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RISK MANAGEMENT PERSPECTIVES
JULY 2022

Advanced Practice Professionals:

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RISK MANAGEMENT PERSPECTIVES

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

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- Apply risk management best practices that increase patient safety and reduce medical professional liability claims

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Advanced Practice Professionals:

Understanding Your Exposure to Liability

INTRODUCTION

Advanced practice professionals (APPs), such as advanced practice registered nurses (APRNs) and physician assistants/physician associates (PAs), can improve patient access to care, patient satisfaction, and quality of care.[1] An Excela Health survey found the majority of surveyed physicians believe that APPs can reduce physician burnout.[2] According to the U.S. Bureau of Labor Statistics, PA employment is expected to grow 31% and APRN (e.g., nurse practitioners, nurse midwifes, and nurse anesthetists) employment is expected to grow 45% from 2020 to 2030.[3,4] This is much faster than the 8% average for all occupations.[4]

With this growth rate, APPs may soon outnumber physicians, with some models predicting that two-thirds of licensed clinicians added between 2016 and 2030 will be APRNs and PAs.[5] Catalysts to this expected growth may include increased demand from the aging population of both patients and physicians, as well as clinical staffing shortages related to the COVID-19 pandemic.[3,4,5]

Scope of practice defines what healthcare services an APP can perform based on state laws and regulations. With the COVID-19 pandemic resulting in an increased demand for APPs, there has been a relaxation in rules surrounding the scope of practice in order to keep up with demand at both the state and federal level.[6,7,8] While time will tell what the future scope of practice will be, keep in mind that the existing relaxations may end when the emergency declaration expires.

The potential for liability exposure for physicians exists, even if they are not directly involved in the patient's care when APPs' actions or inactions cause harm.

This is particularly important since scope of practice and standard of care issues were common themes in the closed claim data analyzed for this article. This analysis included a review of closed APP claims over the past five years, which revealed that the most common and costly allegations over this period were diagnosis errors, followed by allegations related to the improper performance of procedures. Errors related to the diagnosis of breast and lung cancer were most common in these claims, and physician offices were the most common settings.

The potential for liability exposure for physicians exists, even if they are not directly involved in the patient's care when APPs' actions or inactions cause harm. This can be in the form of direct or vicarious liability. Physicians can be directly liable when they hire incompetent APPs or when they fail to properly train or supervise APPs.[9,10] Physicians can also be vicariously liable for the acts or omissions of an APP based upon their relationship, for example when the physician is the APP's employer.[9,10] In a single case there may be allegations of both direct and vicarious liability. Notably, the closed claim data analyzed revealed that liability allegations involving APPs were often directed at both the supervising/collaborating physician and the APP.

The cases in this publication primarily focus on nurse practitioners (NPs) and PAs, but the principles of liability and the risk management recommendations apply to all types of APPs. Prior to exploring these principles, it is important to understand PA and NP training, education, and regulations that govern their practice as outlined in the table below.[11,12,13,14,15,16] This understanding can better equip those serving in a collaborative or supervisory role to utilize these clinicians to their maximum potential without exceeding the scope of practice or breaching the standard of care.

Training, Education, and Regulations Governing Practice

	PHYSICIAN ASSISTANTS	NURSE PRACTITIONERS
EDUCATION	• Individuals earn a master's degree at a minimum and may complete a postgraduate residency or fellowship program. • Education is modeled on the medical school curriculum that involves both didactic and clinical education training. • PAs complete 2,000 hours of clinical rotations in medical and surgical disciplines, including family medicine, internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine, and psychiatry. • Students are trained as medical generalists for all patients, regardless of age or gender.	• Individuals must be registered nurses (RNs), hold a bachelor of science in nursing (BSN), and complete an NP-focused master's or doctoral nursing program. • Students are trained in the advanced practice of nursing, where they gain the advanced clinical knowledge and skills to diagnose, manage, and prescribe medications and other treatments for patients. • NPs complete 1,000 hours of supervised clinical practice. • Students are trained in a chosen health population focus area: family, adult/gerontology, neonatal, pediatrics, women's health, or psychiatric/mental health.
LAWS & REGULATIONS	• Regulated by state medical boards in most states: https://www.aapa.org/advocacy-central/state-advocacy/state-laws-and-regulations/[17]	• Regulated by state nursing boards in most states: https://www.aanp.org/practice/practice-information-by-state[18]
PRACTICE	• Work under a physician's supervision, pursuing Optimal Team Practice[19]	• May practice independently in some states, pursuing Full Practice Authority[20]
CERTIFICATION MAINTENANCE	• One certifying body: National Commission on Certification of Physician Assistants (NCCPA) • Take a recertification exam every 10 years • Earn 100 CME credits every two years, including at least 50 Category 1 CME credits	• Five certifying bodies from which to choose • Recertify every five years or less, depending on their population focus and credentialing entity • May take recertification exam or recertify by completing 1,000 clinical practice hours and 100 contact hours of advanced continuing education within five-year certification period

SCOPE OF PRACTICE

Nurse Practitioners and Physician Assistants

NP scope of practice varies by state and is determined by the state's Board of Nursing. One aspect of NP scope of practice is the practice authority, also known as practice environment, which determines the extent to which NPs can practice.[21] The three different levels of practice authority are as follows:[21,22]

- **Full Practice:** NPs are able to practice to the fullest extent without supervision, which includes the ability to evaluate patients; diagnose, order, and interpret diagnostic tests; and initiate and manage treatments, including prescribing medications and controlled substances.
- **Reduced Practice:** The ability of NPs to engage in at least one element of full practice is reduced; collaborative agreements are generally required.
- **Restricted Practice:** The ability of NPs to engage in at least one element of full practice is reduced; physician supervision is generally required.

The Tri-Council for Nursing and the National Council of State Boards of Nursing (NCSBN) created a Scope of Practice Decision-Making Framework[23] to assist nurses and their employers in determining whether specific activities are permitted under the nurse's level of education, licensure, and competence while meeting the standards established by the Nurse Practice Act and rules/regulations of each state or jurisdiction.

PA scope of practice also varies by state. PAs and physicians either have a supervisory or collaborative arrangement, but in most states it is supervisory.[24] Requirements related to supervision and collaboration are outlined by the state, and scope of practice is determined with the supervising physician at the practice site.[24] Since each PA's training and experience may be different, and PAs work across multiple specialties, the scope of practice may vary depending on the physician's judgment. The requirement to have written protocols or delegation of authority agreements also varies by state, with some states not technically requiring either. Regulation of PA practice is determined most commonly by state medical boards, but several states have independent PA boards.[24] The following case highlights the importance of understanding state laws while acting in a supervisory or collaborative role.

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Delayed Diagnosis

Since diagnosis errors were the most common and costly allegations found in the closed claim analysis, this publication will focus on cases in which diagnosis errors were at the center of the claim. Diagnostic error has been defined as: "the failure to (a) establish an accurate and timely explanation of the patient's health problem(s) or (b) communicate that explanation to the patient."[25] Keep this definition in mind as the details of the case studies unfold.

CASE ONE

Allegation: Lack of supervision contributed to the delayed diagnosis of cauda equina syndrome.

A PA approached a friend and former supervising physician and asked him to supervise a new urgent care clinic in which there would be a total of three PAs. Two of the PAs had previously worked in the emergency department (ED) for many years, and the third PA previously worked in a family medicine practice. The plan was for the supervising physician to be on site at least once a week to review charts, be available for questions, and address any concerns found during chart review to ensure the quality of care was to his standard. When the physician was not physically on site, he would be immediately available by phone most of the time. In exchange, the physician would receive a percentage of the revenue generated each month.

After the urgent care clinic was up and running, a 65-year-old male presented on a Wednesday complaining of low back pain. He was seen and evaluated by the PA who previously worked in family practice. The patient explained that he had a history of back pain over the years, but that usually when he rested, iced, and took anti-inflammatories, he felt better after a few days. Occasionally he was prescribed steroids by his primary care physician (PCP) when he wasn't improving, but his PCP was out of town, so he came to the urgent care clinic. When asked about symptoms, he explained that his pain was eight out of 10, came on pretty suddenly the day prior, was located in the low back, radiated down into his groin, and was associated with numbness and tingling.

On exam, the patient was noted to have an antalgic gait, decreased range of motion, and pain in the spinal and hip joints. He was also noted to have decreased sensation in the bilateral lower extremities in the L5/S1 dermatomes. The review of systems (ROS) was documented as positive for difficulty with urination. Documentation further reflected a history of an enlarged prostate and an episode of near urinary incontinence earlier that morning. The PA ordered a complete blood count (CBC), urinalysis (UA), and x-rays of the lumbar spine and pelvis. His CBC showed mildly elevated white blood cells (WBCs), but his UA was normal. The x-rays showed arthritis in both his spine and hips.

The diagnosis documented was low back pain and bilateral hip osteoarthritis. He was prescribed methylprednisolone and advised to follow up with his PCP when he was back in town to discuss an orthopedics referral for his hips. He was also told that it may be time for a new low back MRI to make sure there weren't any significant changes, but that in the meantime the steroids should provide some relief. And finally, he was advised to go to the ED if his pain worsened or he developed a fever.

Two days later, the supervising physician was reviewing the PA's charts and came across this case. He was a bit concerned about some of the red flags he noticed, especially the associated urinary symptoms, and reviewed this with the PA. He also asked the PA to contact the patient to see how he was doing. The patient reported that his pain was maybe a little bit better, but he thought he had caught a stomach virus because he had diarrhea and fecal incontinence. The patient was told to go to the ED immediately.

At the ED, a rectal exam revealed decreased rectal tone and a STAT MRI revealed a large disc herniation at L4/5, with significant compression of the adjacent cauda equina nerve roots. A STAT neurosurgical consultation was requested, and a surgical decompression was completed. The patient sued the APP and the supervising physician. He claimed lack of supervision led to the delayed diagnosis of cauda equina syndrome, resulting in mental and physical pain and suffering, and permanent disability related to bowel and bladder dysfunction. Additionally, the patient's wife filed a loss of consortium claim.

When asked if he knew how many PAs he was allowed to directly supervise according to the practice state's statute, he responded that he had not read the statute but trusted the PAs' knowledge and judgment of the rules.

DISCUSSION

In this case each of the APPs were PAs. It became clear during the deposition process that the supervising physician was not aware of the legal requirements for supervising PAs. When asked if he knew how many PAs he was allowed to directly supervise according to the practice state's statute, he responded that he had not read the statute but trusted the PAs' knowledge and judgment of the rules. When asked if he knew the laws in his state for chart review and countersignature, he again explained he trusted the PAs' knowledge of the statutes governing their practice. He was unaware that the rules for chart review and countersignature were not the same for each of the PAs he was supervising. In this state, chart review and countersignature requirements varied based upon the PA's experience. For the PA who had previously worked in family medicine, he was required to countersign 100% of the patient records for the first 12 months because the PA was practicing in a new specialty. The other two PAs, however, had worked with this supervising physician in the past in this specialty, so the current process of reviewing a set number of charts weekly was likely sufficient. The physician's limited understanding of the law supported the plaintiff's allegation that the lack of supervision caused the delayed diagnosis.

RISK REDUCTION STRATEGIES

If the care rendered by an APP violates a statute or regulation (e.g., a statute outlining PA supervision requirements), the plaintiff might be able to establish negligence per se—negligence would be presumed due to a clear violation of statute. This allegation can severely compromise the ability to defend care that otherwise met standards. For that reason, it is important to understand the scope of practice and comply with all laws and regulations for NPs and PAs.

Scope of Practice

Consider the following strategies:

- Ensure supervising physicians and APPs know and follow the state laws and regulations associated with scope of practice:
  - PAs: State Overview of PA Scope of Practice[24]
  - NPs: State Overview of NP Scope of Practice[26]
- Ensure APP tasks are consistent with the supervising physician's own competence and expertise. Orthopedic surgeons, for example, should not be collaborating with or supervising APPs who provide prenatal care.

Collaboration, Supervision, and Standardized Procedures/Protocols

Consider the following strategies:

- Understand that laws vary by state and may differ depending on whether you are supervising a PA or NP.
- Follow state laws and regulations pertaining to how many APPs a physician may collaborate with or supervise.
- Cultivate a collaborative climate where the APPs you supervise feel empowered to consult with you.
- Explain to APPs how you wish to be contacted regarding questions about patient care and procedures.
- Identify triggers for consultation (e.g., unusual conditions, abnormal study findings, failed responses to treatment, red flags, etc.).
- Develop and follow collaborative agreements and standardized procedures/protocols with the APPs you supervise. These should be in writing, dated, and signed by both the supervising physician and the APP. Consider doing so even if it is not required by state law.
- Periodically (every two to three years) review standardized procedures or protocols and update them whenever scope of practice or duties change, and when there is a change in APP or supervising physician personnel.
- While standardized procedures/protocols should adhere to laws and regulations set by the states in which the APP practices, also consider including:
  - The functions the APP may perform and under what circumstances
  - Any specific requirements the APP is to follow in performing these functions
  - Experience, training, and/or education requirements, if any, specific to the functions to be performed
  - The scope of supervision required for the performance of these functions (e.g., immediate supervision by a physician)
  - Limitations on settings, if any, in which the functions may be performed
  - A list or formulary of the drugs or classes of drugs, including controlled substances, the APP may furnish or prescribe
  - The method for initial and continuing evaluation of the APP's competence, including the documentation of such in the personnel file
  - Any special circumstances under which the APP is to immediately communicate with the physician concerning the patient's condition

Lack of Effective Communication

Effective communication among healthcare teams and patients is vital to help ensure safe healthcare delivery. When communication breakdowns occur between clinicians and/or patients the risk of medical error and liability increase. In the following case, ineffective communication resulted in the initial misdiagnosis of cancer, and a medication error ensued. A medication error has been defined as "any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient, or consumer."[27] Notably, 16% of the closed claims analyzed for this article were complicated by a medication error. Patients can often help clinicians communicate with and care for them if they take an active role as a partner in the clinician-patient relationship. Engaged patients are more likely to have better outcomes and greater satisfaction with their healthcare experience.[28,29,30]

CASE TWO

Allegation: Failure to communicate resulted in the misdiagnosis of cancer.

A 65-year-old male with a history of colon cancer presented to the ED with abdominal pain. He explained colon cancer was discovered in a polyp a little over a year ago, but that after the polyp was removed no other treatment was necessary. In the ED, a CT of the abdomen and pelvis was performed. This revealed acute sigmoid diverticulitis, but there were also a few liver lesions incidentally noted. He was sent home with antibiotics and encouraged to follow up with his oncologist to further evaluate the liver lesions.

A few weeks later he followed up with his oncologist, and a PET scan and CT-guided liver biopsy were ordered. The oncologist explained his concern that the colon cancer may have metastasized, and, if so, his prognosis was likely poor. He counseled the patient on chemotherapy, and the patient wished to proceed. The physician planned to be out of town when the patient returned for his next visit, so he placed the chemotherapy order in the electronic health record (EHR) in anticipation of his APP seeing the patient in his absence.

In addition to placing the order, the physician texted his APP a list of the medical record numbers of the patients she would see while he was away, with instructions related to executing pending care plans. For this patient, the APP was advised to delay chemotherapy unless the biopsy results were positive; however, the APP did not have time to review the detailed text from the physician, so she did not realize there were specific instructions. When the patient returned to the oncology office, the APP saw the order for the chemotherapy. She confirmed the patient's understanding of the cancer diagnosis and administered the medication as per the physician's orders.

The physician returned from vacation and reviewed the results of the PET and liver biopsy, which were negative for cancer. He reviewed the notes from the last visit and discovered that the chemotherapy had been administered. When the patient came in for his next visit he apologized for the mistake and gave the patient the good news; all his test results indicated no cancer.

The patient filed a claim against the APP and the physician for negligence resulting in physical and emotional pain and suffering related to the misdiagnosis and treatment.

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DISCUSSION

Experts were critical of the care provided by the APP. They were also critical of the communication methods relied upon by the supervising physician to relay important instructions. Although the communication was poor, it did not excuse the APP's actions. The plaintiff alleged that she should have had the ability and knowledge to review the patient's chart and understand the importance of awaiting the pending diagnostic results prior to initiating chemotherapy, even in the absence of reading the text. Complicating matters further, the APP blamed the physician for placing an order he did not want executed and argued that the documentation in the EHR and the patient's understanding of the plan supported her action to initiate chemotherapy.

During testimony, the patient explained he was almost certain he had metastatic cancer based upon his recollection of the conversation with the physician. In fact, the patient was so convinced he had metastatic cancer and a poor prognosis that his emotional damages were a large impetus for proceeding with the lawsuit. Ultimately, poor communication, poor documentation, and the general confusion regarding the patient's diagnosis and treatment made this case difficult to defend.

RISK REDUCTION STRATEGIES

Since effective communication among clinicians and patients affects so many aspects of care, it is not surprising that communication breakdowns are at the heart of many medical professional liability claims. This case demonstrates how poor communication can initiate a stream of events leading to a misdiagnosis of cancer with associated emotional injuries, as well as a medication error with associated physical injuries related to chemotherapeutic side effects.

A medication error can occur during any of the stages of the medication delivery process, including prescribing, transcribing, and communicating orders, as well as dispensing, administering, monitoring, and/or using medications. In this case multiple factors led to the error. The order was prematurely placed, necessary information related to the order was poorly communicated, and order instructions were not documented in the same location as the order itself in the EHR. While EHRs have created efficiencies and ease of use for prescribers, it is important to recognize their limitation in preventing prescribing errors when other aspects of the medication delivery process break down.

Communication

Effective communication can reduce medication errors.[30] Consider the following strategies:

CLINICIAN-PATIENT

- Actively engage patients to help ensure an understanding of diagnosis and treatment plans.
- Ask patients open-ended questions and show empathy towards their concerns.
- Consider utilizing the "Ask-Tell-Ask"[31] communication method, which can facilitate patient engagement by making it more likely that:
  - The patient's perspective is understood.
  - The needed information is delivered.
  - There is an opportunity to respond to the patient's emotions.
  - The recommendations by the clinician are truly related and understood.
- Ensure interpreter services are available for patients with limited English proficiency.

PHYSICIAN-APP

- Establish sound methods for communicating with each other.
  - Develop a plan for situations where the physician or APP is not on site.
  - Develop a strategy for planned and unplanned absences resulting in patient handoffs.
- Whenever you have any doubt about a patient management situation, speak with one another directly prior to executing a care plan.
- Ensure vital information related to orders is documented in an area where the executing clinician would expect to find it.
- Actively consider whether a fellow clinician would understand the patient's history, differential diagnosis, and treatment plan when documenting.

Medication Error Prevention

Medication errors are often the result of poorly designed healthcare processes and system issues, rather than individual choices or performance.[32] Consider the following strategies:[30,33]

- Make sure you have a system in place to report errors with an understanding that these are educational opportunities, not punitive.
- Review any medication errors and near misses within your organization.
- Identify and implement system changes to prevent future errors.

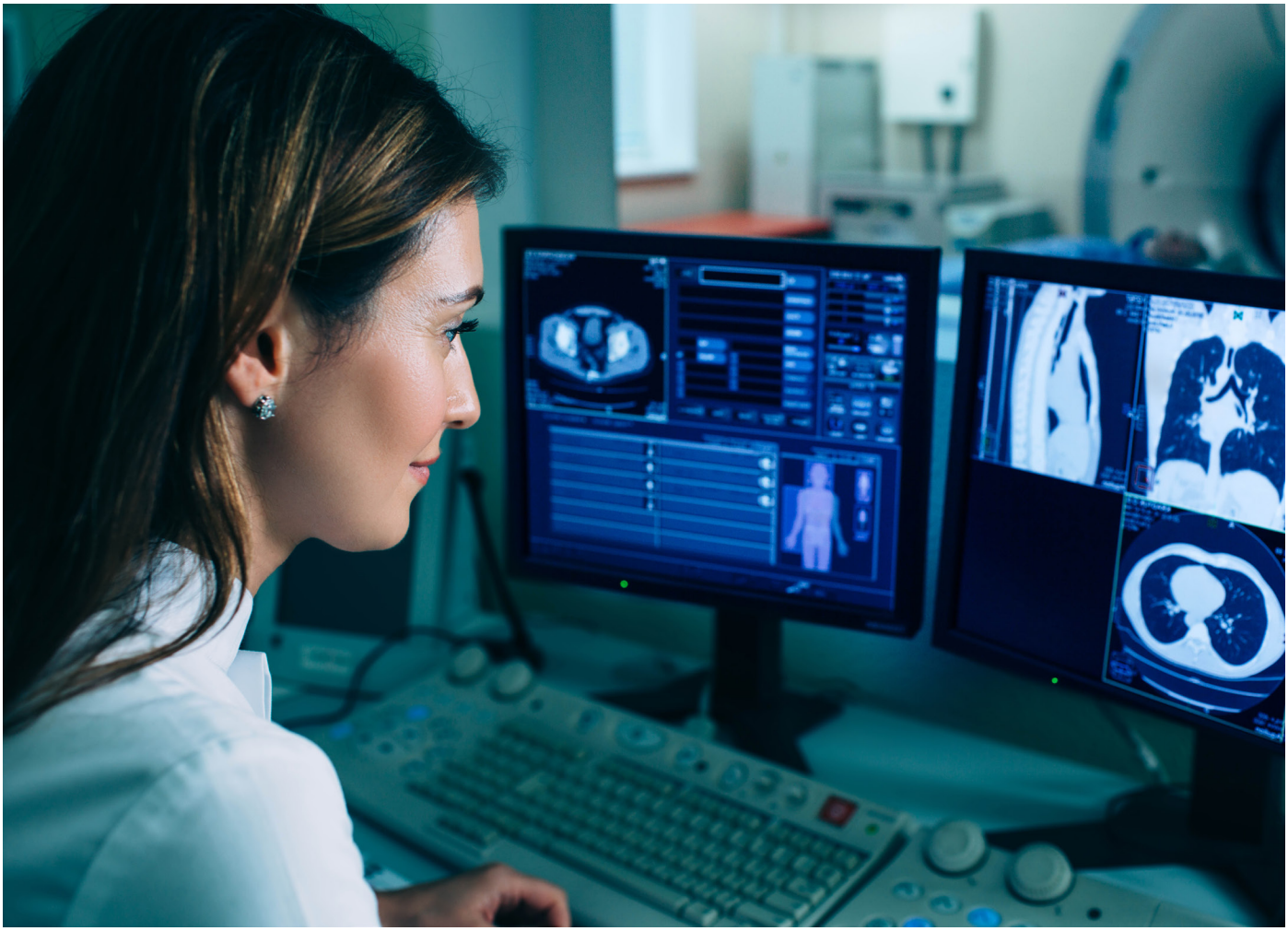
ADDITIONAL RESOURCES

American Academy of Family Physicians: Simple Strategies to Avoid Medication Errors[33]
Simple, low-cost strategies for safe prescribing drawn from research conducted by the Institute for Safe Medication Practices (ISMP)

Institute for Healthcare Improvement: What is "Ask-Tell-Ask"?[34]
Video explaining how the "Ask-Tell-Ask" technique can help clinicians optimize patient receptiveness while delivering medical advice

American Medical Association (AMA): Ask-Tell-Ask Sample Dialogue[35]
Sample "Ask-Tell-Ask" dialogue to help clinicians communicate

Medical Group Management Association (MGMA): Six Steps to Improve Physician/Staff Communication[36]
Steps to simplify and improve clinician communication with patients



Failure to Follow Up

Even when supervising physicians have no direct involvement in a patient's care, they can be found negligent for injuries caused by the action or inaction of the APPs they supervise.

CASE THREE

Allegation: Failure to follow up delayed cancer diagnosis.

A 55-year-old female with a history of hypothyroidism, diabetes, and a 30-pack-year smoking history presented to her PCP for a well visit. The PCP practice consisted of a physician and an APP. During the well visit, the patient was seen by the APP, who ordered a low-dose computed tomography (LDCT) to screen for lung cancer. The LDCT was completed, and the radiologist noted the findings as benign-appearing nodules with a recommendation for continued annual screening with repeat LDCT in 12 months. The radiologist also noted an incidental finding of a soft-tissue mass in the right breast with a recommendation to correlate with mammography and/or ultrasound. These results were faxed to the PCP's office.

Over the next year, the patient was seen every two months by the APP for follow-up and continued treatment of thyroid disease and diabetes. During this time, the LDCT results were not reviewed with the patient.

One year following the LDCT, the patient reported an area of pain and swelling near her right breast. The APP examined it. Suspecting an abscess, she ordered antibiotics. Due to increased pain and swelling, the patient eventually presented to the ED, where she was diagnosed with a large right breast mass. Further testing revealed invasive breast cancer with metastasis, which was inoperable and terminal.

The patient and her husband sued the APP, the supervising physician, the radiologist, and the breast center for negligence, alleging delayed diagnosis and treatment of breast cancer.

DISCUSSION

Experts were critical of the care provided by the APP and supervising physician, citing multiple opportunities to follow up on the results of the ordered LDCT and communicate the results to the patient, including when the patient later complained of pain and swelling in the right breast. Experts also questioned whether the documentation could be an accurate description of the patient's clinical picture based on her subsequent cancer diagnosis weeks later.

The APP and her supervising physician were questioned regarding the policies and procedures in place related to abnormal result management. They explained that office protocol required the medical assistant (MA) to task abnormal results to the physician in the EHR for further review, but in this case that did not occur. It was speculated during testimony that since the results of the test were noted as negative for lung cancer, the incidental finding must have been overlooked. While this practice had a protocol in place to alert the supervising physician of test result abnormalities, the protocol was not initiated because the MA failed to recognize the importance of the radiologist's noted findings. Arguably, it was beyond the MA's scope of service to determine the significance of an incidental finding noted by a radiologist.

While this practice had a protocol in place to alert the supervising physician of test result abnormalities, the protocol was not initiated because the MA failed to recognize the importance of the radiologist's noted findings. Arguably, it was beyond the MA's scope of service to determine the significance of an incidental finding noted by a radiologist.

During deposition, the supervising physician was also asked about his process for chart review and countersignature. It became clear that he was unaware of the state laws, as he was not meeting the minimum requirement. The lack of monitoring supported the plaintiffs' negligence allegations against the physician and tied him directly to the patient's unfortunate outcome.

RISK REDUCTION STRATEGIES

Follow-up protocols and systems are only as reliable as those who are utilizing them. Staff education and training is vital to ensuring your staff understands how these protocols minimize errors. Chart review and countersignature are also important aspects of minimizing errors. A physician who reviews APP record entries on a regular basis will be able to monitor the APP and determine if he or she is providing treatment within parameters of the written protocols, making accurate diagnoses, consulting appropriately, and ordering appropriate medications and tests. This process serves to document accountability and is a requirement in many states.

Follow-Up

Consider the following strategies:[37]

- Ensure there is an established, reliable follow-up process for managing tests and consults for your practice. Analyze existing systems to detect and eliminate gaps.
- Do not assign medical assistants follow-up tasks that are outside of their scope of service as further outlined in Medical Assistants: Strategies for Increasing Patient Safety and Reducing Liability Risk.[38]
- Consider the following method to support effective test result management:
  - All results are routed to the ordering clinician.
  - The ordering clinician signs off on all results.
  - The practice informs patients of all results, normal and abnormal, at least in general terms.
  - The practice documents that the patient has been informed.
  - Clinicians or staff tell patients to call after a certain time interval if they have not been notified of their results.
- Analyze EHR follow-up mechanisms for possible weaknesses.
  - Remember that simply automating poor processes will not fix inherent process problems.
  - Ensure medical staff can efficiently utilize the technology through training and protocol.
- Educate patients about the importance of continuing evaluation until a definitive diagnosis for their symptoms is reached. Document this action.
- Document your review of the results by initialing or signing and dating reports or by otherwise noting your review in the patient's medical record. Document what action is required and what has been implemented.

Chart Review and Countersignature

Consider the following strategies:

- Understand that laws vary by state and may differ depending on whether you are supervising a PA or NP.
- Follow any state requirements for record review and countersignature. In the absence of state requirements, consider including in standardized procedures the following provisions for minimal chart review:
  - Ten percent (10%) review of charts of primary care patients
  - One hundred percent (100%) review of charts of secondary and tertiary care patients
  - One hundred percent (100%) of patients with conditions identified as most likely to require physician input
  - One hundred percent (100%) review of charts where narcotics and/or high-alert medications have been ordered, if applicable
- If there is a problem in the APP's care identified during the review of notes, this should be discussed with the APP and utilized as a teaching opportunity to help ensure patient safety and quality of care.
- Create an environment in which APPs feel free and comfortable seeking the input of physicians to proactively review a chart or case.

ADDITIONAL RESOURCES

AMA Advocacy Resource Center: Physician Assistant Scope of Practice State Law Chart[24]
State-by-state requirements for PA chart review and countersignature

AMA Advocacy Resource Center: Nurse Practitioner Practice Authority State Law Chart[25]
State-by-state requirements for NP chart review and countersignature

NORCAL Group: Fundamentals of Follow-Up Webinar[39]
CME activity available to NORCAL Group insureds via MyACCOUNT or the MyNORCAL CME mobile app to aid in developing follow-up protocols to minimize diagnostic error and improve patient safety

ProAssurance: Back to Basics Loss Prevention Seminar, Module Two[40]
CME activity available to ProAssurance insureds to aid in developing follow-up protocols to minimize diagnostic error and improve patient safety

Incomplete Exam Resulted in Failure to Diagnose

Adequate supervision involves consultation and proper review of an APP's work. A physician who properly monitors an APP can better determine if he or she is following written protocols, making accurate diagnoses, consulting appropriately, and ordering appropriate medications and tests.

CASE FOUR

Allegation: Failure to diagnose acute appendicitis caused significant patient harm.

A 35-year-old female presented to the ED with diffuse abdominal pain with associated nausea and vomiting. She also complained of nasal congestion, fever, and body aches. She was evaluated by an APP and her exam revealed the patient to be tachycardic and febrile but otherwise normal; however, no abdominal exam was completed. No laboratory studies were ordered. The APP diagnosed the patient with influenza and prescribed medications to help with the nausea and congestion. She was advised to return if her symptoms worsened. The APP's supervising physician agreed with the diagnosis and plan, and he signed off on the encounter, attesting to also seeing and evaluating the patient.

The following day, the patient returned to the ED with increased abdominal pain and fever. At this visit, an abdominal exam revealed diffuse tenderness, and labs revealed leukocytosis and lactic acidosis. A CT of the abdomen and pelvis suggested a ruptured appendix. The patient was admitted to the hospital for an emergent appendectomy. During the procedure, she was noted to have a peritoneal abscess, which was drained. The patient's hospitalization was

complicated by septic shock, and multi-organ and respiratory failure. She ultimately required mechanical ventilation and additional abdominal surgery. Eventually she recovered and was discharged home after being in the hospital for over a month.

The patient sued the APP, her attending physician, and the hospital for damages associated with the failure to diagnose appendicitis at the first ED visit. She claimed this resulted in mental and physical pain and suffering, lost wages, and permanent disability.

DISCUSSION

During the APP's deposition, she could not recall if she completed an abdominal exam. She explained she did not order any labs because she thought the patient had the flu. The supervising physician claimed that when he signed off on the note, he had not noticed the APP omitted the abdominal examination.

Experts were critical of the care provided by the APP and the supervising physician at the first ED visit. They believed it was below the standard of care to not complete an abdominal exam on a patient who presents with a complaint of abdominal pain. They speculated that the patient's appendix was already ruptured at the time of the initial ED visit due to her elevated temperature and heart rate. Experts agreed that sending her home directly resulted in the patient's outcome because it wasted critical time, complicated the hospital course, and possibly caused permanent lung damage.

In this case, it was determined that all the elements necessary for a plaintiff to prevail in a malpractice case existed: 1) the APP had a duty to properly care for the patient, 2) there was a breach in the standard of care, 3) this breach caused the patient injury, and 4) damages resulted.[41] Even though the physician in this case was not personally involved in the patient's care, he was directly responsible for supervising the APP, which experts agreed he did not do appropriately. The hospital was vicariously liable since it employed both the physician and the APP.

RISK REDUCTION STRATEGIES

In most professional liability cases, the best liability protection is prevention of the patient injury. While not all injuries can be prevented, supervising physicians can help reduce liability and increase patient safety by taking steps to ensure APPs are competent and providing quality care.

Supervising/Collaborating Physicians

Consider the following strategies:

- If you are hiring an APP:
  - Verify the following information from the primary sources (e.g., schools attended and licensing boards): education, licensure, certifications, DEA number (if applicable).
    - Record the information, including expiration dates, and place copies in the APP's personnel file. Update these documents on an ongoing and timely basis.
  - At the time of hire, verify the current skill and competence of the APP.
    - Dedicate time and attention to truly understanding what amount of training will be needed based upon your observations.
- Verify ongoing competence through medical record review, regular meetings with the APP, direct observation of procedures, or other means at defined intervals (e.g., three, six, and 12 months after hiring, and at least annually thereafter).

- Develop and carry out a plan to help ensure the quality of care provided by the APPs you supervise (e.g., identify areas to review, establish a review timeline, and determine how needed quality of care improvements will be addressed and implemented).
- Encourage APPs to consult with you when they encounter clinical tasks that may be beyond their competence levels or have any questions regarding the care and treatment of patients.
- Thoroughly review any APP patient record before cosigning.
  - ► Take action if something you noticed during the review is not consistent with the standards you expect or if you have clinical questions regarding the care executed to arrive at the diagnosis.
- Review auto-populated messages attached to your signature. Adjust these to reflect a truthful representation of your involvement in patient care.

Advanced Practice Professionals

Consider the following strategies:

- Recognize your comfort level. Clearly understand under which circumstances immediate physician consultation must be obtained.
- Regularly review supervisory/collaborative agreements and ensure they are updated as new skills are learned and expected duties change.
- Keep lines of communication with your supervising physician open. If you feel the environment does not foster the ability to continuously learn and protect the safety of patients, bring this to the attention of the physician or an authority that can mediate and drive change.
- Foster your own growth by taking advantage of educational opportunities such as procedural workshops and educational conferences. Actively engage in continuing education required to maintain licensure.
- Explore and engage in quality improvement activities offered through your practice or through hospitals in which you are privileged.

ADDITIONAL RESOURCES

NORCAL Group: Vicarious Liability Risk Management[42]
Claims Rx article available to NORCAL Group insureds covering strategies for reducing vicarious liability risk

The Association of Postgraduate PA Programs (APPAP): Postgraduate PA and NP Program Listings[43]
Residency/fellowship opportunities for APPs to develop confidence, experience, and advance clinical skills

Institute for Healthcare Improvement: What Boards Must do to Achieve Better Quality Health Care[44]
Framework and assessment tool to help achieve better quality care in health systems

NORCAL Group: Mitigating Risk with a Quality Plan[45]
Claims Rx article available to NORCAL Group insureds presenting an overview of healthcare quality, including key components of a quality plan on which to build a program

AMA: Responsibility and Collaboration in Health Team Care[46]
Article highlighting how the balance of shared and individual responsibility and trust between physicians and APPs is among the most complicated and beneficial relationships in healthcare delivery

Advanced Practice Professionals:
Understanding Your Exposure to Liability

CONCLUSION

Increased utilization of APPs can improve patient access to care, patient satisfaction, quality of care, and physician productivity, as well as reduce physician burnout.[1,2] This article provides risk reduction strategies and resources to better understand APP scope of practice, collaborative/supervisory requirements, standardized protocols, and chart review and countersignature. Understanding these strategies and being educated on state law parameters can decrease liability while allowing APPs to practice to the full extent of their education and training.

Special thanks to Kelly Riedl, PA-C, Senior Risk Management Consultant, for authoring this article.

ENDNOTES

The NORCAL Group documents referenced in this article, along with many other risk management resource documents and past editions of *Claims Rx*, are available in the Risk Solutions area of MyACCOUNT, or by policyholder request at 855-882-3412.

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ENDNOTES

The NORCAL Group documents referenced in this article, along with many other risk management resource documents and past editions of *Claims Rx*, are available in the Risk Solutions area of MyACCOUNT, or by policyholder request at 855-882-3412.

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