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Expanded Scope of Privileges & Liabilities: Insuring and Defending the Physician Extender

I. Defining the Physician Extenders and Their Usual Roles

A. Certified Nurse Midwives

It is said that nurse midwives came into being in the United States in the 1920s in the Appalachian mountains using public health registered nurses educated in England. Today, nurse midwives received their formal education at colleges and universities and most hold Master's degrees from programs accredited by the American College of Nurse-Midwives (ACNM). Applicants for nurse-midwife programs usually must be registered nurses with a minimum of 1 to 2 years of nursing experience and after graduating from an accredited program take a National Certification Examination.

Nurse midwife practices are found both in urban and rural areas, meaning they can be found most anywhere, managing perinatal care and providing family planning and gynecological services to women of all ages. The scope of practice authorized by most states' regulatory boards most commonly includes taking a medical history and performing a physical examination, ordering laboratory tests and procedures, managing therapy, delivering babies, and in some states, writing prescriptions. The practice settings include private practices, hospitals, birthing centers, health departments and health maintenance organizations. https://medlineplus.gov/ency/article/0020000.htm

B. Nurse Practitioners

All nurse practitioners must complete a master's or doctoral degree program and have advanced clinical training beyond their initial professional registered nurse preparations. Nurse practitioners work autonomously and in collaboration with doctors, providing a full range of primary care services including ordering, performing and interpreting diagnostic tests such as lab work and x-rays, diagnosing and treating chronic and acute conditions such as diabetes, high blood pressure, infections and injuries, managing patient care, counseling and educating

patients on disease prevention and positive lifestyle choices. They are licensed in all 50 states plus the District of Columbia and practice in many varied settings including urgent care clinics, hospitals, emergency rooms, clinics, nursing homes, schools and public health departments. They are licensed by individual states' boards of nursing. https://www.aanp.org/all-about-nps/what-is-an-np#education-and-training

C. Certified Registered Nurse Anesthetists

Historically, CRNAs have worked under the supervision of anesthesiologists but are now being seen to do their work without supervision of an anesthesiologist so long as a doctor is on the premises.

Nurse anesthetists have been around providing anesthesia care to patients in the United States for more than 150 years. The CRNA credential was created in 1956. In rural America, CRNAs are the primary providers of anesthesia care, enabling healthcare facilities in underserved areas to offer obstetrical, surgical, pain management and trauma stabilization services. In some states, CRNAs are the sole providers of anesthesia in nearly 100 percent of rural hospitals. When anesthesia is administered aby a nurse anesthetist, it is recognized as the practice of nursing. CRNAs collaborate with surgeons, anesthesiologists, dentists, podiatrists and other health care professionals. Educational requirements for CRNAs include at least a baccalaureate degree in nursing, an unencumbered license as a registered professional nurse, a minimum of one year of full-time work experience or equivalency as a registered nurse in a critical care setting, graduation with a minimum of a master's degree from an accredited nurse anesthesia educational program and passing the National Certification Exam. www.aana.com/ceandeducation/becomeacrna/Pages/Nurse-Anesthetists-at-a-Glance.aspx

D. Physician Assistants

The first ever Physician Assistant program was founded in 1965 at Duke University. Most programs require applicants to have at least 2 years of college experience plus experience in health care such as work as an emergency medical technician, ambulance attendant, licensed practical nurse or associate-degree nurse. The physician assistant provides health care services under the d irection and supervision of a medical doctor or doctor of osteopathic medicine. Their functions include performing diagnostic, therapeutic, preventative and health maintenance services. In all 50 states plus D.C., physician assistants have prescriptive practice privileges and are licensed by states according to specific state laws. Certification is established through a national organization and nearly all states require national certification before licensure. https://medlineplus.gov/ency/article/001935.htm

II. Trends in Scope of Privileges and Autonomy in Practice

A. Expanded Privileges in Rural States

Because of a perceived shortage of physicians in rural states, advance practice nurses have seen their defined scope of privileges relaxed by individual states legislatures with resulting greater autonomy in decision making.

According to a 1999 bulletin from the American Association of Colleges and Nursing, advanced practice nurses give care of equal or better quality than comparable care by physicians but at a lower cost. www.aacn.nche.edu/media-relations/fact-sheets/apn-roles In 2014, the National Governors Association declared PAs constitute 10% of the U.S. primary care workforce but play a special role in federally designated rural health clinics, which are required to have a PA, a nurse practitioner or certified nurse midwife available during at least 50% of their operating hours.
https://www.nga.org/files/live/sites/NGA/files/pdf/2014/1409TheRoleOfPhysicianAssistants.pdf

B. Supporting versus Competing with Physicians

Anesthesia groups completely owned by CRNAs are now providing services in surgery centers without supervision from anesthesiologist physicians. Nurse practitioners are owning and staffing urgent care clinics with no doctors on site. While these advance practice professionals continue to support physicians in many instances, some are taking the step of creating independent practices.

In some states, CRNAs are the sole providers of anesthesia in nearly 100 percent of rural hospitals. Nurse practitioners own and operate acute care clinics with no doctor on site. As the scope of practice delegated by state law expands, physician extenders become increasingly independent financially and in practice from the physicians they once supported. It is becoming increasingly common for advance practice nurses to introduce themselves to patients as a doctor because they hold a doctorate.
http://www.nytimes.com/2011/10/02/health/policy/02docs.html As the result, legal challenges are being lodged to control the use of the term “doctor” through bills introduced in Congress and in state legislatures. Id.

C. Insurance: Group versus Individual Policy Coverage

Some insurers include advance practice nurses in policies issued to clinics supported by doctors but refuse to issue individual policies because of uncertainty in risk and pricing. Other insurers are seizing the opportunity to enter the market created by these newly independent professionals. In recent years, more advance practice nurses are obtaining their own individual professional liability policies, reflecting their autonomy in practice and potential exposure to professional liability claims. Where in many jurisdictions it was once the case that any nurse would be considered covered under the hospital’s or clinic’s professional liability policy and the

non-employed physicians on staff would have their own separate policy, in current times several medical malpractice policies require nurse practitioners to be scheduled so they are not covered unless named in their employer's policy . In many such cases, the advance practice nurses need their own policies and some traditional insurers have been slow to bring such policies to market. Other insurers have seen the market need for such insurance and offer policies insuring advance practice nurses for professional liabilities attendant to their patient care duties and responsibilities.

III. Defending and Distinguishing Standards of Care

A. Standard of Care: Physician or Advance Practice Nurse

It has been said that when a doctor interprets an image or lab result or assesses an acutely ill patient, that physician is practicing medicine and when an advance practice nurse does the exact same thing, that professional is practicing nursing. The courts have historically not allowed nurses to question or criticize the care provided by a doctor, differentiating between the standard of care owed by a nurse to a patient versus the duty owed by a doctor to that same patient. Because of the increased scope of practice afforded advance practice nurses, when advance practice nurses take on the actions traditionally performed by medical doctors, they can be accused of practicing under the standard of care owed by a physician to a patient as well as the standard of care owed by a nursing professional. Many practicing physician extenders are unaware that in the event of an adverse outcome resulting in litigation, the care provided may be criticized by a doctor not generally considered a peer.

B. Effectively Defending Against Criticism of Physician Experts

Defense of physician extenders requires a coordinated approach between defense counsel and the industry professional in formulating a thorough cross examination that explores issues of physician bias against physician extenders as peer reviewed and accepted standards of care. The age-old bias expressed by doctors against nurses performing duties traditionally performed by doctors also exists in jury pools so time must be taken to develop an understanding that the physician extender ordinarily and routinely performs these tasks in question and in so doing meets the standard of care owed by a nurse practitioner, PA, nurse midwife or CRNA to a patient, even when such actions are in essence the same actions a medical doctor or doctor of osteopathy might do in other places or even in the same community. Nursing literature supports favorable comparisons between outcomes of patients whose care was afforded by a physician extender as compared to that performed by a medical doctor in many instances.

C. Recent Trial Results Across the Country

In February of 2017, a New York appellate court reversed a summary judgment in favor of an outpatient nurse practitioner working independently in the care of psychiatric patients, holding criticism expressed by a psychiatrist and a fellow nurse practitioner criticizing the nurse practitioner's assessment of a suicidal patient who was not immediately institutionalized and

committed suicide two days later created an issue of fact for a jury to decide as to whether the nurse practitioner met the standard of care.

A 2016 Texas case discussed the challenge to a patient plaintiff's expert criticism against a CRNA's provision of anesthesia in an orthopedic case with resulting congestive heart failure and death. The challenge was that the expert, a cardiothoracic surgeon, did not demonstrate familiarity with the standard of care owed by a CRNA, but the objection was overruled. Defendant also objected to the designation's failures to establish causation and that objection was upheld but the appellate court sent the case back to the trial court to allow the plaintiff an opportunity to cure the deficiency.

In 2014, a New York jury found a nurse midwife liable to a patient whose 38 week fetus was stillborn based upon the testimony of an expert witness who testified the nonstress test revealed the fetal heart rate test was inadequate and the patient should have been referred for additional monitoring. The appeal of the defendant nurse midwife was denied.

Florida treats certified nurse midwives as participating physicians for purposes of limited financial exposure under the Florida Birth-Related Neurological Injury Compensation Plan when they both pay 50% of the physician assessment required by the plan and are supervised by a participating physician who has also paid the assessment required by the plan.