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RISK MANAGEMENT PERSPECTIVES

Medical Assistants:

Strategies for Increasing Patient Safety and Reducing Liability Risk

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RISK MANAGEMENT PERSPECTIVES

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

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Medical Assistants:

Strategies for Increasing Patient Safety and Reducing Liability Risk

INTRODUCTION

Medical assistants (MAs) can increase medical practice efficiency, patient satisfaction, and patient care quality. Increased satisfaction and quality can reduce malpractice liability risk. But MAs can also increase liability risk for their supervising/delegating clinicians and employers. Physician employers of MAs may be found vicariously liable for MAs' negligent actions and may also be directly liable for negligent supervision, delegation, hiring, and/or training of MAs. Additionally, MAs who exceed their own scope of service to the degree that they are practicing medicine (or nursing), can expose the person delegating tasks to charges of aiding and abetting the unlicensed practice of medicine (nursing), which can result in board discipline and criminal prosecution. MAs who perform tasks outside of their scope can be charged with the unlicensed practice of medicine (nursing), which is a crime.

Determining the appropriate scope of service for MAs can be complicated. Some state laws list what MAs can and cannot do, which makes scope of service determinations more straightforward. Other states are vague or silent on the issue. Such ambiguity is often at the root of unintentional delegation of tasks beyond an MA's scope of service.

While allegations in malpractice lawsuits involving MAs vary, a closed claims analysis revealed common themes, including:

- Clinicians inappropriately delegated MAs tasks, which either were or were not outside the scope of MA service, but were beyond their capabilities (e.g., a physician directed an MA to observe a patient who had lost consciousness).
- MAs negligently performed appropriately delegated tasks (e.g., an MA injected triamcinolone at the incorrect depth).
- MAs intentionally violated policies and protocols designed to appropriately limit MA scope of service (e.g., an MA gave a patient treatment advice because she believed she was competent to do so).
- MAs unintentionally provided treatment beyond their scope of service (e.g., an MA gave Botox® injections, which was specifically prohibited by state regulation, but neither she nor the delegating physician realized it).

Providing safe and lawful patient care is a group endeavor. Administrators must create MA policies and protocols that are consistent with state laws and regulations. Clinicians must be familiar with scope of service laws and individual MA competency to ensure MAs are only delegated appropriate tasks.

Providing safe and lawful patient care is a group endeavor. Administrators must create MA policies and protocols that are consistent with state laws and regulations. Clinicians must be familiar with scope of service laws and individual MA competency to ensure MAs are only delegated appropriate tasks. Administrators and clinicians must regularly assess MA competency and compliance with MA scope of service. MAs must know their scope, work within it, and have the confidence to refuse tasks that are outside of their scope or beyond their level of competence. These are the basic elements of a patient safety/risk reduction program for practices that utilize MAs.

The case studies in this article are based on real malpractice claims. The risk reduction strategies that follow each case are offered to create a multi-modal risk reduction approach that includes using tools to define and contain MA duties; providing education on scope of service for MAs, delegating clinicians, and office managers; regularly reiterating scope of service; and reassessing MA job duties and expertise as they expand and develop.

Psychological Safety

A physician's office can be a high reliability organization. A high reliability organization "operate[s] in complex, high-hazard domains for extended periods without serious accidents or catastrophic failures."[1] Cultivating an environment where staff are authorized and responsible for prioritizing safety over performance pressures is an important element of highly reliable healthcare entities.[1] Ensuring all employees feel safe when advocating for patient safety — a concept described by the term "psychological safety"[2] — is a necessary aspect of high reliability teamwork concepts. The following case study presents a missed opportunity for an MA to question the propriety of a physician's delegation of patient monitoring to her.

CASE ONE

Allegation: The physician's negligent use of conscious sedation drugs without proper monitoring resulted in the patient's death.

An 18-year-old male patient presented to a "pain management clinic" operated by an internal medicine specialist. He reported neck and right shoulder pain at 9 on a 10-point pain scale. The patient also reported paresthesia in his hands, with the right being greater than the left. The physician diagnosed the patient with cervical strain and myofasciitis of the right shoulder. His plan included trigger point injections, if the patient's pain did not improve with medication and physical therapy. He prescribed metaxalone and oxycodone with acetaminophen.

The patient returned two months later, reporting the medication and physical therapy had not reduced his pain to a tolerable level. The patient requested the trigger point injections that had been discussed at the earlier appointment. The physician administered two injections, one in the cervical paraspinal area and the other in the brachial area. The injection contained lidocaine, bupivacaine, fentanyl, and diazepam. His standard practice for this type of trigger point injection was to insert the needle into muscle tissue at the location the patient had identified as painful, and then push 4 ccs in three different directions.

The patient became drowsy immediately following the injections, was verbally unresponsive, and was unable to stand. The physician and MA moved the patient from the chair he was seated on to an examination table. The physician checked the patient's pulse and respirations, which were not concerning to him. The physician instructed the MA to monitor the patient occasionally, and went to treat another patient. After observing the patient for a few minutes, the MA thought he had fallen asleep. She checked the patient's pulse, which was normal, and left the room to attend to other business. She looked in on the patient approximately every five minutes. On her third check, she noticed the patient was turning blue and called the physician back into the room. The patient was not breathing and was pulseless. The MA called for an ambulance, and the physician administered CPR with chest compressions until the ambulance arrived. The patient could not be revived and was later pronounced dead. An autopsy revealed his cause of death as cardiopulmonary arrest with development of severe anoxic encephalopathy due to an epidural injection of pain medications.

DISCUSSION

According to experts, the physician was essentially performing conscious sedation without proper monitoring equipment or emergency response capabilities, which was below the standard of care. Furthermore, they considered it below the standard of care for the physician to leave the semi-conscious patient to be monitored by the MA. Due to her lack of training and the absence of monitoring machines, it was unlikely she would have realized the patient was progressing towards cardiac arrest.

One expert theorized that the injections paralyzed a nerve, which caused the patient's breathing to stop. The physician explained that although he could not recall the exact locations of the injections (it was not documented and he did not use fluoroscopy), they were not intended to go into or near the spinal column. Unfortunately, when asked to demonstrate where the injection was given on the patient, the MA pointed to the middle of her spine at the back of her neck, which, along with the autopsy report, conflicted with the physician's recollection and standard practice.

She admitted that it made her uncomfortable when the physician asked her to monitor patients who seemed to be put to sleep following trigger point injections because she was not sure what she was looking for. In a highly reliable organization, the MA would feel empowered to challenge the physician's plan to delegate patient monitoring to her, because she would recognize that the delegation presented a patient safety risk.

There were many causative elements to this patient's injuries for which the physician would be directly liable, including his delegation of monitoring to the MA. However, the MA's acquiescence was also problematic. She admitted that it made her uncomfortable when the physician asked her to monitor patients who seemed to be put to sleep following trigger point injections because she was not sure what she was looking for. In a highly reliable organization, the MA would feel empowered to challenge the physician's plan to delegate patient monitoring to her, because she would recognize that the delegation presented a patient safety risk.

RISK REDUCTION STRATEGIES

Members of a high reliability organization understand that human error is inevitable, but also that it can be anticipated and mitigated. Monitoring each other and empowering all team members to interrupt care whenever there is a suspected patient safety risk are essential aspects of effective teamwork and communication inherent in a high reliability organization. MAs who can identify a patient safety risk in real time and are proficient with escalating assertiveness can improve outcomes.[3] Consider the following strategies:[3,4,5]

Clinicians

- Ensure MAs have the education, training, and competency to perform the tasks delegated to them.
- Ensure MAs know they are expected to speak up when they are concerned for patient safety.
  - TeamSTEPPS®[6] can provide a framework for accomplishing MA engagement and confidence in patient safety efforts.

- Openly invite MAs to respectfully ask for clarification or to double check an order or procedure when they believe patient well-being is at risk.
- When MAs ask questions or raise a patient safety concern, acknowledge that the concern has been heard, and agree on the next steps.
- When MA suggestions are not appropriate for the situation, thank them for speaking up and educate them to further their knowledge and understanding.

MAs

- Take responsibility for healthcare team decisions and consider team failures and successes as your own.
- Monitor other team members (including clinicians) for behavior or actions that may result in patient injury.
- Firmly and respectfully advocate for the patient when you recognize a patient safety risk.
- Concisely and assertively bring the problem to the attention of the decisionmaker and state why it is a safety concern.
- Use progressive communication techniques such as the CUS Tool. (I am concerned. I am uncomfortable. This is a safety issue.)
- If your initial assertive statement is ignored, escalate your assertiveness using a tool such as the Two-Challenge Rule or the Four-Step Assertiveness Tool.

  ► **Two-Challenge Rule**

  1. Repeat it again to ensure it has been heard.
  2. If the safety issue still hasn't been addressed, take a stronger course of action.

  ► **Four-Step Assertiveness Tool**

  1. Capture the clinician's attention (e.g., change your intonation or use a first name instead of title).
  2. Restate the concern using CUS-like statements as a preface (e.g., "I am uncomfortable monitoring the patient because I don't know how to gauge her well-being.").
  3. Propose a solution or next steps (e.g., "A nurse would be a more appropriate person to monitor the patient.").
  4. Place the onus back on the clinician to agree on next steps by posing a question (e.g., "Will you remain with the patient while I find a nurse?").

- If escalated assertiveness strategies are not effective, utilize the chain of command.

Operations

- Ensure that all members of the healthcare team know their own scope of practice/service and the scopes of practice/service of other team members.
- Avoid creating an environment where MAs are pressured to complete tasks that are beyond the scope of their service or competence level.
- Cultivate a culture of safety[7] where all MAs feel empowered to consult with a supervising clinician whenever they need help or feel they are being pushed past the limit of their scope of service.
- Train MAs on how to express safety concerns and effectively use escalated assertiveness tools.

ADDITIONAL RESOURCES

Agency for Healthcare Research and Quality (AHRQ): TeamSTEPPS®[6]
Teamwork tools, aimed at optimizing patient outcomes by improving communication and teamwork skills among healthcare professionals

Sculli GL, et al: Effective followership: A standardized algorithm to resolve clinical conflicts and improve teamwork[3]
Techniques for challenging authority and escalating assertiveness to improve team communication

Vicarious Liability for MA Negligence

In the most general sense, vicarious liability allows an injured patient to hold a third party (e.g., a physician) financially responsible for the negligence of the person who caused the injury (e.g., an MA). Vicarious liability arises in a variety of legally recognized relationships. In malpractice litigation, vicarious liability is most frequently associated with an employment relationship. In other words, liability for patient injuries flows through the employee (by virtue of the employment relationship) to the employer. Vicarious liability is an entirely dependent theory of liability — a finding of liability is not based on improper action by the principal. For example, if a physician appropriately hires, trains, supervises, and retains an MA, but the MA still negligently causes a patient injury, the propriety of the physician's management of the MA will not shield the physician from vicarious liability. Similarly, if the MA did not negligently cause the patient injury, vicarious liability does not attach to the physician.[8]

In many medical malpractice actions involving patient injuries caused by an MA, the plaintiff's attorney will simply name the employer of the MA as a defendant instead of naming the MA. Although the attorney must prove the MA's negligence caused or contributed to the injury, the attorney will seek damages via a vicarious liability claim against the employer.

Because vicarious liability is automatic in an employer-employee relationship, taking steps to decrease the risk of employee-related harm to patients is essential to minimizing exposure to vicarious liability claims.[8] For instance, an employer (e.g., a physician group, solo practice, etc.) would strive to hire competent MAs and keep them adequately trained and managed via patient safety policies and protocols. Of course, patient injuries cannot always be prevented. If a lawsuit is filed, to support defense arguments that an MA's treatment of the patient was consistent with the standard of care, MAs should be trained to appropriately document their encounters with patients, appropriately respond to unanticipated outcomes, and otherwise engage in risk reduction strategies.

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Vicarious Liability for Delegated Tasks

Medication errors are common in malpractice claims involving MAs. In the following case study, a family practice physician (FP) did not believe he should have been named in the lawsuit, because his MA independently caused the medication error. However, as the MA's employer, he was vicariously liable. Consider what the FP could have done to reduce his vicarious liability risk.

CASE TWO

Allegation: An MA negligently called in an incorrect dosage of warfarin to the pharmacy, which resulted in toxicity.

An FP had been prescribing warfarin 2 mg per day to an elderly patient for many years. The patient called the office one day and spoke to an MA. He requested a refill of warfarin 10 mg. The MA did not review the patient's record (which was counter to office policy and her MA training) to verify what strength of warfarin the patient was taking. She called in the 10 mg prescription to the pharmacy, which filled it. The patient took 10 mg warfarin daily for two weeks, which caused a gastrointestinal bleed requiring surgery, multiple hospitalizations, and extensive rehabilitation.

The patient sued the FP and the MA, alleging the MA negligently called in the wrong prescription, and the FP (her employer) was vicariously liable for the incorrect refill because the MA was acting in the course and scope of her employment when the prescription was called in.

DISCUSSION

The defense team believed it would be very difficult to defend the vicarious liability claims against the FP because failing to check the correct dosage before calling in the prescription was considered negligent by experts, the defendant physician, and the MA herself.

If the MA had cross-checked the request for a 10 mg dosage with the order in the patient record and noted it was different, she would have then called both the patient and the FP to confirm the difference in dosage was appropriate. In other words, it is likely that this injury would not have occurred if the protocol had been followed.

Cross-check protocols were in place to promote patient safety. Unfortunately, there were no redundancies in the system to catch the type of error that occurred: The MA was authorized to call in refills for warfarin without the physician's approval, and the physician would not have seen this request because it was identified as a "refill." The MA admitted she was previously trained during school and at the FP's office to always cross check the requested refills with the prescription from the physician in the patient file, but she failed to do so in this case. It is also likely that this was not the first time the MA failed to cross check a requested refill. However, because neither the FP nor the office manager were monitoring the MA's compliance with medication protocols, there were limited opportunities to prevent this type of error.

One would hope that the pharmacy would have caught an error like this but, in this case, it did not. Experts noted that 10 mg of warfarin would have been a highly unusual dose for this patient, whose INR had historically been maintained on 2 mg. Although the pharmacy was named as a defendant in the lawsuit, the pharmacy negligence did not supersede the MA's negligence.

RISK REDUCTION STRATEGIES

In most cases, MAs are responsible, but sometimes they cut corners, or unintentionally fail to follow protocols. MAs, under the direct supervision of a clinician, should only call in routine refills that are exact, patient-specific, have no changes in the dosage levels, and have been authorized by the clinician. Consider the following strategies:[9]

- Hire people who are trustworthy and qualified.
- Provide ongoing scope of service training and education.
- Ensure the office protocol for prescription refills reflects proper clinician supervision and does not allow MAs to exceed their scope of service.
- Regularly audit employee performance and compliance with policies and protocols.
  - Consistently coach, further educate, and discipline, if necessary, those who don't comply. Consider a "Just Culture" approach[10] to managing performance.
- Research whether systems issues are making compliance difficult. Remove barriers to perform duties successfully and safely without cutting corners.
- Find ways to reiterate that refill protocols must be followed, for example, by integrating them in daily safety briefings.[11]
- Even if an MA has been through a training program or has work experience, provide job-specific training, which includes an introduction to administrative and patient care protocols. Do not rely solely on shadowing or ad hoc training.
- Initially assess and regularly reassess MA competencies.
  - To assess the MA's compliance with scope of service and competency requirements, develop a performance appraisal form based on the MA's job description.
  - Retrain and retest MAs who do not meet expectations.
    - Document the process of ascertaining competency and compliance.
  - Periodically review and update performance appraisal forms to align with the MA's current job duties.

ADDITIONAL RESOURCE

ProAssurance: Sample Unlicensed Employee Skills Checklist
Sample form to facilitate the creation of a practice-specific checklist to assess the competency of medical assistants

Vigilance for Clinical Knowledge Deficits

In the following case, a newly hired MA confused a patient report of oxygen saturation ranges for blood pressure readings. It was an error that most likely would not have been made by a person with more clinical training. Unfortunately, instead of recognizing and questioning the MA's error, the clinician took the numbers she was provided and made them make sense as blood pressure values. Clinicians must remain vigilant when relying on clinical information delivered by MAs, who often have limited clinical training.

CASE THREE

Allegation: The MA negligently advised the nurse practitioner (NP) that the patient's oxygen saturations were blood pressure readings. The NP negligently relied on that information to counsel the patient. The miscommunication resulted in a delay in treatment of a pulmonary embolism.

The patient presented to her primary care clinic for increased dyspnea and coughing over the past three days. The patient was morbidly obese. She had a history of respiratory issues, including asthma-like attacks; dyspnea on exertion, which was due to her obesity and respiratory issues; sleep apnea, for which she used a CPAP; and hypertension, for which she took amlodipine. She monitored her blood pressure, pulse, and oxygen saturations at home. Earlier that year, the patient had a cardiac work-up to assess her hypertension and exertional dyspnea. The stress test and EKG were essentially normal.

On the day in question, the patient was examined by an NP. The patient described her dyspnea episodes as similar to past flare-ups. Her blood pressure was 122/86, heart rate was 77, and oxygen saturation was 94%. (Her usual oxygen saturation range was 90-94%, which would drop on exertion.) Her cardiovascular examination was normal. Pedal pulses were normal, and there was no pedal edema. The NP thought a cardiac issue was unlikely but could not be excluded. The NP prescribed methylprednisolone, ordered an x-ray, made a pulmonology referral, and advised the patient to go to the emergency department (ED) if her symptoms worsened.

The next morning, the patient called the clinic and spoke to an MA. The MA called the NP and told her the patient's blood pressure the prior night had been in the range of 76/82, and it was 82/90 that morning. The NP assumed the patient must have been indicating her systolic pressures were in the ranges of 76-82 and 82-90. She told the MA to advise the patient to hold her blood pressure medications until her blood pressure was over 100 systolic. The MA passed on the message to the patient. At 5:00 p.m., the NP called the patient to discuss her x-ray results. During that call, the patient clarified that she had reported oxygen saturations at 76-82 and 82-90 to the MA earlier that day, not systolic blood pressure ranges. The NP told the patient to go to the ED for further evaluation. The patient went into cardiac arrest and died before she arrived at the ED. According to an autopsy, the cause of death was pulmonary embolism due to deep vein thrombosis.

DISCUSSION

The NP explained that she took the ranges reported by the MA to mean systolic blood pressure ranges, since 76/82 and 82/90 blood pressures would not occur, and the MA said, "blood pressure." This error resulted in an approximately eight-hour delay in advising the patient to go to the ED. Experts believed the patient would have survived if she had been immediately referred to the ED and treatment had been initiated in the morning.

The MA in this case had been onboarded by the office manager, who focused training on administrative tasks. Although the MA had taken an MA training course, her understanding of blood pressure was not sufficient to prevent her communication error. She was not aware of the gap in her understanding of blood pressure, and the NP assumed she was competent.

Experts agreed that the MA was negligent in reporting the oxygen saturations as blood pressures. Because she was an employee, the clinic would be vicariously liable. The issue with the NP was whether she reasonably could have believed the MA was referring to systolic blood pressures and whether the standard of care required the NP to call the patient earlier for further clarification.

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RISK REDUCTION STRATEGIES

Supervising clinicians must have a comprehensive understanding of the competency of MAs (particularly new hires) with whom they collaborate to provide patient care. Consider the following strategies:[12]

- If a clinical measurement or value reported by an MA seems questionable, question it.
- Confirm individuals responsible for MA training understand their responsibility to ensure a new hire is learning best practices for delegated clinical tasks.
- Train MAs to accurately report information provided to them by patients without making assumptions or interpretations.
- Create a supportive environment in which MAs feel comfortable seeking clarification and asking questions when necessary.
- Implement a method to verify the content and accuracy of information provided.
- Evaluate MAs to determine whether their level of competency matches your expectations.
  - Be familiar with your own office's MA job description and when appropriate adjust expectations accordingly.

Unchecked Autonomy

In the following case, the MA had worked with the primary care physician (PCP) for many years and the physician did not feel the need to assess the MA's injection skills. However, the unchecked autonomy resulted in a patient injury and inadequate medical record documentation, which complicated the defense of the claim.

CASE FOUR

Allegation: Negligent injection of triamcinolone resulted in necrosis.

A 30-year-old male patient presented to his PCP's office complaining of a skin rash. After examination, the PCP told the MA to give the patient a triamcinolone shot. The MA administered the injection 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 procedures to resolve the indentation. The patient sued the PCP, alleging negligent supervision of the MA, vicarious liability for the MA's negligent injection, and lack of informed consent.

DISCUSSION

The MA, who was a long-time employee of the PCP, had given countless injections of all types over the years. He had learned to give injections under the observation of his former employer. The PCP never considered assessing the MA's injection skills, assuming his competence. The expert reviewers in this case, however, felt the MA did not inject the triamcinolone deeply enough into the muscular tissue. It likely only reached the subcutaneous level, which caused the damage to the superficial tissue surrounding the injection site. Since the PCP had never observed the MA's injection technique and had never provided the MA with training, he had difficulty answering questions about whether the MA was competent.

Further, the MA failed to document the injection technique or location of the injection. Regarding informed consent, the MA documented "RBAs discussed." It was unclear who obtained the informed consent, and which risks were discussed. The patient denied being advised of any risks, and further claimed he would not have consented to the injection if he had known it could cause subcutaneous fat atrophy. Lack of documentation significantly complicated the defense of the claim.

He had learned to give injections under the observation of his former employer. The PCP never considered assessing the MA's injection skills, assuming his competence.

RISK REDUCTION STRATEGIES

Initial and ongoing skills competency assessments can decrease the risks of errors due to an MA's lack of knowledge and/or incorrect techniques.[12] Consider the following strategies:

Supervising Clinician

- Confirm that MAs are competent to perform all tasks delegated to them, including injection administration.
  - ► Consider the patient injury risk level of tasks assigned to an MA when judging competence to perform a delegated task.

Operations

- Determine competencies by written assessments and observation of key tasks and technical skills.
- Provide training to MAs whose competency levels are lower than expected.
- Keep a written record of competency assessment, training, and confirmation.
- Ensure clinicians who delegate a task to an MA obtain informed consent (when required) for the task from the patient.
- Educate MAs about medical record documentation and ensure documentation is adequate through chart review.

SCOPE OF SERVICE
Tasks an MA Can Perform

When they call the Risk Management Department, physicians sometimes ask what tasks can be appropriately delegated to MAs. The answer varies due to differences in state laws and regulations that affect which services MAs can provide. Some states regulate MAs very specifically and have detailed statutes and regulations outlining supervision requirements and the services an MA may perform. Other states' statutes and regulations make no mention of what tasks MAs can perform.

In states with no laws or regulations specifying MA scope of practice, it is helpful to determine those tasks that statutes and regulations specifically describe as the practice of medicine, nursing, or other licensed healthcare profession. Those tasks would be outside of MA scope of service. Even if not mentioned in a statute or regulation, tasks that require an MA to exercise independent professional judgment, or make clinical assessments, evaluations, or interpretations, would be outside of MA scope of service.[13] State medical societies and licensing bureaus can also serve as resources for determining whether a particular task may be legally delegated to an MA.

Some states regulate MAs very specifically and have detailed statutes and regulations outlining supervision requirements and the services an MA may perform. Other states' statutes and regulations make no mention of what tasks MAs can perform.

On its website, the American Association of Medical Assistants (AAMA), a national professional society for MAs, lists tasks MAs often perform in physician offices, including (but not necessarily limited to) the following:[14]

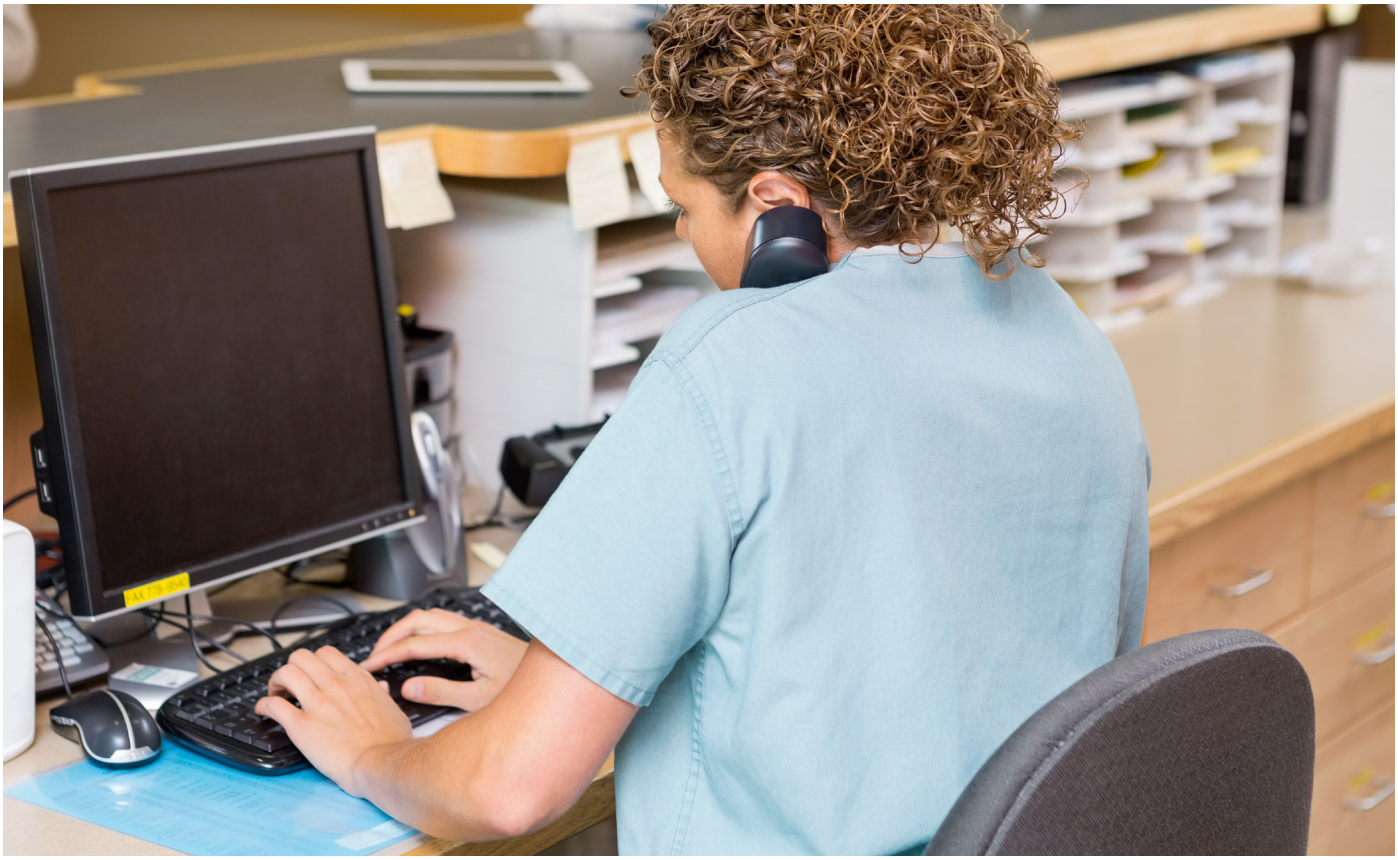
- **Administrative Duties** — answering telephones, greeting patients, completing insurance forms, scheduling appointments, billing, and bookkeeping
- **Clinical Duties** — (completed under the direction and supervision of a clinician) taking medical histories, drawing blood, preparing and administering medications, transmitting prescription refills, performing electrocardiograms, and removing sutures

It should be noted that some of these example MA tasks may fall outside of the scope of MA service outlined in a particular state's laws and regulations. When that is the case, an MA must comply with the applicable state's laws and regulations instead of relying on guidance on the AAMA's website.

The line between what an MA can and cannot do is often subtle, but if MAs perform duties that are supposed to be performed by licensed individuals only, then they are operating outside the appropriate boundaries of their positions. An MA "practicing medicine" can be prosecuted for the unlicensed practice of medicine, which may result in fines and imprisonment. A clinician who has delegated professional responsibilities to an MA can be charged with aiding and abetting the unlicensed practice of medicine, which can result in criminal prosecution and medical board discipline.

ADDITIONAL RESOURCE

AAMA: MA State Scope of Service Laws[15]
Links to MA scope of service laws in many U.S. states and AAMA general counsel opinion letters about delegable duties in states without specific MA scope of practice laws



Providing Medical Advice

MAs giving and patients accepting their medical advice is a common theme in closed claims involving MAs. A study by Elder, et al. indicates that some MAs are confident in their ability to give clinical advice and do so with and without their supervising clinician's approval and/or knowledge.[16] In the following case, the MA indirectly discouraged a patient's mother from bringing her child in for an evaluation. Consider how this type of error could be avoided in the future.

CASE FIVE

Allegation: The MA exceeded her scope of service by providing medical advice on the telephone.

An MA in a pediatrician's office answered a call from the mother of a two-year-old patient. The mother explained that her child had a 103˚ temperature, was vomiting, and was very irritable. Many children had presented to the office with similar symptoms within the past week, and the pediatricians and nurses had been discussing the probability that a virus was going around. The MA's child had identical symptoms, which she treated with infant Motrin® until they resolved a few day later. She shared this information with the patient's mother and then asked if the mother was interested in scheduling an appointment. The mother assumed her child had the same virus and declined the appointment. Unfortunately, the child had pneumococcal meningitis. Delayed treatment resulted in blindness, seizures, and cognitive delays. The parents brought a lawsuit against the MA and pediatrics practice alleging failure to diagnose meningitis, failure to give proper and sufficient advice, failure to properly respond to a telephone call, and failure to properly supervise.

DISCUSSION

The MA did not equate her conversation with the patient's mother as providing treatment advice. However, experts believed the MA was negligent, and the negligence was a cause of the patient's injuries. It was likely the pediatric practice, as the MA's employer, would be found vicariously liable for the delayed diagnosis of meningitis caused by the MA's treatment advice.

RISK REDUCTION STRATEGIES

MA scope of service can be ambiguous. Education and assessment should be ongoing, expectations of MAs (consistent with laws regulating scope of service) should be consistent among all members of the healthcare team, and tools to define and contain MA scope of service should be used. Consider the following strategies:

MAs

- Anticipate that patients will attempt to solicit medical advice from you.
- If a patient asks for medical advice, inform them that you are an MA and do not have authority to give medical advice.
- Use a telephone decision grid, developed by clinicians at the practice, that guides MAs on the proper response and the urgency of certain patient inquiries.
- Refer patient clinical concerns to a clinician.
- Document communication with patients verbatim, and that patient medical complaints were routed to a licensed healthcare provider in a timely manner.

Operations

- Do not allow MAs to triage patient calls or provide medical advice.
- Put processes in place to discourage MAs from providing medical advice in response to a patient's report of symptoms.
- Anticipate that patients will attempt to solicit medical advice from MAs.
- Offer training and education that provide strategies for appropriately responding to patient telephone inquiries.
- Recognize the limitations and roles of MAs. Be familiar with applicable state laws and regulations to ensure MAs are not exceeding their scope of service and are being supervised 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 scope of service limitations with existing MAs and supervising clinicians and staff on a regular basis.

ADDITIONAL RESOURCES

NORCAL Group: Sample Telephone Contact Form
Form to be used by any person answering a patient call

NORCAL Group: Sample Telephone Decision Grid
Decision grid containing sample types of telephone calls and sample responses

Medical Assistants:
Strategies for Increasing Patient Safety and Reducing Liability Risk

CONCLUSION

The line between what an MA can and cannot do is often subtle. However, failure to consider, define, and monitor MA scope of service 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. In addition to appropriate delegation policies and procedures, MA competence to perform a delegated task must be initially assessed and then reassessed on a regular basis. Effective communication, supervision, and training among administrators and healthcare team members based on thorough, workable policies and procedures can further diminish the liability and patient safety risks MAs can introduce into healthcare settings. Applying the risk reduction strategies proposed in this publication can potentially minimize the incidence of adverse outcomes and increase the probability of successfully defending malpractice claims should they occur.

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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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