ADVANCED PRACTICE CLINICIANS

A Preventive Action and Loss Reduction Guide

HELPING YOU NAVIGATE YOUR PRACTICE ENVIRONMENT

In this time of rapid changes in healthcare, advanced practice clinicians are a key force in improving patient care quality and access. TDC Group, through medical professional liability insurance company The Doctors Company and its affiliate The Doctors Company Risk Retention Group, is proud to provide superior malpractice coverage for advanced practice clinicians—industry-leading policies designed specifically with your needs in mind. Founded and led by healthcare practitioners, TDC Group is focused on helping you navigate healthcare change with confidence.

We are here to provide expert guidance and support in navigating your practice environment. Contact your patient safety risk manager whenever you have questions or need help.

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INTRODUCTION

Current market research and labor statistics show that increasing numbers of advanced practice clinicians (APCs) have joined the healthcare workforce, with predictions of even greater growth to meet the demands of caring for our aging population.

The APC group encompasses different types of clinicians practicing in many specialty areas and clinical settings. The group includes physician assistants/associates (PAs) and advanced practice registered nurses (APRNs), such as nurse practitioners (NPs), certified nurse midwives (CNMs), and certified registered nurse anesthetists (CRNAs).

APCs are subject to the state laws and regulations in the jurisdictions in which they practice. Depending on the state, an APC may be allowed the authority to practice autonomously, as part of a collaborative agreement, or under the supervision of a physician.

Regardless of an APC's practice status or employment arrangement, all individuals can be held liable for their own acts of negligence.

Regardless of an APC's practice status or employment arrangement, all individuals can be held liable for their own acts of negligence. APCs who practice independently and employ or contract with other staff may also be held liable for the acts of others.

This guide, an essential reference for APCs practicing at every level, provides strategies to enhance safety and mitigate risk.

CLOSED CLAIMS STUDIES: OUR APPROACH

The Doctors Company closed claims studies, reinforced by expert insights, focus on the following areas:

- Most common patient allegations.
- Injury severity.
- Factors contributing to patient injury.

Allegations: Our approach to studying APC malpractice claims began by reviewing allegations against clinicians made by plaintiffs/patients. This methodology gives us insights into patients' perspectives and motivations for filing claims and lawsuits.

Injury Severity: To understand the full scope of harm, we also examined patients' injuries and classified them into low, medium, and high categories.

Contributing Factors: To prevent injuries, it is essential to understand the factors that contribute to patient harm. Experts for both the plaintiffs/patients and the defendants/practitioners reviewed the claims and conducted medical record reviews. Clinical analysts drew from these sources to gain an accurate and unbiased understanding of events that lead to actual patient injuries. The study identified these contributing factors, and the reviewers evaluated each claim to determine whether the standard of care was met. Contributing factor categories included clinical judgment, technical skill, patient behaviors, communication, clinical systems, clinical environments, and documentation.

Our team studied all aspects of the claims and identified risk mitigation strategies that APCs can use to decrease the risks of injury.

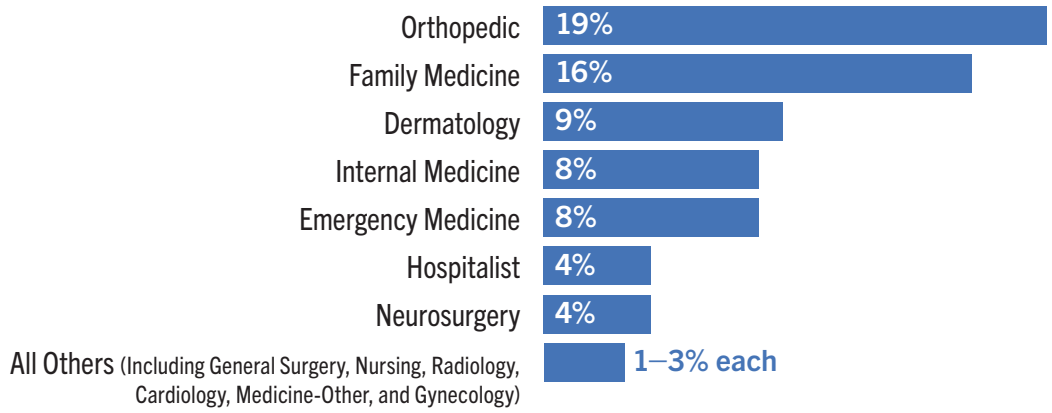
Our team studied all aspects of the claims and identified risk mitigation strategies that APCs can use to decrease the risks of injury, thereby improving the quality of care.

PHYSICIAN ASSISTANT/ASSOCIATE AND NURSE PRACTITIONER CLOSED CLAIMS STUDY

The Doctors Company analyzed 1,003 claims (defined as a demand for payment) against PAs and NPs that closed between 2012 and 2020. Of these claims, approximately 62 percent were against PAs and 42 percent were against NPs. The distribution of medical malpractice claims by practitioner type and specialty is shown in **FIGURES 1** and **2**. The "responsible service" is the clinical service of the practitioner who was responsible for the patient's care at the time of the event.

FIGURE 1

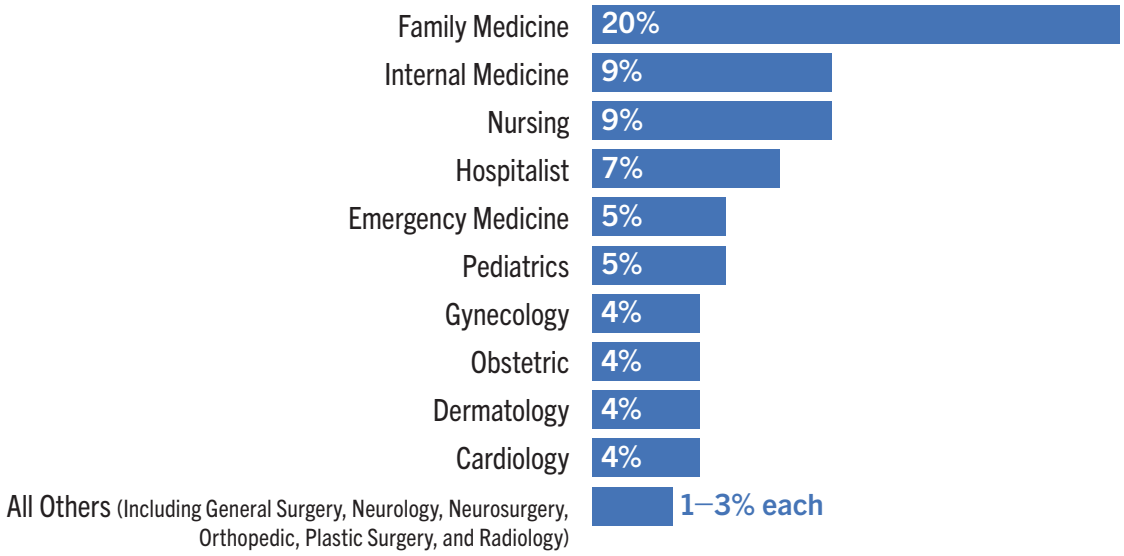
PA: TOP CLAIMS BY RESPONSIBLE SERVICE



Source: The Doctors Company Closed Claims 2012–2020

FIGURE 2

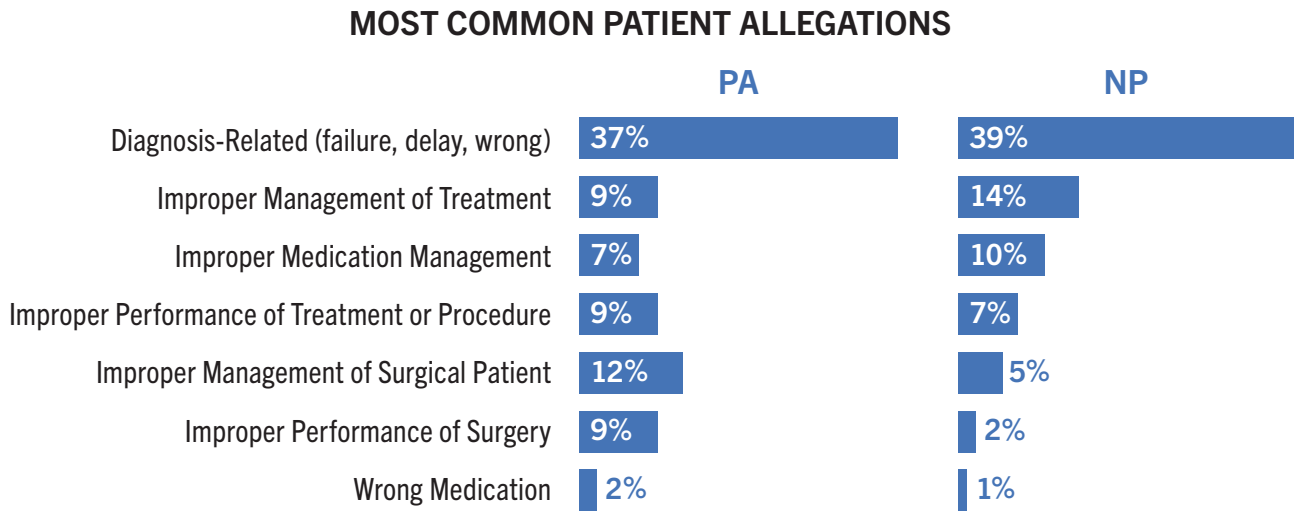
NP: TOP CLAIMS BY RESPONSIBLE SERVICE



Source: The Doctors Company Closed Claims 2012–2020

As shown in **FIGURE 3**, the top allegation for both PAs and NPs was **diagnosis-related (failure, delay, wrong)**. Diagnosis-related allegations were made when the patient's condition was incorrectly diagnosed or the diagnosis was delayed to the detriment of the patient's health.

FIGURE 3



Source: The Doctors Company Closed Claims 2012–2020

Improper management of treatment was alleged when medical treatment complaints were made. This allegation was related to a patient's belief that something was wrong with the selection or implementation of a treatment. Other factors included failure or delay in obtaining a consult or referral and inadequate patient assessments. In cases of inadequate patient assessments, APCs were faulted for failing to order appropriate diagnostic tests (such as gentamicin blood levels) or failing to reconcile relevant signs and symptoms (such as hearing loss) with test results. Patient behaviors also contributed to injury; for example, patients did not follow instructions for prescribed medications or did not adhere to treatment plans or instructions for follow-up appointments.

Allegations of **improper medication management** are related to failure to appropriately monitor high-risk medications (e.g., anticoagulants, narcotics, and antibiotics), failure to address medication side effects, failure to identify drug interactions, or mismanagement of dosing. Allegations of **wrong medication** included ordering errors, such as ordering medications that were inappropriate for the patient's condition, prescribing medications that were contraindicated because of another medication the patient was taking, or ordering the wrong dose.

Both **improper performance of treatment or procedure** and **improper performance of surgery** allegations are associated with surgical specialities. These allegations are more common for PAs because they are more likely to work in surgical settings.

Improper management of the surgical patient focuses on the steps practitioners take in managing patients through the surgical procedure process. These events encompass all phases of the surgical process, including preoperative, intraoperative, and postoperative phases. Events occurred in the office, OR, postanesthesia care unit, or the patient's home.

PATIENT INJURY SEVERITY

Patient injury severity was identified using the National Association of Insurance Commissioners (NAIC) Injury Severity Scale (see **FIGURE 4**). The scale was rolled into low, medium, and high categories.

FIGURE 4

NAIC INJURY SEVERITY SCALE

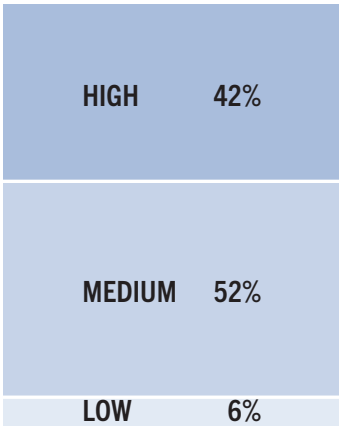
LOW SEVERITY	1. Emotional only	
	2. Temporary insignificant	Lacerations, contusions, minor scars, no delay in recovery
MEDIUM SEVERITY	3. Temporary minor	Infections, fractures, missed fractures, recovery delayed
	4. Temporary major	Burns, surgical material left in the patient, drug side effect, recovery delayed
	5. Permanent minor	Loss of fingers, loss or damage to organ, nondisabling injuries
HIGH SEVERITY	6. Permanent significant	Deafness, loss of limb, loss of eye, loss of one kidney or lung
	7. Permanent major	Paraplegia, blindness, loss of two limbs, brain damage
	8. Permanent grave	Quadriplegia, severe brain damage, lifelong care, fatal prognosis
	9. Death	

As illustrated in **FIGURE 5**, the percentages of high-severity injuries and medium-severity injuries are reversed for PAs and NPs. Low-severity injuries are similar for each type. The large number of medium-severity injuries for PAs is related to their work in orthopedics, where the majority of claims fall within that category.

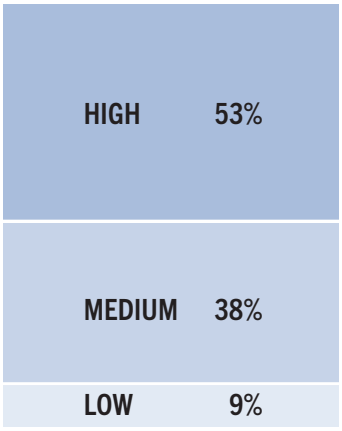
> The large number of medium-severity injuries for PAs is related to their work in orthopedics.

FIGURE 5

PA CLAIMS BY PATIENT INJURY SEVERITY



NP CLAIMS BY PATIENT INJURY SEVERITY



Source: The Doctors Company Closed Claims 2012–2020

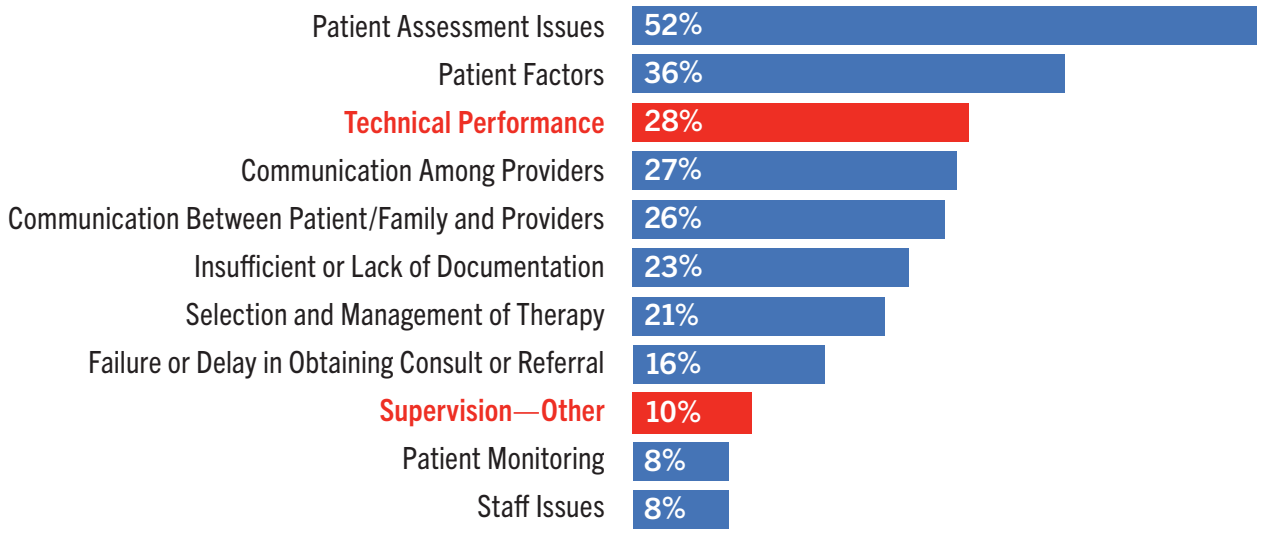
FACTORS CONTRIBUTING TO PATIENT INJURY

Practicing clinicians evaluate our malpractice cases and identify factors that contributed to patient injury. **FIGURES 6** and **7** illustrate the top contributing factors identified by our expert reviewers.

Note that because multiple factors often contributed to patient injury, the percentages total more than 100 percent. The categories highlighted in red differ between PAs and NPs by more than 10 percent.

FIGURE 6

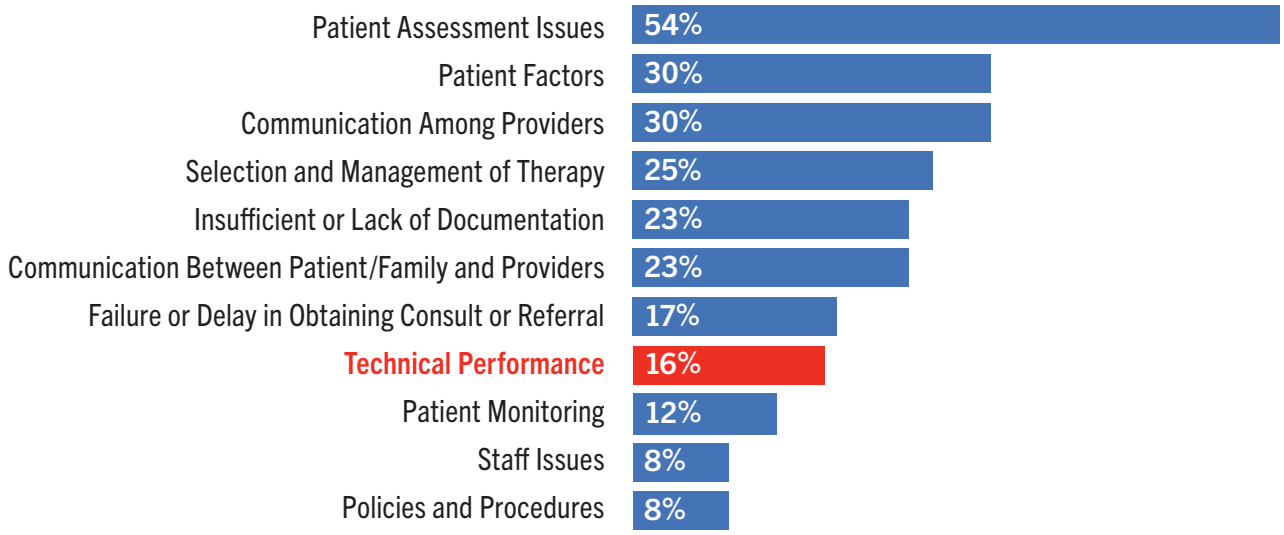
PAs: TOP FACTORS CONTRIBUTING TO PATIENT INJURY



Source: The Doctors Company Closed Claims 2012–2020

FIGURE 7

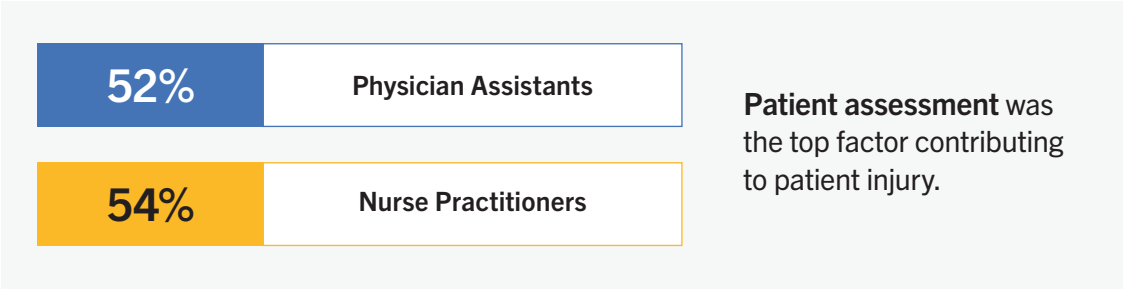
NPs: TOP FACTORS CONTRIBUTING TO PATIENT INJURY



Source: The Doctors Company Closed Claims 2012–2020

Many contributing factors were similar in PA and NP claims:

Patient assessment issues: Patient assessment is a key component in clinical judgment. More than half of all PA and NP claims involved inadequate assessments. Inadequate assessments are closely related to a failure or delay in diagnosis. An incorrect diagnosis was often due to failure to establish a differential diagnosis or failure or delay in ordering diagnostic tests.



Patient factors: Patient engagement is critical in healthcare outcomes. Patient factors were involved in 36 percent of PA claims and 30 percent of NP claims. Factors included patients who failed to participate in recommended treatment plans, did not respond to reminder calls, or canceled follow-up appointments.

Communication among providers: Communication among providers was identified in 27 percent of PA claims and 30 percent of NP claims. The APC did not communicate the patient's condition or failed to read the medical record.

Technical performance: Technical performance, found in 28 percent of PA claims and 16 percent of NP claims, is a contributing factor closely related to surgical cases. This factor often referred to complications known to the patient as a risk of the procedure and was not considered by the reviewer as substandard care. Incorrect surgical sponge or instrument count was also associated with technical performance.

Selection and management of therapy: These factors, found in 21 percent of PA claims and 25 percent of NP claims, reflect a practitioner's decisions regarding the management of a patient's therapy. It may refer to therapies that were not appropriate based on the patient's diagnosis. Examples included selection of medications and selection and management of treatment modalities.

Insufficient or lack of documentation: Expert reviewers identified insufficient or lack of documentation in 23 percent of PA and NP claims. In these cases, medical record entries by APCs were criticized for insufficient or lack of clinical findings and clinical rationale. Documentation was also deficient when it lacked entries by physician practitioners who were known to have provided care.

OBSERVATIONS

The data show the specialties in which both types of APCs work. As shown in **FIGURES 1** and **2**, a higher percentage of PAs work in surgical specialties, while more NPs work in primary care. The types of injuries that patients suffer while in the care of PAs and NPs reflect the specialties in which they work. NPs have more issues with diagnosis and management of medical treatment, while PAs face more issues related to diagnosis and surgical care.

CASE EXAMPLE: PA

A 59-year-old female underwent redo quadruple coronary artery bypass grafting surgery, including a left internal mammary artery graft. Her medical history was significant for the original coronary artery bypass grafting 12 years earlier and well-controlled type II diabetes. Surgery was performed uneventfully by the cardiothoracic surgeon. It is noteworthy that the patient's white blood count (WBC) was 11.8 mcL preoperatively (normal range 4.5–11 mcL); four days later prior to discharge, her WBC was 13.9 mcL.

When the patient was next seen, the physician noted that she reported feeling well but complained of lightheadedness. The sternal wound was noted to be healing well, and the balance of the exam was unremarkable.

The patient's spouse subsequently testified that his wife complained of neck and shoulder pain during the visit. He called the physician's office two days later and spoke with a PA, who advised him to increase the patient's pain medication.

The patient's spouse also testified that he contacted the physician three days later and was again directed to the PA. He reported a continued complaint of pain. Although the medical record had no documentation of either phone call, the plaintiff produced evidence that the PA had, in fact, called in a prescription for pain medication.

The following day, the patient called and spoke with the PA, indicating that she was experiencing chest pain with movement and deep breathing. She was instructed to report to the emergency department (ED) for evaluation. The ED physician noted that the patient was taking hydrocodone for chest pain. An ECG was unremarkable. Her WBC was 14.8 mcL. The patient was prescribed Ultram and discharged with a diagnosis of "chest wall pain." The ED physician testified that he spoke with the physician's PA, but no documentation of that call was found in either the hospital record or the patient's office chart.

The following day, the patient again phoned the physician and complained to a second PA of neck and shoulder pain. The patient testified that the PA instructed her to continue taking the pain medication prescribed by the ED. Because of continuing severe neck pain and spasm, the patient sought care from a chiropractor, who noted a reddened, swollen area at the incision site and directed the patient to contact the physician.

That evening, the patient called the physician and was directed to a third PA. She described her symptoms and was given instructions to continue the pain medications. Although the PA acknowledged the phone call, she had not documented it. The patient's spouse testified that he called the physician five times the following day, demanding that the patient be seen, before being given an appointment. Upon arrival, the patient was evaluated by a PA, who summoned a physician in the group to examine the incision. The physician admitted the patient, but she ultimately experienced diminished sensation below the diaphragm and underwent surgery for a ventral epidural abscess. Unfortunately, the patient was rendered an incomplete C6 quadriplegic.

A suit was filed against the physician, the physician's three PAs, and the physician's medical group practice, alleging that a delay in diagnosis of the sternal wound infection resulted in progression to an epidural abscess and subsequent quadriplegia.

CASE EXAMPLE: NP

A 41-year-old male presented to a primary care practice with complaints of fever and abdominal pain for four days with bright red blood clots from the rectum, anorexia, dehydration, nausea, and straining to defecate. The NP noted the abdomen was soft with diffuse tenderness and hypoactive bowel sounds but no masses. The anus and rectum were examined and were also negative for masses, fissures, or hemorrhoids. Family history was negative for colon cancer. The NP noted recent antibiotic therapy for methicillin-resistant *Staphylococcus aureus* (MRSA).

The NP ordered lab work, wrote prescriptions for Flagyl, Lomotil, and Percocet, and documented "possibly needs colonoscopy if tests yield nothing." Laboratory results revealed an elevated WBC at 12.7 mcL (normal range 4.5–11 mcL) and erythrocyte sedimentation rate (ESR) at 43 mm/hr (normal range for males under age 50 is 0–5 mm/hr). His stool tested positive for *Clostridium difficile*.

Four days later, the patient returned with complaints of bloody diarrhea with abdominal pain. A urinalysis revealed a moderate amount of blood. The physical exam of the abdomen was positive for diffuse tenderness, but it was otherwise within normal limits for bowel sounds and no masses or distention. The NP recommended continuing Flagyl and a repeat urinalysis.

One week later, the patient presented with bright red blood from the rectum and a moderate amount of abdominal pain. The abdomen was soft and bowel sounds were within normal limits. The urinalysis was negative, but the NP recommended continued antibiotics.

One month later, the patient presented with complaints of abdominal pain, but the NP noted that the abdomen was soft, and no further treatments or testing was ordered.

Two months later, the patient was seen for bloody diarrhea over three days and abdominal pain. The NP ordered a stool culture and recommended that the patient avoid dairy products and take probiotics.

FAILURE TO REFER

Patient presents to NP
Complains of rectal bleeding, fever, and abdominal pain.

Four days later
NP continues patient's antibiotics and orders repeat urinalysis.

One week later
Patient's symptoms continue. NP continues antibiotics.

One month later
Patient's symptoms continue, but NP orders no further testing or treatment.

Two months later
Patient's symptoms worsen. NP orders stool culture and recommends dietary changes.

One year later
Patient is referred for colonoscopy that reveals stage IIIA cancer.

Over three-year period
Patient saw only the NP. No physician evaluation. No referral to specialist.

The patient continued to be seen over the next year with similar complaints. One year later, the patient was referred for a colonoscopy due to complaints of diarrhea. The colonoscopy revealed a large sigmoid mass positive for stage IIIA cancer.

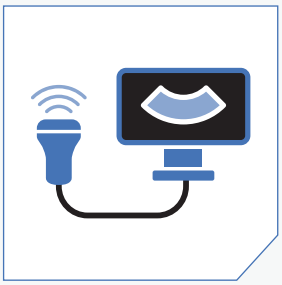
Defense experts were critical that the patient saw only the NP over a three-year period. No physician evaluated the patient despite ongoing complaints, and the patient was not referred to a gastroenterologist.

CASE EXAMPLE: NP

A 40-year-old male presented to an NP complaining of a flare-up of his previously diagnosed gout. The NP prescribed prednisone and gave him a steroid injection in his left leg.

He returned three weeks later, complaining of swelling of his left calf with pain behind the knee and medial thigh. The NP measured the left calf as 42 cm. The right calf was 40.5 cm. The NP's documentation attributed the pain to gout, Baker's cyst, or radiculopathy and noted he did not believe it was due to deep venous thrombosis (DVT). The NP recommended placing another prednisone injection in the ankle and documented that if the calf continued to swell, he would order an ultrasound to rule out DVT.

Later that day, the patient called the office complaining of increased swelling and pain. The NP ordered an ultrasound, which was performed the following day and revealed a DVT. The result was called to the NP's office, and the patient was instructed to come to the office for an evaluation. The calf was larger than the day before, so the patient was sent to the ED. Shortly after arrival, the patient arrested. Resuscitation efforts were unsuccessful. An autopsy revealed a pulmonary embolism.



Experts stated that the NP should have ruled out a potential DVT by ordering the ultrasound when the patient first complained of swelling in his calf. They opined that an earlier diagnosis would likely have resulted in a different outcome.

RISK REDUCTION STRATEGIES: PA and NP

Consider these strategies for mitigating risk and increasing patient safety.

FAILURE TO DIAGNOSE AND DELAY IN DIAGNOSIS

Primary factors associated with allegations of failure to diagnose and delay in diagnosis are lack of physician supervision if required and failure of the APC to consult with a physician. Findings included APCs who misinterpreted information provided by patients and APCs with inadequate levels of experience in diagnosing and managing specific conditions.

When supervised APCs are uncertain about a diagnosis or a plan of care, they are required to consult with their supervising physicians. Liability exposure in these situations is reduced when the APC follows the established protocols prescribed by statute.

The importance of documenting the patient's clinical symptoms with specificity cannot be overstated. Successfully defending claims of failure to diagnose and delay in diagnosis often depends on supporting the APC's clinical rationale based on documented clinical symptoms.

FAILURE OR DELAY IN OBTAINING SPECIALTY CONSULTATION OR REFERRAL

An allegation associated with failure or delay in obtaining a specialty consultation or referral involves APCs who independently manage a complication that is beyond their expertise, skill set, or scope of practice. Patient safety and risk management findings include overconfidence in skill set, lack of communication between the APC and other practitioners, and patient compliance issues.

APCs have legal and ethical obligations to refer patients to specialists or order specific diagnostic tests when indicated based on a patient's presenting signs and symptoms.

APCs have legal and ethical obligations to refer patients to specialists or order specific diagnostic tests when indicated based on a patient's presenting signs and symptoms. To further reduce exposure to liability, communicate to the supervising, participating, or collaborating physician (if required) all uncertain diagnoses or courses of diagnostic treatment to determine a diagnosis, and make a specialty referral when indicated. Documentation is critical to successfully defending a claim. The chronology should include initial workup, internal consultation (if indicated), specialty referral submission (if indicated), and a documented plan of care based on referral findings.

INADEQUATE EVALUATION AND PHYSICAL EXAM

Failure to perform an adequate patient assessment or exam occurs when the APC relies on a previous medical record history and other sources to determine the diagnosis, rather than performing a comprehensive exam.

COMMUNICATION ISSUES

Patient-practitioner communication issues are associated with failure to interview the patient. This situation leads to inadequate knowledge of current medications, illnesses, and any changes that may contribute to a patient's signs and symptoms. It may also lead to an inappropriate plan of care. To reduce liability exposure in this area, the APC must perform a thorough physical exam, including a review of the medical history and current complaints communicated by the patient. Documenting complete findings will reduce exposure to liability while ensuring continuity of care.

The following case example illustrates factors discussed above.

The APC must perform a thorough physical exam, including a review of the medical history and current complaints communicated by the patient.

CASE EXAMPLE: NP

A 42-year-old male presented to the NP in a primary care practice for a mole check on his forearm. The mole was thought to be benign and was not biopsied. The patient was not referred to a dermatologist. The patient was seen by the NP on two other occasions over the next eight months for unrelated conditions. One year later, the patient moved to another area and was seen by a dermatologist who removed the mole. The biopsy came back positive for melanoma that had spread to the lymph nodes.

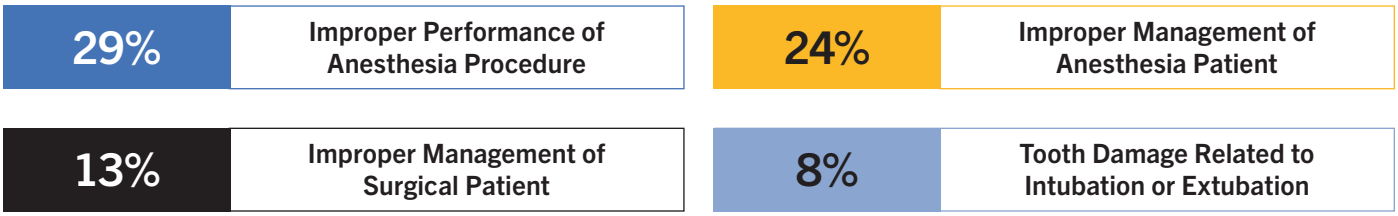
The NP was found to be responsible for the failure to follow up with the patient about the mole, failure to obtain a dermatology consultation or referral, and for the subsequent delay in diagnosis.

CERTIFIED REGISTERED NURSE ANESTHETIST CLOSED CLAIMS STUDY

A study of The Doctors Company claims involving CRNAs from 2012 through 2020 examined allegations and contributing factors. **FIGURES 8** and **9** provide the most common allegations against CRNAs and the top factors contributing to patient injuries.

FIGURE 8

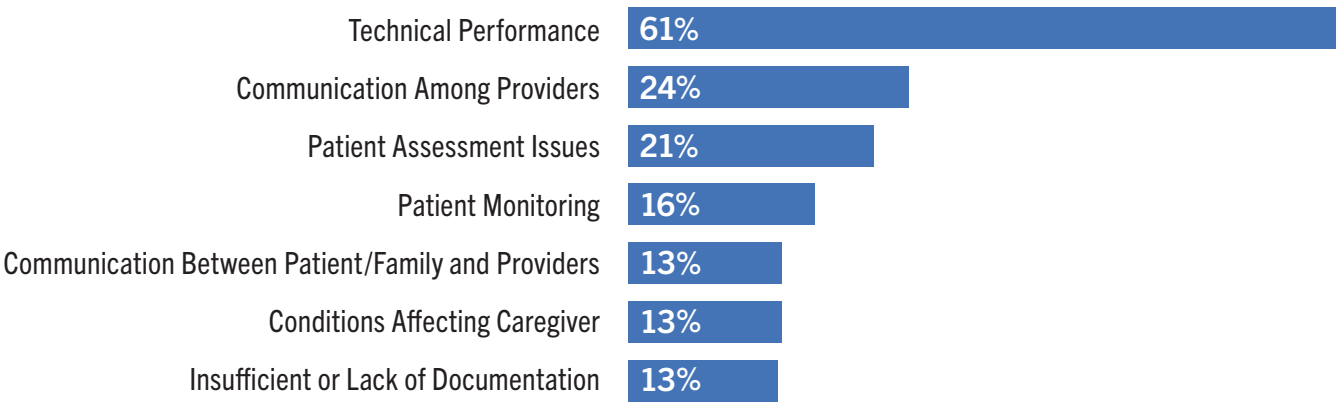
CRNAs: MOST COMMON PATIENT ALLEGATIONS



Source: The Doctors Company Closed Claims 2012–2020

FIGURE 9

CRNAs: TOP FACTORS CONTRIBUTING TO PATIENT INJURY



Note: More than one factor may contribute to patient injury, so the percentages total more than 100 percent
Source: The Doctors Company Closed Claims 2012–2020

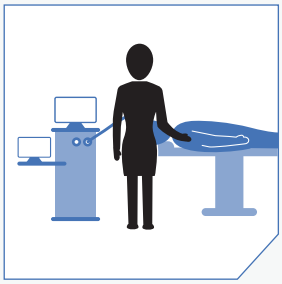
Allegations of **improper performance of anesthesia procedure**—the most common type of claim—included difficulties with intubation, such as intubation injuries or improperly located endotracheal tubes, or injection of anesthesia into a peripheral nerve or into the spinal canal when not indicated.

Allegations of **improper management of anesthesia patient** were due primarily to respiratory, central nervous system, and cardiac complications.

Improper management of surgical patient allegations occurred when improper positioning caused injury to the patient.

CASE EXAMPLE: CRNA

A 72-year-old male with a history of rheumatoid arthritis presented for an arthroplasty of the right hip due to severe pain and dysfunction. The preoperative assessment by the CRNA documented the patient as a Mallampati class 2—easy intubation. Upon induction of anesthesia, however, the CRNA was unable to visualize the vocal cords and was unsuccessful in intubating the patient after three attempts. Blood was noted in the mouth. The patient developed a laryngospasm, and the procedure was canceled.



The patient was admitted to the hospital for observation due to stridor and subcutaneous emphysema. A CT scan and swallow study revealed a perforation of the hypopharynx, requiring surgical repair and a five-week stay in ICU and the hospital with a feeding tube. The patient has ongoing difficulties with swallowing.

The CRNA failed to adequately assess the patient preoperatively to appreciate how the rheumatoid arthritis, stiff neck, and history of difficulty swallowing might affect successful intubation. The inability to view the vocal cords should have alerted the CRNA to the need for a flexible laryngoscope and that blind intubation attempts should have ceased. In addition, there was no evidence of informed consent for anesthesia listing perforation as a risk of intubation.

CASE EXAMPLE: CRNA

A 55-year-old male with obesity (BMI 36) was given general endotracheal anesthesia for an open reduction internal fixation of the right humeral shaft with bone grafting. The patient was placed in a lateral position with beanbags supporting his torso and hips. There was initial documentation of arm board restraints and that pressure points were checked and padded, an axillary roll was positioned under the left chest wall, and the right arm was on a padded arm board. At no time during the six-hour surgery did the CRNA document any further checks of the patient's position or padding.

At the end of the procedure, it was noted that a portion of the beanbags had moved, allowing the patient's hips to slump forward. In the PACU, the patient complained of severe pain in his left chest wall, and reddened areas were noted in the left axilla, pectoral area, and thigh. The patient had no motor or sensory function in his left upper extremity and was ultimately diagnosed with a brachial plexopathy. He has continued complaints of burning pain and needs assistance with grooming and toileting. The CRNA was held responsible for the patient's positioning injuries.

RISK REDUCTION STRATEGIES: CRNA

The following strategies can assist CRNAs in reducing risk and improving quality of care:

- Include information in the informed consent/shared decision-making discussion about anesthesia risks, including special positioning risks and risks of special procedures like nerve blocks and arterial lines. Patients with dental conditions or teeth at risk need to be specifically informed.
- Work with your surgeons, proceduralists, and healthcare organizations to ensure adequate time for preoperative assessments and testing. Some practitioners report pressure to proceed with surgery when they have not had time to do more than a cursory examination and review of the patient's history.

- Include a review of the patient's previous experience with anesthesia in the history and physical. If possible, review previous anesthesia records.
- Tailor an anesthesia plan for each patient to specifically address any abnormal findings from the history or physical exam.
- Document the preoperative anesthesia assessment fully—including the dental exam and screening for obstructive sleep apnea.
- Rely on your examination of the patient's vital signs during anesthesia care rather than assuming that OR equipment is defective when it appears to be malfunctioning. Relying on or ignoring monitors rather than examining the patient is one of the most frequent cognitive errors made by anesthesia practitioners.
- Communicate concerns about the patient's physiological condition to the OR team. Most anesthesia practitioners are reluctant to speak up about the patient's condition unless they detect severe or pre-arrest symptoms.

> Relying on or ignoring monitors rather than examining the patient is one of the most frequent cognitive errors made by anesthesia practitioners.

- Ensure that equipment and supplies for emergency tracheostomies are immediately available in the postanesthesia area. Use simulation drills to prepare for this emergency.
- Monitor the mean arterial pressure in cases that involve bleeding and positioning to prevent brain injury from inadequate oxygenation during surgery. More importantly, do not assume that a mean pressure of the traditionally taught 60 torr is adequate for cerebral circulation for all patients and for all surgical positions.

CERTIFIED NURSE MIDWIFE CLOSED CLAIMS STUDY

Our analysis of claims involving CNMs that closed from 2012 through 2020 examined allegations and contributing factors.

FIGURES 10 and **11** provide the most common allegations against CNMs and the top factors that contributed to patient injuries.

FIGURE 10

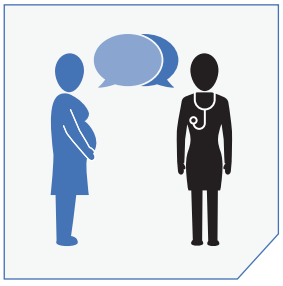
CNMs: MOST COMMON PATIENT ALLEGATIONS

43%	25%	11%
Delay in Treatment of Fetal Distress	Improper Performance of Vaginal Delivery	Diagnosis-Related (failure, delay, wrong)

Source: The Doctors Company Closed Claims 2012–2020

Delay in treatment of fetal distress (43 percent of claims) was alleged when there were injuries such as hypoxic brain injury, cerebral palsy, or neonatal death in the presence of a fetal monitoring strip that displayed multiple late decelerations or a prolonged National Institute of Child Health and Human Development (NICHD) Category III tracing during the intrapartum period. Notably, these cases also commonly included the use of Pitocin and a prolonged second stage of labor.

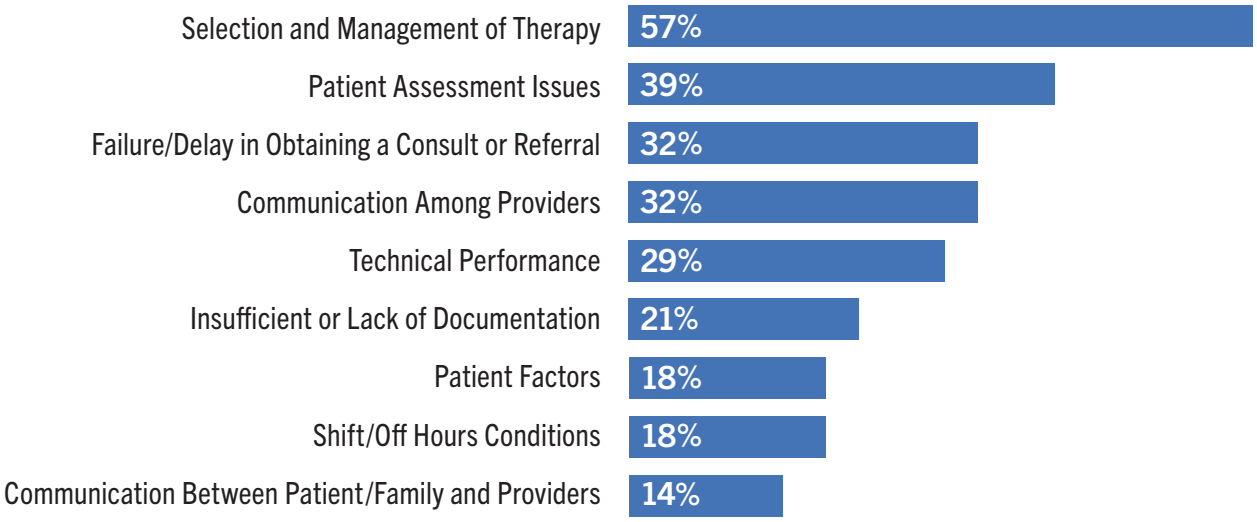
Allegations of **improper performance of vaginal delivery** (25 percent of claims) involved shoulder dystocia deliveries with resulting brachial plexus injury. Although most of the mothers in this group of claims had obesity, other factors—such as post-term dates, macrosomia, or gestational diabetes—were not often present.



Diagnosis-related allegations (11 percent of claims) involved failure, delay, or wrong diagnosis of neonatal and maternal conditions such as intrauterine growth restriction, gestational diabetes mellitus, congenital abnormalities, group B *Streptococcus* infection, and preeclampsia/eclampsia.

FIGURE 11

CNMs: TOP FACTORS CONTRIBUTING TO PATIENT INJURY



Note: More than one factor may contribute to patient injury, so the percentages total more than 100 percent
Source: The Doctors Company Closed Claims 2012–2020

Contributing factors such as **selection and management of therapy** and **patient assessment issues** included not moving to a cesarean section in either the delay in treatment of fetal distress cases or in deliveries that ended in shoulder dystocia.

Patient assessment issues also related to instances such as not noting the estimated fetal weight on shoulder dystocia cases or not recognizing signs of NICHD Category II or III tracings on the fetal monitoring strip.

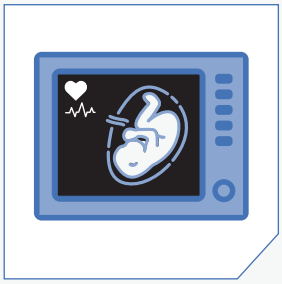
The CNM's failure to consult with the supervising physician played into several of the **failure/delay in obtaining a consult or referral** cases, while **communication among providers** addressed factors such as suspected macrosomia diagnosis not being relayed to the CNM by the referring physician service.

Delay in treatment of fetal distress was alleged when there were neonatal injuries in the presence of a fetal monitoring strip that displayed multiple late decelerations or prolonged NICHD Category III tracing during the intrapartum period.

CASE EXAMPLE: CNM

A 31-year-old, G3P0 patient with an uncomplicated pregnancy at 38+2 weeks estimated gestational age was admitted in labor at 13:15. The fetal heart rate (FHR) baseline was 140. Some late decelerations, occasional accelerations, and moderate variability were noted. Oxygen at 2 liters via non-rebreather mask was ordered along with a 250 cc IV bolus of Lactated Ringers.

At 16:00, an epidural was administered. At 17:45, the FHR was 160 when the CNM called in for a report. The nurse advised that the patient was 4 centimeters dilated and on 3 units of Pitocin for augmentation of the labor and the fetal heart tones were reactive with spontaneous accelerations. The CNM ordered rupture of membranes and internal monitors placed. This was performed by the OB hospitalist on the unit who noted a small amount of clear, odorless fluid. Internal monitors were placed.



At 17:59, the FHR was 160 with moderate variability and variable decelerations. From 18:15 to 19:00, the FHR was 165–170 with moderate variability, no accelerations, intermittent late decelerations, and variable decelerations. The patient was dilated to 6 centimeters, 90 percent effaced, and 0 station.

From 19:15 to 20:00, the FHR showed no accelerations, possible early decelerations, and moderate variability. At 20:10, the patient was 9 centimeters dilated, 100 percent effaced, and 0 station. The CNM was updated by phone that there was moderate variability and occasional late decelerations. Patient's temperature was 99.8. Tylenol and a 250 cc bolus of Lactated Ringers was ordered. The nurses were asked to check the patient in one hour and report back to the CNM.

> The patient had been pushing for two and a half hours with no progress.

At 22:00, the CNM was called with a status. There were no orders. At midnight, the CNM was called again with a status and advised that the patient had progressed to complete dilation. At 02:23, the CNM was at the bedside. The FHR was 165, without accelerations, and variable decelerations were present. At 02:47 the Pitocin was stopped. By 02:52 the patient had been pushing for two and a half hours with no progress. The CNM called the obstetrician to perform a cesarean section.

Prior to transporting the patient to the operating room, the FHR showed prolonged decelerations that expedited the transport of the patient and changed the procedure to emergent status. The infant was delivered at 03:25.

The Apgar scores were 0, 4, 5. The mother was noted to be febrile in the operating room. The infant was intubated, experienced seizures, and was diagnosed with hypoxic ischemic encephalopathy. Cooling protocols were done but over the first four years of life, the child was found to have both gross and fine motor deficits, low IQ, attention deficit hyperactivity disorder, and a speech/language disability.

The infant was intubated, experienced seizures, and was diagnosed with hypoxic ischemic encephalopathy.

The family sued, alleging a delay in treatment of fetal distress. Experts were critical of the labor management due to the late decelerations noted in the fetal monitoring strip as well as the continued Pitocin administration and delayed movement toward an operative delivery.

RISK REDUCTION STRATEGIES: CNM

The following strategies can assist nurse midwives in reducing risk and improving quality of care:

- Maintain competency on FHR tracing interpretations through periodic training and certification. Use the standardized NICHD terminology when describing strips.
- Use technology that allows review of FHR patterns from remote locations so that you are able to see the same information as the bedside nurses when discussing the next steps in labor and delivery care.
- Avoid delay in activating the emergency cesarean section team. Practitioners who choose to attempt operative vaginal deliveries (as permitted by state scope of practice) when faced with Category II or III FHR tracings indicative of metabolic acidemia should activate the contingency team to be available for an emergency cesarean section delivery in case the operative delivery fails.
- Consider multidisciplinary simulation drills for metabolic acidemia, maternal hemorrhage, respiratory arrest in mother or newborn, shoulder dystocia, placental abruptions, amniotic fluid embolism, ruptured uterus, use of forceps and vacuum extraction, and meconium aspiration.
- Conduct an accurate prenatal assessment to identify patients who may be at risk for shoulder dystocia.
- Document informed consent/shared decision-making discussions regarding vaginal versus cesarean delivery.
- Monitor periodic weights and measurements closely.
- Use prompts or checklists to help document thorough assessments, rationale for recommended care, information shared with patients and families, care provided, and outcomes of care.

- Create a follow-up tracking mechanism to monitor all office diagnostic test results and scheduled repeat or serial testing.
- Schedule appropriate follow-up office visits frequently enough to provide adequate monitoring of the pregnancy and of pending test results.
- Refer the patient promptly for consultations with specialists when indicated.

UNDERSTANDING THEORIES OF LIABILITY

When adverse medical events occur, patients frequently seek counsel to explore their legal rights and remedies. Depending on the nature and extent of the damages, attorneys will evaluate whether the circumstances warrant litigation and, if they do, identify which theories of liability might be available.

As a preliminary step, attorneys obtain the patient's records and consult with an independent expert to examine the care rendered by each clinician involved in the case and determine the relative degree of each individual's culpability.

DIRECT LIABILITY FOR NEGLIGENCE

APCs can be held directly liable for their own acts or omissions. It is a concept based on the premise of negligence, which is the most common theory of liability in a medical malpractice action. This can occur when an individual renders care that deviates from the acceptable standard of care and causes harm or injury to the patient.

A negligence cause of action for professional liability includes four elements:

1. **Duty** (the APC's legal responsibility based on the practitioner-patient relationship).
2. **Breach in the standard of care** (the failure to act as a reasonably competent APC would act in the same or similar circumstances).
3. **Causation** (the APC's actions or failure to act that result in injuries to the patient).
4. **Damages** (compensable harm suffered by the patient).

VICARIOUS LIABILITY FOR NEGLIGENCE

The legal theory of vicarious liability holds one person liable for the negligent acts, omissions, or torts (that is, wrongful acts or infringement of a right) committed by another person because of the nature of the relationship between them. It is often used to hold a clinician liable for the conduct of a supervised individual who may be an employee or even an independent contractor.

One type of vicarious liability, *respondeat superior*, is the common law doctrine meaning "let the master answer." Under this doctrine, physicians or APCs can be held legally and financially liable for their employees' negligent acts or omissions that happen during the course and scope of employment. This situation can occur even when the supervising clinician did not personally treat the patient or provide any clinical consultation.

The intent is to ensure that the injured party has a right to full recovery from the entity or practitioner who directed the employee's actions.

Agency theory may also be used to hold a physician or an APC vicariously liable for the negligent acts or omissions of another clinician, even when the clinician is classified as an independent contractor. If it appears to the public that an agency relationship exists between the two individuals, it might be reasonable to assume that the contractor is acting as an agent of the physician or APC. For example, in states that require some level of physician oversight, it would be difficult for a physician to avoid vicarious liability simply by classifying an APC as an independent contractor.

DIRECT LIABILITY FOR NEGLIGENT SUPERVISION

An allegation of negligent supervision can arise in various situations. Negligent supervision can occur when a physician or an APC does not provide adequate oversight of supervised clinicians for services rendered to patients or allows a supervised individual to function beyond the scope of license.

The definition of what constitutes appropriate collaboration with or supervision of an APC can, however, vary greatly from state to state. Typically, PAs are regulated by the state medical board or physician assistant board, and NPs are regulated by the state nursing board. It is imperative for physicians and APCs to be thoroughly familiar with and remain current on the prevailing state laws and regulations in the jurisdictions in which they practice.

Considerations for physicians and APCs when determining the roles and responsibilities of APCs in the practice may include the number of APCs a physician can legally supervise or oversee, criteria for medical record review and documentation, requirements for obtaining and maintaining prescriptive privileges, criteria for consulting with a supervising or overseeing physician, requirements for written practice or collaboration agreements, and requirements for written treatment protocols between a physician and an APC.

It is imperative for physicians and APCs to be thoroughly familiar with and remain current on the prevailing state laws and regulations in the jurisdictions in which they practice.

DIRECT LIABILITY FOR NEGLIGENT HIRING AND CREDENTIALING

Clinicians are responsible for ensuring that their staff members are qualified and properly licensed. It is imperative to prescreen a staff member's background (including a criminal background check) and references thoroughly. For licensed individuals, verify licensure status directly with the licensing authority. Further recommendations to consider when hiring and credentialing staff can be found in the "Employment and Contracting Concerns" section.

LIABILITY CONCERNS

Many malpractice claims attributed to APCs can be traced to clinical and administrative factors: failure to adhere to the scope of practice, inadequate physician supervision or oversight if required, absence or deviation from written protocols if required, and failure or delay in seeking a referral or physician collaboration.

It is essential that APCs provide care and treatment only within their scope of practice.

SCOPE OF PRACTICE

It is essential that APCs provide care and treatment only within their scope of practice and—if required—consult with any collaborating or supervising physicians on complex cases to help ensure that the delivery of services is consistent with the prevailing standards of care.

RELATIONSHIPS WITH PHYSICIANS

Safe patient care is a collaborative effort. APCs should have a low threshold for obtaining consultations or making referrals. Promote an environment without barriers in the patient management process. The APC claims analyzed highlight the importance of good communication between NPs and their physician partners.

Collaboration or supervision agreements, if applicable, should outline circumstances that require the APC to refer patients to the physician or seek a second opinion. APCs and their physician partners must agree on the APCs' scope of practice based on the laws and regulations specific to that state.

COMMUNICATION WITH PATIENTS

Patient satisfaction survey results are favorable for APCs as APCs often provide patients with increased access to healthcare. Studies generally show that APCs spend more time with their patients than physicians. It is, however, important to understand the communication issues that occur in APC claims and the special considerations for building rapport with patients.

All 50 states mandate that every APC must wear a nametag clearly identifying the APC's licensure and role. APCs can avoid allegations of false representation by correcting patients who mistakenly assume that they are physicians.

Claims that involved a communication issue as a contributing factor included lack of patient or family education regarding risks of medications, follow-up, or post-op instructions, and poor rapport involving an unsympathetic response to patients or inadequately addressing unrealistic expectations or patient concerns.

Although communication issues alone do not always lead to an APC claim, they can be a catalyst—especially when coupled with a complication or poor outcome. Patients sometimes perceived that they were improperly informed or received inadequate education or information from the APC. In these situations, documentation at the time of the clinical interaction is critical in the event of an ensuing adverse result.

To mitigate the risk of communication issues in situations involving language barriers, provide a qualified medical interpreter and clearly document the use of the interpreter in the patient's record with sufficient information to identify the individual. Family members are not recommended as interpreters due to their emotional involvement and the potential for misinterpretation.

Document the patient's record with all education efforts and include copies of any materials given to the patient. Address any unrealistic expectations and document attempts to clarify the information.

If ongoing communication problems cannot be resolved, consider taking steps to end the patient relationship (including consulting with the supervising physician, if applicable).

Although communication issues alone do not always lead to an APC claim, they can be a catalyst—especially when coupled with a complication or poor outcome.

For more information, see our articles, "Patient Relations: Anticipate and Address Challenging Situations" at **thedoctors.com/challengingsituations** and "Terminating Patient Relationships" at **thedoctors.com/terminatingrelationships**.

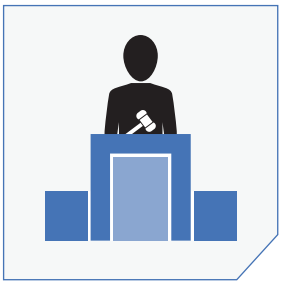
EXPOSURE TO DISCIPLINARY ACTION

State professional licensing boards have jurisdiction for managing the disciplinary actions of licensed APCs. APCs may be subject to licensing board actions for violations such as failing to practice according to the standard of care or practicing outside the scope of their license.

In states that require a supervising physician, the physician and APC are often both subject to discipline if a lack of supervision is discovered. In states that require practice or collaboration agreements or the use of standardized procedures, disciplinary action can be taken against the physician and APC by the state's licensing boards for failure to practice according to the requirements.

Each state board and many professional associations have codes of ethics that all licensees must follow.

Criminal acts and quality-of-care concerns are examples of issues that can lead to investigations by state licensing boards. In many states, a licensed individual who is found guilty of a crime committed outside of work, such as driving while intoxicated, can be subjected to disciplinary action by a licensing board. Quality-of-care issues or drug diversion may necessitate notification by an employer to a licensing board. These situations can result in suspension of the APC's (or physician's) license, followed by revocation if no subsequent evidence confirms the practitioner's competency to perform duties or completion of a specified wellness or drug diversion program.



Each state board and many professional associations have codes of ethics that all licensees must follow. State boards may investigate any concerns reported by patients, government agencies, or facility peer review committees. Depending on the nature and severity of the circumstances and the degree of harm suffered by the patient, potential sanctions include probation, suspension, or even license revocation.

Check your state board and professional designation websites to learn more about disciplinary actions, codes of ethics, and professional scope of practice. For additional information on this topic, please read "Practice Protection for Administrative and Regulatory Actions" at **thedoctors.com/practiceprotection**.

EMPLOYMENT AND CONTRACTING CONCERNS

The hiring process requires screening and verifying the credentials of all prospective employees or independent contractors thoroughly to ensure their qualifications and training. Verify all contact references, licensures, and credentials independently, and conduct additional background inquiries.

Proactively managing employment-related issues can protect patients from harm caused by unqualified staff and decrease liability exposure for the practice. Detailed background reviews, original source verification, and ongoing competency training and evaluation can also help to prevent hiring or contracting with individuals who have fraudulent credentials.

Proactively managing employment-related issues can protect patients from harm caused by unqualified staff and decrease liability exposure for the practice.

The following strategies can assist when hiring or contracting with practice staff:

- Verify the applicant's credentials and prior experience thoroughly. Verify qualifications with original sources.
- Obtain authorization to conduct credit, reference, and police background checks.
- Use a skills checklist and consider proctoring for a set period to determine any required additional training.
- Obtain facility privileges for each APC, if needed, but don't rely solely on the healthcare organization's credentialing process.
- Develop written guidelines for examinations, treatment, delegation, supervision, chart reviews, and consultations.
- Educate other members of your staff and on-call practitioners about the APC's role and limits.
- Be thoroughly familiar with the state statutory requirements, limitations, and licensing guidelines that affect each type of employed or contracted staff.
- Insist that all employees and independent contractors wear badges so that patients can distinguish each staff member's name, licensure, and role.
- Use surveys to determine your patients' satisfaction with the care and services they receive.
- Obtain professional liability insurance coverage for all employed staff, and verify coverage for independent contractors by obtaining a valid certificate of insurance each year.
- Notify your professional liability carrier of any changes to the scope of practice or employment status of your licensed staff.

POLICY AND PROCEDURE MANUALS

Policy and procedure manuals can be valuable reference tools for members of the practice. Manuals can be written for both the clinical and administrative aspects of a practice.

A policy and procedure manual can be the primary reference document for communicating and interpreting office-specific policies, programs, and procedures. Properly written, the manual encourages consistency and adherence to clinical practice guidelines. In contrast, a poorly drafted or outdated manual can increase liability exposure for the practice. Failing to adhere to written policies and guidelines can also increase liability exposure and undermine the defense of a malpractice claim.

A policy and procedure manual can be the primary reference document for communicating and interpreting office-specific policies, programs, and procedures.

Consider the following strategies for managing policy and procedure manuals and educating staff:

- Address commonly performed clinical procedures with specificity.
- Make policies and procedures succinct and easily understood by all staff.
- Review and update individual policies as needed and schedule entire manual review every one-to-three years.
- Avoid protocols that may create unrealistic standards for the practice.
- Date revisions to policies and procedures as they are made.
- Collect and archive all old policies to prevent inadvertently using an outdated policy.
- Retain all archived material indefinitely, if possible, or according to state regulatory or accreditation requirements.
- Provide education on *new* policies and procedures and require staff members to read and acknowledge their understanding.
- Educate new staff and review *current* policies and procedures with all staff.
- Update protocols adopted from reference materials and include sources.

POSITION DESCRIPTIONS

Creating position descriptions can help ensure that employees and independent contractors practice within their scope and follow appropriate guidelines. Descriptions can also help the practice meet state statutory requirements. A written description memorializes the staff member's scope of practice, roles, and responsibilities, and it clarifies any supervision guidelines. Written standardized policies and procedures may be required for APCs with prescriptive privileges. Some states provide sample agreements.

When drafting position descriptions:

- Identify the license or certification required by statute or regulation.
  EXAMPLE: Licensing from the state board of medicine or nursing.

- Identify mandatory certifications and continuing education (CE) requirements.
  EXAMPLE: Fulfills mandatory educational requirements annually *[list requirements]*, which include but are not limited to, The Joint Commission and other institutionally required education; BLS and ACLS, or appropriate certification related to specialty; and CE hours, as required by specific national certification.

- List the drug therapies that the APC may prescribe, initiate, monitor, alter, or order.
  EXAMPLE: The APC may prescribe, initiate, monitor, alter, or order the following medications: *[List medications or classifications according to the APC's prescriptive authority as outlined by state law and granted by the licensing body]*.

- Define the duties and responsibilities of each position clearly, including minimum knowledge, clinical skills, and abilities required for the job.
  EXAMPLE: The APC may treat and manage acute and chronic medical problems of patients in a primary care setting, including interviewing patients, obtaining and recording health histories, performing physical assessments, ordering appropriate diagnostic tests, diagnosing health problems, managing the healthcare of patients for which the APC has been educated, providing health teaching and counseling, initiating referrals, and maintaining health records. Medications are prescribed as outlined in the protocols, and physician supervision or collaboration is provided in accordance with applicable law.

- For any supervised APCs, specify the maximum number of APCs a physician may supervise, based on state regulations.
  EXAMPLE: The APCs are supervised by licensed physicians. All care is rendered in accordance with the guidelines set forth by the state licensing boards and applicable law. *[Specify the number of APCs the physician can supervise.]*

- Identify consultation guidelines that specify when APCs must seek guidance from a supervising physician (if required).
  EXAMPLE: The physician will be consulted for the following conditions: *[List medical conditions or clinical situations]*. One example: workers' compensation.

- Specify the physician's duties for supervising or overseeing APCs.
  EXAMPLE: The physician will provide general supervision for routine healthcare and management of common health problems and provide consultation and/or accept referrals for complex health problems. The physician will be available by telephone or by other means of communication when not physically available on the premises. If the physician is not available, the physician's associate, *[Name of Physician, MD/DO, License #XXXXXX] [or other description of designated doctor(s) or groups]*, will serve as backup for consultation, collaboration, and/or referral purposes.

- Include the signature of the APC and any supervising practitioner.
  EXAMPLE: All parties to this agreement share equally in the responsibility for reviewing treatment protocols at least annually or more frequently as needed.

PATIENT SAFETY AND RISK MANAGEMENT CHECKLIST

Pre-Employment or Pre-Contract

- ☐ Obtain authorization to conduct credentialing and background verification for a candidate.
- ☐ Verify a candidate's credentials and licensure status before employment or contract.
- ☐ Use a skills checklist to assess a candidate's clinical skills prior to employment or contract.

Licensing, Certification, Privileging

- ☐ Verify that all staff members' licensing and certification requirements are current.
- ☐ Obtain APC facility privileges, when required.

Training and Environment

- ☐ Ensure that new staff undergo comprehensive orientation to the practice.
- ☐ Require all staff to wear name badges delineating their roles and licensure.
- ☐ Foster open communication among all staff members.
- ☐ Ensure that all staff members project a professional demeanor.
- ☐ Encourage and promote continuing staff education.
- ☐ Ensure the staff schedule includes time off, vacations, and equitable workload.
- ☐ Promote an environment in which staff can report errors without fear of reprisal.
- ☐ Implement a staff attitude/patient safety culture assessment to identify culture issues that may affect patient safety.
- ☐ Train office staff to recognize the types of complaints from patients or families that warrant immediate follow-up. Allocate office time to seeing patients with fever, bleeding, shortness of breath, and pain who may be experiencing complications of surgery or other invasive procedures. Direct patients with potentially serious conditions to an ED for immediate care.
- ☐ Provide ongoing patient safety and risk management training to all staff.

Position Descriptions, Handbooks, Guidelines, and Protocols

- ☐ Develop written position descriptions.
- ☐ Develop written guidelines and protocols that specify an APC's responsibilities relative to examinations, assessments, diagnoses, treatment, prescriptive privileges, and administrative functions.
- ☐ Clarify the type and extent of physician supervision or oversight required by state laws.
- ☐ Delineate in written guidelines and protocols how often the physician must see the patient and under what circumstances the physician must personally assess the patient when supervision or collaboration agreements are in place.

- ☐ Ensure that all tasks assigned to staff are within the staff member's competence and scope of practice.
- ☐ Develop a handbook for employees and a contractor handbook if using independent staff.
- ☐ Have employees and contractors acknowledge policies and procedures and confidentiality statements.
- ☐ Keep clinical guidelines up to date.

Performance Evaluations and Competency

- ☐ Test competency and document performance evaluations periodically.
- ☐ Establish criteria for periodic review and evaluation of medical record documentation.
- ☐ Monitor the APC's prescription practices and maintain a current copy of the APC's DEA certificate.
- ☐ Conduct annual performance evaluations for all staff.
- ☐ Include patient safety and patient satisfaction in evaluation criteria.

State and Licensure Requirements

- ☐ Obtain and review state licensing board requirements periodically.
- ☐ Remain current on and comply with staff licensure requirements, scope of practice, and supervisory limitations.

Patient Interactions

- ☐ Determine patient satisfaction with the care provided by staff members.
- ☐ Determine patient satisfaction with the practice overall.
- ☐ Document all patient communications, including after-hours call, email, and text interactions.

Business Operations

- ☐ Maintain copies of professional liability insurance coverage.
- ☐ Notify managed care plans, when required, of APC participation in patient care.
- ☐ Notify insurance carriers promptly of clinician staffing changes.

FREQUENTLY ASKED QUESTIONS

Can APCs practice independently and own their own practices?

The answer depends on state laws and regulations where you practice. Check your state board and professional designation websites to learn about laws and regulations in your state.

What are the legal differences between an NP and a PA?

An NP's scope of practice varies from state to state. In many states, NPs are permitted to practice independently without the supervision or collaboration of a licensed physician. However, NPs often practice under the guidance of a licensed physician through a required supervision or collaboration agreement. A PA is generally licensed to practice only with a supervising, participating, or collaborating physician.

Is a PA required to have written protocols in order to practice?

It depends. While it is recommended that a PA practice under written protocols in all clinical settings, many states require written protocols only in certain practice settings.

Is the scope of a PA's practice determined by the supervising, participating, or collaborating physician?

Most state laws permit a PA to practice within the scope of practice of the supervising, participating, or collaborating physician. It follows that a PA's scope of practice may be defined by the limitations set forth by the physician in coordination with the PA's education, training, and experience.

How many APCs is a physician allowed to supervise?

The ratio of APCs to supervising physician (when required) varies. While the American Medical Association does not state a specific ratio, it recommends that the appropriate ratio of physician to APCs should be determined by physicians at the practice level, consistent with good medical practice, the prevailing standard of care, and state law where relevant. In some states, the ratio is specified and may be based on whether the APCs are furnishing or prescribing medications. It is also important to maintain a ratio consistent with any terms specified in your billing contracts, payer-provider agreements, or professional liability policy language.

What are the physician's co-signing requirements for documentation by an APC?

It varies. Each state has regulations that outline which APC type requires co-signature and how many or which type of patient records require review and co-signature. In addition, co-signatures may be required for some third-party reimbursement or as part of a standardized procedure. Regardless of co-signature requirements, establishing a protocol to review records on a regular basis helps ensure quality and reduce exposure to liability. Periodic record review helps ensure that procedures remain consistent with evolving standards and technologies and also assists in achieving and maintaining compliance.

Does the name of a licensed physician need to be on prescriptions issued by an APC?

It depends on state law, the type of APC, and the prescribing privileges. If required, consider that in the case of on-call coverage, the alternate physician's name may need to be indicated.

Which drugs can a prescribing APC write prescriptions for?

While states may allow many types of medication prescriptions within formulary standards (including controlled substances with a DEA registration number), some states impose restrictions on prescribing authority.

Some states have adopted requirements for APCs to complete advanced courses in pharmacology before they are allowed prescribing privileges, especially for controlled substance prescribing. Check state requirements.

Can an APC with prescribing privileges sign for medications received from a pharmaceutical representative?

Yes, but generally only for medications that the APC is authorized to prescribe. Check state laws on prescribing authority to verify the scope of what is permitted legally.

Can an APC dispense medications?

The answer depends on state law and regulation. In some cases, an APC may dispense sample medications as indicated by prescribing privileges.

Does a change in employment affect an APC's prescribing privileges?

The answer depends on state law and regulation. Prescribing privileges, while allowed through licensure, may require approval by the employer, physician, or practice location and may also require submission of new information to the respective licensing board, depending on the state of practice.

How can I protect myself if my supervising, participating, or collaborating physician is not fulfilling the agreed or required responsibilities?

Your relationship with the supervising, participating, or collaborating physician must be built on mutual trust and respect. When that is undermined, patient care ultimately suffers.

Clear communication is critical. Initiate a meeting with the physician centered around your mutual desire to provide the best care for your patients. Bring agreements that you have signed with the group or physician regarding responsibilities and delineation of your role. This could be a good time to clarify any misunderstandings and reset expectations. Proactively bring up cases in which you would need further guidance. After the meeting, follow up with an email summarizing what was discussed and the arrangement going forward. You may need to have multiple discussions to address this issue, and it may involve going up the chain of command to other managing partners of the group if the physician is unwilling to change.

In the meantime, stay within your scope of practice and formally refer the patient to a physician when the patient's care requires treatment outside your scope of practice.

CONTACT US

Our patient safety risk managers are here to assist you.

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