

Virtual Mentor

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CLINICAL CASE

Physicians and Advanced Practice Registered Nurses: The Supervisor-Employer Relationship

Commentary by Erin L. Bakanas, MD

Ms. Nolan was a nurse practitioner approved by the board of nursing in her home state as an advanced practice registered nurse (APRN). After 15 years' experience, she decided to team with another local nurse practitioner and establish an independent practitioner clinic. The law in the state where Ms. Nolan practices requires physician supervision of APRN-run clinics. A written collaborative agreement establishing the supervisory relationship must be registered with the state medical board and must contain a plan for addressing the technical requirements of supervision as set forth by the state, including the duration of the collaborative agreement; the roles, duties, and tasks the nurse practitioner can perform; and the medical treatments and prescriptions he or she can provide. APRNs may expand their scope of practice only as delegated and supervised by a physician. Supervision must be continuous but does not necessarily require the physical presence of the supervising physician every time service is rendered to a patient.

Ms. Nolan and her partner hired a physician, Dr. Roberts, who wished to decrease the level of stress in his life as part of his path to retirement a few years away. He was excited to have an administrative role that would still afford great responsibility but was much less demanding than employment as a partner in a bustling family practice. The collaborative agreement signed by the APRNs and Dr. Roberts outlined their new relationship and settled on a yearly salary for the latter's involvement with their practice.

About a month into the job, Dr. Roberts began to recognize differences in the way he and Ms. Nolan practiced. While confident in Ms. Nolan's abilities in matters of routine care, he was concerned about her base of clinical knowledge and diagnostic skills, noting that she often did not consider important possible diagnoses in certain cases. She would ask him to sign off on recommendations for treatment without offering him as much information as he would have liked. When Dr. Roberts voiced this concern, Ms. Nolan responded, "We apparently have differences in our approach to patient care." Dr. Roberts disagreed, and thought that Ms. Nolan was dangerously unaware of the limits to her medical knowledge. Otherwise happy in his job, Dr. Roberts worried that if he repeatedly questioned some of Ms. Nolan's recommendations, she would find another supervisor.

Soon after their first discussion of their practice differences, Ms. Nolan approached Dr. Roberts and requested his approval to expand her scope of practice to include the prescription of controlled substances. The idea seriously worried Dr. Roberts.

Commentary

Dr. Roberts has voluntarily assumed the position of an employee who is also serving as the supervisor of his employer. Such a relationship departs from the usual physician-as-employee dynamic. Physicians certainly have a history as employees, most typically in the context of institutions like HMOs, hospitals, or group affiliations which seek to organize and promote physician services in the clinical setting. What is unique to this case is the employer's dependence on her employee to function in her role. Without the supervising physician, the nurse practitioner is unable to practice. In this example, Dr. Roberts experiences a conflict of interest in his role as supervisor-employee who is receiving financial compensation from his supervisee.

If we look closely at the conflicting interests, Dr. Roberts' choices are clear. In the short description above, it is apparent that the "collaborative" aspect of their agreement is not being honored. "Collaborative practice" has been defined as "an inter-professional process for communication and decision making that enables the separate and shared knowledge and skills of care providers to synergistically influence the client/patient care provided" [1]. We are told that Dr. Roberts has confidence in Ms. Nolan's routine skills, but is unconvinced when the scope of her practice broadens to new clinical presentations requiring diagnosis and treatment. It is at this juncture that the knowledge- and skill-sharing of collaboration should occur. Yet such information is not willingly received by Ms. Nolan, and Dr. Roberts' supervision is challenged.

As a physician, Dr. Roberts has accepted a professional commitment to beneficence in patient care [2]. The patient's good is the focus of his professional activity. Any patient encounter, whether it be taking a history, doing a physical exam, or formulating and launching a treatment course must always be motivated by concern for the patient's well-being. This requirement logically extends to the actions of any party Dr. Roberts has agreed to supervise in his professional capacity. If he questions whether the patient's best interest is being served, he must respond immediately on the patient's behalf. He believes that Ms. Nolan is not providing him with the information he needs to supervise effectively; if true, this situation is dangerous. He also worries that the patients are not receiving the highest level of care. Dr. Roberts should pause and evaluate whether their practice arrangement remains tenable.

As a professional, Dr. Roberts has also committed to maintaining a license and practicing in a manner consistent with standard medical practice. He is required to keep up with the medical literature and best practices guidelines and give care in line with evidence-based medicine recommendations. He must be able to demonstrate that he has met these requirements or he is at risk for accusations of substandard

practice and formal legal action against him. Yet here again he is challenged; the practices he supervises may be leaving him vulnerable to malpractice liability.

The relationship between Ms. Nolan and Dr. Roberts comes to a critical point when she requests his approval on the expansion of the scope of her practice to include the prescribing of controlled substances. The authority to prescribe controlled substances is highly regulated by the Department of Justice via the Drug Enforcement Administration (DEA). The reasons for this heightened scrutiny of prescription activity are many. Controlled substances typically have addictive potential and require scrupulous clinical monitoring and adjustment. Misuse of these medications carries ominous risks, including poisoning or death from overdose. Many of these substances are diverted and become the currency of illegal drug transactions. Indeed, there is evidence that a major source of drugs for illegal trafficking is prescription medications [3]. Therefore professionals who prescribe these substances must be registered with the DEA, maintain meticulous records of these prescriptions, and provide adequate documentation of adherence to practice standards. Dr. Roberts' approval for the expansion of his supervisee's scope of practice to include the prescribing of controlled substances would imply that he is confident she will meet the stringent requirements put forth by the DEA. But he is conflicted about her ability to interpret and share information. It would be unwise to sign off on her request given the magnitude of his concern.

A final obligation that Dr. Roberts must fulfill comes from the profession's responsibility for self-regulation. This responsibility carries with it the expectation that a health care professional who believes another professional is impaired and putting the good of patients at risk will make his or her concern known. Dr. Roberts thinks that Ms. Nolan seems "dangerously unaware of the limits to her medical knowledge." Lack of knowledge itself is not the problem. Patient care is inherently uncertain because the focus of the activity is the individual person. Each patient encounter takes in the entirety of the individual, including not only medical diagnoses but also individual preferences, values and goals. It is no surprise that a health care professional feels uncertain about the best approach in a particular clinical situation. Professionalism requires, however, that this uncertainty be addressed by seeking information, whether by consulting the right resource or referring the case to someone with more expertise. If Ms. Nolan is truly unaware of her limitations, she is not meeting the requirements of her practice. Dr. Roberts cannot simply dismiss this as "differences in their approach to patient care," and must consider the next appropriate step in registering his concern.

The case poses the question of whether the physician-supervisor-employee role inevitably creates a conflict of interest, and it is true that a potential financial conflict of interest always exists in this setting. But it is the relationship between this particular MD and APRN that is the real source of conflict. Dr. Roberts must acknowledge that his financial status may be endangered if he asserts his authority, but his professional commitments demand that he not allow concerns for his financial security to compromise his obligations as a physician. The potential

financial conflict of interest in this instance is best managed by the two parties adhering to their professional commitments to patient care. If these two are unable to create a practice environment in which they can collaborate effectively, then they must admit the agreement has failed and dissolve their association.

References

1. Way D, Jones L, Busing N. Implementation strategies: collaboration in primary care—family doctors and nurse practitioners delivering shared care. College of Family Physicians of Canada. May 2000. <http://www.cfpc.ca/english/ocfp/communications/publications/default.asp?s=1>. Accessed December 12, 2009.
2. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. 6th ed. New York, NY: Oxford University Press; 2008. 197-239.
3. Catalano J. Pain management and substance abuse: a national dilemma. *Soc Work Public Health*. 2009;24(6):477-490.

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