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Delegating Duties to Medical Assistants

Competent, properly trained and supervised medical assistants (MAs) can help make a medical practice an efficient organization with a high level of patient satisfaction and quality of care. However, failure to consider and define MAs' appropriate duties can lead to serious patient safety and professional liability problems.

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LEARNING OBJECTIVES

By reviewing medical professional liability claims and/or emerging topics in healthcare risk management, this enduring material series will support your ability to:

- Assess your practice for risk exposures.
- Apply risk management best practices that increase patient safety and reduce medical professional liability claims.

TARGET AUDIENCE

All physicians and healthcare professionals.

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INTRODUCTION

Competent, properly trained and supervised medical assistants (MAs) can help make a medical practice an efficient organization with a high level of patient satisfaction and quality of care. However, failure to consider and define MAs' appropriate duties can lead to serious patient safety and professional liability problems.

NORCAL Risk Management Specialists often find – through phone consultations and onsite risk reviews – that improper delegation of duties to MAs is common. Furthermore, NORCAL closed claims analysis indicates that improper delegation of duties to MAs is an underlying cause of many malpractice allegations against physicians and other clinicians. Additionally, allowing unlicensed MAs to perform duties that are only supposed to be performed by licensed personnel can lead to medical board disciplinary actions against supervising clinicians.

This article reviews the risks associated with delegating duties to MAs that are beyond their permissible scope of service. Our goal is to help medical practices integrate MAs into their organizations in a way that promotes effective, safe, and lawful patient care. We will look at how these risks arise in claims and in everyday practice, and we will provide strategies to mitigate those risks.

Claims Experience

Patients may bring claims against supervising physicians for not only an MA's negligence (vicarious liability) but also negligent hiring, training and supervision (direct liability). NORCAL Risk Management identified 268 claims closed between 2009 and 2016 that involved MAs. Diagnostic error was the most frequent chief medical factor in 43 (or 16%) of the claims. Diagnostic errors can often be traced to a physician's thought process, but certain administrative processes – including those that involve MAs – can also contribute to claims against physicians. NORCAL data shows that the most frequent associated issue in the diagnostic error claims was failure to follow up on tests or to order recommended tests (43% of diagnostic error claims). The next most frequent associated issues were problems with records (34%) and communication problems between healthcare providers (30%).*

(*Total is greater than 100% because each claim can have more than one associated issue.)

The claims in NORCAL's database stem from 185 different incidents (one incident may result in multiple claims). Allegations that specifically stated the nature of the MA's involvement (84 of the 185 incidents) fell into the following categories:

- 18 falls
- 13 negligent injections
- 12 medication errors
- 10 negligent performance of procedures (other than medication administration and injections)
- 10 breach of confidentiality/improper disclosure
- 8 clerical/administrative errors
- 7 scheduling errors (including failure to schedule)
- 5 mishandling of test results
- 1 infection control issue

Medical Assistants Are Here to Stay

The Department of Labor projects that by 2024 there will be approximately 730,200 MAs employed in the United States. Source: U.S. Department of Labor. Bureau of Labor Statistics. Available at: ***bls.gov/ooh/healthcare/medical-assistants.htm*** (accessed 2/20/2019)

For more information about vicarious liability, see the September 2015 *Claims Rx* article ***Vicarious Liability Risk Management***.

Keeping it Simple = Keeping it Safe

In order to provide safe and lawful patient care, physicians must be aware of what MAs can and cannot do, ensure the MAs they supervise are aware of what they can and cannot do and ensure these MAs are actually providing patient care within their defined scope of service. Determining the appropriate scope of service for MAs can be complicated. Some states regulate what MAs can and cannot do, which helps clarify the role they should play in a practice. Other states are not specific about MAs' scope; laws might set forth that MAs can perform "simple" tasks or "noninvasive" procedures after appropriate training and if a physician supervises. Such ambiguity is often at the root of practices unintentionally delegating to MAs beyond their scope.

Elder, *et al*, studied clinician-MA relationships in five small (i.e., fewer than five physicians) family practice settings.[1] The physicians in one office reported they did not let MAs answer patient questions without their permission; however, the MAs said they did answer patient questions independently. Physicians in two other practices felt they could trust their long-term MA employees to answer patient questions and provide education to patients. When the researchers interviewed the MAs and physicians, they found consensus that the MAs' main role was to facilitate patient flow by "checking in patients, preparing exam rooms, and directly assisting the clinicians." The interviews also revealed some contradictions: The physicians recognized that patients could perceive MAs as nurses, and that this could be a risk given that MAs don't have the same level of training. The MAs, however, thought of their work as "nurse-level," with some degree of autonomy. The researchers found that "MAs in every office expressed confidence in their clinical skills."[1]

In order to provide safe and lawful patient care, physicians must be aware of what MAs can and cannot do, ensure the MAs they supervise are aware of what they can and cannot do and ensure these MAs are actually providing patient care within their defined scope of service.

In considering how MAs work in your own practice, think about whether a particular responsibility involves doing something invasive or requires clinical analysis or decision-making. If the answer is "yes," you'll want to reconsider how that responsibility can be carried out more safely and with less liability exposure for you.

For example, an **MA generally can:**

- Prepare patients for examinations.
- Collect and record patient data, such as height, weight, temperature, pulse, respiration, blood pressure, chief presenting complaint and previous conditions.
- Transmit information, such as normal lab results, to patients as instructed by the physician.
- Call in unchanged renewal prescriptions after patient-specific authorization by the physician, physician assistant (PA) or certified registered nurse practitioner (CRNP) who is authorized to prescribe medications.
- Administer medications (e.g., flu shots or immunizations) by specific routes upon written orders.

(Most states require supervising clinicians to be on the premises when MA's perform patient care. Specific functions an MA can perform, as well as limitations related to those functions, may be regulated by state law.)

However, an **MA cannot:**

- Diagnose, treat or perform, absent patient-specific direction from a physician, any task that is invasive or requires assessment, interpretation or medical decision-making.
- Answer medical questions or provide medical advice without physician involvement, perform triage, or interpret test results or clinical data.

Keep in mind that these are the activities that often become permissible and impermissible extensions of what MAs can safely do, and they are the areas that tend to be involved in malpractice claims. From a risk management perspective, the key is providing care that is safe for the patient and that minimizes liability exposure to the physician. The case examples below show how extending an MA's role can have negative consequences for patients and physicians.

"Mission Creep" and Long-term Employees

In many practices that utilize the services of MAs, especially those with longstanding relationships between the physician and MAs, "mission creep" can occur. In other words, an MA progressively extends his or her boundaries of independence. In the following case, the MA had worked with the primary care physician for so many years, and had done so many injections, the physician did not feel the need to assess the MA's injection skills. The unchecked autonomy resulted in patient injury and a malpractice lawsuit.

CASE ONE

A 30-year-old male patient presented to his primary care physician's office complaining of a skin rash on his chest and pain when he urinated. The MA took the patient's vital signs (normal), examined the rash and checked other areas of the skin, and performed a urinalysis. The MA diagnosed acute cystitis and eczema. He then called the physician into the exam room to review his findings and confirm the diagnosis. The physician agreed, and wrote the patient prescriptions for triamcinolone cream; ciprofloxacin to treat the cystitis; and a methylprednisone tablet. She told the MA to give the patient a Kenalog (triamcinolone) shot, advised the patient to call or return to the office if his symptoms worsened, and left the room. The MA then administered the Kenalog injection (80 mg) intramuscularly into the right buttock.

Four months later, the patient noticed an indentation and depigmentation in the area near the injection site. He consulted with a plastic surgeon, who told him he would need several fat transfer procedures and liposuction to resolve the indentation.

The patient sued the physician, alleging negligent supervision of the MA who administered the steroid injection, resulting in necrosis and physical defect, and the need for cosmetic procedures.

DISCUSSION

The MA had been working in this practice for 10 years. The doctor felt comfortable having him work up patients prior to her own evaluation, especially those who presented with common conditions such as rashes and urinary tract infections. In addition, the MA had given injections of all types of medications over the years. He had learned to give injections in school and under the observation of his former employer. The physician in this case said the MA came to her practice with solid experience; therefore, she did not observe him every time he administered shots to patients. The expert reviewers in this case, however, felt the MA did not inject the Kenalog deeply enough into the muscular tissue, and might have only gone to the subcutaneous level, which caused the damage to the superficial tissue surrounding the injection site.

Experts also noted a lack of documentation about a skin allergy (as opposed to an irritation); such documentation would have helped explain the rationale for administering Kenalog. Others thought the dose was high, particularly in light of the other medications the physician had prescribed. The patient's chart also contained no documentation regarding the injection technique, location of the injection, and the size/gauge of the needle. The MA's chart notes included, "RBAs w/Kenalog discussed," but there was nothing about the risk of skin deterioration, so it was difficult to know whether this had been communicated to the patient and, further, if the patient understood this potential complication and agreed to proceed regardless.

RISK MANAGEMENT **RECOMMENDATIONS**

Performing injections intramuscularly is a typical task that MAs perform. This case is a good example of how an MA who gave injections also crossed the line into performing assessment, diagnosis, and a consent discussion. Consider the following recommendations to avoid this type of situation:

- Recognize the limitations and roles of MAs. Be familiar with applicable state laws and regulations to ensure your MAs are not exceeding their scope of practice and that you are supervising appropriately.
  - Develop job descriptions for MAs with precise explanations of their roles, responsibilities, and duties.
  - Train MAs for their specific responsibilities and job duties. Review these responsibilities and duties to ensure they do not exceed the legal scope of service.
  - Include the scope of service of MAs in orientation and training for new hires. Reiterate this with all existing staff, including medical providers.
- Confirm that MAs are competent to perform all procedures, including infection control, aseptic technique, appropriate use of equipment and route when administering injections they are permitted to perform.
  - Have a licensed individual verify the appropriateness of a medication and dose prior to an MA administering a medication to a patient.
  - Carefully assess whether an MA is competent to perform any procedure tasked to them (e.g., administering a deep intramuscular Kenalog injection).
  - Verify ongoing competence through chart review and regular meetings.
    - Keep a written record of the MA's continuing competence.
- Ensure the physician or other licensed clinician is responsible for the informed consent discussion with the patient, and for obtaining the patient's consent.
  - Consider providing a printed education sheet explaining the risks, benefits, complications and side effects of medications to the patient to facilitate education.
- Document a complete order in the chart, using a "what, by whom, how much, where, and why" formula.

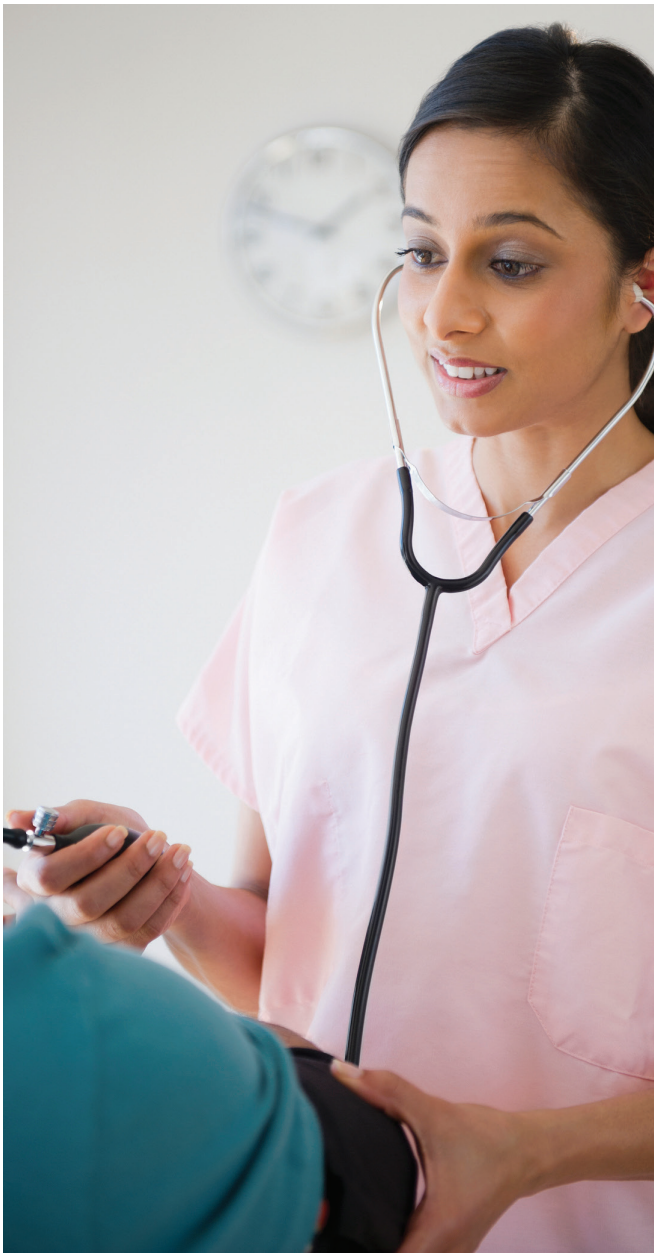
Assessing MA Performance

What initially may seem to be a task that can be accomplished by an MA may be too complex. Consider how the following case outcome may have been different if the supervising physician had assessed the MA's performance and determined whether she could safely perform the task.

CASE TWO

A 21-year-old male presented to a primary care clinic located in the town where his family was vacationing. His left eye was red and swollen, and he complained of a "scratchy" feeling in that eye. He had been playing volleyball at the beach the day before, and he thought a piece of sand might be stuck in his eye. The doctor performed a slit-lamp exam, which revealed a 2mm corneal abrasion. He prescribed polymyxin eye drops and instructed the patient to come back for a follow-up in one week. The clinic had an in-house dispensary, and the physician entered the order for the medication into the computer, which then generated a label. The MA printed the label, along with two other labels for different patients (one for neomycin ear drops, one for ciprofloxacin). The MA then pulled all three medications and affixed the labels to the packages. She gave the patient the box labeled polymyxin; however, the medication inside was neomycin.

The next day, the patient experienced severe burning in his left eye. He returned to the clinic, reporting he had started using the drops. The doctor realized the error, gave the patient erythromycin ophthalmic ointment, and instructed him to see an ophthalmologist for a complete eye exam when he returned to his hometown. (The patient who was supposed to receive the ear drops had not picked up her medication yet, so the eye drops were returned to the dispensary and her prescription was redone.) The clinic office manager left a phone message for the patient two days later to check on him, but the patient never returned the call. One month later, the patient's eye healed, but he had missed his first week of college classes and incurred fines for changing his airline ticket. The patient made a claim against the physician and the clinic, alleging negligent supervision of the MA, leading to the medication error that resulted in eye pain, infection, and other damages (subsequent medical bills, lost wages, and travel expenses).



What initially may seem to be a task that can be accomplished by an MA may be too complex.

DISCUSSION

Following this incident, the physician reviewed the system aspect of the error. He originally thought that after he issued the initial prescription, the process was primarily clerical. In retrospect, he realized he had tasked the MA with a function that required multiple steps, which increased the risk of error occurring. The clinic revised its process so the MA could only print one label at a time, and the prescribing physician (or licensed designee) had to reconcile the label with the package (and with the chart documentation).

RISK MANAGEMENT **RECOMMENDATIONS**

Consider the following recommendations:

- Be familiar with the federal and state laws that regulate the dispensing of medication from a physician's office.
- Confirm that the medication is dispensed in the proper container and properly packaged and labeled, that the dosage is correct, and that the expiration date has not passed.
- Do not delegate the function of prepackaging or dispensing to someone who is not authorized by law to package or dispense medication.
- Prior to dispensing, offer to provide a written prescription that the patient may elect to have filled by any pharmacy. Document the patient's choice in the medical record.

The Problem with Physician Signature Stamps

In the following case, the MA was accustomed to affixing her supervising physician's signature to orders and other documents when she considered the need for the physician's signature a clerical task. Unfortunately, she did not have the training to understand that doing so was outside of her scope of service. Consider how the outcome of the following case would have been different if systems were in place that would have alerted the physician or administration to the MA's improper practices.

CASE THREE

A 59-year-old female patient with a history of diabetes, COPD, sleep apnea, and hypertension presented to the emergency room (ER) with upper back, abdominal, and side pain. The ER record noted that the patient had an allergy to iodine, so she underwent a CT scan without contrast. The radiologist who read the CT felt the patient could have a renal cortical lesion. The patient's primary care physician was consulted, and the patient was discharged with a plan to have an MRI with and without contrast to determine if the lesion was solid or cystic. The imaging facility had received an unsigned order for the MRI with and without contrast (the order specified a gadolinium-based contrast agent), prompting them to contact the primary physician's office. The primary physician's MA filled out a new order form with the information the imaging center provided to her, stamped the form with the doctor's signature, and faxed it to the imaging center.

The radiologist administered the contrast agent and started to take the images; however, the patient began to have difficulty breathing. The radiologist administered oxygen and epinephrine, and called 911, but the patient could not be resuscitated.

The patient's son and daughter sued the imaging facility, the hospital, and the primary physician. The allegation against the physician was negligence for allowing the patient to receive contrast dye.

A receiving provider relies on the veracity of information provided (e.g., orders) to initiate safe and appropriate patient treatment.

DISCUSSION

The MA relied on the information the imaging center communicated to her, without attaching it to the patient's chart and having the physician review it and instruct as to next steps.

Expert reviewers were critical of the office process that allowed for the physician's stamped signature without the physician having reviewed and verified the accuracy of the information on the order. Had the physician reviewed the order – with the patient's chart that contained documentation of the patient's dye allergy – before signing it, he might have revised the order and communicated the change to the imaging center.

RISK MANAGEMENT **RECOMMENDATIONS**

A receiving provider relies on the veracity of information provided (e.g., orders) to initiate safe and appropriate patient treatment. Consider the following recommendations:

- Do not allow MAs to triage or make clinical patient decisions independent from supervising physicians.
- Prior to communicating information about a clinical intervention, ensure that the responsible physician or other licensed professional reviews the information.
- Implement a method to verify the content and accuracy of information provided. Ensure that signed orders reflect actual physician review.
- Prohibit the use of signature stamps by anyone other than the person whose signature is being stamped on a document.Prior to dispensing, offer to provide a written prescription that the patient may elect to have filled by any pharmacy. Document the patient's choice in the medical record.

Phone Inquiries Indicate Scope-of-Service Issues

Policyholders frequently call NORCAL Risk Management Specialists to ask about what office tasks they can delegate to their MAs or unlicensed technicians. In a study conducted on those inquiries between 2014 and 2016, about half were related to scope of service, focusing on specific procedures physicians wanted MAs to perform. Most of the care or procedures in question would generally be considered outside the scope of service for an MA.

The answers to these inquires depend, in part, on whether the respective states' laws address the role of MAs. State law generally allows delegation of services and tasks to MAs that are consistent with known standards of medical practice and not prohibited by the laws and regulations relating to physicians or to other practitioners. These regulations governing delegation generally also require that the "delegate" (i.e., the MA in this discussion) has the education, training, experience and continued competency to safely perform the service being delegated. The American Association of Medical Assistants provides links to MA scope of practice laws in various states on its website at: ***aama-ntl.org/employers/state-scope-of-practice-laws*** (accessed 8/16/2016).

Onsite Assessments Reveal Risks

During onsite risk assessments, NORCAL Risk Management Specialists often learn that practices are not using MAs appropriately. Here are examples of five issues we regularly encounter.

Issue – Identification

Onsite Assessment Findings

- Doctors and staff refer to MAs as nurses.
- MAs do not wear nametags.

Risk Exposure

Referring to MAs as nurses gives patients the false impression that MAs can provide advice and services beyond their scope of practice. It can also create an environment in which physicians task MAs with responsibilities that should be carried out by licensed individuals. When MAs do not wear nametags with a designation of "MA," this contributes to misunderstandings about roles and appropriate functions.

Recommendations

- Do not refer to MAs as nurses. They should be identified as medical assistants.
- Do not allow MAs to refer to themselves as nurses.
- Disclose the status of MAs to patients by ensuring they wear name tags reading "Medical Assistant." If applicable, comply with state laws that address name tag specifications.

Issue – Telephone Advice

Onsite Assessment Finding

- There are no written instructions describing how MAs should handle specific signs and symptoms patients report by phone.

Risk Exposure

Lack of written instructions presents a risk of MAs possibly practicing beyond their scope of service by performing telephone triage instead of telephone screening. Triage is a function that involves clinical analysis and decision-making, and is typically reserved for nurses or other licensed healthcare professionals.

Recommendations

- Do not allow MAs to provide independent telephone advice or triage, as activities involving interpretation of data or diagnosis of symptoms would fall outside of their scope of service.
- Consider the use of a Telephone Decision Grid (see pages 14 and 15) to provide guidance for MAs.

Issue – Prescription Refills Based on Protocols

Onsite Assessment Finding

- MAs renew certain medications for certain conditions according to a drug- and/or disease-specific, rather than patient-specific, protocol. For example, an MA will look in the patient's chart to see when the patient was last seen; if the refill request falls within the range described in the protocol, the MA may renew the prescription. If the patient has not been seen within the timeframe specified by the protocol, the MA will coordinate the patient's labs (e.g., lipid and liver) and schedule an appointment.

Risk Exposure

Although the MAs are following a process and checking the patient's chart in compliance with the protocol, this is not the same as acting on a patient-specific order documented in the chart by the physician. A patient-specific order demonstrates physician supervision, whereas a disease- or drug-specific protocol requires a degree of independent analysis and interpretation that is not appropriate for an MA to exercise.

Recommendation

- Write a standing, patient-specific order in the chart at the time the prescription is ordered. This way, the MAs can rely on the chart note, and there is documentation that they are acting on a patient-specific, written physician order.

Issue – Electronic Prescription Refill Process

Onsite Assessment Finding

- MAs select a tab within the electronic health record's (EHR) e-prescribing function labeled "Prescriber." From there, they select the prescribing physician's name from a drop-down list, enter the prescription details, and transmit it to the pharmacy. The finished prescription reads, "Done by [MA Name], signed by [Dr.]."

Risk Exposure

Even if an MA prepares prescription refill information, the physician still must review and approve the refill before it is sent to the pharmacy; otherwise, it can appear that the MA is issuing a refill independently, and thus practicing beyond his or her scope of practice.

Recommendations

- Ensure that the office procedure for prescription refills reflects proper physician or advanced practice professional supervision and does not allow MAs to exceed their scope of practice. MAs, under the direct supervision of a physician or advanced practice professional, where appropriate, should only call in routine refills that are exact, patient-specific, have no changes in the dosage levels and have been authorized by the physician.
- Consider creating a policy and procedure for prescription refills outlining the following:
  - Describe who in the office is licensed to renew prescriptions, create a drug order or transmit a refill to the pharmacy.
  - When transmitting a physician's approval of a refill, ensure that documentation consistently reflects physician review and approval of the refill.
  - Describe the refill policy for weekend and evening requests.

› Ensure physicians enter the record (i.e., under his or her log-in) and physically approve the refill before it is sent to the pharmacy.

Issue – Lab Result Follow-Up

Onsite Assessment Finding

› Long-time, unlicensed employees review test results the office receives by fax. They separate normal results from abnormal. They give abnormal results to a licensed person (physician, PA, or NP). They report that they know when a result is abnormal "based on experience."

Risk Exposure

This is another example of MAs acting outside of their scope of services by performing clinical analysis and exercising judgment.

Recommendation

› Do not delegate tasks to unlicensed personnel that require analysis, synthesis, and evaluation of clinical patient data (e.g., review of lab results).

During onsite risk assessments, NORCAL Risk Management Specialists often learn that practices are not using MAs appropriately.

CONCLUSION

The line between what an MA may and may not do is often subtle, and failure to consider, define and monitor MA scope of services can increase the risk of patient injury, professional liability lawsuits and medical board disciplinary actions. Knowing the laws and regulations that apply to MA scope of service in your state is the first step toward complying with the laws. Good communication and supervision based on thorough, workable policies and procedures can further diminish the liability and patient safety risks MAs can introduce into your healthcare setting. Applying the risk management strategies proposed in this publication can potentially minimize the incidence of bad outcomes and increase the probability of successfully defending them if they happen.

Special thanks to Jane Mock, Risk Management Specialist, for authoring this article.

ENDNOTES

The NORCAL documents referenced in this article, along with many other Risk Management Resource documents and past editions of the *Claims Rx*, are available in the Risk Solutions area of MyACCOUNT, or by policyholder request at 855.882.3412.

1. Elder NC, Jacobson CJ, Bolon SK, Fixler J, Pallerla H, Busick C, et al. Patterns of relating between physicians and medical assistants in small family medicine offices. *Ann Fam Med* 2014;150-157. Available at: ***annfammed.org/content/12/2/150.long*** (accessed 2/20/2019).

Telephone Decision Grid

Instructions: After the physician marks the appropriate boxes, consider laminating this grid to keep by the phones. Ensure that all care-related conversations with patients are documented in the medical record. Below is a sample Telephone Decision Grid with examples of some types of calls. It is not all-inclusive. Questions should be developed by the physicians for the employee to ask as related to the symptoms.

Type of Calls	Obtain immediate physician response	Refer to hospital ED/ Advise pt. to call 911	Inform patient physician will call back ASAP	Obtain immediate APP response	Take message for RN or APP to return call same day	Make same-day appointment	Take message, physician will return call when available
I. Patient Symptoms							
Patient/Caller stated emergency							
Fever over: _____							
Chest pain							
Heavy bleeding							
Severe pain							
Shortness of breath							
Reaction to medication (describe reaction)							
Disoriented, confused							
Numbness in arm or leg							
Inability to urinate							
Vomiting							
Diarrhea							
Sore throat							
Contractions (pregnant)							

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Type of Calls	Obtain immediate physician response	Refer to hospital ED/ Advise pt. to call 911	Inform patient physician will call back ASAP	Obtain immediate APP response	Take message for RN or APP to return call same day	Make same-day appointment	Take message, physician will return call when available
II. Patient Requests							
Information on medical condition							
Test results							
Medication change/Question							
Copy of medical records							
Explanation of bill							
Health/Life/Disability insurance form (FMLA) completion							
Angry patient							
III. Other							
Admission to ED/Hospital							
Hospital staff with lab or test results							
Hospital with notification of change in patient condition							
Laboratory with test results							
Consulting physicians							
Insurance company or attorney requests							
NOTE: Add additional items to the lists above as needed and appropriate.							

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This sample is a template only and is not intended to be used "as is." It is an example to assist the policyholder in the development of a document that is tailored to the individual practice. This sample is intended solely for the use of NORCAL policyholders as reference material only. It does not constitute legal advice, but is intended to supplement risk management advice. You may want to have this information reviewed by an attorney to determine if it is appropriate for use in your practice or institution.

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CME ACTIVITY

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Delegating Duties to Medical Assistants