

# **Physician Assistants and Nurse Practitioners in Emergency Medicine**

*An Information Paper*

*Created by Members of the ACEP  
Emergency Medicine Practice Committee*

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Emergency medicine (EM) continues to experience a significant workforce shortage in the face of increasing demand for emergency care. Physician assistants and nurse practitioners are increasingly being utilized to help satisfy the need for emergency medicine providers. In 2006, more than 12 percent of emergency department (ED) cases were cared for by nurse practitioners or physician assistants, and more than 77 percent of EDs surveyed claim to have used at least one physician assistant or nurse practitioner.<sup>1</sup> This information paper is designed to serve as a resource to emergency physicians and other hospital personnel, by outlining issues involving education, certification, scope of practice, physician collaboration, economics and liability.

### **Education and Certification**

Clinical nurse specialists (CNS) and certified nurse practitioners (CNP) are the two types of advanced practice registered nurses (APRN) who practice in emergency medicine. The educational preparation of APRNs in emergency care requires graduate education at the master's, post-master's, or doctoral levels. In addition to graduate course completion, APRNs wishing to specialize in emergency care must obtain educational preparation related to emergency care and may do so through various pathways including:

- 1) successful academic course completion specific to emergency care;
- 2) continuing education course completion; and/or
- 3) on-the-job instruction in emergency care.<sup>2</sup>

There are currently six academic programs offering emergency nurse practitioner specialization training. At this time, no certification program exists for APRN in emergency medicine; however, the Emergency Nurses Association (ENA) continues to explore the topic and methods for certification in emergency care.

Physician assistant (PA) education is modeled after physician education, typically lasts 27 months, and most often results in a Master's degree. All PA students must pass a national certifying exam to obtain a license. Most PAs will receive on-the-job instruction in medical care, although postgraduate training programs specific to emergency medicine are becoming increasingly available. In 2011 the National Commission on Certification of Physician Assistants unveiled an additional level of competency evaluation in emergency medicine, called the certificate of additional qualifications (CAQ) in emergency medicine. The PA candidate must possess a state license, successfully pass the national certifying exam, document 3000 hours of practice in emergency medicine, document 150 hours of continuing education specific to emergency medicine, complete ACLS, PALS, ATLS and an airway course, provide an emergency physician's attestation indicating the PA's procedural expertise, and finally, complete a mastery level examination in emergency medicine.

Significant variation exists among the APRN and PA educational programs and their graduates. Successful completion of training and certification as a PA or APRN does not guarantee competency in emergency care. The prudent medical director (or designee) should assure adequate orientation and training of newly-hired APRNs and PAs, in addition to ongoing supervision and education.

### **Scope of Practice**

The scope of practice for APRNs and their relationship to emergency physicians is continuously evolving and is ultimately based on state licensure, regulatory requirements, and institutional bylaws, rules and regulations. While some states allow practice independent of physicians, others require supervision and/or collaborative agreements. Individual institutions may specify more restrictive supervision/collaborative requirements, as may individual EDs.<sup>3</sup>

Physician assistants are dependent practitioners. The PA's scope of practice is developed in conjunction with the supervising physician. The PA may perform any task or treatment that the supervising physician delegates to the PA, unless it violates institutional or departmental bylaws, rules or regulations. PAs may not practice independently. The exact form of supervision required is dependent upon state regulations. As is true for the APRN, individual institutions may specify more restrictive supervision/collaborative requirements, as may individual EDs.

The American College of Emergency Physicians released two policies in 2007, referable to APRN/PA scope of practice. The first, *Providers of Unsupervised Emergency Department Care*, states that mid-level providers, such as nurse practitioners or physician assistants, should not provide unsupervised emergency department care.<sup>4</sup> The second, *Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department*, states that the PA's and NP's scope of practice and degree of supervision must be clearly delineated, and PAs and NPs must be aware of and participate in the performance improvement activities of the ED.<sup>5</sup> Thus, it may be prudent for ED medical directors to develop guidelines for PAs and APRNs, outlining the types of conditions PAs and APRNs may or may not routinely evaluate and treat either independently, with verbal consultation with a supervising physician, or in conjunction with a supervising physician physically attending to the patient as well.

When a physician plays more than a supervisory role, it is prudent to document the degree of physician involvement in the patient encounter. This would include, for example, the PA/APRN documenting that the case was discussed with a particular physician, or the PA/APRN and/or the physician documenting the physician's assessment and/or treatment of the patient.

The American College of Emergency Physicians and the Society of Emergency Medicine Physician Assistants (SEMPA) engaged the National Commission on Certification of Physician Assistants (NCCPA) to conduct a survey of PAs working in emergency medicine, collecting information on topics such as gender, age, experience, practice pattern/location, salary and benefits, among others.<sup>6</sup> No similar document for APRNs exists. According to the survey, 70% of PAs work in a main ED, approximately 20% exclusively in a fast-track and 10% exclusively in an urgent care setting. PAs are increasingly being utilized in and around the triage process as a component of rapid medical assessment systems, particularly during times of peak ED volume and occupancy.

### **Economic Considerations**

Data from the NCCPA survey of PAs mentioned in the prior paragraph revealed a mean annual compensation (exclusive of benefits) of \$102,018 for PAs practicing emergency medicine. APRN compensation is believed to be similar. PA and APRN compensation appears to be approximately half of the compensation received by emergency physicians. Approximately 2/3 of the PAs surveyed stated that they were compensated on an hourly, as opposed to salary, basis. Benefits are commonly similar to physician benefits. Since PA and APRN compensation and thus costs to "employ" are lower, are PAs and APRNs a better value than physicians? There is no data published to help answer this question. Emergency department medical directors and others may perform their own analyses, comparing productivity of PAs and APRNs vs. physicians. When comparing productivity, one must take into account that some of the ED physicians' duties may consist of providing oversight to PAs, APRNs, medical students, residents and possibly other learners that PAs and APRNs don't typically supervise. In addition, physicians must undertake certain tasks, such as EMS medical command, that PAs and APRNs often are not permitted to perform.

## Liability Issues

Physician assistants and advanced practice registered nurses are considered legally liable for actions or omissions concerning patients they treat, and must, in all states, carry adequate medical liability insurance. If a physician is personally involved in the care of a patient which led to a medical liability claim the physician most likely will be named in the suit, as well.

Physicians providing medical direction and/or supervision may also be held liable for the actions or omissions of PAs and/or APRNs, even if no patient/physician interaction occurred. Such liability exists in three separate manners: negligent selection, negligent supervision and *respondeat superior*.

The medical director and/or other party responsible for hiring a PA or APRN may be accused of negligent selection, claiming that the party responsible for hiring the PA or APRN knew, or should have known, prior issues in the PA's or APRN's past that may have predicted future performance insufficiencies. Diligent research and reference review, with adequate documentation of same, should help prevent and protect from such claims.

Negligent supervision may be alleged against the supervising physician of record, claiming that the supervising physician did not follow state, hospital or departmental supervision regulation/policies/guidelines, or if the plaintiff's expert believes the physician's supervision was otherwise below the standard of care. In order to decrease ambiguity, EDs utilizing APRNs and PAs should have guidelines specifying supervising physician responsibility, including factors that trigger when a PA or APRN should seek supervising physician consultation, and when a supervising physician should physically attend to a patient evaluated by a PA or APRN.

If not named for any of the aforementioned reasons, a supervising physician may be included in a medical liability action against a PA or APRN under the *respondeat superior* claim. *Respondeat superior*, Latin for "let the master answer," is the primary vehicle used to assert vicarious liability of the supervising physician for the alleged negligent acts of a PA or APRN. Under this principle, the supervising physician may not have been present or even aware of the patient encounter, but as the "master of the ship" may be considered liable. Should no claim of negligent selection or supervision be raised, often, supervising physicians named under the concept of *respondeat superior* will eventually be dismissed from the case.

Historically, there have been fewer medical liability cases brought against PAs and APRNs. In 2009, Hooker, Nicholson, et al undertook a 17-year review from the United States National Practitioner Data Bank from 1991 through 2007.<sup>7</sup> During the study period, compared to physicians, the probability of making a malpractice payment was 12 times less for PAs and 24 times less for NPs.

## Summary

Advanced practice registered nurses and physician assistants are increasingly being utilized to help strengthen the emergency medicine practitioner workforce to meet the ever-increasing demand. PAs and APRNs help provide a valuable service, but do not undergo the same degree and intensity of training as physicians, particularly those physicians residency trained in emergency medicine. In every state, PAs are physician-dependent practitioners. APRN regulations differ among states, but even where permitted to practice independently, institutional and/or ED policies, rules and/or regulations should specify some degree of physician supervision and/or collaboration. Emergency physicians should be available to provide appropriate guidance and collaboration. The ED medical director or designee should provide overall direction of PAs and APRNs, who must be involved in the performance improvement activities of the ED. While APRNs and PAs are named far less often than emergency physicians in medical liability

actions, emergency physicians may become involved in medical liability cases involving PAs and APRNs.

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