

Physician Extender Liability:



Preventive Action & Loss Reduction Plan



First Professionals Insurance Company

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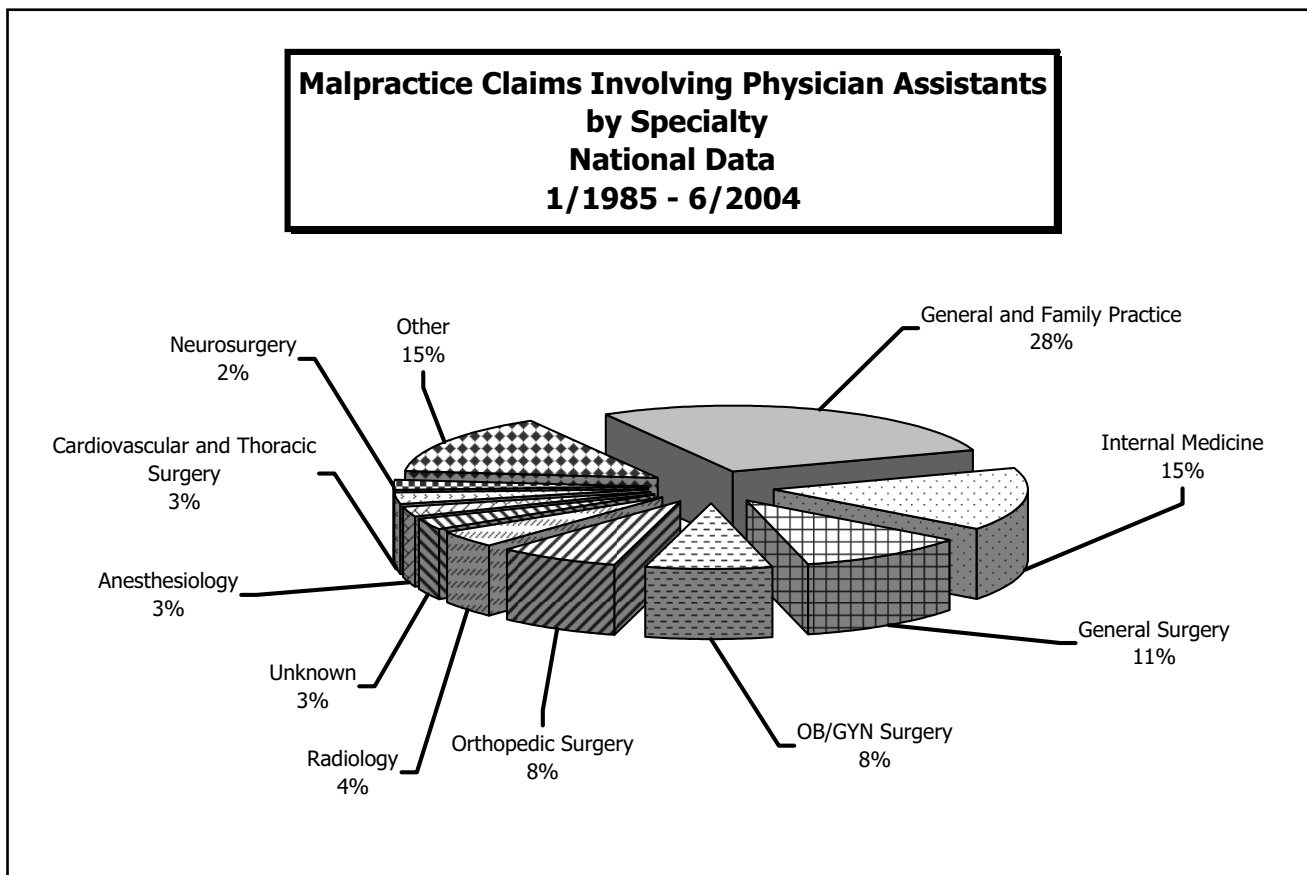
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Introduction

Since the advent of managed care, the number of physicians who support the use of physician extenders continues to grow. Physician extenders include a large number of non-physician providers, including nurse practitioners, nurse midwives, nurse anesthetists, anesthesia assistants, and physician assistants. In 2003, there were well over 111,000 practicing nurse practitioners (NPs) in the United States.⁽¹⁾ It is estimated that there will be as many NPs practicing in this country as family physicians.⁽²⁾ Approximately 5,000 to 6,000 newly prepared NPs enter practice each year. The number of physician assistants (PAs) has increased 110 percent since 1993, to over 46,000.⁽³⁾ In tandem with the increasing use of physician extenders is the spiraling frequency and severity of medical malpractice claims against physicians attributed to physician extenders (PEs). Recent data from the Physician Insurers Association of America (PIAA) reveals that the average indemnity paid on behalf of PAs is \$282,320. Over 28 percent of malpractice claims against general and family practice physicians involved a PA. Under expanding theories of tort liability, physicians are increasingly being held responsible for the acts of physician extenders in virtually all clinical settings.

Although the practical benefits of utilizing PEs are numerous, myriad legal doctrines hold the physician responsible for the acts and omissions of such employees. Implementing effective risk management measures will help ensure that the benefit of using physician extenders in your practice is not at the expense of increased liability exposure and malpractice claim development.



Understanding Theories of Liability

Most physicians realize that they have responsibility for the actions of their office staff and those who are directly employed by them. As mentioned previously, physicians are increasingly being held responsible for the acts of others. Such liability can be divided into two broad categories – direct and vicarious.

Direct Liability

Direct liability is defined simply as being responsible for your own acts. If you deviate from the acceptable standard of care, then you are negligent and directly responsible.

Vicarious Liability

Vicarious liability is a term used to describe the imputation of neglect to another person not directly involved in an allegedly negligent act. Generally, the common law test under which vicarious liability is determined is that of direction and control of another's actions. The greater the degree of control or direction an employer has of an employee, the greater the degree of employer responsibility or liability. Vicarious liability encompasses those situations where you may have acted appropriately but find yourself responsible for the failure of another. This is best illustrated when a person is held responsible, or vicariously liable, for the tort of another even though the person held responsible may not have done anything wrong. Such is often the case with employers who are held vicariously liable for the damages caused by their employees. Many physicians practice as an employee of their own entity, such as a professional association or corporation. As an employer, the entity can be held directly liable for the acts of its employees as well as vicariously liable. This applies to both physician and non-physician employees of the entity. Legal theories hold that as an employer, the professional association or corporation becomes the master and each of the employees become a servant. A common theory of law called "respondent superior" comes into play. Under this theory, the professional association is responsible for the acts of each of its employees. A good example occurs when a physician assistant is alleged to have missed a diagnosis resulting in patient harm. Although the PA may be responsible for the error made, his employer, the professional association, and the supervising physician can be held directly liable as well as vicariously liable. Moreover, the physician can also be held vicariously liable for the professional association. Although a professional association is not a person, it is run by people. Therefore, if an employee of the professional association injures another, the employee is responsible, as is the professional association, provided that the employee was operating within the scope of employment. The intent of this imputation of fault is to ensure that the injured party has a right to full recovery from the entity directing the employee's actions.

Agency

Another theory of liability that may expose a physician to the negligent acts of another is that of agency. Two common categories of agency are apparent agency and ostensible agency. Under these theories, if a reasonable individual would assume that an entity (such as a professional association) would in some way be responsible for the acts of itself and its employees – including independent contractors of the entity, it might reasonably be assumed that these others were acting on behalf of the professional association. As most patients will take any information they receive in the doctor's office as authoritative, an essential risk management practice is to instill in PEs to provide care and treatment only within the scope of practice and within the guidelines of the practice.

Respondent Superior

The legal doctrine of “respondent superior” (translated “let the master answer”) and the “borrowed servant rule” are generally invoked when the physician is being held liable for the PE whose actions the physician controls, or has the right to control. Moreover, depending on the situation, the right of control need not have been exercised to permit invoking these doctrines. “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 law, the testimony of experts, and the standard of care.”⁽⁴⁾ While similar, many physicians confuse the legal doctrine of respondent superior and the borrowed servant rule with the “captain of the ship” doctrine.

Collaboration and Supervision

The definition of “collaboration” and “supervision” varies greatly in both the Florida Statutes and Administrative Codes. Therefore, the physician’s scope of collaboration and supervision must be determined by the context of the clinical setting, patient acuity and medical condition, and type of PE, professional licensure, and even duration of PE employment. For example, under current Florida law, a PA’s medical charting entries must be countersigned by the supervising physician within seven days for the first six months in an employment setting, and then within 30 days thereafter. However, within a hospital setting, PE charting entries and physician cosigning requirements are set forth by the hospital. Generally, neither collaboration nor supervision requires the on-site presence of a physician. Here again, the requirements of certain medical specialties and clinical settings must be considered. While a CRNA may render anesthesia without the direct supervision of an anesthesiologist, obstetrical procedures usually require that the CRNA be supervised by a physician “readily” available, which is defined by many as physically present or in-house. Moreover, professional liability policies vary in their definitions of collaboration and supervision and may set forth very specific language depending on the clinical setting.

Although the physical presence of the collaborating or supervising physician may not be required, it is essential that the physician or his or her designee be available to the PE either by telephone or in person for consultation or referral. For these reasons, collaboration and supervision are important factors to consider when taking call or covering for another physician.

The definitions of collaboration and supervision will also vary from state to state. This is an important factor when providing care and treatment across state lines.

CASE SUMMARY

A 53-year-old married female underwent a laparoscopic cholecystectomy performed without incident by the insured general surgeon. The surgeon saw the patient three days postop, noting that she was doing well and had no complaints other than the expected incisional pain. The patient was next seen at five days postop by the surgeon's physician assistant (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 the 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 non 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 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, settlement was necessitated in the amount of \$800,000: \$550,000 for the surgeon's direct and vicarious liability for the PA; and \$250,000 for the surgical practice for the negligence of the PA.

Physician Extender Closed Claim Analysis

Malpractice claims attributed to the negligence of a physician extender are frequently made against the PE's employer, which in many cases is the supervising physician. Frequently, the professional liability insurance of PEs is written under the physician's policy or that of the employer – commonly the professional association or corporation. Myriad closed claim reporting requirements result in a lack of uniformity relative to PE identification. Consequently, it is difficult to assess the inherent liability exposures attributed exclusively to the use of physician extenders.

Closed Claim Data

According to closed claim data compiled by the Physician Insurer's Association of America (PIAA) for the 20 year period 1985-2004, 42 percent of claims involving PAs resulted in an indemnity payment. The cumulative average indemnity paid on behalf of a PA was \$174,871 before adjustment to present day value. In most cases, indemnity payment is made on behalf of a PA or other PE by the supervising physician's policy or that of the physician's professional association. The PIAA claim data indicates that most malpractice claims involved diagnostic error on the part of the physician extender. In terms of medical specialty, general and family practice had the greatest number of claims.

The most prevalent medical condition involved in claims attributed to PAs was acute myocardial infarction, most often due to a failure to diagnose. The most prevalent type of procedure involved the failure to render treatment. Although both the majority of claims and the greatest number of paid claims were made in general and family practice, the highest average indemnity payment was made on behalf

of PAs in the specialty of neurosurgery. The highest average indemnity payment by type of misadventure was for the delay in performance (of a procedure) or treatment. However, the most prevalent treatment for which claims were made against PAs involved the prescription of medication.

High-risk Conditions, Procedures, Misadventures, and Medical Specialties

Most Prevalent Medical Condition

- Acute Myocardial Infarction
- Injury – All Types
- Chronic Ischemic Heart Disease
- Brain Damaged Infant
- Breast Cancer
- Cervical and Uterine Cancer
- Ectopic Pregnancy
- Osteoarthritis
- Pneumonia
- Pregnancy

Most Prevalent Procedures

- No Treatment Rendered/Lack of Treatment
- Prescription of Medication
- Comprehensive Physical Examination
- General Physical Examination
- Comprehensive Consultation
- General Consultation
- General Anesthesia
- Diagnostic Interview and Evaluation

Most Prevalent Misadventures

- Diagnostic Error
- No Medical Misadventure
- Improper Performance
- Failure to Supervise/Monitor case
- Improper Supervision
- Failure to Recognize a Complication of Treatment
- Medication Error
- Unnecessary Treatment /Contraindicated Procedure
- Failure to Perform
- Delay in Performance

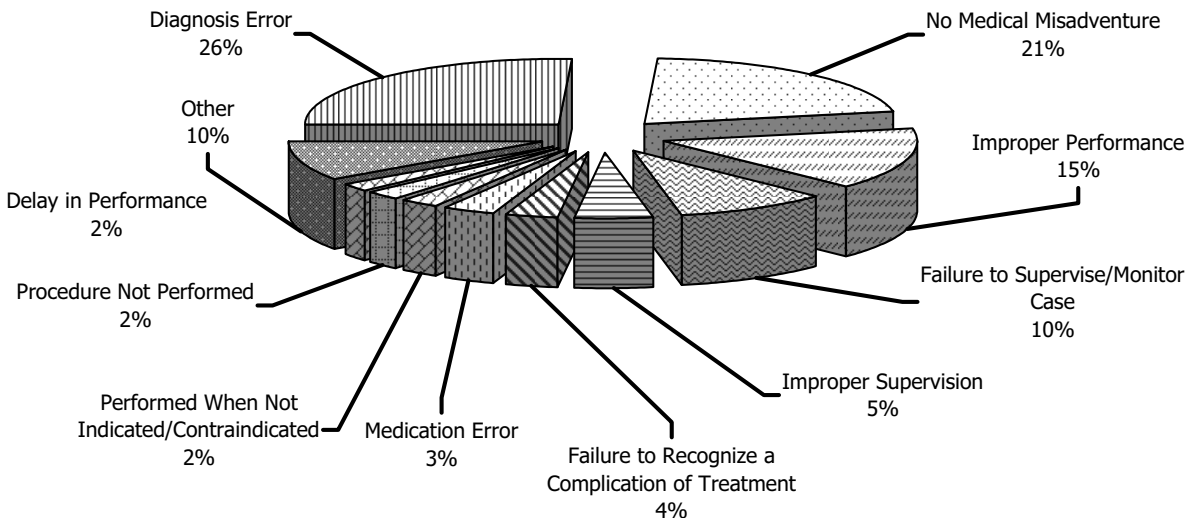
Most Prevalent Medical Specialties – by Rank

- General Practice/Family Practice (GP/FP)
- Internal Medicine
- General Surgery
- OB/GYN – Surgery
- Orthopedic Surgery
- Radiology
- Anesthesiology
- Cardiovascular and Thoracic Surgery
- Neurosurgery

PA Claim Statistics

- Greatest number of closed claims by medical specialty: GP/FP
- Greatest number of paid claims by medical specialty: GP/FP
- Payment ratio of paid to closed claims: 41.9%
- Highest average indemnity payment, by medical specialty: Neurosurgery - \$379,314.
- Highest average indemnity payment by medical condition: Brain damaged infant - \$436,499
- Highest average indemnity payment by procedure: General physical exam - \$276,001.
- Highest average indemnity payment by misadventure: Delay in performance - \$302,411
- Most prevalent medical condition: Acute myocardial infarction
- Most prevalent treatment rendered: Prescription of medication
- Most prevalent misadventure: Diagnostic error

**Malpractice Claims Involving Physician Assistants
by Misadventure Type
National Data
1/1985 - 6/2004**



Root Cause Analysis of Claims

Failure and Delay in Diagnosis

The primary root cause of malpractice claims involving physician extenders and attributed to failure and delay in diagnosis is a lack of physician supervision. Contributing factors include misinterpretation of information provided by the patient to the PE, often as a result of the PE's lack of skill in diagnosing and managing the case. To reduce this exposure, protocols should clarify that, in those situations where the PE is uncertain about the assessment of the patient or if the patient's condition does not follow the customary or anticipated course, supervising physician should be promptly consulted. The importance of documenting the patient's clinical symptoms with specificity cannot be overstated. Successfully defending failure and delay in diagnosis claims often depends on supporting the PE's clinical rationale in the face of otherwise silent clinical symptomology.

Failure and Delay in Referral

The primary root cause of malpractice claims attributed to failure and delay in referral is the PE's management of complicated conditions which are beyond their scope of training and skill. The supervising physician should instill in all PEs the need to practice within the PE's abilities and the scope of the medical practice. If the patient does not respond to treatment, or if there is uncertainty about the patient's medical condition, referral should be initiated in a timely manner. The reason for the referral should be clearly documented in the medical records. To ensure prompt response to referral recommendations, a tracking mechanism should be implemented to capture delinquent referral recommendations. All reports should be initialed by the reviewing clinician and the results incorporated in the plan of care as indicated.

Inadequate Evaluation and Physical Exam

The failure to perform an adequate evaluation is often attributed to reliance on previous medical records rather than obtaining a complete, updated history from the patient. Documentation of the patient's current complaints and updating pertinent clinical information should be made at the time of each evaluation. The extent of the PE's evaluation and physical examination of the patient should be fully documented. Instruct staff to utilize a consistent and uniform format for charting negative clinical findings and the absence of pertinent symptoms. Generally, the defense of failure to diagnose allegations must demonstrate that there was a lack of clear and compelling symptoms or findings prohibiting the practitioner from making the diagnosis and thus the care provided in light of the patient's otherwise silent clinical status was appropriate. A good risk management tool is the use of a model Physical Examination and Evaluation Form. Before the supervising physician cosigns chart entries, any deficiencies in the entries or clinical evaluation should be brought to the PE's attention for clarification and/or follow-up action.

CASE SUMMARY

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 preoperatively was 11.8 and 13.9 four days later prior to discharge. When 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 and had 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 continued complaint of pain.) Although the medical record was silent 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 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 noted in either the hospital record or the patient's chart.) The following day the patient again phoned the physician and spoke with another PA due to complaint of neck and shoulder pain. (The patient testified that the PA instructed her to continue taking the pain medication prescribed by the ER.) Due to 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 did not document 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.

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

Exposure to Disciplinary Action

In addition to the potential for increased liability exposure, a PE also subjects a physician to exposure to possible disciplinary action. For example, pursuant to FS 458.331, a physician may be disciplined by the Board of Medicine for failing to adequately supervise the activities of a PE acting under his/her supervision. In Florida, disciplinary action ranges from probation, suspension, and revocation of the physician's license and administrative fines of up to \$10,000 per offense. An unfavorable ruling in disciplinary action may also include submitting to quality assurance review and continued medical education. In addition, the administrative costs incurred by the board as well as the defense costs incurred in connection with the disciplinary action must be considered. More troublesome than the economic factors is the fact that when disciplinary action is taken, it becomes open to public record and a permanent part of the physician's record.

Defining Physician Extenders

Physician Assistant (PA)

Physician Assistants must complete a two to three year 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. In many cases, they may not be denied hospital privileges. The physician selecting an appropriate PA candidate 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 Nurse Practitioner (ANP)

The term advanced nurse practitioner is a description that includes nurse practitioners (NP), certified nurse-midwives (CNM), certified registered nurse anesthetists (CRNA) and clinical nurse specialists (CNS).

Nurse Practitioner (NP)

Nurse practitioners 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. NPs function most often in primary care physicians' offices performing physical exams and treating noncomplex complaints. They can be supervised by a PA employed by the monitoring physician or physician group.

Clinical Nurse Specialist (CNS)

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 teaching, staff education, and overseeing particular physician/departmental protocols. Their scope of practice is largely well-defined by their state board of nursing.

Certified Nurse Midwife (CNM)

Nurse midwives 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 utilize 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)

Nurse anesthetists practice in surgical settings under the supervision of either an anesthesiologist or a surgeon. National certification and re-certification is required. 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.

Anesthesiologist Assistant (AA)

An anesthesiologist assistant is a graduate of an approved program who is licensed to perform medical services delegated and directly supervised by a supervising anesthesiologist. 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.

Florida Statutes (FS) and Administrative Codes (FAC)

Caution should always be exercised when referencing statutes and administrative rules. Specific citations and statutory language frequently change. Additionally, depending on the clinical setting, federal law may apply and supersede state law. For these reasons, the following cites, although current at the time of publication, should be verified contemporaneously.

Advanced Registered Nurse Practitioners; Certified Nurse Midwives; and Certified Registered Nurse Anesthetists

FS 464.003 (3)(c) – Definitions – Advanced or specialized nursing practice

FS 464.012 – Certification of advanced registered nurse practitioners

FS 456.0391 – Advanced registered nurse practitioners; information required for certification

FS 458.348(1)(a) – ARNP Protocol Notice to the Board of Medicine

FAC 64B8-35 – Advanced Registered Nurse Practitioner

FAC 64B9 – Advanced Registered Nurse Practitioners

Anesthesiologist Assistants

FS 458.3475 – Anesthesiologist Assistants – Definitions (MD)

FS 459.023 – Anesthesiologist Assistants – Definitions (DO)

Health Professions and Occupations

FS 456 – General Provisions

Midwife

FS Chapter 467 – Midwifery

Physician Assistants

FS 458.347 – Physician Assistant (MD)

FS 459.022 – Physician Assistant (DO)

FS 154.04(21) – Written Protocols Requirements

FAC 64B8-30 – Physician Assistant

Florida Administrative Codes

FAC 64B8-30 – Florida Administrative Code: Board of Medicine - Physician Assistant

FAC 64B8-30.008 – Florida Administrative Code: Board of Medicine - Physician Assistant - Formulary

FAC 64B15-6 – Florida Administrative Code: Board of Osteopathic Medicine - Physician Assistant

FAC 64B8-30.007 – Written prescribing agreement for PAs

FAC 64B15-6.0037 – Physician supervision of prescribing PA

Physician Extenders in Private Practice

Just like any other business decision, hiring a PE requires advance planning. Consider the volume of your practice, patient demographics, patient's expectations and acceptance and managed care/payor reimbursement issues which may be less for PE services. PEs 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, PEs are trained to perform 20-60 percent of the tasks formerly considered to be a physician's domain. Increasingly, group practices offer patients the option of seeing a midlevel practitioner immediately versus waiting for an appointment with a physician. Numerous studies indicate that the majority of primary care office visits can and increasingly are being adequately handled by physician extenders. Although the majority of PEs are employed in group practices, increasing numbers of solo practitioners are utilizing PEs. The benefits of using PEs include:

- Economic factors, including lower operating overhead
- Faster patient access to health care
- 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
- Enhanced patient satisfaction

Prevalent PE Type and Scope

Physician Assistant (PA)

It is estimated that approximately 206 million patient visits were made to physician assistants (PAs) and approximately 250 million medications were prescribed or recommended by PAs. According to the AAPA (American Academy of Physician Assistants), PAs have a mean of 9.2 years in clinical practice and a median of 6 years. Approximately 85 percent of PAs work in one clinical setting. Fifteen percent work in one or more clinical positions concurrently. Forty-three percent of PAs are employed by a single or multi-specialty group practice, while 22 percent are employed by hospital. At 14 percent a relatively small, but growing number of PAs, are employed by a solo practitioner. Forty percent of all PAs perform invasive procedures. The following table (1) contains the number and percent distribution nationally and in Florida of PAs by clinical practice function.

Table 1: Number and Percent Distribution of Clinically Practicing Respondents
Who Perform Select functions at Primary Clinical Job*

	Florida		All Others		Total	
	Count	Percent	Count	Percent	Count	Percent
Respondents	1111	100.0%	19724	100.0%	20839	100.0%
Function as hospitalist	53	4.8%	1264	6.4%	1317	6.3%
Perform invasive procedures	450	40.5%	8249	41.8%	8699	41.8%
Assist at surgery	323	29.1%	5204	26.4%	5527	26.5%
Manage care for inpatients	424	38.2%	6958	35.3%	7382	35.4%
Perform quality assurance	219	19.7%	3953	20.0%	4172	20.0%
Educate other providers	343	30.9%	6367	32.3%	6710	32.2%
Utilization review	57	5.1%	1173	5.9%	1230	5.9%
Research	146	13.1%	2047	10.4%	2193	10.5%
Pharmaceutical selection review	33	3.0%	438	2.2%	471	2.3%
Therapeutics committee	23	2.1%	421	2.1%	444	2.1%
Make decisions about procurement	235	21.2%	4205	21.3%	4440	21.3%
Supervise other PAs	105	9.5%	1710	8.7%	1815	8.7%
Supervise clinical staff other than PAs	233	21.0%	3830	19.4%	4063	19.5%
Supervise non-clinical staff	101	9.1%	1814	9.2%	1915	9.2%
Precept PA students	273	24.6%	7365	37.3%	7638	36.7%
Precept students of other health professions	255	23.0%	4954	25.1%	5209	25.0%

*Percentage sum to more than 100 because respondents were instructed to mark all that apply.

As of January 1, 2005, over 3,000 PAs practice in the state of Florida. PAs practicing general pediatrics, family medicine, and emergency medicine account for more patient visits per week than other medical specialties. Nationally, in 2004, more PAs (32%) practiced family medicine than any other specialty. Approximately 40 percent of PAs take calls for their primary employer. Nearly one-half of the medications issued in general practice are prescribed or recommended by PAs. In terms of specific in-patient clinical settings, the percent distribution of PAs is as follows: 33 percent inpatient units; 29 percent ER; 26 percent OR; 21 percent hospital outpatient units; and 20 percent ICU/CCU.

In healthcare facilities (hospitals, nursing homes, surgical centers, and others), PAs are usually credentialed and privileged through the medical staff in a manner parallel to that used for physicians. Each facility determines the scope of practice of PAs. This is an important consideration for the supervising physician that covers more than one health care facility. Approximately 64 percent of PAs see patients in at least one hospital.

The following table (2) contains both the national and state of Florida number and percent distribution of clinically practicing PAs by type of primary employer.

Table 2: Number and Percent Distribution of Clinically Practicing Respondents
By Type of Primary Employer

	Florida		All Others		Total	
	Count	Percent	Count	Percent	Count	Percent
Respondents	1112	100.0%	19720	100.0%	20832	100.0%
Self-employed	58	5.2%	495	2.5%	553	2.7%
Solo physician practice	215	19.3%	2714	13.8%	2929	14.1%
Single-specialty physician group	408	36.7%	5843	29.6%	6251	30.0%
Multi-specialty physician group	121	10.9%	2579	13.1%	2700	13.0%
University hospital	56	5.0%	1461	7.4%	1517	7.3%
Other hospital	102	9.2%	2981	15.1%	3083	14.8%
Freestanding urgent care center	20	1.8%	368	1.9%	388	1.9%
Freestanding surgical center	1	.1%	24	.1%	25	.1%
Nursing home or LTC facility	2	.2%	53	.3%	55	.3%
Home health agency			3	.0%	3	.0%
Hospice	1	.1%			1	.0%
HMO	7	.6%	543	2.8%	550	2.6%
Community health center	31	2.8%	1196	6.1%	1227	5.9%
Medical staffing agency	2	.2%	56	.3%	58	.3%
Physician practice mgmt org	24	2.2%	285	1.4%	309	1.5%
Integrated health system	4	.4%	197	1.0%	201	1.0%
Corrections system	12	1.1%	217	1.1%	229	1.1%
Other	48	4.3%	705	3.6%	753	3.6%

The medical specialty distribution of practicing PAs is contained in the following table (3), revealing that compared to the national distribution, a slightly higher percent of Florida PAs practice in surgical subspecialties and emergency medicine. The majority of PAs are employed in the primary care specialties. Twenty-four percent practice in General Surgery/surgical subspecialties. Approximately 11 percent of PAs practice Emergency Medicine in Florida.

Table 3: Number and Percent Distribution of Clinically Practicing Respondents
By General Specialty Practiced for Primary Employer

	Florida		All Others		Total	
	Count	Percent	Count	Percent	Count	Percent
Respondents	1099	100.0%	19451	100.0%	20550	100.0%
Family/general medicine	228	20.7%	5824	29.9%	6052	29.5%
General internal medicine	95	8.6%	1512	7.8%	1607	7.8%
Emergency medicine	120	10.9%	1911	9.8%	2031	9.9%
General practice	21	1.9%	502	2.6%	523	2.5%
General surgery	22	2.0%	559	2.9%	581	2.8%
Internal medicine subspecialties	140	12.7%	1864	9.6%	2004	9.8%
Pediatric subspecialties	23	2.1%	286	1.5%	309	1.5%
Surgical subspecialties	255	23.2%	4072	20.9%	4327	21.1%
Obstetrics and gynecology	15	1.4%	519	2.7%	534	2.6%
Industrial/occupational medicine	18	1.6%	477	2.5%	495	2.4%
Other	162	14.7%	1925	9.9%	2087	10.2%

Nurse Practitioner (NP)

Nurse practitioners are a prevalent type of PE utilized in many private practice settings. According to the American Academy of Nurse Practitioners, the largest percentage of NPs are engaged in family medicine clinical settings. 62 percent of NPs see three/four patients per hour, with 12 percent seeing five or more patients per hour. Nearly 97 percent of NPs prescribe medications and write an average of 19 prescriptions per day. NPs write over 494 million prescriptions annually. 65 percent of NPs are authorized to prescribe controlled substances.⁽⁵⁾ Nurse practitioners 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.

AMERICAN ACADEMY OF NURSE PRACTITIONERS

Incorporated 1985

U.S. Nurse Practitioner Workforce 2004

NP Facts:

- 88% of NPs have graduate degrees
- 92% of NPs maintain national certification
- 39% of NPs hold hospital privileges; 13% have long term care privileges
- The average (full-time) NP salary is \$73,620, across all specialties and settings
- The average hourly rate for NPs across all specialties and settings is \$36.44
- 20% of NPs practice in rural or frontier settings
- Average NP is female (95%) and 48 years old. She has been in practice for almost 9 years as a family NP (41%).

- There are ~106,000 nurse practitioners (NPs) practicing in the U.S.
 - 5,000 -- 6,000 new NPs are prepared each year
 - 62% of NPs see 3-4 patients/hour; 12% see >5 patients/hr
 - 66% of NPs practice in at least one primary care site; 31% practice in at least one non-primary care site (such as inpatient, emergency, surgical, or specialty practice)
 - 96.5% of NPs prescribe medications and write an average of 19 prescriptions/day
 - NPs write over 494 million prescriptions annually
 - 65% of NPs are authorized to write controlled substances; 61% have a DEA number

NP Population Distribution, Mean Years of Practice, and Mean Age, by Specialty

Specialty	Percent of NPs (%)	Years of Practice	Age
Acute Care	4.5	5.9	50.0
Adult	19.5	8.8	47.0
Emergency	1.2	6.5	53.7
Family	41.2	6.8	46.6
Gerontological	4.1	8.6	51.0
Neonatal	2.3	10.3	47.8
Occupational	.9	9.5	53.3
Oncology	1.0	6.5	48.2
Pediatric	10.9	11.0	48.6
Psych/Mental Health	2.8	8.6	55.8
School Health	.6	13.0	54.3
Women's Health	11.3	12.3	49.6

These data are from AANP's 2003-2004 NP Practice Site Survey (35,000) and 2004 NP Sample Survey (n=16,500). Additional information from this survey and others is available at the AANP's website: www.aanp.org.

Liability Concerns

Most malpractice claims attributed to PEs can often 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 and assurances that the employing physician should initiate. Determine that your PE is 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 their abilities, and at regular intervals thereafter to assure continued quality performance. Monitoring enables detection of misdiagnoses, delays in diagnoses, improper orders, or any other issues requiring attention. Physician extenders are the agents of their employers - their malpractice reflects directly upon the supervising physician.

FLORIDA ADMINISTRATIVE CODE REFERENCE MATRIX

	Protocol	Supervision	Prescriptions	Order Diagnostics	Co-Signing
ARNP	Filed w/ BON annually	General ¹ or per protocol.	Per protocol with the exception of controlled substances	Yes	Medications: Not required Medical Records: Not Required
AA	Filed w/ BOM & updated biennially	Direct ² Currently, only 2 AAs may be supervised by an anesthesiologist at the same time.	No. AA may not order, prescribe, compound any controlled substance, legend drug or medical device, nor dispense sample medications.	No	Medications: N/A AA is not permitted to prescribe Medical Records: Not Required
CNIM	Filed with BON annually	General ¹ or per protocol.	Per protocol with the exception of controlled substances	Yes	Medications: Not required Medical Records: Not Required
CRNA	Filed with BON annually	General ¹ or per protocol. The number of CRNAs to be supervised should be limited to insure an acceptable standard of medical care is rendered.	Per protocol with the exception of controlled substances	Yes	Medications: Not required Medical Records: Not Required
PA	Affidavit and evidence of CME must be filed with the BOM to receive license to prescribe. Written agreement of the medicinal drugs the PA is authorized to prescribe must be maintained. A written protocol is required when the PA practices in a county health department.	Direct ³ or Indirect ⁴ as determined by the supervising physician. Supervision requires the easy availability ⁵ or physical presence of the physician for consultation and direction. A physician may supervise no more than 4 PAs at any one time.	Per written agreement and with appropriate licensure as prescribing PA. PAs approved to prescribe are not authorized to prescribe: controlled substances, antipsychotics, general, spinal, or epidural anesthetics, radiographic contrast materials, or any parenteral preparations except insulin and epinephrine.	Yes. Interpretation is not permitted under indirect supervision	For initial 6 months, medical records must be co-signed by supervising physician within 7 days. Subsequently, the supervising physician must co-sign within 30 days. Prescriptions must be reviewed and signed by the supervising physician

¹General Supervision: Physician authorizes procedures but need not be present while procedures are performed. The supervising physician must be available for consultation or advice either in person or by communication devices.

²Direct Supervision (AA): On-site, personal supervision by an anesthesiologist who is present in the office or surgical or obstetrical suite when the procedure is performed in that office or surgical or obstetrical suite, and who is immediately available in all instances to provide assistance and direction to the AA while anesthesia services are being performed.

³Direct Supervision (PA): Physical presence of the supervising physician on the premises so that the physician is immediately available to the PA when needed.

⁴Indirect Supervision: Easy availability of the supervising physician to the physician's assistant, which includes the ability to communicate by telecommunications. The supervising physician must be within reasonable physical proximity.

⁵Easy Availability: Includes the ability to communicate by way of telecommunication.

Employment Concerns

Check credentials carefully and verify qualifications with original sources. Unfortunately, credentials can be forged. Original source verification is the only way to verify authenticity. Obtain the PE's authorization to conduct credit and police checks. Utilizing a skills checklist will assist you in determining those expected skills that require additional training before proficiency can be achieved. Obtain hospital privileges if appropriate. Develop written guidelines for exam, treatment, delegation, supervision, and the patients' right to access the doctor. Set guidelines for types of charts that require review or co-signature. Ensure that the other members of your staff and on-call physicians understand the PE's role and limits. Be thoroughly familiar with statutory requirements, limitations, and licensing guidelines that affect the particular practitioner you are hiring, especially those regarding your responsibility for supervision. It is also an excellent idea to require that PEs wear a name badge with title so that patients will not be misled into assuming that they are a physician.

Ask your patients about their satisfaction with the care the PE has provided. Since the PE is your agent, obtain adequate insurance coverage for them if they do not provide their own. Make certain that your professional liability carrier knows that you employ a PE in light of the additional exposure and any duty you may have under your insurance coverage to provide such notice. Utilization of physician extenders can be a great load relief, stress saver, and expense reduction for a physician. Know who you are hiring, be sure of their competence, and use them wisely.

Policy and Procedure Manuals

Policy and procedure manuals are excellent reference tools for physician extenders. Properly written, they encourage consistency and adherence in all levels of clinical practice. Policy and procedure manuals can be written for both clinical and administrative aspects of your practice. Caution must be exercised to ensure the accuracy and adherence factor of any written manual. Loss prevention measures begin with recognizing that a poorly written, outdated policy and procedures manual will increase your liability exposure. Failure to adhere to a well written, up-to-date manual also increases claim risk and can significantly undermine a defense. Protocols should address clinical procedures with specificity. A good manual should be brief and to the point. It is important that policy and procedures be easily understood by all levels of staff. The manual should be kept up to date. It is important that the procedures addressed be practical in the context of your practice environment. Avoid protocols that may create unrealistic standards. Archive and date revisions as they are made. Retain all material for at least a seven year period.

Make certain that outdated manuals are collected from the staff in order to avoid faulty reference. If manuals are not circulated, require that staff members read and acknowledge their understanding of the newly enacted procedures. Require that staff initial and sign affected procedures.

Employment orientation at all levels should include familiarization of the current policies and procedures in force.

Risk Management Guidelines

- Check credentials carefully – verify education and employment
- Verify that all licensing and certification requirements are current
- Obtain authorization to conduct credentialing verification
- Utilize a skills checklist
- Obtain PE hospital privileges, when required
- Notify managed care plans, when required
- Develop written job description(s)
- Develop written guidelines and protocols
- Ensure that all staff members understand the PE role and limitations
- Obtain state licensing board guideline requirements
- Clarify the type and extent of physician supervision required
- Require that staff and PEs wear a name badge delineating their title
- Ensure there is appropriate professional liability insurance covering all staff
- Periodically test competency and document performance evaluations
- Determine patient satisfaction with PE care provided
- Ensure that newly hired PEs undergo orientation of the practice
- Do not delegate clinical responsibilities outside your scope of practice
- Provide disclosure language in patient authorizations and/or consent forms indicating that treatment will be rendered by physician extenders under your supervision
- Conduct performance evaluations for all PEs
- Delineate in written guidelines and protocols how often the physician must see the patient and when the supervising physician must personally assess the patient.
- Promptly notify insurance carriers of PE staffing changes
- Foster open communication in order to encourage guidance
- Ensure that patients are seen by the physician at defined intervals
- Document all communications between physician and PE
- Monitor prescription practices
- When used, keep clinical guidelines up-to-date
- Observe the limits of delegated duties
- Ensure projection of a professional demeanor
- Verify an applicant's credentials and prior experience as thoroughly as you would a physician's
- Remain current and comply with PE licensure requirements, scope of practice, and supervisory limitations
- Prepare written protocols that specify the PE responsibilities relative to examinations, assessments, diagnoses, treatment, and administrative functions.
- Establish criteria for periodic review and evaluation of PE medical record documentation
- Require that non-employed PEs carry professional liability insurance with coverage limits at least equal to your own or that of the practice
- Provide written notice to patients that PEs work collaboratively with the physician, who is ultimately responsible for treatment decisions. Assure patients that they will be seen by a physician when they or the doctor feel it necessary.

Frequently Asked Questions

Are PAs 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, Florida Statute 154.04(1)(c) requires written protocols only for PAs that practice in a health department setting.

How many PEs may be supervised by a physician?

The ratio of PEs to supervising physician will vary. While the American Medical Association does not state a specific ratio, it recommends that the appropriate ratio of physicians to physician extenders should be determined by physicians at the practice level, consistent with good medical practice, and state law where relevant. It is important to maintain a ratio consistent with the term, if any, of your professional liability policy language.

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

Yes. Florida 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.

When must charting entries made by a PA be countersigned?

Under current Florida law, all records must be countersigned by the supervising physician within seven days for the first six months employed, and then within 30 days thereafter. Hospital records may have to be countersigned under different timeframes, depending on hospital bylaws. Records in long-term facilities must be countersigned within 30 days.

Do PA charting entries need to be co-signed by a physician who is covering for the primary supervising physician?

Yes. All charting entries made by a PA must be countersigned by the supervising physician. An alternate supervising physician must co-sign all charting entries and notes that were made during the supervision timeframe.

Is it permissible for a Physician Assistant to sign the Application for Disabled Person Parking Permit Placard?

Yes. Under Florida law, Section 320.0848, pursuant to the Division of Motor Vehicles Procedures, the signature of a physician assistant is acceptable since a physician assistant can act on behalf of the supervising physician. However, the supervising physician's name, address, and medical license number must be shown on the application.

May a Physician Assistant sign the Baker Act forms to involuntarily admit a patient for psychiatric evaluation?

Yes. Per Florida Statute 394.451(21) providing that such authority is within the scope of practice of the PA's supervising physician.

Does the name of the supervising physician need to be on prescriptions issued by a PA?

Yes. Providing the PA has prescribing privileges, the name of the supervising physician must be on all prescriptions written by a PA. In the case of on-call coverage, the alternate supervising physician's name must be indicated.

Which drugs can a prescribing PA write prescriptions for?

Under current Florida law, a PA may not write prescriptions for controlled substances, anti-psychotics, general anesthetics, radiographic contrast materials, and parenteral injectables except for insulin and epinephrine. Only a PA with a current license with approved prescribing privileges can write prescriptions in Florida.

Where can a current formulary be found for Florida PAs with prescribing privileges?

A current exclusionary formulary may be found in the Formulary Rule in the Florida Administrative Codes, FAC 64B15-6.0038.

Does a change in employment affect a PA's prescribing privileges?

Yes. Prescribing privileges are granted to a PA working under the supervision of a specific physician or physicians. A change in employment requires that the new employer/supervising physician delegate prescribing privileges to the PA, and the necessary application submitted to the PA's licensing authority.

Can a PA sign for medications received from a pharmaceutical representative?

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

Is a PA required to maintain a listing of the medications prescribed?

Yes. Per current Florida statutes and specifically Florida Administrative Codes 64B8-30.007 and 64B15-6.0037, the supervising physician and prescribing PA shall enter into and keep on file a written agreement outlining which of the medicinal drugs in the formulary that the supervising physician has specifically authorized the prescribing PA to prescribe. It must be signed and dated by all parties and maintained on file for at least five years.

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

No. Providing that the prescription is for an approved drug on the formulary and is included in the agreed upon medication listing on file with the supervising physician.

Can a PA dispense medications?

No. Under current law a PA cannot register as a dispensing practitioner in Florida. However, a PA may dispense sample medications if the PA is licensed to prescribe.

What information must be on a prescription written by a PA?

The prescription form must be preprinted with the prescribing physician assistant's name, practice address, phone number, and prescriber number. It must also contain the supervising physician's name, address and phone number if different than that of the prescribing PA. If there is more than one supervising physician, each physician must be identified on the prescription form and the name of the physician under whose supervision the prescription was written must be designated.

What are the legal differences between a nurse practitioner and a physician assistant?

A nurse practitioner's scope of practice varies from state to state. In many states, they are allowed to practice independently, without a physician. However, NPs often practice under the guidance of a licensed physician. A physician assistant is licensed to practice medicine under a physician's supervision and can practice 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.

Can a PA see those patients of a physician under whose license the PA is not registered?

No. This is an important consideration when the patients of a physician-partner of the practice are being covered and for those PAs who make take call for a supervising physician under whose license they are not registered.

Sample Forms and Models

Sample Physician Extender Position Description

SECTION I. - GENERAL INFORMATION

A. **Primary Purpose of Practice**

(Description of medical practice or Organization Unit, if an institution)

B. **Primary Purpose of Position**

In collaboration with supervising physicians, provides comprehensive inpatient and outpatient medical care to patients of the (Practice Sites). The physician extender is responsible for diagnosis, treatment, and management of the patient's acute or chronic healthcare problems. Responsibilities include performing a variety of diagnostic and therapeutic procedures.

C. **Work Schedule**

(Negotiate flexibility in day-to-day hours depending on the needs of the practice team. When applicable, indicate hours per week, on-call and weekends per month.)

D. **Changes in Responsibilities or Organizational Relationship**

SECTION II. - DUTIES AND RESPONSIBILITIES

A. **Description of Duties and Responsibilities**

1. **Patient Care (75%)**

Inpatient (90% of patient care)

Will provide care to hospitalized patients. Care includes performing admissions to (name of hospital) from the emergency department and the (Practice Site), daily subsequent care visits, and discharging patients from the hospital. Initiates, monitors, alters, and interprets diagnostic and therapeutic interventions consistent with the patient's medical condition and level of acuity. Reevaluates the patient throughout the hospital stay and modifies the plan of care as needed in collaboration with attending staff. Assists with orders and discharge summaries to expedite early morning discharges. Arranges appropriate follow-up care, providing detailed documentation of hospital course in the outpatient record. Follows clinical practice protocols and guidelines agreed upon by supervising physician.

Outpatient (10% of patient care)

Diagnoses, treats, and manages acute and chronic medical problems of patients in a primary care setting. Assesses the patient's medical condition and current health problems. Obtains complete or problem-focused examinations as necessary. Develops a plan of management and treatment either independently or on approval by the preceptor/supervising physician after consultation. The types of medical services provided by the physician extender include primary care for minor or acute illness, chronic disease follow-up, routine physicals, health maintenance examinations, preventative care for all ages, and complete physical examination and history of new and established patients. The physician extender is involved in patient counseling and education regarding physical, social, health, and psychosocial problems.

The physician extender performs special procedures, including minor surgery, suturing lacerations, injection of medication, aspiration of fluid, treatment of uncomplicated fractures, administration

of IV fluids, and emergency medication. The physical extender may also perform examinations for disability, pre-employment, school enrollment, sports participation, insurance, the Department of Transportation, and other related examinations. The physician extender orders, collects, and interprets appropriate laboratory tests or diagnostic procedures to assist in the assessment and care of patients. The physician extender informs the patient/guardian of test and procedural results and provides appropriate treatment care and/or medications. Medications prescribed to patients are prescribed as outlined in the prescribing protocols and physician supervision in accordance with applicable law for physician extenders.

The physician extenders are supervised by fully licensed physicians. All care is rendered in accordance with the guidelines set forth by (State Board of Medical) and applicable law.

2. Documentation (10%)

Documents clinical findings in the medical record. Documents physical findings and plan of care in the progress notes. Documents results of studies and plan of care based on study results in progress notes. Completes charts with attention to coding. Documents legibly using hospital approved abbreviations. Completes discharge note to include summary of instructions and follow-up information provided to patient and family. Completes discharge summary at time of discharge/transfer of patient. Reviews and signs all typed medical dictation and corrects for errors and omissions. Documents that laboratory and diagnostic test results have been reviewed and that appropriate action has been taken. Writes referral letter for consultants describing the patient's condition and requesting follow-up care. Utilizes computer systems appropriately to collect, enter, or view information.

3. Coordinate Patient/Family Care Needs (5%)

Communicates and coordinates the plan of care with patients and families. Facilitates interdisciplinary plan of care through coordination with physicians, nurses, and allied health practitioners, including the use of care paths and protocols. Consults clinical services when appropriate. Provides patient and family education.

4. Education (3%)

Fulfills mandatory educational requirements annually, which include, but are not limited to JCAHO and other institutionally required education, BLS and ACLS or appropriate certification related to specialty, CME hours as required by specific extender national certification. Communicates and coordinates the plan of care with patients and families. Facilitates interdisciplinary plan of care through coordination with physicians, nurses, and allied health practitioners, including the use of care paths and protocols. Consults clinical services when appropriate. Provides patient and family education.

5. Leadership (3%)

Demonstrates service excellence. Demonstrates effective interpersonal communication skills. Demonstrates effective written communication skills. Works effectively with others in a team approach. Serves as a role model for advance level practice. Serves as a clinical resource. Participates in hospital and family medicine department committees and task force.

6. Performance Improvement (2%)

Participates in benchmarking and quality improvement activities. Participates in advance practice and departmental meetings.

7. Teaching (1%)

Physician extender may, based on interest and teaching ability, participate in the training of physician assistant, and/or nurse practitioner students during their clinical training rotations in family medicine. Completes written evaluation of students during clinical rotation and submits to the students' training program.

8. Contribution to Clinical Research (1%)

Participates in research projects and data collection as appropriate. Provides patient care as it relates to research endeavors of the practice site. Becomes familiar with the specific research protocol and performs a physical exam based on criteria established by the protocol. Reports results to the principle investigator of the study in the format that is specified in the protocol.

B. Other Position Characteristics**1. Accuracy Required**

Precision and accuracy are required 100 percent of the time. Accuracy is indicated in prescribing medications, diagnosing, and treating medical problems.

2. Consequence of Error

The extender's work affects the health status of patients to whom he/she provides medical care. The extender's work also affects the physicians and staff employed in the department. Error can result in adverse consequences to the patients. These include death, continued illness, and inappropriate treatment leading to additional medical problems.

3. Instructions Provided to Employees

Supervising physicians provide instructions on how and when to carry out activities both verbally and/or written to ensure appropriate patient care. They vary from being detailed to general in nature.

4. Guides, Regulations, Policies, and References Used by Employee

HIPAA, Blood Borne Pathogen, Employee Handbook, Office Policy and Procedure Manual.

5. Supervision Received by Employee

All documentation of the physician extender's patient care is reviewed upon completion daily by the supervising physician to ensure appropriate medical care of patients. Direct observation of the physician extender's work also occurs daily.

6. Variety and Purpose of Personal Contacts

The physician extender works closely with nursing personnel, physicians, residents, medical receptionists, laboratory technicians, radiology technicians, pharmacists, psychologists, social workers, nutritionists, physical and occupational therapists, and business office personnel. Close communication following HIPAA codes ensures high quality patient care and allows for appropriate patient confidentiality of potentially life altering and sensitive personal health information.

7. Physical Effort

Physical effort is limited to less than 20 pounds of lifting and supporting patients when they are unable to sit up or ambulate on their own due to their condition.

8. Work Environment and Conditions

The physician extender works in (Hospital Site) and the (Practice Site). Hospital is a (tertiary) care hospital with a full complement of medical specialties. The (Practice Site) is an (outpatient medical office building). In a medical environment, the employee is exposed to ill patients who may have infectious diseases, needles, or body fluids, and to hazardous medical chemicals. Given the nature of the job, 90 percent of the physician extender's time is spent in contact with the above mentioned hazards. Contact, airborne, blood, tuberculosis, and SARS precautions are followed for appropriate patients. Needed supplies to follow precautions are furnished.

9. Machines, Tools, Instruments, Equipment, and Materials Used

Stethoscope, minor surgical instruments, ophthalmoscope, otoscope, tongue blade, microscope, telephone, automobile, nebulizers, reflex hammer, computer with various software packages.

10. Visual Attention, Mental Concentration, and Manipulative Skills

Medical examinations require close visual attention, specifically examinations of the optic fundi, tympanic membrane, various dermatological lesions, and cervix. Close visual effort is required for examining radiology films and the use of the microscope. Intense mental concentration is required for patient interviewing, examination, and determination of the patient's diagnosis. Manipulative hand skills are needed to examine patients and conduct procedures. All of the above occur during patient interaction throughout the day.

11. Safety for Others

Universal precautions must be followed to avoid cross-contamination after examining an infected patient. Care must be taken when performing procedures so to prevent injury of others.

12. Dynamics of Work

Depending on the needs of the patients, medical care may be given either in (Hospital Site) or the (Practice Site).

SECTION III. - KNOWLEDGE, SKILLS, ABILITIES, AND TRAINING/EXPERIENCE REQUIRED**A. Knowledge, Skills, and Abilities**

1. Thorough knowledge of interview techniques, medical and relevant history taking, principles and practices of general medicine and disease states as they relate to the area of work.
2. Thorough knowledge of health appraisal tools, laboratory tests and findings, and therapeutic procedures as they relate to the area of work.
3. Thorough knowledge and ability to plan a regime of care based on assessment and findings.
4. Thorough knowledge of available resources and appropriate referral methods.
5. Skill in performing clinical and/or minor surgical functions.
6. Ability to supervise and coordinate other nursing and medical staff.

7. Ability to supervise and teach physician assistant and nurse practitioner students training in (Hospital Site) or (Practice Site).
8. Ability to accurately and completely record all information necessary to evaluate and plan care and to convey this to the physician.
9. Ability to communicate well orally.
10. Ability to teach and counsel individuals, families, and groups in areas of health maintenance, preventative medicine, and care of the sick.
11. Ability to establish and maintain effective working relationships with staff and to gain the confidence of patients and family and work effectively with them.

B. Training and Experience

1. Required Minimum Training

Graduation from an acceptable Type A physicians assistant program as recognized by the Board of Medicine of the National Academy of Sciences or from a program otherwise designated for physicians assistants that has been approved either by the (Name of State) Medical Society or the American Medical Association; or from an accredited school of nursing followed by graduation from a recognized nurse practitioner program is required.

2. Additional Training and Experience

3. Equivalent Training and Experience

C. License or Certification Required by Statute or Regulation

Certification of approval from the (State Board of Medicine) and if a nurse practitioner, licensure from the (State Board of Nursing).

Sample ARNP Protocols

Practicing ARNPs must file a yearly protocol with the Board of Nursing. Alterations or amendments should be signed by all parties and filed with the Board within 30 days.

The protocol and any amendments or changes are to be mailed to the **ARNP Department, Board of Nursing, 4052 Bald Cypress Way, Bin #C02, Tallahassee, FL 32399-3252**. If there are no changes to the protocol, only a dated signature page is needed with a statement that there have been no amendments or changes since the last submission. A copy for each review period should be kept by each party for a period of four years. The supervising physician is responsible for submitting a notice to the Board of Medicine that they have entered into a supervisory relationship with an ARNP.

SECTION I. - REQUIRING AUTHORITY:

- A. Nurse Practice Act, Florida Statutes, Chapter 464
- B. Florida Administrative Code, Rules Chapter 64B9-4 Administrative Policies Pertaining to Advanced Registered Nurse Practitioners

SECTION II. - PARTIES TO PROTOCOL (Should only list one ARNP and one doctor here)

- A. (Name of Nurse), ARNP, RN (License number)
(Address)
(Address)
- B. (Name of Physician), MD/DO, (License Number), (DEA Number)
(Practice Name)
(Address)
(Address)

SECTION III. - NATURE OF PRACTICE

This collaborative agreement is to establish and maintain a practice model in which the nurse practitioner will provide healthcare services under the general supervision of Dr. (Name of Physician). This practice shall encompass (medical specialty of practice) and shall focus on health screening and supervision, wellness and health education and counseling, and the treatment of common health problems (Use appropriate description for your specialty and activities). **Practice Location(s):** (Address of each practice location)

SECTION IV - DESCRIPTION OF THE DUTIES AND MANAGEMENT AREASE FOR WHICH THE ARNP IS RESPONSIBLE

A. Duties of the ARNP

The ARNP may interview clients, obtain and record health histories, perform physical and development assessments, order appropriate diagnostic tests, diagnose health problems, manage the healthcare of those clients for which he/she has been educated, provide health teaching and counseling, initiate referrals, and maintain health records. (Specific guidelines for patient care decision making may be referenced here - i.e., ARNP developed practice guidelines, professionally developed guidelines, text books, etc. Do not send these references to the Board of Nursing with protocol agreement.)



Board of Medicine

ARNP / EMT / Paramedic Protocol Form

s. 458.348(1)(a), Florida Statutes, states in part, when a physician enters into an established protocol with an Advanced Registered Nurse Practitioner, an Emergency Medical Tech (EMT) or a Paramedic which protocol contemplates the performance of medical acts identified and approved by the joint committee pursuant to s. 464.003(3)(c) or acts set forth in s. 464.012(3) and (4), the physician shall submit notice to the board. The notice shall contain a statement in substantially the following form.

I, _____,
(Please type or print name of physician)

License number ME00 _____ of _____

(Please type or print practice location)

have hereby entered into a terminated my formal supervisor relationship, standing orders, or an established protocol with (amount of) ARNP(s), EMT(s), Paramedic(s).

s. 458.348(1)(b), F.S. Notice shall be filed within 30 days of entering into the relationship, orders, or protocol. Notice also shall be provided within 30 days after the physician has terminated any such relationship, orders, or protocol.

(Print or Type Name of ARNP/EMT/Paramedic)

(Print or Type Name of ARNP/EMT/Paramedic)

(License Number)

(License Number)

(Effective Date)

(Effective Date)

(Signature of Physician)

Complete this form and return it to: Department of Health, Board of Medicine, 4052 Bald Cypress Way, BIN #C-03, Tallahassee, FL 32399-3253, or fax it to 850-488-0596. **No additional documentation required.** The Protocol form must be filed yearly with the Department.

NOTE: Only one physician per form. Use extra sheets for additional ARNPs / EMTs / Paramedics.

DH-MQA1069, 03/03

References

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