Health professionals have a long-standing history of working together to deliver quality, sustainable health care for Canadians and to ensure the optimal use of resources. However as the demand for health care increases, new models are being explored. Increasingly, care is being provided by collaborative teams employing the skills of the most appropriate health care provider for the care required. This new model of health care delivery has the potential to provide better outcomes for patients and improve the efficiency of the system overall.

From a patient safety point of view, well functioning teams have great promise to deliver superior care. Poorly functioning, in particular poorly communicating teams, increase safety risks for patients.

However, for collaborative care to be effective and the goals realized, risks to patients must be mitigated and provider accountability and liability issues must be addressed.

This document identifies potential medico-legal risks and proposes solutions to mitigate those risks and addresses potential accountability and liability concerns which, if left unaddressed may hinder the achievement of collaborative care goals. Collaborative practices are likely to be more successful if the interests of patients, health professionals and those of the overall system are well protected.
What is collaborative care?

**DEFINITION**

Numerous definitions are currently used to describe practices in which health professionals work together to provide care. Collaborative care is the most common, but the terms multidisciplinary, inter-professional, shared or team care are often used interchangeably.

The Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative (EICP)

1 provides the following working definition:

“Interdisciplinary collaboration refers to the positive interaction of two or more health professionals, who bring their unique skills and knowledge, to assist patients/clients and families with their health decisions.”

**COLLABORATIVE CARE BENEFITS**

Collaborative care advocates have identified a number of potential benefits. While there is currently insufficient evidence available to support all of the assertions, many of these benefits may be achievable. Two of the most important goals for collaborative care include: optimizing Canadians’ access to the skills and competencies of a wide range of health professionals; and improving primary and even specialty health care by further encouraging and facilitating health promotion and the prevention of illness. The current and forecasted critical shortage of health professionals limits a patient’s access to timely care. Collaborative care is promoted as a solution to health human resource shortages, and as a way of increasing access to and improving the quality of care. While collaborative practices should lead to the best use of the health human resources available, they do not address the current and forecast future shortages of physicians, nurses, and other health professionals. The Canadian Medical Protective Association (CMPA) believes that collaborative care alone will not resolve the gaps between the requirement for and the availability of health professionals. However, by optimizing the use of existing resources, collaborative care can be an important element of a more comprehensive solution to improving patient access to care.

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1 The EICP is spearheaded by a steering committee of ten national health care associations (including the Canadian Medical Association and the College of Family Physicians of Canada) and a health care coalition. EICP is funded through the Primary Health Care Transition Fund of Health Canada. The definition is drawn from The Principles and Framework for Interdisciplinary Collaboration in Primary Health Care.
In 2003, the federal government established a five-year $16 billion Health Reform Fund. One goal of this Fund is to ensure that at least 50% of Canadians have “24/7 access to multidisciplinary teams by 2011.” While it is not clear to what extent collaborative practice has taken hold, the available evidence suggests that, at the current rate of adoption, this goal may be difficult to achieve.

Research commissioned by the EICP found that the composition of collaborative care teams depends upon the patient being served and the environment in which care is provided. Remote northern and Aboriginal communities have much experience and a long history with collaborative care teams. These teams often comprise a wide range of professionals and paraprofessionals, including local community health representatives, health and social service providers, family service workers, mental health workers and grief counsellors, as well as traditional healers, elders, band counsellors and clergy.

Canada is not the only country to pursue collaborative care teams as a means of enhancing the delivery of care to patients. Various levels of collaborative care practices are underway in the United Kingdom, United States, Europe and Australia. In examining initiatives in other jurisdictions, it is important to consider the challenges associated with transporting solutions from one system to another, likely very different, system. The Canadian government and other health care authorities should actively monitor experience in other jurisdictions but be cautious in adopting elements that may not align with the overall Canadian system.

The CMPA believes clear responsibilities and accountabilities
Whenever individuals are brought together in teams, questions inevitably arise concerning the coordination of care and team leadership. While everyone recognizes the importance of effective and efficient communication between all team members, some argue that a single professional ultimately needs to be responsible for all clinical decisions and actions; this team leader is likely to be the physician for an individual patient. Another viewpoint is that a “team leader” is not required and that, as a collection of professionals, each practicing within their own professional scope of practice, the team co-provides care and the team collectively shares responsibility for the outcomes. Yet another viewpoint is that the health professional permitted by their regulatory authority to independently provide care assumes responsibility and therefore accountability for those health decisions arrived at independently. The physician, for example, only becomes accountable if consulted. This discussion raises important issues pertaining to direction of care, the delegation and supervision of medical acts, accountability and liability and patients’ understanding of the team’s approach to care.

Teams unable to answer the following questions may carry significant clinical risk for patients and increased exposure to medico-legal risk for individual providers:

- Are the roles and responsibilities of each team member clearly defined, based on their scopes of practice and also the individual’s knowledge, skill, and ability?
- Does every team member know their role and the role of the other team members?
- How will health care decisions be made? Who is responsible and therefore accountable for health delivery decisions?
- Is there a quality assurance mechanism to monitor the team function and health outcomes?
- What are the anticipated health care outcomes the team is striving to achieve?
- Has the patient remained an integral if not a central member of the team?
- How will the team manage patient expectations and respond to patient concerns?
- Is there a sound policy and procedural framework in place to define and support the team function?
- Does the team have sufficient resources to achieve the desired health outcomes?
- Who will coordinate care, manage the team, and ensure efficient and effective communication among team members and across teams?

The CMPA believes clear responsibilities and accountabilities among professionals in a collaborative care team are essential to promote patient safety, reduce the risk of medico-legal issues, and provide a record for consideration should problems arise in the future. Agreement must exist among the members of the team regarding their relationship, roles, and responsibilities. A policy and procedural framework that defines and describes the collaborative team function is required.

among professionals in a collaborative care team are essential.
A solid understanding of accountabilities already exists among regulated professions and this provides a sound foundation upon which to build collaborative practices. The following steps will ensure that the policies and procedures defining and describing the team function establish a rigorous accountability regime:

- Provincial/territorial health professional regulatory authorities for each health profession should mandate that scopes of practice be updated in light of evolving collaborative care practices.
- Working together, regulatory bodies must ensure gaps between scopes of practice are minimized. Operating within the scopes of practices established by regulatory bodies, collaborative care teams must then formally establish their own accountability arrangements.

The CMPA does not see the need for a standard template that defines accountabilities within an interdisciplinary environment. The specific accountabilities assigned to health professionals already differ from one province and territory to another. Within scopes of practice and with the important proviso that accountabilities are documented and are clearly understood by all members of the team, it is likely these accountabilities will also differ from one group of professionals to another. The emphasis should be on what works best for the circumstances at hand. In some cases, this may result in physician-led teams where the doctor retains much of the decision-making responsibility for those health decisions delegated to another health professional and hence the physician shoulders the bulk of the accountability; in other cases, it may give rise to self-managed teams where each team member accepts accountability and therefore potential liability for decisions made independently of a physician. Generally, each team member remains accountable for the care he or she provides within the team model and may also be held accountable for his or her role in the team’s health care outcomes.

Achievement of the straightforward steps identified above would address many of the accountability issues that are purported to be obstacles to progress. These steps do not require a fundamental change to existing accountability frameworks or to the conceptual foundations upon which self-regulating professions operate. What they do require is a greater understanding of the roles and responsibilities for each team member as defined by their scope of practice and the impact on the need for delegation or supervision by a physician.

Clearly-established scopes of practice help mitigate accountability risks within collaborative practices of regulated health professionals. However, the situation becomes much more complicated with the introduction to the team of non-regulated professionals. Non-regulated professionals practicing within collaborative care teams raise important questions of risk for physicians, other regulated professionals, and their patients. The potential concerns associated with non-regulated providers should not however be allowed to hinder the development of collaborative care teams of regulated professionals.
Fear of increased medico-legal liability is often cited as a barrier to health professionals participating in collaborative care practices. To date, there appears to have been only limited action to overcome this perceived barrier. The CMPA believes the same medico-legal liability system that currently protects the interests of both patients and providers can also support collaborative practices.

First, it is imperative that all health professionals carry adequate liability protection. However, at the current time, such mandatory protection is neither a legislated requirement in a number of provinces/territories nor for a number of professions. A legislated environment in which all health professionals must have and maintain adequate professional liability protection as a condition of licensure would remove a major barrier. This has important implications for the current health care model and even greater implications for a model based on collaborative care teams.

Until this is the case, each member of the team should verify that other health care professionals in the team have and maintain adequate liability protection. For those with claims-made protection this would include the requirement for tail coverage (extended reporting clause) to provide protection for claims initiated sometimes many years after the medical care was provided. There are various mechanisms through which regulated health professions can obtain liability protection. As examples, physicians can obtain protection through CMPA membership or insurance coverage through a variety of commercial insurers; nurses can obtain coverage through the Canadian Nurses Protective Society (CNPS) or in British Columbia and Québec, through local providers. For hospital-based teams, the hospital insurers generally indemnify hospital employee team members.

Each member of the team, both individually and in collaboration with the other team members, should carefully consider what constitutes an adequate level of protection. Given that the collaborative care model may call for a number of professions to be taking on responsibilities that were previously performed solely by others (usually physicians), those professionals and their employers must adjust the levels of their protection to reflect the higher risk profiles they will be adopting. In many cases, these higher risk profiles will result in increased liability protection costs and funding authorities should take these costs into consideration. Failure to do so may discourage these professionals from entering into collaborative practice or, equally distressing, from doing so without adequate protection.

Physicians have long been exposed to the concept of joint and several liability (where more than one party is responsible for having caused injury to another but the plaintiff may recover full compensation from the provider most able to pay, even though that recovery is out of proportion to the degree of liability). Under a collaborative care model, the risks posed by joint and several liability will now be extended to other professionals and they should all make adequate provision for this risk.
Vicarious liability is a risk posed when health professionals are employees of an individual or other legally recognized entity (such as a corporation or a partnership). The employer (for example, a hospital or a physician or a group of physicians) may be liable for the negligence of employees. Depending on the composition and functioning of the collaborative team, vicarious liability may also be extended to other team members.

None of the above should impede collaborative care. A 2005 CMPA/CNPS Joint Statement on Liability Protection for Nurse Practitioners and Physicians in Collaborative Practice is an example of a positive approach to many of the concerns. The statement advises both physicians and nurses working collaboratively to have appropriate and adequate professional liability protection and/or insurance coverage, and to ensure the other members of the collaborative care team are also adequately protected. This statement is a solid model upon which to build; a copy of it is attached at the end of this paper.

An important, but often unstated element of supporting collaborative care lies in ensuring that the regulatory and judicial authorities charged with enforcing accountability frameworks and adjudicating liability are familiar with the evolving nature of health care delivery and the changing roles and responsibilities of health professionals. These authorities and the courts need to adapt to the changed circumstances in the same manner as the providers and patients. Lahey and Currie addressed this issue by advising that systemic changes in professional practice are “learned” by the courts on a slow, conservative, incremental, case-by-case basis.

Nevertheless, recognition of the circumstances and complexities of team-based care by the judiciary is an important ingredient for successful implementation.

The unsubstantiated view that liability issues are barriers to the implementation of collaborative care has caused some groups and individuals to postulate the need for wholesale changes to the medical liability system. Such an approach would be unwise, unfounded and would place the overall system at risk.
Other liability protection models

Two alternative models are often raised as possibilities for addressing liability issues within collaborative care.

ENTERPRISE LIABILITY MODEL

An enterprise liability model operates on the principle that there is no individual liability of team members but rather liability is assessed against the team as a whole.

The Health Council of Canada notes Canadian regulatory and insurance traditions focus on individual responsibility and that there is little experience with structures that hold teams accountable for health care decisions. This assertion may in fact underestimate the situation in that the law does not recognize teams as entities that can be sued. Current legal frameworks are based on the legal standing of individuals and of legally constituted entities such as corporations and partnerships; there is no legal recognition of an unincorporated “team”.

For team liability to be recognized, Canadian law would need to be changed; the CMPA believes this is not necessary. Such a process would be highly disruptive and time consuming. As long as all health professionals have clearly defined and clearly understood scopes of practice, and all members of the team who treat patients have their own adequate professional liability protection to cover both their individual contribution to patient care, as well as their contribution as a member of the team, then the current system effectively addresses medical liability within a collaborative care setting.

Advocates of the enterprise liability model do not fully recognize the potential impact of removing individual professional accountability. Individual professional accountability makes a solid contribution to patient safety and to public confidence in the profession. These profession-specific frameworks reflect the standard of care appropriate to the respective scopes of practice. It would appear contrary to suggest the elimination of individual liability without also eliminating individual accountability.

NO FAULT MODEL

Another alternative being proposed by some stakeholders is “no-fault” compensation. The 2006 Health Council of Canada report titled Renewal in Canada: Clearing the Road to Safety recommends that no-fault compensation for victims of adverse events be examined.

In a recent paper, the CMPA detailed the limitations of no-fault systems in terms of their affordability, their ability to compensate injured patients, and the link to necessary accountability frameworks. This paper also demonstrates that no-fault systems are inherently no more supportive of patient safety and the root cause analysis of adverse events than other liability systems. A no-fault model is not required to advance collaborative care as the mechanisms to support such practices are fully available within the current system.

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3 An adverse event refers to harm to the patient caused by health care delivery rather than the underlying illness.
5 The Lahey and Currie paper on the current regulatory and medico-legal barriers to collaborative practice agreed that a shift to a no-fault system would create complex and far reaching change, and represents a “blunt and disproportional manner” to deal with the issues related to collaborative care.

the interests of both patients and providers can also support collaborative practices.
ISSUES FOR POLICY MAKERS

Legislation should require all health professionals to have adequate professional liability protection in place as a condition of licensure.

Regulatory authorities for each health profession need to ensure existing scopes of practice are adapted to reflect the accountability of individual team members within the collaborative care approach.

The accountability and liability of regulated and non-regulated health care providers working within collaborative care teams pose challenges and require careful consideration.

Efforts to amend the current law to introduce the concept of team liability rather than individual liability should be discouraged as a “team” has no legal status, and any change to this would be highly disruptive and time-consuming.

The current medical liability system supports collaborative practices, and with easily achievable adjustments, it can be improved. There is no need to risk the viability of the Canadian health care system by introducing no fault or enterprise liability alternatives.

ISSUES FOR HEALTH PROFESSIONALS

Health professionals should clearly understand the scope of practice of those with whom they work.

Where scopes of practice within a team overlap, there should be well-documented delineation of responsibilities.

The overall responsibility for health care decisions should be clearly specified and understood by all.

Effective and efficient communications within the team, with the patient and across teams will take on added importance; this should be supported by clear documentation of care.

Each professional in the team has a responsibility to the other members to obtain adequate medical liability protection. For professions taking on expanded responsibilities, this will likely entail greater protection than is currently the case.

Each member of the team should also confirm the others have adequate liability protection.
Collaborative care has significant potential to greatly enhance the delivery of health care in Canada. By making the best use of all health professionals, collaborative care practices should be able to improve patient access to certain types of care and deliver that care in a more efficient manner. However, as with any major change, it should be approached with a prudent combination of enthusiasm and caution.

Although some have suggested medical liability concerns are a barrier to the implementation of collaborative care, the CMPA believes, while there are important issues that must be addressed, the principal elements of the solution already exist within the current medical liability system. Governments, courts, regulatory authorities and liability protection providers are well positioned to take the readily-achievable actions to resolve concerns about liability and professional accountability. They must now take action.

For their part, health professionals must also ensure that they have done all that they can do to mitigate risks and reduce concerns about accountability and liability. A key element must be to ensure that the roles and functions of each member of the team are clearly understood by all, including the patient, and supported by a robust policy and procedural framework. This will not only reduce liability risk, but will reduce the likelihood of adverse medical events caused by confusion or ambiguity. As team members, those providers also have a responsibility to each other to ensure that they have adequate medical liability protection. The determination of adequacy must be based on the circumstances involved.

The CMPA is committed to working with stakeholders to support the advancement of collaborative care. It is also committed to identifying and reducing risks in collaborative care and ensuring discussions of medical liability are supported by fact so that innovative health delivery models, such as collaborative practice, are not hindered by lack of knowledge or unfounded fears.
REFERENCES


CMPA/CNPS JOINT STATEMENT ON LIABILITY PROTECTION
FOR NURSE PRACTITIONERS’ AND PHYSICIANS IN COLLABORATIVE PRACTICE

March 2005

INTRODUCTION

New and evolving models for health care delivery have increased the opportunity for collaborative practice between physicians, nurse practitioners (NPs) and other health care providers. Collaborative practice inevitably reinforces the need for health care professionals to ensure they individually have adequate personal professional liability protection and that the other health care professionals with whom they work collaboratively are also adequately protected so that neither is held financially responsible for the acts or omissions of another. The Canadian Medical Protective Association (CMPA) and the Canadian Nurses Protective Society (CNPS) have developed this document to respond to questions from NPs and physicians working in collaborative practice.

LIABILITY RISKS

When a patient commences a legal action regarding health care treatment, it is likely that all health care professionals who were involved in the treatment, as well as the institution or facility where that treatment was rendered, will be named as defendants. A finding of negligence by the court may have a financial impact on the defendant(s) in three ways:

1. Direct Liability

   Each health care professional, both individually and as a member of the collaborative practice team, is accountable for his or her own professional practice. Therefore, if a physician or NP is found to have been negligent, a court may award damages to the plaintiff that are to be paid by the individual defendant. This form of liability is called direct liability. CMPA and CNPS professional liability protection is designed to assist physicians and NPs with this kind of damage award.

   A defendant employer or facility may also be found negligent and held directly liable for breaching duties it owed to the patient. These could include, for example, the duty to: select professional staff using reasonable care; review staff performance on a regular basis; have and enforce appropriate policies and procedures; provide reasonable supervision of staff; and provide adequate staffing, equipment and resources.

1. There is currently no legislated title common to all Canadian jurisdictions to identify registered nurses with a legislated extended scope of practice. For CNPS purposes, an NP is a nurse registered by a member association or college as “RN extended class (EC),” “RN extended practice (EP),” “Nurse Practitioner” or other legislated title.
2. Vicarious Liability

If an employee is found negligent, the court may order that damages be paid by the employer pursuant to the doctrine of vicarious liability. This legal doctrine provides that an employer, which may be an individual or an institution, can be held financially responsible for the negligence of its employees. An employment relationship must have existed at the time of the incident and the defendant employee must have been sued for work done within the scope of his or her employment. It will be up to the court to determine in each case if an employer/employee relationship existed and therefore whether vicarious liability would apply. Some of the factors the court would consider in determining if an employment relationship existed are the level of control the employer has over the employee’s activities, any agreements which describe the relationship and requirements to follow the employer’s policies or procedures.

3. Joint and Several Liability

When a court finds more than one defendant negligent, the court will assess the amount of damages (often expressed as a percentage of the total damage award) to be paid by each defendant. Defendants can be jointly and severally liable for the damages awarded. This means the plaintiff may recover full compensation from any one of the negligent defendants, even though that defendant may then be paying for more than their share of the damages. That defendant may then seek contribution from the other negligent defendant(s).

For this reason, it is essential for physicians and NPs working in collaborative practice to verify that all members of the collaborative practice team and the facility or institution have adequate professional liability protection in place at the beginning of the work relationship and on an ongoing basis.

LIABILITY PROTECTION

Because of these potential liability risks, all members of the collaborative health care team and the institution or facility must have appropriate and adequate professional liability protection to protect themselves and the patients they treat.

When a CMPA member is sued by a patient regarding medical treatment, that member is generally eligible for assistance from the CMPA. This protection is occurrence-based, which means the eligible professional’s protection extends from the date the incident occurred regardless of when the claim is made. For CMPA members, there is no financial limit. In some circumstances, clinics and other practice arrangements may be eligible for assistance.

CNPS provides professional liability protection to registered nurses who are members in good standing of the following professional associations or colleges: AARN, SRNA, CRNM, RNAO, NANB, CRNNS, ANPEI, ARNNL, RNANT/NU and YRNA. An NP who is a member in good standing of one of these associations or colleges at the time of an incident is eligible for personal, occurrence-based (see above definition) professional liability protection in the amount of $5 million per incident with an annual aggregate of $5 million.

2. Alberta Association of Registered Nurses (AARN), Saskatchewan Registered Nurses’ Association (SRNA), College of Registered Nurses of Manitoba (CRNM), Registered Nurses Association of Ontario (RNAO), Nurses Association of New Brunswick (NANB), College of Registered Nurses of Nova Scotia (CRNNS), Association of Nurses of Prince Edward Island (ANPEI), Association of Registered Nurses of Newfoundland and Labrador (ARNNL), Registered Nurses Association of the Northwest Territories and Nunavut (RNANT/NU) and Yukon Registered Nurses Association (YRNA).
The protection extends to the NP as an individual for defence of legal actions arising from the provision of professional nursing services. CNPS assistance is not available for claims against: an NP's employees for whom an employer is vicariously liable; a business entity such as an incorporated company or partnership; the directors, officers or shareholders of a corporation; general liability claims; or professional discipline defence costs.

To meet nurses additional liability protection needs, two group insurance plans have been developed. Nurses in all Canadian provinces and territories may purchase commercial insurance from CNPS Plus® (1-800-267-9364), a CNPS-sponsored group insurance plan. The Registered Nurses Association of Ontario also sponsors a group insurance plan available to RNAO members called Nurselnsure (1-888-711-8399).

RISK MANAGEMENT

Taking the following steps will help decrease your risks when working collaboratively:

• have appropriate and adequate professional liability protection and/or insurance coverage;
• confirm the continuing appropriate and adequate professional liability protection and/or insurance coverage of the other members of the collaborative health care team;
• physicians should contact the CMPA at 1-800-267-6522 to discuss issues related to collaborative practice or the extent of assistance for clinics and other practice arrangements;
• NPs should contact CNPS at 1-800-267-3390 to discuss issues related to collaborative practice or the extent of assistance;
• if you have or require commercial insurance, you should consult a business lawyer or insurance professional about how to identify your business insurance needs and protect your individual and business interests. Consider scheduling a periodic review of these issues;
• if commercial insurance is purchased, abide by the terms of the policy and report any potential or actual claim to the insurer while the policy is still in effect; and
• if you change insurers or do not renew a claims-made³ insurance policy, purchasing tail coverage⁴ is recommended.

If you have questions about information in this document, physicians should contact the CMPA directly and nurse practitioners should contact CNPS.

³ A “claims-made” policy requires reporting a potential or actual claim to the insurer before the policy’s expiry date. Only incidents that have occurred after the “retroactive date,” if there is one in the policy, and that are reported during the policy period are covered. If there is no retroactive date in the policy, incidents that occurred before the policy came into effect are covered if they are reported during the policy period and you were unaware of the claims at the time you purchased the policy.

⁴ “Tail coverage” may also be called an “extended reporting clause” or “discovery clause.” Tail coverage is only applicable to claims made policies and it extends the reporting period in which a claim can be made.