a staff attitude assessment to identify culture issues that may affect patient safety.
- Provide patient safety and risk management training to all staff.

Frequently Asked Questions

Is a PA required to have written protocols in order to practice?

It depends. While it is strongly recommended that a PA practice under written protocols in all clinical settings, many states only require written protocols in certain practice settings. However, all states require a supervising physician in order for a PA to practice in any setting.

How many MLPs may be supervised by a physician?

The ratio of MLPs to supervising physician varies. While the American Medical Association does not state a specific ratio, it recommends that the appropriate ratio of physician to MLPs should be determined by physicians at the practice level, consistent with good medical practice and state law where relevant. In some states, the ratio is specified if MLPs are furnishing or prescribing medications. It is important to maintain a ratio consistent with the terms, if any, of your professional liability policy language.

Is the scope of a PA's practice determined by the supervising physician?

Yes. State law permits a PA to practice within the scope of practice of the supervising physician. It follows that a PA's scope of practice may be defined by the limitations set forth by the supervising physician in coordination with the PA's education, training, and experience.

What are the physician co-signing requirements for documentation by an MLP?

It varies. Each state has regulations that outline which MLP type requires co-signature and which type of charts require review and co-signature. Regardless of state law, to reduce exposure to liability, a protocol for chart review for quality assurance purposes should be established.

Does the name of a licensed physician need to be on prescriptions issued by a PA or APN?

Yes, providing the specified MLP has prescribing privileges. The name of the licensed physician must be on all prescriptions written by an MLP. In the case of on-call coverage, the alternate physician's name must be indicated.

Which drugs can a prescribing MLP write prescriptions for?

While some states allow prescribing of many types of medications within formulary standards, including controlled substances with a DEA registrant number, some states do not allow such prescribing. States are adopting requirements for completion of advanced courses in pharmacology before prescribing privileges are allowed, especially for controlled substance prescribing. An NP's standardized procedure must outline what is allowed, while a PA's supervising physician decides what is allowed through delegation, while considering state laws for prescribing certain pharmaceuticals. As mentioned earlier, while a written protocol may not be required in certain states and practice sites, it is highly recommended that written protocols, with specified formulary for prescribing, accompany delegation of services and be archived in case they are needed in the future.

Does a change in employment affect an MLP's prescribing privileges?

Yes. Prescribing privileges, while allowed through licensure, require approval by employer, physician, and practice location. A change in employment requires that the new employer/supervising physician delegate prescribing privileges to the PA. For the NP, a standardized procedure specific to the new location must be drafted. This may also require submission of new information to the respective licensing board, depending on the state of practice.

Can an MLP with prescribing privileges sign for medications received from a pharmaceutical representative?

Yes; however, only for those medications the MLP is authorized to prescribe.

Does a supervising physician have to countersign prescriptions written by a PA?

No, as long as the prescription is for an approved drug on the formulary that is included in the agreed-upon medication listing on file with the supervising physician.

Can an MLP dispense medications?

No. Under current law, an MLP with prescribing privileges cannot be a “dispensing practitioner.” However, an MLP may dispense sample medications as indicated by prescribing privileges.

What are the legal differences between an NP and a PA?

An NP’s scope of practice varies from state to state. In many states, NPs are allowed to practice independently, without the supervision of a licensed physician, depending on the practice setting. However, NPs often practice under the guidance of a licensed physician. A PA is licensed to practice medicine under a supervising physician, practicing only under a physician’s license. A PA can conduct physical exams, diagnose and treat illnesses, order and interpret tests, and, in many states, write prescriptions.



185 Greenwood Road
Napa, CA 94558
(800) 421-2368
www.thedoctors.com