Physician liability for the actions of midlevel providers

While the use of physician extenders can bring added legal risks to a practice, they can also help prevent incidents of malpractice by providing more individualized care for patients

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Physician extender (PE) is a term applied to midlevel professionals who work under the supervision of a physician and carry out functions within the scope of the physician’s practice. The term refers primarily to physician assistants and nurse practitioners. Their roles vary from state to state, based on the specific statutory provisions of the state in which they practice.

These statutes and associated regulations typically govern training and licensing requirements, PE to doctor ratios, presence and availability of the supervising doctor, and review and cosigning of charts. Some statutes also specifically establish an agency relationship between the physician and the PE for purposes of imposing liability on the physician for acts of the PE.

The starting point in deciding whether to employ PEs, incorporating them into a medical practice and understanding their liability implications is a full familiarity with the governing statutes and regulations.

There has been an explosion in the number of PEs in the United States over the past decade. According to the American Association of Physician Assistants there are more than 85,000 certified physician assistants practicing in the United States, more than double the number practicing 10 years earlier. The American Association of Nurse Practitioners reports that there are 192,000 nurse practitioners employed in the United States, with an additional 14,000 annually completing their training.

It is likely that number of PEs will continue to go up as a consequence of the shortage of primary care doctors, the increase in insured patients under the Affordable Care Act, and dwindling reimbursements that require physicians to see an ever-increasing volume of patients.
Potential benefits of using PEs

This discussion of the financial impetus for using PEs is not meant to imply that utilizing PEs does not have the potential for improving the quality of medical care. They certainly can and do when employed in the right setting and under appropriate supervision.

The corollary to this is that there are a number of ways that PEs can reduce a physician’s exposure to liability. One of the primary causes of medical malpractice is that physicians cannot or do not spend enough time caring for an individual patient. This may include time spent taking a thorough history, doing a proper physical examination, ordering and reviewing tests, speaking with consultants or sometimes just taking a few minutes to think about the patient’s problems before moving on to the next patient. In the complex practice of medicine, not having enough time will inevitably lead to mistakes.

Having a PE on staff allows for the thorough and careful treatment of more patients. Having more time facilitates better communication with patients and increases patient satisfaction. Routine tasks such as returning telephone calls, reviewing and acting on test results, communicating with other providers, and ordering prescriptions can be done more quickly and efficiently.

Perhaps most importantly when it comes to liability risk, good communication and a positive relationship with patients can reduce the likelihood of a malpractice claim in the event of a perceived bad outcome.

Sources of liability for acts of PEs

The good news is that the growing use of PEs has not lead to an increase in malpractice lawsuits or payouts.

A 2009 study found that between 1991 and 2007, the first 17 years that the National Practitioner Data Bank was in operation, payments were made on behalf of 37% of physicians, but only 3.1% of physician assistants and 1.5% of nurse practitioners. The study concluded: “There were no observations or trends to suggest that PAs and APNs increase liability. If anything, they may decrease the rate of reporting malpractice and adverse events.”
Although the overall risk of being sued may not increase with the employment of PEs, a physician can be exposed to liability for malpractice when a patient is harmed by the actions or inactions of a PE, even if the physician was not directly involved in treating the patient.

There are several legal theories that may be applied to attach liability to a physician, either directly or vicariously, for a PE’s negligence. First, the physician may be directly responsible for negligent hiring of a PE. The screening process necessary to determine whether a PE is competent and capable of performing the specific functions that will be required includes a review of educational background, appropriate certification, prior work history and recommendations from previous employers or professors.

The other legal ground for finding a physician directly liable for the actions of a PE is a failure to supervise properly. The starting place for determining the required level of supervision is the applicable state statute and regulations. Many statutes specify whether the supervising physician must be physically present in the facility where the PE is working, or can have some lesser degree of availability. The ratio of supervising physicians to PEs also may be spelled out in the statutes.

The responsibility for quality assurance, including review and cosigning of charts is also a common statutory provision. Failure to perform any of these functions may in some instances be deemed negligence *per se* such that the supervising physician may be held liable even without proof of negligence by the PE.

Of course, these statutes set forth just the minimum requirements for supervision. To minimize liability risks and maximize patient safety, the physician must establish a system for meaningful and effective supervision.

A physician may also be held vicariously liable for the acts of a PE on the grounds that the PE is acting as an agent of the physician. In some states, statutes create a conclusive presumption of agency so that a physician will always be responsible for the negligence of a PE. In other states, liability will depend on whether the physician has a right to control the work done by the PE.

However, given the typical requirements of supervision, it will be a rare circumstance when a PE will not be found to be an agent of the supervising physician.
It is also important to be aware, to the extent possible, of the applicable standard of care for PEs. In some states, the PE is held to the standard of care of the supervising physician, on the theory that the PE is carrying out the function of the doctor and the patient is entitled to an equivalent level of treatment regardless of the provider.

In other states the PE is held to the lesser standard of a similarly trained and certified PE, while in still other states the standard of care has not yet been determined by the courts. In this latter circumstance it is best to err on the side of caution and assume that the PE will be held to the higher standard of care.

Minimizing exposure to liability

From my experience representing plaintiffs in medical malpractice cases I have seen three main areas where physicians get into trouble in using PEs.

First is the failure to have a system in place for working with PEs. This relationship should be managed on an ad hoc basis. Practices must have a written list or description of the activities and procedures the PE is allowed to perform. If professional organizations or hospitals have adopted written guidelines or policies for carrying out specific activities relevant to the PE’s practice, those guidelines or policies should be adopted, taught and enforced by the supervising physician.

Review of patient charts for quality assurance purposes, in addition to routine cosigning of PE’s notes, also should be performed regularly and should include a meaningful, ongoing assessment of competence.

A minimum number of annual hours of continuing medical education should also be required for all PEs. Developing and adhering to this type of systematic oversight can help prevent patient safety issues from falling through the cracks.

The second, and undoubtedly the most important element in avoiding problems is effective communication. It is not enough for a PE to have access to the supervising physician. The PE must feel comfortable initiating communication, and must understand that communication is expected as part of the PE’s responsibilities.
Problems may arise when a PE is concerned about bothering the doctor, or is afraid to be seen as incompetent. As professional as PEs may be, they lack the education and training of a doctor, and the relationship only works safely when there is active collaboration between them.

The third suggestion is to recognize and avoid the temptation to give too much autonomy to a PE. Human nature may lead a busy doctor to delegate more and more responsibilities with less and less oversight as long as that trend seems to be working. Likewise, a competent and ambitious PE may be pleased to be given more responsibilities, even if they start going beyond that PE’s level of education and training.

This arrangement may work wonderfully until disaster strikes. Then the physician and PE will be asked to explain why the PE was performing functions that should only be undertaken by a doctor.

The way to avoid this insidious process is to adhere strictly to the list of duties and responsibilities assigned the PE, and to regularly reassess the quality of the PE’s work. By following these suggestions, physicians, PEs and, most importantly, patients will reap the many benefits of PEs’ participation in the healthcare team.