

Laser Physician Legal Responsibility for Physician Extender Treatments

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Background and Objective: Increased demand for non-invasive cosmetic laser procedures has led to an increase in the use of physician extenders (PE). This demand has now led to a variety of medical legal concerns surrounding the use of lasers by non-physician PE.

Study Design: This review looks at the evolution of the relationship between physicians and the various types of PE. The focus of the manuscript is on the variety of legal issues that may arise because of this relationship. Physicians are increasingly utilizing PE in their laser facilities leading to potential legal issues.

Conclusions: An understanding of these legal issues will lead to better defensive practices by both the physician and PE. *Lasers Surg. Med.* 37:105–107, 2005.

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Key words: lasers; legal; physician extender

As the cosmetic laser trend continues to grow, physicians are increasingly using physician extenders (PE) to assist them with such procedures. The reason for the popularity of such PE use is obvious. They can significantly increase the use of various lasers and laser-like technology in an office setting. However, without appropriate supervision and training one can expect a higher incidence of complications for these non-physicians.

The American Society for Lasers in Medicine and Surgery, American Academy of Dermatology, and the American Society for Dermatologic Surgery have all developed guidelines for PE using lasers in the dermatologic and cosmetic laser setting [1–3].

Although there are subtle differences between the different recommendations, they all are consistent with those of the AMA and require that a PE, where allowed by state law to do laser treatments, have a supervising physician on site and immediately available while the laser procedure is being performed.

PE as a broad group, includes physician assistants (PA), registered nurses, nurse practitioners (NP), a variety of other categories of licensed nurses and estheticians. According to the American Academy of Physician Assistants, there were 46,002 PA in the United States in the beginning of 2003, a nearly 110% increase since 1993. In March 2000, there were an estimated 1,02,829 NP, according to the Nurse Practitioner Alternatives in Education, Inc. [4].

Currently, about 1/3rd of US dermatology practices employ PE. They are more commonly used with newer practices and those practices employing multiple physicians. In addition, approximately 13% of dermatologists hoped to hire a PA within 12 months after the survey; 6% wished to recruit a NP. There are currently about 1,350 PAs in dermatology practices [5].

Regulations as to who can/cannot perform laser procedures vary from state to state. In addition, various interested professional societies have promulgated a variety of guidelines. It should be noted that state laws always supercede professional society guidelines even when the latter are stricter than the actual state laws. What is clear, though, is that the enthusiasm for PE use has also brought added liability for the supervising physician.

PEs scope of practice varies from state to state. In many states, NP are allowed to practice independently, without a doctor. NP are involved with primary health care, assessing and diagnosing common illnesses and managing chronic, stable conditions. NP can order EKGs and X-rays in many states and perform cosmetic laser procedures. However, NP often do practice under the guidance of a licensed physician. In contrast, PA are licensed to practice medicine only under physician supervision and can practice only under a physician's license. PA can conduct physical exams, diagnose, and treat illnesses, order and interpret tests and write prescriptions in most states. In general, most other categories of PE do work with some "physician supervision." The degree of that supervision varies from almost non-existent to direct supervision.

Although vast literature exists regarding the use of PE, few studies have thoroughly examined the supervisory role of physicians using PEs [6]. The issues of concern are: (1) PE scope of practice; (2) the supply of PE; (3) the roles and degree of PE responsibility; (4) the roles of PE in providing care in rural and underserved areas; (5) the impact of the employment of PE on service use, cost and outcomes of care,

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Accepted 15 June 2005

Published online 29 August 2005 in Wiley InterScience (www.interscience.wiley.com).

DOI 10.1002/lsm.20215

or patient satisfaction; (6) task delegation and patient assignment to PE; and (7) comparisons of models of care or organizational structure in the practice setting, for example, variations on a collaborative practice model, network models, and team models.

The results from the few studies, which examine the use of PE or the mix of physicians and PE, suggest that the frequency of PE use will depend upon the practice arrangement, size, and location.

For example, a 1986 study of large group practices reported the ratio of physicians to PE in three health maintenance organizations varied from 1:1 to 17:1 [7].

More recently, a study by the American Medical Association (AMA) Center for Health Policy Research examined data from their 1994 Socioeconomic Monitoring System (SMS) survey on physician utilization of PE [7]. Physicians participating in the 1994 SMS survey were asked how many non-physician personnel (i.e., clinical and administrative office staff) were employed in their practice during 1993. Information was also collected on the utilization of other PE (i.e., PA and three types of advanced practical nurses (APN), nurse midwives, NP, and clinical nurse specialists).

The survey results indicated that 56% of group practice physicians reported employing PE. In contrast, rare solo physicians utilized PE. Physicians in both types of practices were more likely to employ PA than other classes of PE. Across specialties, surgical specialists were the most likely to work with PE, regardless of their type of practice. The findings also suggested that employing PE increased the size (total visits) of solo physicians' medical practice and physician productivity (i.e., office visits per hour, and patient visits per week and per year). The change in practice size was accompanied by an average increase in 18 hours spent providing patient care and a small decrease in the number of weeks worked per year.

Among surgical specialists in solo practice, physicians in general surgery employed the greatest number of PE (2.24 PE/solo general surgeon). "Other specialists" (i.e., physicians in dermatology, radiology, anesthesiology, pathology, psychiatry, aerospace medicine, neurology, occupational medicine and rehabilitation, general preventive medicine, public health, emergency medicine, and other or undefined specialties) have traditionally worked with the fewest number of PE.

It should be noted that current AMA policy includes comprehensive guidelines for the use of PE [7]. Policy 4-160.947, (AMA Policy Compendium), contains suggested guidelines for physician/PA practice. Guideline 6 of this policy states that the physician must be available for consultation with the PA at all times, either in person or through telecommunication systems or other means. Similarly, Policy H-160.950 endorses guidelines, which include the roles and responsibilities of NP and other APN, and the responsibilities of the physician in supervising and coordinating care in a collaborative practice. Guideline 8 in this policy states that at least one physician in an integrated practice must be immediately available at all times for supervision and consultation when needed by the

NP. Other guidelines in both policies provide the physician and PE with principles for the management and coordination of patient care. In addition, Policy 4-360.987 outlines the physicians' responsibilities and authorities for patient care and implementing quality control programs for PE delivering care in integrated practices. Policy 35.989 also states that the state medical licensing board should determine on an individual basis the number of PAs that a particular physician may supervise or a group of physicians may employ.

Although medical malpractice claims can and do arise because of PE related issues, other issues can also arise [8,9]. This review will evaluate PE issues outside the realm of medical malpractice. The difficulties associated with PE associated negligence will be addressed in a future review.

One of the more common situations arises when the PE does not identify him/herself as such. The argument comes down to the fact that the PE was acting like a physician, and the patient relied on his or her advice or treatment as if that individual was a physician. One of the easier ways to avoid potential litigation for such PE activities is to hire the PE as an independent contractor. This, in practicality, would only apply to NP who can practice on their own. Even then, the fact that the NP is working in the physician's office may form the basis for liability. From a legal standpoint, it is a little easier to defend a lawsuit if the NP is an independent contractor [10]. Anytime you have someone working as an employee, you can be held vicariously liable for their activities. An employee is defined as an individual receiving a salary, benefits, and performing within the scope of his/her duty. If the employee (PE) is negligent in this capacity, the physician will be vicariously liable for the employee's actions [11].

In any event, it is prudent for the physician to be fully aware of the clinical expertise of every PE delivering care in his or her office. In addition, there should be adequate notice to patients that a particular individual, or individuals, is an independent contractor who is not under the physician's supervision.

In theory the same principles about the legal benefits of using an independent contractor should apply to other PE as well. Thus, for example, the physician should be fully aware of the clinical expertise of the PA delivering care in his or her office. However, in practicality there is no legal advantage to hiring a PA as an independent contractor because the PA can only practice medicine under the supervision of a licensed physician. Consequently, care that a PA provides is, by its very nature, attributed to the physician who hired the PA. The same would apply to nearly all categories of PE.

The obvious question that arises is how can physicians safely guard themselves from legal liability when working with a PE? The obvious answer lies in getting to know the PE's clinical skills and expertise. Watch him or her interact with and evaluate patients. Review of charts is mandatory. Physicians often bring on problems for themselves when they sign off on everything a PE does without reviewing the chart, or without ever examining the patient. Sometimes employer physicians are in fact totally unaware of the PE's

clinical competence or expertise. The physician must ask the simple question "How much do I, the physician, trust that person's clinical expertise?"

The PE issue can be even more confusing in those states that allow the use of PE, there is the occasional requirement that the PE be "registered" to work under a specific physician's license. In that scenario, the PE may be able to work with one physician in a group practice, but not another physician in the same practice. An example of this is a Texas case, where a physician was named in a lawsuit even though the individual filing the suit was not his patient [12]. The PA was seeing someone else's patient, but the PA was only licensed to practice medicine under the defendant physician's medical license. Although the PA had already applied to work under the second doctor, the state had not finished processing the application. The case was ultimately settled, but the take home message is self-evident. Physicians using PE must know their state laws and ensure compliance.

Currently, state laws and regulations which define the legal relationships between physicians and PEs differ significantly between states [13]. Differences are partially determined by the specific PE, their scope of practice, and the practice setting. State regulations generally include the responsibilities of the supervising physician and the criteria, or definition for supervision. However, as described above, approximately one-half of the states now allow NPs to practice independently. State laws also place limits on the number of PAs that physicians may supervise. For example, state laws covering physician to PA supervisory ratios generally limit physicians to supervising not more than two PAs. Limits on the supervisory ratio between physicians and other PEs are generally higher, and vary from state to state. In addition, some states allow the formation of collaborative practice arrangements between physicians and certain PEs.

The specific definition of physician supervision also varies across states, but typically refers to overseeing, controlling, and directing the services provided by the PE. Supervision also includes accepting the responsibility and liability for the activities delegated to the PE. Supervision may be direct, in that the supervising physician is physically present when the PE is providing care. Constant physician presence is not required by many states. Some state PE laws allow for on-site and off-site supervision. On-site supervision often requires the supervising physician be in the same location as the PE. Off-site supervision specifies that the supervising physician be continuously and easily available for direct communication with the PE. The means of communication and distance limits are often included as conditions for off-site supervision [13].

In the ultimate analysis, it must be recognized that PE are available to help care for patients. However, PE can also be a source of legal liability. Clearly, adequate (as defined above) physician supervision is not only desirable, but is essential, if not mandatory.

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