The Scope of Practice and Medical Professional Liability

Healthcare delivery in the United States has undergone numerous changes over the past 10 to 15 years, and its metamorphosis continues. These changes have created new medical professional liability (MPL) risks for physicians and other healthcare providers. Although scope of practice is not a new concept, it is an increasingly important and evolving issue regarding MPL risk.

The Patient Protection and Affordable Care Act (PPACA) became the law in March 2010. One of its major goals was to improve healthcare access, and in order to reduce the rising cost of healthcare, incentives to shift healthcare delivery from the inpatient hospital setting to the outpatient and office setting came into play. This change ushered in new demands on physicians and the health system in general. Additional system strains became inevitable due to the increasing number of people obtaining health insurance coupled with an existing physician shortage.

The American Association of Medical Colleges (AAMC) estimates the United States will face a physician shortage of approximately 122,000 physicians by 2035. This deficiency is partly due to an aging population, physicians leaving the practice of medicine, and higher rates of chronic diseases. The existing and anticipated physician shortage has propelled advanced practice providers (APPs) – formerly referred to as mid-level providers, physician extenders, or non-physician clinicians – into an increasingly important role to fill the physician gaps in patient care. Incorporating APPs into all fields, especially primary care, has helped to alleviate the pressures associated with physician shortages.

Physician assistants and nurse practitioners predominately encompass this group. Although they carry the collective reference of APP, their approach to healthcare delivery, as well as the degree of liability for physicians utilizing their expertise, varies. With respect to the scope of practice, these changes in the provision of healthcare create another layer of risk for physicians.

Recent data suggests there are more than 270,000 nurse practitioners and over 131,000 physician assistants currently practicing. Their scopes of practice are different from that of physicians. In addition, physicians should be aware there must be well-defined responsibilities for their employees, such as medical assistants, reception staff, telephone intake, etc. Although this is not a new MPL issue, the scope of practice liability is evolving.

Scope of practice is broadly defined as healthcare services that a physician or other healthcare practitioner is authorized to perform. Responsibilities are based on education, training, experience, and demonstrated clinical competency. Scope of practice is also defined by professional state licensing boards, registration, and/or certification and describes procedures, actions, and processes practitioners are permitted to undertake in terms of their professional licenses.

The APP's scope of practice will also differ depending on their state of licensure. Nurse practitioners may have full, reduced, or restricted practice privileges. States allowing full practice privileges do not require physician supervision, whereas the restricted privilege model requires a greater deal of physician governance. The law usually requires a supervisory agreement when the physician is required to monitor the nurse practitioner. Physician assistants, conversely, tend to require closer management by their supervising physician. The state board of licensure outlines the degree of supervision necessary for each of these professionals. Physician assistants are required to have some degree of supervision from a physician in all 50 states, and in supervisory states, a practice agreement is required. Some states require a designated physician to review all the physician assistant's charts, while other states require only limited review.

Each state defines what the APP is permitted to do with regard to patient care. The APP's scope can include performing histories, physical exams, ordering and performing diagnostic and therapeutic procedures, developing and implementing treatment plans, formulating a working diagnosis, counseling patients, assisting with surgery, and making referrals to specialists. These professionals are authorized to prescribe medicines in all 50 states. If the APP goes beyond the allowed scope of practice, the supervising physician can be held legally responsible, and it is the physician/employer's responsibility to monitor the APP as state law requires. Be clear that in supervisory states, physicians may be liable for their APP's medical malpractice even though they personally did not provide the service that is determined to be beyond the APP's scope.

To avoid risk, physicians should ensure that *all* employees at *all* levels have appropriate training, supervision, and expertise, and it should be clear what level of responsibility pertains to each employee's job description, including APPs. Checking the legal requirements for your state's supervision and scope of care is paramount to preventing a

professional liability issue. Physicians need to check the scope of practice laws within their individual states and when moving to practice in a different state. Do not let unqualified staff, i.e. medical assistants, receptionists, techs, etc., handle patient issues. All job descriptions should be in writing and documented. Ultimately, responsibility for patient care and outcome falls on you, so do not shirk your supervisory responsibilities. Regularly monitor those who are interfacing with your patients – hire, delegate, and supervise carefully to ensure best practices are performed in your office. You must have a low tolerance level if you discover unqualified staff have handled patient problems without your knowledge.

The use of APPs will continue to increase as the physician shortage escalates. The careful use of APPs will allow physicians to concentrate on seeing the acutely ill patients, and the combination will allow the collective healthcare arena to care effectively for more patients needing medical assistance. However, because the APP's scope of practice varies from state to state, the physicians and employers need to be aware of any limitations placed on their individual scopes of practice to avoid medical liability.

See state-by-state APP governing regulations here.

Who's In Your Net?

In military communications parlance, your “net” is defined as several people on the same radio frequency channel as you. An axiom followed by leaders in the United States Army in order to win on the battlefield is, “Shoot, move, and communicate.” Timely and effective communication is the key principle in completion of any mission, and without it, you are likely to fail. Failure can cause injuries and even losses. Much the same can be said when it comes to the practice of medicine. The following case study illustrates an avoidable failure to timely and effectively communicate an intention that led to a bad result for this patient.

Meet Tom, a 41-year-old male with severe aortic regurgitation and moderate aortic stenosis, a prior history of Hodgkin’s lymphoma and radiation therapy, and worsening symptoms of congestive heart failure and associated pulmonary hypertension. Tom was appropriately referred by his cardiologist to a cardiovascular surgeon for consideration of surgical aortic valve replacement surgery. The procedure was done on Wednesday, April 10. Tom’s course was largely uneventful, except for fluctuations in his post-operative PT/INR values that required close monitoring. After beginning anticoagulation with heparin and Coumadin dosing on April 12, this chart provides Tom’s Coumadin dosing and INR values after surgery:

Date	Days PostOp	Coumadin Dose Given
April 12	2	5mg
April 13	3	10mg
April 14	4	0-Withheld
April 16	6	5mg Oral

On Tuesday, April 16, the cardiovascular surgeon considered him stable enough for discharge home later that day on 5 mg daily oral dose of Coumadin. The cardiovascular surgeon's NP gave written discharge instructions for the patient to follow-up with his primary referring cardiologist, "late this week or early next week," for repeat PT/INR.

Based on the discharge instructions, the hospital scheduler contacted the scheduler at the cardiologist's office on April 16 to set the appointment for Wednesday, April 24 - eight days after discharge. However, on April 23, the day before his follow-up visit, Tom presented to the hospital complaining of recent onset of weakness and fatigue. His bloodwork revealed an INR of 12, and he was diagnosed with a pericardial effusion resulting in cardiac arrest, pulmonary arrest, ischemia, and damage to his kidneys and liver.

Tom filed suit against the hospital, the cardiovascular surgeon, the cardiovascular surgeon's NP, and his cardiologist alleging they failed to timely and properly test and monitor his coagulation status following his April 10 valve replacement surgery and especially after discharge from the hospital on April 16. There was no question that the cardiologist agreed to follow Tom's INR after discharge, but the question surrounds when this obligation became her responsibility. The cardiovascular surgeon's NP recognized the INR follow-up was set for Wednesday, April 24, consistent with the order "later this week or early next week." Essentially, the hospital scheduler and the cardiologist's scheduler determined the date of Wednesday, April 24 was acceptable for the follow-up with the cardiologist. The schedulers testified that they interpreted a "Wednesday" as falling within the meaning of "early next week." The scheduler at the cardiologist's office further testified he knew the importance that patients on Coumadin therapy should be seen in a "few days," but he did not think eight days was significant enough to raise it with the cardiologist. The experienced NP knew the repeat PT/INR needed to be done within four days of discharge but failed to recognize the follow-up cardiology visit was set eight days after discharge. The cardiovascular surgeon assumed the patient's follow-up visit with the cardiologist would be set within four days of discharge. The cardiovascular surgeon and the cardiologist did not follow-up on the date the appointment was set.

The plaintiff's experts focused on the handling of the INR and Coumadin in the post-discharge period. The allegation was that setting the first lab check at eight days after discharge falls outside the standard of care. There was a breakdown in communication with scheduling a follow-up appointment between the cardiovascular surgeon's office, the hospital, and the cardiologist's office. Should a certain date or a time frame (within four days of discharge) have been communicated that fits within the standard of care? Unfortunately, we were unable to find an expert who would support that eight days complied with the standard of care. All of the defense's consulting experts said the follow-up appointment should have been no more than four days after discharge. The defendant providers were critical of each other, and the case settled at mediation for a significant six-figure sum.

Why is effective communication so important? Let me introduce a Gettysburg vignette where ineffective and vague communication resulted in a bad impact that had "significant

consequences.” On the first day of the Battle of Gettysburg, Confederate attacks drove Union troops through the town to the top of Cemetery Hill, a half-mile south. At first, the battle appeared to be another Confederate victory; however, General Lee could see that, so long as the enemy held the high ground south of town, the battle was not over. He knew that the rest of the Union Army of the Potomac must be hurrying toward Gettysburg, so his best chance to clinch the victory was to seize and hold hills and ridges before the Union troops arrived. General Lee gave General Richard Ewell discretionary orders to attack Cemetery Hill “if practicable.” Had Stonewall Jackson still lived, he undoubtedly would have found it practicable to attack. But Ewell was not Stonewall Jackson. Thinking the enemy position too strong, Ewell arguably lost his nerve and did not attack – thereby creating one of the controversial “ifs” of Gettysburg that have echoed down the years. It has been debated that Ewell’s decision not to take Cemetery Hill cost the Confederacy the war.[1]

What does “if practicable” mean? When it comes to Tom, what did “later this week or early next week” mean? Is it sufficient to not be specific when, as in this instance, days can be the difference between well-managed INR or an adverse outcome? As a physician, it is imperative that you communicate clearly – both verbally and in written form. Understand that your success as a physician depends on your ability to think critically and creatively, to communicate your intentions and decisions to others in your “net”, which may include the patient, consultants, your staff, hospital staff, the patient’s family members, and others, and to follow-up to make sure your intentions are understood and acted upon.

[1] https://opinionator.blogs.nytimes.com/2013/07/02/general-ewells-dilemma/

https://www.statnews.com/2016/09/01/gettysburg-teach-hospital-leadership/

Effective and Efficient Recruiting for Your Practice

Hiring is a constant in a medical practice. According to the Medical Group Management Association, the employee turnover rate for surgical practices is 33 percent, 25 percent, and 30 percent for reception, nursing, and billing/collections staff, respectively. Although the rate varies by position, there is no doubt that recruiting an employee will be on your agenda sometime soon, if it isn't at the top of the list today. Consider these steps to ensure that your practice performs staff hiring effectively and efficiently.

Tip 1: Host a Working Interview

Once you decide on your ideal candidate, invite them to come for a final "working" interview. Typically scheduled for four hours, if not the entire business day, this opportunity allows you and your team to see the candidate in action. Engage your team in the decision – an action that will surely boost their morale – by asking them for their opinion. Further, the working interview also gives the candidate a better understanding of your practice, often preventing that "this is not the job that I expected" departure after just a few days post-employment. The ability to conduct such a working interview on a pre-employment basis may depend on state law, as well as the candidate's exposure to protected health information (PHI), so please check with an attorney familiar with employment and privacy regulations in your area before implementing this idea.

Tip 2: Cover the Basics

Retention challenges often stem from a lack of training. From your receptionist to your nurse supervisor, provide orientation and basic training on all of the management

information systems that you use. This includes the practice management, electronic health record, and telecommunications systems. Having a working knowledge of all three not only helps new employees in their roles, but it also ensures they can comfortably serve as team members. Although each individual is tasked with a specific job, it is this opportunity to work together as a team that ensures a successful practice.

Tip 3: Hold Departure Interviews

Losing an employee is never ideal since it leaves a gap in your practice's administration or operations. However, understanding *why* that employee is departing can provide valuable insight. Ask for (at least) 15 minutes to sit down with the employee during his or her final days of employment and have a frank discussion about the employee's decision to leave the practice. You may not agree with the reasoning, and often the issue comes down to money. However, with nothing to lose, this final meeting can increase your awareness about potential opportunities to improve your practice to ensure that it is a desirable place to work. Remember that it's crucial to be non-judgmental and to listen with an open mind, rather than using this forum to argue at this stage. Consult with an attorney about the protocols for exit interviews; if there are any contentious issues related to the employee's departure, consider seeking the advice of your lawyer as to whether to even hold such a meeting.

Tip 4: Engage a School

Educational institutions involved in educating medical assistants, phlebotomists, radiology technologists, and many other skill-based positions incorporate a requirement for external training. Engage in a partnership with an institution – or more than one – to accommodate their externships. This has a two-fold benefit: your practice gains valuable labor at little to no cost, while providing you the opportunity to view first-hand the skills, experience, and work ethic associated with potential candidates. In other words, you gain access to the best and the brightest before they go on to the labor market. If you find the relationship draining – i.e. the students take more time and investment than any benefit to your practice – you can always discontinue the association with the institution.

Tip 5: Determine Fit, Not Just Function

Historically, practices have hired based on two criteria: (1) Have you worked in our specialty before and (2) Are you trained in our information systems (e.g., practice management and electronic health record)? If not, then the candidate is typically discarded from consideration with the notion that we are, of course, so unique that no one could possibly work here without experience in both areas. While every practice is different, this approach limits the pool of candidates, sometimes so much that the only option is rehiring the employees who were let go last year! Instead of specialty and system expertise, considering looking for loyal, hard-working team players who are service- and team-oriented. Remember, you can train someone to assist you in a procedure, but you can't teach them how to smile.

Tip 6: Know Where to Look

Job postings in the newspaper are no longer an effective option; getting the word out about your new position takes hard work and a bit of ingenuity. Use posting boards and listservs based at local community colleges, universities, and training schools; try professional networking sites such as LinkedIn.com; and benefit from healthcare-focused job sites like HealtheCareers.com. In addition to posting positions, it pays to be on the lookout. This may include current employees who have a friend or colleague seeking a new position (consider paying a small "finder's fee" if their recommendation ends up as a hire) or associates you bump into at a retailer who impress you with their skills.

Tip 7: Invest

Hiring is a key part of your human resources strategy, yet this area is challenging because humans are, well, human. You may find yourself in the position of an extreme drought of qualified candidates, followed by a rash of great ones. Consider introducing a little flexibility in your hiring practices. If you encounter two out-of-this-world medical assistants (MAs), for example, but only have one MA position open, hire both, cross-training them on needed front-office duties. While this isn't always possible, making a small advance related to hiring "excess" staff, if expectations are set appropriately, may be the best investment you can make.

Tip 8: Recognize Appropriate Payment

Candidates won't pursue your open positions if they don't feel the payment is fair. Glean market data about salaries – for free – from websites like Salary.com or reference the U.S. Bureau of Labor Statistics (bls.gov). Because wages fluctuate, double check this information every six to 12 months to ensure that you're not only able to hire the greatest but also retain the best. As you well know, wages are only a portion of the investment you make into an employee. Yet, most of your staff focus only on that element of their compensation. Why? That's what employers post about the position – "$14.50 per hour," for example. Sometimes the term, "plus benefits," is added, but it's nebulous. Create a spreadsheet with all employee benefits listed with a description and the associated value. Sum the "actual" hourly wage at the bottom and provide a professional-looking compensation statement to all candidates. This will certainly boost interest in your practice and may even sway the best candidates to join you.

Tip 9: Start Retaining from Day One

Extending an offer of employment may be routine for your practice, but it's a life-altering opportunity for candidates. Avoid leaving voicemails or texting; rather, call or meet with the individual to make the offer. Use positive terms like "welcome," "team," "value," and "opportunity" during your discussion, providing the candidate with a strong impression about your culture. On the first day, create a written agenda for the day or week with a "thank you for joining our team" message at the top. Have the employee's nametag ready, avoiding the label stuck on top of an old employee's tag scenario, and provide the uniform

(or be prepared to take the measurements to order it). You want the employee to feel engaged with your practice from the very moment they start. For a special touch, consider sending flowers to their house with a message of welcome.

Hiring employees for your practice is never a one-time occurrence. The more prepared you are when it comes time to hiring, the more likely you are to find the best candidate for your next open position.

Is It Time for Your Practice to Conduct a Mystery Patient Survey

While secret shoppers have long been a method of gleaning customer feedback in the retail world, the notion of using an anonymous “mystery patient” in a medical practice is certainly less common. However, since secret shoppers provide an opportunity for an objective, customer-focused evaluation, they can be an asset for your practice.

In general, mystery patients can provide an objective vantage point for analyzing both the success stories and opportunities within a practice. This can be as simple as searching your practice online, and giving you feedback about that process, as well as your web presence. Or, they can dial your practice to gauge the number of rings, your receptionist’s phone manner, the efficiency of the interaction, and the quality of the voice response menu, if applicable.

To take this notion further, consider the following tips for integrating mystery patients to evaluate and enhance your practice:

- **Determine your objectives**. Do you want to focus on your wait times? Communications efforts? Pre-appointment outreach? Before you take the next step, it is critical to determine what information you want to gather and how you plan to use it. When you determine the areas on which you want to focus, your mystery shoppers can home in on those services and interactions.

- **Start with scheduling**. Access and communication are key attributes to a successful practice. Either hire a consultant or use a reliable friend or family member to call your practice once or twice a day for about two weeks; make sure you cover

all the available time slots (8 to 9 a.m., 9 to 10 a.m., etc.) from open to close. You can create various scenarios (see a sample scenario below), and the mystery patient can share his/her experience over the course of time. If this initial interaction isn't reliably positive, you know you have some work to do. Naturally, you will need to cancel any appointments that are set during mystery patient interactions.

- **Consult with the pros**. There are also a variety of marketing firms and experts who can help you perform a more professional evaluation of your practice. They are skilled in coaching mystery patients and will have surveys and questionnaires available for meaningful review. If you want a deeper dive, consider hiring a firm to take this evaluation to the next level.

If your practice simply is not comfortable with mystery patients, or prefers other methods of evaluation, potential opportunities include developing and sharing an automated post-visit survey for patients (keep it short and simple) as well as following up with patients who transfer their records to another practice of your specialty in your geographical area. All in all, the most important thing is that you are taking the time to evaluate – and then acting on the results.

Mystery patients can show you how patients are truly treated, offering effective feedback. Ensure that your practice is ready to put that constructive criticism into action by updating services and systems. Regardless of how you collect feedback, you can share your results with your patients – let them know how you have improved your practice. For example, you can offer a display (electronic or paper) in your reception area that features anonymous feedback as well as any initiatives which have developed in response. This simple action can make patients feel that they are listened to and valued.

When employed thoughtfully, mystery patients can offer a wealth of wisdom and unbiased first-hand knowledge about what your patients see, hear, and experience.

Sample Scenario:

For a simple scenario, engage a mystery patient to call your practice using this script:

"My mother, who has Medicare, is moving to town in a few months. She would like to establish care with Dr. Y. Can you tell me a little about him?" [Wait for response.] "Is he taking new patients?" [Wait for response.] If so, then follow: "Approximately how long in advance would I need to call to get her appointment?"

In addition to evaluating the responses, the mystery patient should give you feedback about the opening and closing, as well as the ease of locating your telephone number – and how long it took for the telephone to be answered.

---

attorney for legal advice, as specific legal requirements may vary from state to state and/or change over time.