

Virtual Mentor

American Medical Association Journal of Ethics
March 2009, Volume 11, Number 3: 247-252.

POLICY FORUM

Responsibility and Collaboration in Health Team Care

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During one unusually quiet night in the ICU, I delegated a blood draw to a patient-care assistant believing she would perform a venipuncture for routine lab work [1]. An hour or so later, I walked in the room and discovered she had unilaterally decided to stop an infusion and draw blood from the patient's central line, she was preparing to flush the line. The assistant was well aware that accessing the central line was outside the parameters of her delegated nursing duties. I had trusted her (as a professional and with my license) to adhere to those parameters.

I suspect this otherwise benign story sticks with me years later because of the assistant's arbitrary violation of trust and lack of respect for professional boundaries. What is reassuring and surprising, however, is that, after 10 years in practice, this is my only memory of a professional at any level having deliberately stepped over his or her respective scope of practice. Obtaining blood for labs is among the most routine of tasks in health care; yet, even the most routine acts are undertaken in a chain of supervision, delegation, and cooperation ranging from the attending physician to the laboratory technician.

A violation of trust may, at best, undermine otherwise effective practice patterns and, at worst, threaten a patient's life. Adherence to the few existing bright lines in the murky world of professional caregiver roles is essential to the foundation of collaborative patient care. The shared knowledge that those lines will not be crossed and mutual trust among professionals are what justify the gentle push on the margins that occurs when nonphysicians exercise judgment and autonomy at the highest permissible level. This can make all the difference for the patient. It is, for example, what allows an ICU nurse caring for an unstable patient to anticipate the physician's orders in those precious moments between the page and returned call. It enables surgeons to leave their post-op patients in the hands of others while they are in surgery. It underscores quality health care from a carefully choreographed code response to effective preventive care.

In the new model of comprehensive patient care, physicians alone cannot meet the full range of the patients' medical and health-promotion needs. Effective patient care, from the routine to the most sophisticated, depends heavily upon a delicate combination of individual responsibility and collective trust. It often relies upon an intricate system of professional supervision, delegation, and collaboration among caregivers from many disciplines and levels of education, training, licensure, and independence. The role and scope of practice is affected by a host of factors that include state licensure laws, federal and state regulations, institutional policies, and

contractual obligations. And the precise role of any group or individual can be further dependent upon place and circumstance. Hence, each professional is responsible for understanding his or her own and other professionals' scope of practice. For nearly a decade, organizations such as the Institute of Medicine, the American Medical Association, and the American Osteopathic Association have recognized the need for the effective and efficient use of interdisciplinary teams in the delivery of health care [2].

Physicians, more than any other group, must balance the benefits of collaboration with the responsibility for health care delivered by nonphysician health team members. Highly trained nonphysician caregivers—primarily physician assistants (PAs) and advanced practice registered nurses (APRNs)—are increasingly utilized to complement and supplement medical care. PAs and APRNs are distinct disciplines in training and practice but are sometimes collectively referred to as physician extenders, a term that reflects the financial realities and regulatory mandates that have created physician coverage shortages for which PAs and APRNs are often considered a partial solution [3]. Nonetheless, the term physician extenders misrepresents, oversimplifies, and diminishes the role of the PA and APRN in patient care and the relationship between the physician and the PA or APRN.

The balance of shared and individual responsibility and trust between physicians and PAs or APRNs is among the most complicated and beneficial relationships in health care delivery. New physicians undoubtedly need guidance to negotiate the roles and duties attendant upon working with these professionals. Even for those physicians who generally understand the work of PAs and APRNs, specific information regarding an individual's scope of practice is dependent upon multiple factors. Because of the differences in state regulation, training, and individual agreements among PAs or APRNs, institutions, and physicians, the scope of practice varies from individual to individual. Depending upon the circumstances, PAs and APRNs may be practicing independently or subsequent to physician delegation, and each of these has associated consequences for the PA or APRN and the physician. Therefore, collaborating professionals must assume responsibility for communicating and understanding their respective roles and for practicing within these parameters.

Physician Assistants

“Physician assistants seek and embrace a physician-delegated scope of practice. This is unique. No other health profession sees itself as entirely complementary to the care provided by physicians” [4]. PAs practice medicine subject to physician delegation and supervision. Their duties may include diagnosing and treating illness, performing or assisting with procedures and surgery, ordering and interpreting tests, and prescribing medication. Within the boundaries of the physician-PA relationship, PAs make autonomous medical decisions [4].

PA education is based on the medical model. The curriculum is generalist in nature with a focus on primary care, although many PAs subsequently specialize in practice [4]. PA programs are typically graduate programs of just over 2 years of full-time

study and are accredited by the Accreditation Review Commission on Education for the Physician Assistant [5]. At the completion of their studies, PAs take the Physician Assistant National Certifying Examination and must maintain their certification by completing mandatory continuing medical educational courses each year and passing a recertification exam every 6 years [6]. All PAs except those who work for the federal government and are credentialed under a separate process must obtain state licensure to practice. In all 50 states, eligibility for initial state licensure is dependent upon certification [7].

The PA's scope of practice is defined, in part, by state licensing laws and agency rules. Some states allow supervising physicians the discretion to determine appropriate delegation of medical care to the PA while some states literally list tasks and procedures that PAs may perform. There are also significant variations in the definition of supervision, the number of PAs a physician may supervise, and prescriptive authority granted to PAs [8].

Delegation or supervision agreements between the physician and the PA also impact the PA's scope of practice [9]. Institutions often require submission of the agreement to grant a PA privileges. Some state licensing boards require that PA-physician agreements be submitted for approval or rejection by the board [10]. Physicians who fail to adhere to supervision agreements with PAs risk professional discipline from the state medical board [11]. It is therefore imperative that supervising physicians and PAs adhere to the parameters set forth in these agreements and clearly communicate those limits to those with whom they work.

Advanced Practice Registered Nurses

APRNs are registered nurses with "advanced education, knowledge, skills and scopes of practice. Most APRNs possess a master's or doctoral degree in nursing" [12]. APRNs practice in one of four primary roles: (1) nurse practitioner, (2) clinical nurse specialist, (3) nurse midwife, or (4) certified registered nurse anesthetist [13].

The minimum level of graduate education for an APRN is a master's degree, and several groups have endorsed the doctoral level as the entry level for nurse practitioners. The education for APRNs is designed to prepare practitioners to deliver care in one of the four primary roles directed at one or more demographic groups or "population foci" such as families, children (pediatrics), newborns (neonatology), and the elderly (gerontology) [14]. These populations are often the basis for credentialing exams that are frequently a prerequisite for licensure as an APRN. Thus, a medical student could encounter any number of APRNs in a hospital with drastically different skill sets, practice areas, certifications, licensure, and scopes of practice. To complicate matters further, APRNs often have collaborative practice agreements with physicians as well as contracts with hospital systems that further define their scope of practice.

Unlike PAs, APRNs' practice is considered distinct from the practice of medicine. Nursing education emphasizes a holistic approach to patient care across a continuum

of health states from wellness to serious illness. The promotion of health is of primary importance. While APRNs often treat patients with illnesses in much the same way as a PA or physician, the approach to assessment and care is distinct from the medical model. In fact, nursing leaders envision APRNs as independent practitioners without regulatory requirements for physician supervision or collaboration [14]. In practice, the level of independence is dictated by state licensure laws that define if and when collaboration and supervision are needed.

The oldest and perhaps most straightforward of the APRN roles are the midwife and the certified registered nurse anesthetist. Certified registered nurse anesthetists are recognized in all 50 states and are responsible for 65 percent of the anesthesia given to patients. They have well-defined graduate education and certification programs. Nurse midwives are highly autonomous, specialized, and recognized in 48 states.

In academic medicine, hospital systems, and private practice, nurse practitioners and clinical nurse specialists are used increasingly in patient care and, unlike certified registered nurse anesthetists and midwives, practice in a number of settings and specialties. Although the roles of nurse practitioners and clinical nurse specialists are prone to significant overlap, nurse practitioners tend to spend more time providing direct patient care than their clinical nurse specialist counterparts [12].

In 2008, several national organizations including the National Council of State Boards of Nursing and the American Nurses Association endorsed and published a consensus model for the regulation of APRNs [14]. The consensus statement envisions a uniform system of education, credentialing, and state regulation, as well as independent practice for APRNs.

Each APRN is accountable to patients, the nursing profession, and the licensing board to comply with the requirements of the state nurse practice act and the quality of advanced nursing care rendered; for recognizing limits of knowledge and experience, planning for the management of situations beyond the APRN's expertise; and for consulting with or referring patients to other health care providers as appropriate [14].

Liability Concerns for Physicians Working with PAs and APRNs

PAs and APRNs provide documented benefits in the areas of patient satisfaction, quality of care and resource allocation. A significant area of concern for physicians, however, is the potential for exposure to professional and licensure liability. Physicians may be held liable for the actions of a PA or APRN who acts within the boundaries of a supervision agreement or collaborative practice agreement. The determination of liability depends upon the level of supervision and the laws of the state of practice [15].

Independent practice for APRNs would potentially protect physicians from malpractice liability or licensure actions by shifting sole responsibility for practice to the APRN. On the other hand, the PA profession advances the PA as the agent of the

supervising physician in every aspect of the PA's practice [9]. As PAs and APRNs are increasingly prevalent and autonomous in health care, some commentators have urged a change in liability standards that allocate responsibility to PAs, APRNs, and physicians for the care provided [16].

Physicians may also face discipline by their state board of medicine for failing to comply with agreements or even for aiding and abetting the unlicensed practice of medicine [17]. In reality, most of these concerns are manageable by adhering to the agreements entered with the PA and APRN. Physicians who seek to employ, supervise, or collaborate with PAs or APRNs must also verify licensure and certification with the respective state licensing board before allowing the PA or APRN to practice.

For medical students and residents who work with but do not supervise or collaborate with PAs and APRNs, there are far fewer concerns about liability. Physicians cannot presume to know the boundaries of any one health professional's practice because state regulations, practice requirements, and agreements among the PA or APRN, physicians, and institutions are subject to change. Each member of the team is responsible for adhering to his or her scope of practice and communicating with one another about the respective roles in patient care.

Notes and References

1. A patient-care assistant describes unlicensed nurse extenders who meet training and performance requirements beyond those of a nurse's assistant and allow the RNs to increase the patient load in the ICU. This particular assistant went on to complete medical school and is now a highly respected surgeon in a specialty area of practice.
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