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# Commentary: Serving Non-physician Clinicians

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by  
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This *Forum* focuses on non-physician clinicians involved in the direct care of patients in CRICO-insured facilities. It addresses specific questions from and about these clinicians. Using the last 10 years of CRICO claims data, we show the areas of potential liability for both these clinicians and for physicians when they work with non-physician clinicians. Answers to questions frequently asked about policy coverage issues and claims management services available to non-physicians in the CRICO system are also addressed.

## Who is Covered

The CRICO professional liability policy provides coverage for non-physician clinician employees of:

- ◆ Children's Hospital;
- ◆ CareGroup, Inc. and its member hospitals;
- ◆ Dana-Farber Cancer Institute, Inc.;
- ◆ Harvard Pilgrim Health Care, Inc.;
- ◆ Presidents and Fellows of Harvard College;
- ◆ Joslin Diabetes Center, Inc.;
- ◆ Judge Baker Children's Center;
- ◆ Massachusetts Eye and Ear Infirmary;
- ◆ Massachusetts Institute of Technology; and
- ◆ Partners HealthCare System, Inc. and its member hospitals.

This coverage is also available to employees of some other CRICO-insured organizations.

*All of HRM's claims management services are available to any insured employee or clinician who is potentially or actually involved in a malpractice action.*

The policy is written on a "limited claims made" basis, which means it covers claims reported during the current policy year resulting from services rendered on or after the insured's first day of employment.

## How Much Coverage is Provided

CRICO provides limits of \$5 million per claim and \$10 million annual aggregate for each insured clinician and employee. The claims analysis that follows (*Page 2*) shows that non-physicians are sometimes the only defendants named on a claim or suit, but are often named with physicians. Limits of insurance coverage are not shared with other CRICO-insured defendants. So if, for example, a nurse practitioner is named as a defendant along with a physician, each would have \$5 million in coverage.

All of HRM's claims management services are available to any insured employee or clinician who is potentially or actually involved in a malpractice action. A claim representative will interview, support, and assign defense attorneys to each insured employee should the need arise—in the same manner that the claims representatives would serve an insured physician. And, while the preferred strategy is to coordinate the defense by assigning one attorney for all defendants on the case, separate attorneys are assigned if the investigative process indicates that the interests of the various defendants diverge.

## What Activities are Covered

Non-physician clinicians are insured solely for activities performed within the scope of their employment with a CRICO-insured medical institution. Insured employees with other clinical jobs outside the scope of their (CRICO-covered) employment are not covered by the CRICO policy for those activities and are therefore advised to procure supplementary coverage from other insurance companies.

When insured employees retire or otherwise terminate CRICO insurance, automatic tail coverage is provided for any claim brought after they terminate their employment for care rendered during their covered employment. ■

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# CRICO Claims Involving Non-physician Employees

Quality health care in current delivery systems involves the efficient interaction of a variety of caregivers. Providers with a range of experience and responsibility practicing interdependently have concerns about their potential liability for outcomes of care. Physicians, particularly, may worry about liability as they work more and more with non-physician providers. While physicians *are* seen as ultimately responsible for their patients' welfare, nurses and other health care providers do have unique duties to those same patients that may engender independent accountability and, therefore, independent professional liability exposures.

*Forum* looks at non-physician health care employees. Although employees in all nursing categories are the largest non-physician employee group in this analysis, other non-physician clinicians have become more numerous, have gained more visibility as part of the whole health care team, and consequently are at risk for greater potential liability. The March 1993 *Forum* features detailed analysis of nursing claims and related loss prevention issues and remains a valuable reference.

## Allegations and Risk Management Issues

While "allegations" and "risk management issues" stem from similar events, they are arrived at differently. An allegation is what the plaintiff contends went wrong to cause an adverse event. Risk management issues are frequently process issues (that the plaintiff may or may not know about) that contributed to the event (or the plaintiff's dissatisfaction).

The allegations assigned to a CRICO claim are based on HRM's interpretation of statements, or on documents from the plaintiff. If a plaintiff files a lawsuit, the allegations that are noted in the claim file are reported as they appear in the Summons and Complaint. Allegations are expressed in negative terms. Each case has one or more allegation.

HRM defines risk management issues as the circumstances that contributed to allegations, injuries, or initiation of claims. HRM assigns risk management issues after review of the medical record and claim file. A claim may have several issues identified, or none. Regardless of the plaintiff's allegation, risk management issues are expressed in neutral language and are most likely to be amenable to loss prevention/reduction strategies.

Figure 1

### CRICO Claims: 1987-1996

N= 1,843 Claims/3,446 Defendants

Claims naming non-MD clinicians<sup>a</sup> 184

Non-MD defendants	261
Nurses <sup>b</sup>	199
Physician Assistants	17
Technicians <sup>c</sup>	17
Therapists <sup>d</sup>	11
Students <sup>e</sup>	7
Security	4
Other <sup>f</sup>	6

- a** Does not include mental health workers, social workers, and psychologists
- b** RN, NP, CNM, CRNA, LPN, nursing assistant
- c** X-ray, lab, medical
- d** Radiation, occupational, respiratory
- e** Nursing and medical
- f** Transport, orderly, optometrists

This *Forum* looks at not only the importance of nurses as part of the patient care team, but also at the potential liability issues they may encounter as collaborators, supervisors, and employees.

Analyzing claims that involve non-physician providers helps them and the physicians they work with identify areas of risk for both in interdependent practice. In addition, this issue presents models for collaboration and communication among health care providers that can help each optimize the quality, efficiency, and effectiveness of patient care while reducing potential liability.

### Claims Selected for Review

Open and closed claims and suits brought from 1987-1996 involving selected categories of non-physician employees of institutions insured by CRICO<sup>1</sup> were reviewed (*Figure 1*). This included:

- all categories of nurses,
- physician assistants (PA), and
- technicians.

Mental health workers, social workers, and psychologists—excluded in this review—will be the subject of future analysis.

In 98 (53 percent) of these 184 claims, one or more physician co-defendant was also named; 86 claims did not include a physician co-defendant.

Claims naming non-physician clinicians are relatively uncommon in the CRICO-insured institutions. The combined selected categories comprise more than 15,000 employees throughout the CRICO-insured institutions.<sup>2</sup> The 261 non-physician employees named as defendants in the 184 claims in this review represent *less than two tenths of one percent* of insured employees in those categories during the 10-year period studied. Given the vast number of patient care encounters, the news is encouraging.

Focusing on empathy, advocacy, teaching, and sound principles of practice will enable these non-physician clinicians to maintain their high level of care. Understanding the sources of claims and investigating opportunities for improvement will help them raise it even higher.

by  
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*Special thanks to Maryann Small, HRM Business Analyst, for compiling the data for this claims review.*

## Claims Naming Nurses

Claims naming nurses in the categories analyzed represented more than 70 percent of the claims in this review, and 14 percent of all CRICO claims from 1987-1996. A significant number of nurses were named without physician co-defendants, either as sole defendants or with other nurses. This suggests that the “duty” that a nurse has to his or her patients is viewed as independent and separate from that of other health care providers, including physicians.

Nurses in *expanded* roles may have assessing and prescriptive capabilities and responsibilities that put them at the same risk as physicians in the areas of diagnosis and treatment. A nurse in an expanded role making independent judgment without physician consultation has a separate duty and therefore assumes risks associated with the outcome of the care.

Figure 2

### CRICO Claims Naming

**Nurses: 1987-1996**

**N=128 Claims/199 Nurse Defendants**

	Claims	Defendants
Registered Nurses	96	158
Nurse Practitioners	20	25
Certified Nurse Midwives	6	8
Certified Nurse Anesthetists	3	3
LPNs/LVNs	2	4
Nursing Assistant	1	1

## Claims Naming Registered Nurses

Registered nurses (RN) are most commonly named in claims and suits with physician colleagues in surgery and medicine. Almost as frequently, they are named in claims that do *not* include physician defendants.

### Case Example: Medication Error

*An order for epinephrine was written by the physician with the dosage and route of administration incorrect. The nurse did not question the order and administered the dosage as written. The patient became hypotensive and was admitted to the ICU. The suit naming the nurse, the ordering physician, and the institution was settled in the low range.<sup>3</sup>*

### Case Example: Failure to Ensure Safety

*A recovering cholecystectomy patient was given a sleeping pill at bedtime. The siderails were not raised and the patient was found two hours later on the floor. The patient recovered without permanent injury, but a claim was brought against the RN. The case was found in favor of the defense via binding arbitration.*

### Case Example: Triage Error

*A patient whose injured toe had been treated with liquid nitrogen by a dermatologist called to complain of pain. The call was taken by a physician’s assistant (PA), but was not documented. The following day, the patient called again with a complaint of a fever to 101°. An RN told him to take Tylenol for a “viral illness.” Two days later, the patient was hospitalized with severe sepsis, requiring respiratory support and dialysis. Several surgeries on his leg were required. The suit against the dermatologist, PA, RN, and institution was settled in the mid-range.*

### Opportunities for Improvement

Loss prevention techniques for nurses include checking all medication dosages—especially if the order is outside the normal range—as well as documenting all pertinent clinical telephone calls. The claims naming RNs also reflect the need for nurses to thoroughly and repeatedly assess safety measures such as raised siderails or restraints.

Figure 3

### CRICO Claims Naming

**RNs: 1987-1996**

**N=96 Claims/158 RN Defendants**

<b>Claims with no MD co-defendant</b>	<b>46</b>
Claims with MD co-defendant	50

#### Co-defendants

35 Surgeons
26 Medical specialty MDs
26 Psychiatrists
8 Ob/Gyns
1 Nurse Practitioner
1 Physician Assistant

#### Allegations (Top 5)

Failure to ensure patient safety
Improper performance of treatment
Wrong dose of medication
Improper performance of injection
Failure to monitor patient

#### Risk Management Issues (Top 5)

Medication error
-dosage
-administration
-route
-computation
-monitoring
-omission
Documentation
Patient monitoring
Failure to ensure safety
Communication among providers

## Claims Naming Nurse Practitioners

Nurse practitioners (NP) have a distinct and independent responsibility for the care of their patients, which includes clearly defining their practice limits and requesting consultation from the collaborating physician when necessary. When the patient's needs are beyond the scope of an NP's interpretive, diagnostic, or treatment capabilities, he or she is required to obtain physician consultation. NPs who fail to do this may bear the subsequent risks alone.

In a collaborative practice, the responsibility and duty to the patient (and potential liability) is a shared obligation. A commitment from the collaborating physician to provide regular consultation time is an important factor in coordination of care. It also requires the practice or institution to adopt NP practice guidelines and keep them current. These guidelines are a reference as well as a way to define the role of the NP in a particular practice setting.

### Case Example: Physician Consult

*An obstetrician's assessment of a 22-year-old woman being seen for lower abdominal pain and vaginal bleeding was "vaginal bleeding /? early pregnancy." The serum beta sub unit (BSU) from the initial visit was 1435. A telephone encounter with a nurse practitioner three days later included notification to the patient that her repeat serum BSU was 2481. Documentation of this telephone conversation indicated that the patient was planning to terminate her pregnancy.*

*Eleven days after the first encounter, the patient was examined by a second NP whose assessment was "threatened AB, BSU ordered, patient told to call for results, given pelvic precautions." At this time, the obstetrician and NP did not communicate about this patient, who 48 hours later returned with heavy vaginal bleeding. Following a pelvic ultrasound, she underwent a laparoscopic salpingectomy for an ectopic gestation.*

*The patient complained that on her second visit, she should have been seen by a physician and had an ultrasound. Her claim against the physician and NP was settled in the mid-range.*

### Opportunities for Improvement

In this case, as in some others, communication between the physician and NP are critical for optimal patient care. In addition, a review of guidelines (in this case, for suspected ectopic gestation) for identified clinical scenarios as well as indicators for physician consultation may reduce the likelihood of liability.

Coordination of care among providers, as well as good follow-up systems, are essential for quality care. All types of health care providers who take independent responsibility for a patient's care need to make sure that they are following guidelines and that adequate follow-up occurs.

Figure 4

### CRICO Claims Naming

**NPs: 1987-1996**

**N=20 Claims/25 NP Defendants**

<b>Claims with no MD co-defendant</b>	<b>6</b>
Claims with MD co-defendant	14

#### Co-defendants

- 10 Internal Medicine MDs
- 5 Ob/Gyns
- 3 Radiologists
- 2 General Surgeons
- 2 Neurologists
- 2 Pediatricians
- 2 Psychiatrists

#### Allegations (Top 5)

- Failure to diagnose/wrong diagnosis
- Improper management/treatment
- Failure to treat
- Improper performance of treatment
- Failure to order tests

#### Risk Management Issues (Top 5)

- Pt. assessment/narrow diagnostic focus
- Failure/delay in obtaining consult
- Selection/management of therapy
- Managed care-related access
- Failure/delay in reporting findings

## Claims Naming Certified Nurse Midwives

Careful choice of delivery options with physician consultation where indicated by protocol—as well as meticulous documentation of labor progress—are important loss prevention techniques for certified nurse midwives (CMN).

### Case Example: Birth-related Injuries

*A diabetic patient with a history of large babies was cared for during her pregnancy by a nurse midwife who assisted delivery of a 9 lb., 13 oz. baby without episiotomy. The baby's damages included a fractured clavicle and a brachial plexus injury. A claim filed against five physicians, the midwife, and the institution was settled (on behalf of the midwife) in the mid-range.*

### Opportunities for Improvement

The collaborative arrangements under which nurse midwives practice in Massachusetts require development and implementation of practice guidelines for:

- categories of patients for whom the nurse midwife can care in the prenatal period,
- critical triggers for physician consultation,
- rapid access to the covering MD in labor and delivery setting, and
- documentation of all care, especially labor and delivery.

Figure 5

### CRICO Claims Naming

**CNMs: 1987-1996**

**N=6 Claims/8 CMN Defendants**

**Claims with no MD co-defendant 2**  
Claims with MD co-defendant 4

#### Co-defendants

- 7 Ob/Gyn Surgeons
- 2 General Surgeons
- 1 Internal Medicine MD

#### Allegations

- Negligent delivery
- Delay in treatment of fetal distress
- Improper mgmt. of pregnancy

#### Risk Management Issues

- Documentation
- Selection/management of therapy
- Failure/delay in obtaining consult
- Technical performance
- Misinterpretation of diag. studies
- Malfuction of equipment

## Claims Naming Certified Registered Nurse Anesthetists

Two of the three cases that named a Certified Registered Nurse Anesthetist (CRNA) did not include physician co-defendants. The two cases that occurred in outpatient surgery settings were closed without an indemnity payment. The third case, which involved inpatient surgery, is still open.

### Case Example: Delayed Surgery

*A 35-year-old patient was admitted to an outpatient surgical facility for a laparoscopy. She had a history of hypertension and had taken her usual dosage of anti-hypertensive medication prior to surgery that day. The surgery was delayed until several hours later, at which time—during induction of anesthesia—the patient became hypotensive and developed pulmonary edema. She required stabilization, the surgery was not performed, and she was transferred to an inpatient facility. Her claim against the CRNA was dismissed following a favorable tribunal.*

### Opportunities for Improvement

Both outpatient cases involved selection and management of anesthetic agents—functions within the scope of CRNA practice. Preoperative screening of patients, patient selection, and physician supervision are all important parameters in inpatient as well as outpatient surgical facilities. Guidelines for induction of anesthesia, monitoring of patients during anesthesia, and critical patient parameters during anesthesia are necessary in a complete description of CRNAs' functions. Physician supervision, specifically detailing oversight functions, triggers for physician (anesthesiologist) presence in the operating room, and regular review of patient management issues are critical.

Figure 6

### CRICO Claims Naming

**CRNAs: 1987-1996**

**N=3 Claims/3 CRNA Defendants**

**Claims with no MD co-defendant 2**  
Claims with MD co-defendant 1

#### Co-defendants

- 2 Anesthesiologists

#### Allegations

- Improper performance of intubation
- Improper choice of anesthesia

#### Risk Management Issues

- Patient assessment
- Management of medication
- Selection of medication

Non-physician Employee Claims Review *Continued on next page*

## Claims Naming Licensed Practical Nurses

Licensed practical nurses (LPN) have a more limited scope of practice than RNs and advanced practice nurses, but they still have a duty to the patient to provide care within the scope of their practice.

### Case Example: Medication Overdose

*Dilantin was ordered for a 24-year-old patient with a seizure disorder. The pharmacy filled the prescription incorrectly and the nurses (one RN and three LPNs) administered six incorrect dosages. The patient developed complications and died. A claim naming all four nurses, the pharmacist, and the institution was settled in the low range.*

### Opportunities for Improvement

Despite the pharmacy's error, the LPNs had a responsibility to ensure that the correct dosage was administered. Initiatives within institutions to improve pharmacy preparation, as well as checking dosages, is critical. Additionally, efforts to encourage drug manufacturers to produce medications in standard forms (especially for pediatrics) would be helpful.

Figure 7

### CRICO Claims Naming

**LPNs: 1987-1996**

**N=2 Claims/4 LPN Defendants**

**Claims with no MD co-defendant 1**  
 Claims with MD co-defendant 1

#### Co-defendants

- 4 Ob/Gyns
- 2 Neonatologists
- 1 Gastroenterologist
- 1 Pharmacist
- 1 RN

#### Allegations

- Medication error (administration)
- Improper performance of treatment

#### Risk Management Issues

- Medication error
- Technical performance

## Nurses Responsible, but Not Named

When no individual is named in a claim, the institution where the alleged malpractice occurred is deemed responsible because the patient was under its care. The "responsible service" reported is the clinical service deemed most responsible for the event or injury.

Only one clinical service, for each claim, can be identified as responsible. In the 74 claims filed from 1987-1996 for which nursing was named as the responsible service but no specific nurse was named, the most common allegation and risk

management issue identified was failure to ensure safety. In general, injuries in these cases were not life-threatening, while injuries cited in claims naming specific nurse defendants were more often serious.

### Case Example

*Following a laparotomy, the 26-year-old patient developed a second degree burn when a hot water bottle was placed on her lower abdomen. The progress notes and discharge summary referenced the occurrence. The institution was unable to identify the nurse responsible. A claim (against the institution) was settled in the low range.*

### Opportunities for Improvement

This case illustrates several important nursing care issues: failure to report an adverse event, failure to document care and therapeutic interventions in the medical record, and failure to monitor treatment. Quality patient care is dependent on relevant treatment being documented. Risk management and quality improvement are aided by appropriate documentation of adverse events.

These cases speak to different aspects of nursing care, which include coordination, staffing, communication, and supervision.

Physicians are generally less at risk for being named in a suit in the areas of patient safety, although they are responsible for writing orders for monitoring and ensuring safety (i.e., posey, suicide precautions, and ambulation privileges).

-Heidi Groff

### CRICO Claims in Which Nursing was the Responsible Service 1987-1996 N=74

#### Allegations (Top 5)

- Failure to ensure safety
- Improper performance of treatment
- Failure to monitor patient
- Improper maintenance of equipment
- Retained foreign body

#### Risk Management Issues (Top 5)

- Failure to ensure safety
- Documentation
- Improperly utilized equipment
- Medication error
- Patient monitoring

## Claims Naming **Physician Assistants**

Liability for physician assistants usually reflects the specialty in which they choose to practice. Many CRICO-insured PAs practice in the surgical specialties, and thus are exposed to areas of potential liability such as improper performance of procedures.

### Case Example: *Finger Dislocation*

*The patient was seen by a PA for a non-displaced fracture of the finger. The finger was splinted by the PA, but the patient was noncompliant with wearing the splint. At the follow-up visit with the PA, an X-ray was not performed. A subsequent X-ray revealed a dislocation. The patient was not seen by the physician until six weeks post-injury, at which point he required two corrective surgeries. The claim, alleging that the PA improperly treated the patient and that a physician should have been initially involved in the treatment, was settled in the low range on behalf of the PA and the institution.*

### Opportunities for Improvement

A “real time” physician consult may have resulted in earlier detection of the dislocation. A PA’s supervising physician is required (in most states) to be available for consultation. The physician does not need to be physically present, but does need to review cases regularly.

Another practice that would help prevent this type of delayed diagnosis is having and following guidelines for management of specific types of fractures. That might have triggered a follow-up X-ray when one was not ordered.

The responsibility in this case was found with the PA and not the supervising physician, as he was not consulted regarding the follow-up care.

Figure 8

### CRICO Claims Naming

**PA’s: 1987-1996**

**N=16 Claims/17 PA Defendants**

<b>Claims with no MD co-defendant</b>	<b>8</b>
Claims with MD co-defendant	8

#### Co-defendants

- 6 Orthopedic MDs
- 4 Nurse Practitioners
- 2 Internal Medicine MDs
- 1 Cardiac Surgeon
- 1 General Surgeon
- 1 RN

#### Allegations (Top 5)

- Delay in treatment
- Improper performance of treatment
- Wrong/unnecessary treatment
- Delay in diagnosis
- Wrong diagnosis

#### Risk Management Issues (Top 5)

- Failure/delay in ordering tests
- Unresponsive to pts. repeated concerns
- Patient assessment
- Narrow diagnostic focus
- Failure/delay in obtaining consult

## Claims Naming **Technicians**

Technicians in all clinical areas have specialized areas of knowledge and expertise. Although they may not be credentialed or licensed, they have a duty to the patient to perform a certain level of care in their particular area.

### Case Example: *Cast Removal*

*During removal of an infant patient’s bilateral long leg corrective casts, the saw overheated due to a dull blade. The baby sustained a laceration and a burn on her leg from the cast saw. The technician’s job included maintenance of the cast room, upkeep of the equipment, and the technical performance associated with cast application and removal. The suit was settled against the insured institution and the technician in the low range.*

### Opportunities for Improvement

Enhancing competency for these health care providers should include regular reviews of care along with guidelines and supervision when appropriate. Educational preparation that is standard in the technician’s area, along with continuing education and recertification at appropriate intervals, is suggested.

Figure 9

### CRICO Claims Naming

**Technicians: 1987-1996**

**N=16 Claims/16 Technician Defendants**

<b>Claims with no MD co-defendant</b>	<b>10</b>
Claims with MD co-defendant	6

#### Co-defendants

- 4 Neurologists
- 3 Anesthesiologists
- 2 Radiologists
- 1 Cardiac Surgeon
- 1 Cardiologist
- 1 General Surgeon
- 1 Orthopedists

#### Allegations

- Technical performance
- Failure to ensure safety

#### Risk Management Issues

- Technical performance
- Equipment-related

**Non-physician Employee Claims Review** Continued on next page

## Risks for Physicians

The Massachusetts Board of Registration in Medicine allows fully licensed physicians to delegate the performance of medical services to skilled professional or nonprofessional assistants consistent with accepted medical standards and appropriate to the assistant's skills.<sup>4</sup> This is a judgment call which should be thoughtfully considered in light of the specific task, the particular individual, and the context in which the task must be accomplished.

As the claims review illustrates, non-physician clinicians can be named in malpractice claims independent of physicians. Because patient care often involves several members of a team, physicians who collaborate and communicate effectively with other health care team members diminish the risk of untoward patient outcomes and their own potential for liability.

### Opportunities for Collaboration Among Providers

Managing patients' expectations about the types of providers they will see within a collaborative practice is essential. When non-physician clinicians are an integral part of a practice, patients should be informed (via practice literature, etc.) who they are, their qualifications, and their backgrounds. Explain and support decisions to refer to and collaborate with non-physician clinicians.

Read each other's clinical notes. Differences in documentation not only reflect discontinuity in care but can position health care providers against each other. For example, triage nurses often elicit histories that are different from the ones subsequently documented by physicians. Both histories may include pertinent subjective information provided by the patient, information that may or may not be consistent.

Physicians should attempt to be responsive and not dismissive when orders or treatments are questioned by non-physician colleagues. Errors in medical orders

and prescriptions do occur. Because nurses also have a responsibility to provide accurate and safe care, they have a duty to question orders that, in their judgment, appear to be out of the ordinary. As with any such questions about care decisions among clinicians, they should be conducted outside the realm of the patient record.

While each discipline and practice has its own issues and concerns to be addressed, in general, physicians supervising/collaborating with non-physician clinicians should:

- ◆ Update clinical guidelines regularly.
- ◆ Integrate consultation time into their schedules (real time as well as chart review).
- ◆ Be explicit about clinical situations and laboratory and imaging studies that require physician input.
- ◆ Be realistic about the time that they (physicians) will need to integrate collaborating providers into their practice.
- ◆ Insure proper credentialing of the expanded role provider: this includes understanding regulatory and licensing requirements, including state-specific prescriptive practice supervision requirements.
- ◆ Schedule evaluations for non-physician clinical employees at regular intervals. Document those evaluations along with records of recommended training. Also, at the time of review, update and discuss patient referral patterns between physicians and collaborating providers. ■

### Notes & References

- 1 Controlled Risk Insurance Company (CRICO) provides professional liability insurance to health care institutions, their employees, and affiliated physicians.
- 2 The CRICO insurance policy does not list individually employees by name; physicians are listed as additional insured on their institution's policy.
- 3 Low range = < \$99,999; mid range = \$100,000 - \$499,999; high range = \$500,000 - \$999,999.
- 4 243CMR2.07(4)

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# Physicians and Nurse Practitioners in Collaborative Practice

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A nationwide shortage of primary care physicians has combined with recent changes in health economics and politics to give nurse practitioners (NPs) the opportunity to establish a significant and separate role in health care delivery. The success of NPs in keeping patients healthy and happy has not escaped the attention of health care administrators and patients.

In Massachusetts, where some 2,000 NPs practice, several nursing schools have begun or expanded NP programs in recent years. This is adding hundreds of NPs, mostly in family practice and other primary care areas, to the health care system. Recent legislation,<sup>1-2</sup> including mandated third-party billing at the state level and changes in HCFA and Veterans Affairs regulations federally, should encourage NP training and will likely accelerate this trend.

Over the next few years, medical malpractice claims data will likely reflect the increased role of NPs in patient care and almost certainly parallel physician primary care trends. On the other hand, the aspects of the NPs' approach to patient care that focus on education, communication, prevention, and patient advocacy—areas that some physicians assign lower priority—may help minimize their claims experience.

## Building a Working Relationship

The Boards of Registration in Nursing (BRN) and Medicine (BRM) jointly govern NP practice and collaborative physician/NP arrangements. In Massachusetts, collaborative practice is defined by the BRN as a:

“process and relationship in which a nurse practicing in the expanded role works together with physicians and may work with other health professionals to deliver health care within the scope of the various professionals' experiences and lawful practice and with medical direction and appropriate supervision as provided for in [Massachusetts] guidelines 244CMR 4.22-4.25.”

An effective working relationship between the nurse practitioner and the collaborating physician is central to successful risk management.<sup>3</sup> This includes guidelines that designate the collaborating physician and define the nature and scope of the nurse's practice. If the NP will be prescribing medications, both parties need to develop *those* guidelines as well.

In general, a physician need not be present when an NP is examining a patient, however, the most effective partnerships feature same-site collaborative teams with shared decision making, frequent chart review, and daily discussion of patient management.

Close communication with and immediate availability of a supportive collaborating physician are essential, as is a clear understanding and acceptance of the respective roles and liability. Both the physician and NP must understand and accept the fact that an NP is legally liable for his or her actions. (The collaborating physician will often, but not always, share in any care-related liability.)

*Over the next few years, medical malpractice claims data will likely reflect the increased role of NPs in patient care and almost certainly parallel physician primary care trends.*

## Guidelines and Supervision

The best initiatives *for* quality care and *against* liability are written guidelines. NP practice guidelines must designate the collaborating physician, define the nature and scope of practice, and—if the NP holds prescriptive privileges—should include provisions for quarterly practice reviews. Additionally, journals and texts that have been mutually agreed upon as providing acceptable scientific knowledge and standards of care for common medical conditions should be included with guidelines for NP practice and made available at the practice site for consultation.

In defining the role of “supervising physician” of NPs with prescriptive privileges, the BRM in Massachusetts says the physician holds:

“a full, unrestricted license and having completed training in a specialty area appropriately related to the NP's area of practice or with hospital admitting privileges in an area appropriately related to the NP's area of practice, holds controlled substance registration, and signs mutually developed and agreed upon guidelines with the NP engaged in prescriptive practice and reviews the NP's practice at least every three months.”

Additionally, physician supervision of a prescribing NP must take into account geographic proximity, practice setting, volume and complexity of the patient population, and the experience, training, and availability of the supervising physician. Lastly, the BRM guidelines state that a supervising physician shall not enter into a collaborative practice unless the NP has proof of malpractice liability insurance coverage of at least \$100,000-\$300,000.<sup>4</sup>

*Continued on next page*

## Mentorships

Mentorships between NPs within practices are strongly recommended as a tool to foster collaborative, consistent practice and promote education between providers. In such a program, a provider entering the group practice—regardless of previous experience—is mentored by a defined, established practice provider. Mentorships range from three to six months and require that the new practice provider present and discuss each patient case with the mentor during the time of the patient visit. Additionally, the mentor is expected to review the care rendered by the new provider and give constructive feedback regarding standards of care and practice guidelines.

Physician consultation must be available at all times, either in person or by telephone. In general, NPs seek consult in the following situations: 1) an NP has questions interpreting data to make a diagnosis or treatment plan, 2) a patient fails to respond as expected to prescribed treatment, and 3) the initial diagnosis indicates a life-threatening condition.

Each practice setting should additionally develop a listing of potential situations and patient presentations, specific to that practice, that require physician consultation during the time of the office visit (e.g., suspected child or elder abuse, headache with neurologic signs, fever without localizing signs in infants). Adherence to defined consultation guidelines should be appropriately documented by the NP within the patient's chart and reviewed by the supervising physician as part of regularly scheduled NP performance reviews.

To maintain quality patient care in a collaborative practice, provider meetings should be held regularly to discuss both general and specific patient care issues. These discussions may be informal gatherings in which the expertise of the NPs and other clinicians is shared for the mutual benefit of all involved in the care of the patients. Some practices prefer

more formally structured sessions that include case presentations and topic discussions of clinically relevant health care issues. Regularly scheduled provider meetings strengthen the education of the staff, provide for cohesiveness within the provider group, and help ensure consistency in patient care.

Lastly, quality monitoring of NP practice is essential. In addition to reviewing initial prescriptions of Schedule 2 drugs authorized by prescribing NPs, the supervising physician should—at least every

90 days—review 10 records of patients seen by the NP. The reviewer can monitor prescribing decisions and practices of the NP, including: the decision not to prescribe, clinical decision making, adherence to documentation guidelines, and billing practices. The review should be documented and kept on file. ■

*Physician supervision of a prescribing NP must take into account geographic proximity, practice setting, volume and complexity of the patient population, and the experience, training, and availability of the supervising physician.*

## Notes

- 1 Third party reimbursement provisions in Massachusetts direct insurers to make provisions for direct reimbursement of NPs in all settings. This affects HMOs and other private insurers most directly. Medicaid has had 100 percent reimbursement for evaluation and management services for several years. Medicare has provided reimbursement for services in rural settings and nursing homes.
- 2 Medicare and HCFA made significant changes as part of the 1997 balanced budget act. As of January 1, 1998, NPs and clinical nurse specialists working in collaboration with physicians can bill Medicare regardless of the setting in which care is provided. A physician need not be physically present when the services are provided and Medicare will accept claims either directly from the nurse or from the employing hospital, clinic, nursing facility, group practice, or physician in cities or suburbs—not just rural areas. Medicare will pay NPs 80 percent of the lesser of actual charge or 85 percent of the physician fee schedule, without removing the prior “incident to a physician services” option that previously required on-site supervision for NPs.
- 3 In 28 states, including New Hampshire, no supervision or collaboration with physicians is required, and in 18 states, NPs may prescribe without physician involvement. In Massachusetts, NPs are required to collaborate with physicians in managing patients and be supervised by physicians in writing prescriptions.
- 4 Nurse practitioners insured through Controlled Risk Insurance Company (CRICO) are covered up to \$5 million per claim for activities performed within the scope of their employment with a CRICO-insured medical institution.

# Supervising Nurse Practitioners with Prescriptive Authority

by  
Margaret A.  
Fitzgerald, M.S.,  
R.N., C.S.N.P.

*Margaret Fitzgerald is a nurse practitioner at the Greater Lawrence Family Health Center in Lawrence, Massachusetts, and President of Fitzgerald Health Education Associates.*

In Massachusetts,<sup>1,2</sup> nurse practitioner (NP) prescriptive authority requires specific physician supervision in order to meet statutory requisites. However, the NP holds an independent license to practice and is considered responsible for his/her own practice in collaboration with a designated physician.

After proper application, NPs in Massachusetts may obtain a federal DEA number to be eligible to write prescriptions for Schedule 2-5 controlled substances. Numerous other states grant NPs this authority. In fulfillment of Massachusetts requirements, the names of the NP and collaborating physician are printed on all prescriptions.

## Establishing a Collaborative Partnership

The initial choice of a physician collaborator is dictated by several factors. One, the collaborating NP and physician team must share a similar patient population. For example, a pediatric NP may have a pediatrician or family practice physician as collaborator, where an NP seeing adult patients may collaborate with an internist or family practice physician. Generally, both practice at the same clinical site.

In establishing the collaborating relationship, the NP and physician agree to fulfill regulatory requirements developed by Massachusetts' Department of Public Health, the Board of Registration in Nursing, and the Board of Registration in Medicine. Part of the collaborating relationship includes the team agreeing on a select group of references, texts, and guidelines as representing standards of care, including pharmacologic intervention. If the NP chooses a drug intervention outside the established guideline, he or she must consult the physician collaborator.

## The Consultative Process in Practice

A middle-aged man presented to an NP for the treatment of hypertension. Due to additional health problems including morbid obesity, his hypertensive control has been complicated and now includes four medications. As his treatment plan was being developed, arrangements were made for consultative visits with an internist for input on pharmacologic and overall treatment plans. In turn, the NP has been able to see the patient for frequent brief visits to monitor BP continue with education concerning diet, exercise, and other cardiovascular risk factors.

The consultative process is often a two-way street, with physicians seeking out the expertise of NPs in particular areas. For example, women's health NPs frequently advise on hormonal contraception; the adult-care NPs advise on diabetic management.

Since the collaborator may not be available at all times, coverage arrangements must be formalized. This availability is often predetermined through a monthly posted schedule so that all parties are aware of this responsibility.

NP/physician clinical consultation may take place face-to-face or via telephone. The NP may opt to have the physician physically see the patient. As with all other clinical encounters, the consultation is recorded within the medical record.

The NP's prescriptive practice is subject to periodic review, which can be used as a time for dialogue about the ongoing collaborative relationship. To maintain prescriptive authority, the NP must maintain a valid state license for advanced practice nursing and appropriate certification. This requires a combination of ongoing practice and continuing education. A portion of continuing education is devoted to pharmacology-related content. The collaborating physician must also maintain proper licensure.

The NP's prescriptive authority must also be periodically renewed at the state level. Documenting ongoing physician supervision of this aspect of practice is part of this process. If the agreement is broken, such as when the NP or physician leaves the practice, the state must be notified and the prescriptive authority is no longer valid. NP prescriptive licensure is not portable from practice to practice. Proof of a new collaborating arrangement must be provided to obtain or renew a license.

The specifics of the NP-physician collaborative arrangement should be outlined in a document available at each practice site, signed by all involved. That document is subject to periodic review and, as the need arises, modification and updating. This may include the addition or deletion of a certain reference and naming of new members of the health care team or omitting those who have left the practice. ■

## Notes & References

1. In New Hampshire, an Advanced Registered Nurse Practitioner (ARNP) is licensed as having specialized clinical qualifications, including plenary authority to possess, compound, prescribe, administer, dispense, or distribute controlled and noncontrolled drugs. Drugs must be prescribed from an official formulary (distributed yearly to each licensed ARNP in the state) within the scope of the ARNP's practice.
2. In Rhode Island, a nurse practitioner is also required to obtain a state controlled substance registration license. A new law (July 1997) allows NPs to prescribe Schedule 2-5 drugs. However, the federal government allows only class 4 and 5 to be written by NPs. The new drug formulary is still in the process of being generated.

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# The Expanding Scope of Practice for Physician Assistants

Physician Assistants (PA) are part of many health care teams. The majority are initially trained in primary care but may specialize, practicing office-based medicine or assisting physicians in the operating room. As patients have demanded more efficient and affordable health care, PAs have developed complementary roles with their supervising physicians. Although PAs cannot practice independently, their flexibility and training enable them to be used in many ways.

In our multispecialty group practice, four physician assistants practice in two sites with three orthopedic surgeons, two general surgeons, and two urologists. As PAs, we receive patient referrals from colleagues in internal medicine, pediatrics, and urgent care practices. We are office-based full time. The supervising physicians practice at additional sites and spend several days a week in the operating room.

At our site, we see patients with acute and chronic problems, and patients with fractures and soft tissue injuries. Chronic problems such as arthritis may initially be evaluated by us and referred to the supervising physician/orthopedist if the patient requires additional treatment.

## Initial Evaluation

The determination of who initially evaluates patients is based on the complexity of the clinical problem and the patient's preference. We and our supervising physicians review clinical cases regularly, as required by state law. Patients are referred to us based on our experience and training and our supervising physician's confidence in our skills and judgment. Triage of patients allows the physician to see more complex problems while allowing us to provide timely evaluation and treatment of many common surgical problems.

Patients needing surgery are scheduled with the appropriate surgeon. We will often then perform pre-operative evaluation and education. We may also furnish post-operative care by managing drains, monitoring wound healing, and continuing patient education. We can do many minor operative procedures.

## State Regulations

Physician assistant practice legislation varies from state to state.<sup>1</sup> In Massachusetts, PAs are registered through the Board of Registration of Physician Assistants, which works closely with the Board of Registration in Medicine that oversees physicians' supervisory role with PAs.

Massachusetts regulations require that PAs have a minimum of a bachelors degree and have completed training at an approved PA program (which vary from 24-48 months). Massachusetts PAs must pass a certifying exam by the National Commission on Certification of Physician Assistants. In order to maintain Massachusetts certification, PAs must complete 100 hours of approved continuing medical education every two years and complete a recertifying exam every six years.

PAs in Massachusetts can have prescriptive privileges for drug classes 2-5. Prescribing PAs must register with the PA Board and with the Massachusetts Department of Public Health, and then complete guidelines required by the DPH (and approved by their supervising physicians) in order to receive a controlled substance license. To maintain their license, PAs must also complete four hours per year in pharmacology CMEs. PAs prescribing Schedule 2-5 drugs must also be registered with the federal Drug Enforcement Agency. Massachusetts PAs receive their own DEA number. Prescribing in each setting is determined by the PA and supervising physician, as outlined in their written guidelines.

## Supervision

PA supervision must be done by physicians with expertise in the PA's practice specialty. The supervising physicians need not be physically present, but must be available for consultation. Patient cases are reviewed regularly by the supervising physicians. If he or she is not available, a designated physician supervisor must provide coverage. In Massachusetts, physicians may not supervise more than two PAs at once. Each practice should have supervision guidelines defining how and when specific patient problems need to be reviewed with the supervising physician. Physicians must document their review of PA patient cases.

## A Day in the Life of a Surgical Specialty PA

Frequently, as surgical PAs, we are consulted for urgent cases that present to primary care areas. If the primary care provider (PCP) needs assistance, we may see the patient with the PCP, or manage care or conditions. If the patient needs intervention we will initiate surgical treatment according to our physician supervision guidelines. We also coordinate the care of patients who may have been seen acutely in an emergency setting and triage them to the surgeon if his or her expertise is needed.

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by  
Wesley Brooks,  
P.A.C., and  
Ina Cushman,  
P.A.C.

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*Wes Brooks and  
Ina Cushman are  
Physician Assistants  
in Surgical  
Specialties, for  
Harvard Vanguard  
Medical Associates  
in Braintree,  
Massachusetts.*

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When not seeing urgent cases, we conduct pre- and post-operative evaluations. We also treat and follow many cases that may not require a surgeon's expertise such as minor fractures and dislocation, minor skin excisions, and many laceration repairs. We also manage a number of urology problems in consultation with the supervising surgeon.

### Future of Physician Assistants

Academic health centers and universities have responded to increasing interest by establishing new PA programs. Currently, 104 accredited programs in the United States are expected to graduate more than 3,500 new PAs each year. Some hospitals, faced with cutbacks in residencies, are hiring PAs for inpatient care. Physician practices, particularly those with managed care contracts, may find the use of PAs

a cost-effective way to increase productivity while maintaining quality. Medicare coverage of services provided by PAs in all practice settings, including assisting at surgery, is now payable at 85 percent of what would be paid to physicians.

More than 25 percent of PAs practicing in the United States are in primary care practice in communities of fewer than 10,000 people; half work in family practice, general internal medicine, and general pediatrics. The projected health care needs of the aging "baby boomer" generation and the country's 42 million uninsured only increases the value of physician assistants. ■

#### Note

1 Only in Mississippi are physician assistants restricted from practicing.

## Regulations for PA Practice in Massachusetts, New Hampshire, and Rhode Island

Details are available on the American Association of Physician Assistants' web site at [WWW.AAPA.ORG/GANDP/STATELAW](http://WWW.AAPA.ORG/GANDP/STATELAW)

	Massachusetts	New Hampshire	Rhode Island
<b>Qualifications</b>	Graduation from accredited PA program, and current NCCPA certificate.	Graduation from accredited PA program, and current NCCPA certificate.	Graduation from accredited PA program, and current NCCPA certificate. No one holding a medical degree is eligible.
<b>Scope of Practice</b>	Medical services delegated by supervising physician.	Any delegated medical services within the PA's skill and physician's scope of practice.	Health care services delegated by the supervising physician consistent with the physician's and PA's expertise.
<b>Prescribing</b>	PA may prescribe controlled substances (Schedule 2-5).	PA may prescribe legend drugs and controlled substances; must pass pharmacy law exam.	PA may prescribe, including Schedule 5. Must register with state drug control office and DEA.
<b>Supervision</b>	Physician not required to be physically present when PA renders medical services, but must be available for consultation.	Physician must be available for consultation at all times in person or via radio, telephone, or telecommunication.	Physician not required to be physically present when PA renders medical services, but must be available for consultation.

## Delegation: Who is at Risk?

by  
Gloria Legere  
Rawn, R.N., M.S.,  
J.D.

*Gloria Rawn is a consultant for Harvard Risk Management Foundation.*

Patients in a large teaching hospital are cared for by a multidisciplinary team of health care providers. Contributions to care range from complex procedures rendered by specialists, to simple assistance in basic living, often rendered by unlicensed assistants. In most situations, each individual provider is personally accountable for the care that he or she gives. When caregivers function under the direct supervision of others who are licensed to delegate such duties, that accountability is shared.

In response to changing payment delivery systems, health care providers have increased the use of ancillary personnel, including physician assistants (PA) and unlicensed nurse assistants and patient

care assistants. These individuals function as part of the health care team, but receive direction and supervision from physicians and nurses. With the responsibility of delegation, comes the realization that supervisors can be held vicariously liable for the actions of those under their direct supervision.

### Delegating to Physician Assistants

PA training is formal, at the master's level, and requires a certification exam for competency, which must be retaken every six years. In Massachusetts, their certification is a prerequisite to licensure, which is regulated by the Board of Registration of Physician Assistants.

*Continued on next page*

PAs do not practice independently; they perform traditionally “medical” functions delegated directly to them by a supervising physician.<sup>1</sup> These duties must be within the physician’s own competency in order to be properly delegated.

PAs are accountable to their licensing board and subject to discipline, including license revocation. The physician responsible for supervision of the PA’s activities may also be subject to disciplinary action by the state medical licensing board and could receive institutional restrictions on his or her ability to practice. Liability for the physician may result from inadequate supervision or inappropriate delegation of duties. Supervisors may only delegate duties that they are *licensed* to delegate, and only to individuals legally permitted to carry them out.

Apart from the actions of the licensing board, both the PA and the supervising physician may be sued for negligence. Since both clinicians hold licenses to render health care services, standards of care, and the actions of similar practitioners in similar situations—traditional methods of evaluation used by juries—are easily identified. Malpractice trial juries would evaluate their acts based upon a traditional theory of negligence: i.e., that a duty was owed to the patient by the defendant, that *that* duty was breached by sub-standard practice, that the breach directly caused harm, and that the harm led to damages.

### Delegating to Nurse Assistants

The increased use of unlicensed nurse assistants poses liability risks for the professionals overseeing the care these individuals provide. Unlicensed assistants function in a complimentary role to the either the physician or nurse in providing direct patient care in a variety of patient care settings. In hospital settings, they are trained by the institution in basic patient care services, or must at minimum meet the institutionally set level of skill and competency.

In many states, these assistants are not independently licensed by any board. Nurse Practice Acts and associated regulations in a particular state may regulate their activities, job descriptions, and institutional documented competencies to varying degrees.

In Massachusetts, employers of unlicensed assistants must have on file and available to the supervising licensed nurse a documented competency of necessary skills for each assistant. Theoretically, this practice provides to the responsible supervisor a safety check on each unlicensed assistant’s level of

skill and ability. This essential safety measure should be part of a comprehensive quality program, as individual unlicensed assistants may function at different skill levels.

The Massachusetts Board of Registration in Nursing addresses the use of unlicensed assistants in its regulations (244CMR3.05) and specifically states that unlicensed assistants are not to be used as substitutes for licensed personnel. Nurses cannot delegate to unlicensed assistants any patient activity that requires assessment, judgment, planning of nursing actions, teaching, implementation of the nursing care plan, evaluation of outcomes, or the administration of medications.

The regulations require the licensed nurse to determine the appropriate level of supervision required for delegated nursing activities. That determination is to be based upon, but not limited to, assessing the stability of the patient, the training and competency of the unlicensed assistant, the nature of the task, the proximity and availability of the licensed nurse when the activity is performed, the institutional policies, and the assistant’s job description.

Such regulations have been criticized as being vague and unclear in aiding the licensed nurse in deciding exactly what should and can be properly delegated. What most nurses find difficult is discriminating a nursing task that may be delegated appropriately in one scenario, from one which may not be appropriate to delegate in another. For example, delegating

the taking and documentation of vital signs in a stable medical patient may be sound practice but inappropriate for a recent post-op patient who needs fluid volume assessment.

Massachusetts regulations make clear that the delegating licensed nurse is directly responsible for the nature and quality of all nursing care that the patient receives under his or her direction. They specifically state that the decision as to what can be safely delegated is within the scope of that licensed nurse’s professional judgment. The use of unlicensed assistants can work when all parties know the roles and responsibilities afforded each member of the health care team and work together to provide quality patient care within the parameters set by multiple entities. ■

### Note

1 The Massachusetts Board of Registration of Physician Assistants regulations (263CMR5.08) state that the employers of physician assistants (e.g., individual physicians, physicians groups, or health care facilities) are legally responsible for the acts or omissions of the PAs under their employment.

*These individuals function as part of the health care team, but receive direction and supervision from physicians and nurses. With the responsibility of delegation, comes the realization that supervisors can be held vicariously liable for the actions of those under their direct supervision.*

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# The Risks of Patient Encounters by Telephone

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by  
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R.N.C.

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the Program  
Administrator  
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The telephone represents an area of high patient demand, and high stress, for most office practices. While it affords the opportunity to provide a valuable clinical service and efficient allocation of resources, telephone interaction with patients does carry significant medicolegal risks.

The art and science of telephone triage, when practiced with appropriate staff, training, resources, and supervision, is a tremendous asset. Over the past 10 years, this area of practice has developed as a distinct nursing specialty. National conferences, journal articles, published guidelines, and software are all available to train and support telephone triage nurses in their clinical decision-making process.

The nurse's primary role in telephone triage is to determine the level of care needed by the patient: who needs to be seen, when, where, and how. Once the triage decision has been made—often arrived at jointly by the patient and nurse—advice will follow. This may take the form of an emergency department referral, scheduling an office visit, consultation with the physician, self-care treatment options, or provision of patient education.

One of the biggest problems in office practices where nurses handle telephone calls is delegation of this responsibility without assessing the nurse's competency, and without being very explicit regarding how calls should be handled and documented. Physicians should not assume or expect that all staff who triage phone calls will function identically.

Nurses assigned to telephone triage need a comprehensive role description, and appropriate training and resources. They must not be asked to practice outside the scope of their nursing license. The degree of responsibility should be based on the nurse's training, experience, license, and written guidelines available to guide decision making. Once a nurse has triaged a patient call and determined the level of care needed, the advice that follows should be, in part, determined by the training and license of that individual nurse.

Some of the situations which have been shown to represent areas of potential high exposure are:

- the patient who calls back repeatedly and is not seen face-to-face,
- the patient whose anxiety seems out of proportion to the symptoms (this includes anxious parents calling about their child),
- the pregnant patient with a concern, and
- any patient who is uncomfortable with self-care suggested by phone.

## Documentation

Documentation of telephone encounters is as important as documenting face-to-face encounters. A useful tool to assist the nursing staff in documentation is a well-designed telephone encounter form, which features clinical prompts:

- chief complaint,
- past and present history,
- pertinent positives and negatives,
- advice given,
- consultations obtained, and
- expectations for follow up.

Without the structure of a telephone encounter form, which becomes part of the permanent record, documentation may be incomplete. It may not reflect the full clinical content of the call, and will leave a suboptimal record of what transpired. Since most practice sites will not have the benefit of recording calls, documentation is essential. Documentation of calls made to an off-site, on-call clinician is of equal importance, and cannot be "forgotten" when such calls are taken after hours or on weekends.

Clinical guidelines, including telephone management guidelines, are essential for nursing practice. They serve as a training tool and ongoing resource, and become the nursing standards for the individual practice setting. Often, guidelines are customized to meet unique needs of the practice: its philosophy, patient mix, local resources, and ability to handle clinical acuity on-site. The process of developing telephone guidelines is a huge undertaking and requires the participation of both nursing and medicine in their development, collaborative review, revisions, and updating. Many excellent resources are now available in written and electronic form.

The most efficient approach to obtaining guidelines is to research what already exists, select a product that closely matches the patient population, and customize it as needed for the practice site. Over time, the list of written guidelines may need to be more inclusive, but begin with a minimum set, chosen carefully to represent an area of potential risk for an individual practice. Most often, this list will be small in number and will ensure that patients are being screened carefully and in accordance with safe clinical care. Site-specific guidelines should start with those chief complaints that are common for that practice, and where "undertriaging" is a risk (e.g., offering self-care advice or reassurance to a patient when an office visit is most prudent). ■

# Closed Claim Abstract

## Morphine Overdose

by  
Heidi Groff,  
R.N.C., M.P.H., and  
Patricia Hanks,  
R.N.

*Heidi Groff is a Project Coordinator for Harvard Risk Management Foundation. Patty Hanks is a General Claim Representative for HRM.*

### Incident

Parents of an infant witnessed two respiratory arrests after he received an incorrect dose of morphine.

### Background

A child born prematurely at 35 weeks was admitted to the hospital at two months of age to undergo a pyloromyotomy for treatment of pyloric stenosis.

In the first post-operative day, the physician ordered morphine sulfate, 0.2-0.4 mg SC/IM for pain. Instead of using a 5 mg/ml vial, which was her customary practice, the nurse planning to administer the medication used a 10 mg/ml vial of morphine sulfate. The nurse calculated that she needed 0.04 ml of medication in the syringe. She double-checked the dosage with another nurse who did not question her calculations. Instead of .04 ml, the administering nurse drew up 0.4 ml into the syringe, which resulted in the baby receiving 10 times the prescribed amount of medication.(1)

Shortly after administering the morphine sulfate to the baby, the nurse left the room. The baby's mother was holding him when he began having respiratory difficulty. The baby's father summoned the nurse who found the baby in respiratory arrest. The parents were asked to leave the room while resuscitation was performed, including administration of Narcan. Following successful resuscitation of the baby, the parents returned to the room. The parents were told that babies can sometimes have unusual reactions to medications, including morphine. They were assured that he did not need additional supervision such as a cardiac or apnea monitor at that time.(2)

The medical staff left the room and 10 minutes later the baby had another respiratory arrest. The parents were asked to leave the room again while resuscitation was being performed. After being stabilized, the baby was transferred to the Cardiac Intensive Care Unit of the hospital for observation.

The following day, 14 hours after the medication error was discovered, the parents of the baby were summoned to a meeting with the baby's physician who informed them of the overdose.(3) They were told that the error was noted when the routine narcotics count was being performed on the floor, one hour after the administration of the morphine. An incident report was completed, describing the error and patient outcome. Corrective actions were identified.(4)

The baby was discharged in good condition. The parents filed a malpractice suit against the hospital, alleging emotional distress as a result of witnessing respiratory arrest of their two-month-old infant.

### Disposition

Following an unfavorable tribunal, the suit was settled in the low range (<\$99,000).

### Loss Prevention Notes

- 1 Calculation of dosages for pediatric patients is especially important because medications often are not packaged in pediatric dosages. Because calculations are based on weight, dosages can vary in the same age group. A questionable dosage should be verified with the pharmacist. Nevertheless, the ultimate responsibility for administering the correct dosage rests with the individual who actually gives the medication.*
- 2 Parents who have just experienced a traumatic event may be anxious about having sole responsibility for monitoring their baby after that event. While seeking parental involvement is important, if they are not comfortable with the responsibility, acknowledge this and act in a way that supports the parents and provides optimal care for the patient.*
- 3 The extent of the parents' emotional distress was escalated by their fears of why their child had two respiratory arrests. Once all of the facts are known, a thorough explanation of an untoward event can help a family focus on goals towards a safe outcome rather than anger and fear about not being adequately informed.*
- 4 Following an adverse event, maintain contact with the family through one identified provider and clearly discuss the details of the event, outcome, and treatment plan. Rather than wait an extended time for a particular member of the team to deliver the news, have another clinician involved in the patients's care speak with the family. Contact the organization's risk manager for assistance. Empathize with the family and offer support without admitting liability. Avoid writing anything in the medical record unrelated to the medical care (e.g., "incident report filed, legal office notified").*



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# Risk Management Representatives

As part of the formal loss prevention programs developed by medical institutions affiliated with Harvard Risk Management Foundation, key individuals have been designated by each facility to serve as institutional risk management representatives. The following list is printed as a convenience to assist insured physicians and staff in contacting appropriate risk management personnel.

## **Beth Israel Deaconess Medical Center-East**

Charles Conklin, Director of Health Care QA/RM  
(617) 667-2624  
Denise Peterson, Risk Management Specialist  
(617) 667-2624

## **Beth Israel Deaconess Medical Center-West**

Kathleen Murray, Risk Management Specialist  
(617) 632-7013

## **Brigham and Women's Hospital**

Neal Sullivan, J.D., Program Director, Risk Management  
(617) 732-8394

## **Children's Hospital**

Lita Maffett, Office of General Counsel  
(617) 355-6108  
Wendy Ludwig, QI/RM Coordinator  
(617) 355-6221  
Kathryn McKenna, QI/RM Coordinator  
(617) 355-4982

## **Dana-Farber Cancer Institute**

Anita Polli, Esq.  
Deputy General Counsel and Chief of Risk Management  
(617) 632-3293  
Deborah Duncombe, Dept. of QA/RM  
(617) 632-3253

## **Deaconess-Glover Hospital**

Suzanne Skolnick, Vice President  
(781) 444-5600, ext. 1050

## **Deaconess-Nashoba Hospital**

Marie B. Isham, Director, Patient Care Management  
(978) 772-0200, ext. 415

## **Deaconess-Waltham Hospital**

Marie Cantwell, Medical Staff Quality Manager  
(781) 647-6641  
Nick DiIeso  
Senior Vice President, Patient Care Services  
(781) 647-6205

## **Harvard Pilgrim Health Care**

Kimberly Nelson, Esq., Director of Risk Management  
(617) 731-8250

## **Harvard Pilgrim Health Care of New England**

Shelley Allison, Quality of Care Manager  
(401) 331-4034, ext. 43995  
Neal Galinko, M.D., Health Center Director  
(401) 732-0300, ext. 28311  
Stephen Schoenbaum, M.D., Medical Director  
(401) 331-4034, ext. 43041

## **Harvard School of Dental Medicine**

Cynthia Huff, Executive Assistant for Clinical Affairs  
(617) 432-0917

## **Harvard University**

Annamarie Thomas, Director of Insurance  
(617) 495-7970  
Lee Ann Ross, Assistant Director of Insurance  
(617) 495-8668

## **Harvard University Health Services**

Mary Hennings, Associate Director for Administration  
(617) 495-2074  
Audrey Sallèse, Director of Medical Records  
(617) 496-1630

## **Joslin Diabetes Center**

Patricia Eskander, Director of Medical Records, QA/RM  
(617) 732-2518, ext. 4217

## **Judge Baker Children's Center**

Jean Murphy, Director of Finance and Operations  
(617) 232-8390, ext. 2108

## **Massachusetts Eye and Ear Infirmary**

Mary Kennedy, Director of Risk Management  
(617) 573-3790

## **Massachusetts General Hospital**

Marilyn McMahon, J.D., Risk Manager  
(617) 726-2111  
Maryanne Spicer, Director of Corporate Compliance  
(617) 726-5109

## **Massachusetts Institute of Technology**

Elaine Shiang, M.D., Chairman, RM Committee  
(617) 253-7915

## **McLean Hospital**

Gail Tsimprea, Director of Clinical QA/RM  
(617) 855-2514

## **Mount Auburn Hospital**

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# Forum

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Harvard Risk Management Foundation



## Non-physician Clinicians

Issue Editors: Heidi Groff and Peggy Berry Martin

### 1 *Commentary: Serving Non-physician Clinicians*

by Fred Bautista and Peggy Berry Martin, M.Ed.

Which health care employee disciplines are covered by CRICO, and how.

### 2 *CRICO Claims Involving Non-physician Employees*

by Heidi Groff, R.N.C., M.P.H., and Peggy Berry Martin, M.Ed.

A close-up look at the risks and remedies for nurses, physician assistants, and technicians.

### 9 *Physicians and Nurse Practitioners in Collaborative Practice*

by Francisco Trilla, M.D., and Angela Patterson, R.N.C.S.

Building an effective working relationship between an NP and the collaborating MD.

### 11 *Supervising Nurse Practitioners with Prescriptive Authority*

by Margaret A. Fitzgerald, M.S., R.N., C.S.F.N.P.

Establishing, documenting, and monitoring a collaborative relationship.

### 12 *The Expanding Scope of Practice for Physician Assistants*

by Wesley Brooks, P.A.C., and Ina Cushman, P.A.C.

A look at how PAs get started and what happens once they begin practicing.

### 13 *Delegation: Who is at Risk?*

by Gloria Legere Rawn, R.N., M.S., J.D.

Liability is determined by the type of care rendered and the type of supervision involved.

### 15 *The Risks of Patient Encounters by Telephone*

by Susan Sansby, M.S., R.N.C.

As telephone triage becomes a bigger part of patient care, the risks involved deserve attention.

### 16 *Closed Claim Abstract: Morphine Overdose*

by Heidi Groff, R.N.C., M.P.H., and Patricia Hanks, R.N.