Reducing Risk and Maximizing Benefit: Strategies for Physicians and Midlevel Providers

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Course Description

Reducing Risk and Maximizing Benefit: Strategies for Physicians and Midlevel Providers explores how midlevel provider practice affects medical-legal risks for both the physician and the mid-level practitioner who work together. This educational activity examines practice trends, licensure and regulatory matters and medical-legal issues pertinent to the physician-midlevel provider relationship, and offers practical guidance for reducing liability and enhancing the benefits of this healthcare partnership. This activity also provides self-assessment questions and links to additional resource materials.

This course offers a maximum of 2.0 Category 1 credits toward the AMA Physician's Recognition Award. (Please note: CME credit for this test can only be given to our insured policyholders.)

Educational Objectives
At the conclusion of this educational activity the physician will be able to:

- Summarize current and projected trends related to utilization of midlevel providers
- Understand licensure, regulatory and medical-legal issues pertinent to midlevel providers and supervising/collaborating physicians
- Discuss risk management strategies and best practices for midlevel providers and supervising/collaborating physicians

Proposed CME Credit: 2.0 hour(s)

Faculty
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Completed tests are electronically submitted to MAG Mutual by using the "Submit" button at the end of the test. A passing score is 80% or above. If you achieve a passing score, a certificate of completion will be mailed to the address you will provided on your test. You must use a computer that supports either Internet Explorer (Version 3.0 or higher), Netscape Navigator (Version 3.0 or higher) or Mozilla Firefox (Version 2.0 or higher) to take this test online. If you wish to take a written version of this test, please contact us. You must complete the evaluation at the end of the test before credit can be awarded. Your test form will be electronically scored and the results immediately displayed on your screen.
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Term of Accreditation

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I. History and Emerging Midlevel Practice Trends

Evolution of Non-Physician Healthcare Practitioners

Physicians have employed and worked closely with “assistants” of one sort or another for as long as the medical profession has existed. However, the non-physician healthcare practitioner role in the United States has evolved from a “helper” who was trained exclusively by physicians at the bedside or on the battlefield to the formally educated, independently licensed and relatively autonomous professionals of today, often referred to collectively in healthcare settings as “midlevel providers” (MLPs) or “physician extenders” (PEs).

Throughout the early-to-mid 20th century, the growth of these increasingly-independent practice models was spurred on by a physician shortage, particularly in military hospitals and underserved rural and inner-city locations. The first effort to professionalize midwifery, for example, took place in the isolated mountains of Kentucky in 1925, and nurse anesthetists have been principal combat anesthesia providers since World War I.

In 1957, the first Master’s degree “nurse clinician” program was begun at Duke University, developed collaboratively by a physician and a nurse educator. Several years later, this same physician went on to develop a formal “physician’s assistant” program which utilized former military corpsmen, and the program was inaugurated at Duke University in 1965. The first formal education program for “nurse practitioners” was also established in 1965 at the University of Colorado, with a curriculum focused on health promotion, disease prevention, and children’s health. Today, MLPs attend advanced degree programs, practice under state licensure regulations and work in virtually every setting that physicians do.

The nomenclature used for MLPs sometimes confusing. These professionals are interchangeably referred to by most physicians and boards of medicine as “midlevel providers” (which is what this article will use) or “physician extenders”; however, the professional associations representing MLPs generally advocate for the use of more specific titles. MLPs or PEs are actually comprised of two primary groups, Advanced Practice Registered Nurses (APRN) or Advanced Practice Nurses (APN) and Physician Assistants (PA).

According to the National Council for State Boards of Nursing, an APRN is a nurse who has:
- completed an accredited graduate-level education program;
- passed a national certification examination;
- acquired advanced clinical knowledge and skills preparing him/her to provide direct care to patients (including health promotion and maintenance, assessment, diagnosis and management of patient...
problems and prescription of pharmacologic and non-pharmacologic interventions); and

- obtained a license to practice in one of the four recognized APRN roles:
  1. certified registered nurse anesthetist (CRNA)
  2. certified nurse-midwife (CNM)
  3. clinical nurse specialist (CNS)
  4. certified nurse practitioner (CNP) (1)

More recently, there are a growing number of APRNs in clinical practice who also hold doctorate level degrees (Doctorate of Nursing, or DNP). In 2004, the member schools affiliated with the American Association of Colleges of Nursing (AACN) endorsed a decision calling for moving the current level of preparation necessary for advanced nursing practice from the master's degree to the doctorate level by the year 2015. (2) There is currently controversy in both the medical and nursing communities due to disagreement about the level of practice autonomy these nurses should have and their use of the title “doctor”.

According to the American Academy of Physician Assistants, PAs are healthcare professionals who are authorized by the state to practice medicine as part of a team with physician, certified by the National Commission on Certification of Physician Assistants, and are licensed, certified or registered in the state in which they practice. PAs have completed rigorous accredited training programs, most of which are now at the graduate level, and they deliver a broad range of medical and surgical services, including:

- Conducting physical exams
- Obtaining medical histories
- Diagnosing and treating illnesses
- Ordering and interpreting tests
- Counseling on preventive health care
- Assisting in surgery
- Prescribing medications (3)

In addition to the didactic components of their programs, all MLPs complete hundreds of hours of clinical training in various settings. Most MLP students have bachelor's degrees and several years of prior clinical experience before they begin a MLP program. To maintain professional certification, MLPs are required to complete ongoing continuing education credits and typically must re-certify every few years.

**Emerging Employment Trends**

The number of MLPs in the US is growing quickly, due to several factors:
• There is an increasing demand for healthcare services as our population grows and ages.
• Significant shortages in primary care physicians have been projected for the near future.
• MLPs typically provide safe, cost-effective care.
• There has been a push at the governmental level to increase utilization of MLPs due to economic pressures, projected primary care physician shortages and changes in healthcare delivery initiated by the federal Affordable Care Act in 2010.

Numerous studies and sources illustrate these trends:
• Between 1992 and 2000, the number of NPs increased 240% and the overall number of NPs, PAs, and CNMs combined increased 160%; at the same time, the scope of practice and approved procedures for these professions expanded and the level of required direct physician supervision decreased. (4)
• From 1996 to 2008, the number of PAs increased from 29,000 to 75,000, while NPs grew from 71,000 to 158,000. (5)
• The U.S. Bureau of Labor projects the number of PAs to rise to 103,900 in 2018, representing an increase of nearly 40% from 2008. (6)
• According to the American Academy of Nurse Practitioners (AANP), nearly 1000 new NPs completed U.S. academic programs in 2010-2011. (7)
• The American Association of Colleges of Nursing reports there are currently 184 US DNP programs with an additional 101 DNP programs in the planning stages. From 2010 to 2011, the number of students enrolled in DNP programs increased from 7,034 to 9,094. (8)
• In 2009, the Center for Disease Control’s National Ambulatory Medical Care Survey (NAMCS) concluded 49% of physicians overall in primary, surgical and medical ambulatory care practices were working with at least one NP, CNM or PA. (9)
• In 2000, 10% of outpatient hospital visits were with only a PA or APRN, which increased to 15% in 2008. (10)
• In 2010, the Institute of Medicine published the Report on the Future of Nursing. The report’s number one recommendation was “removing scope-of-practice barriers so that advanced practice RNs can practice to the full extent of their education and training”. Key provisions of this recommendation included, for example, expanding the Medicare program to include coverage of APRN services and increasing Medicaid reimbursement rates for APRNs providing primary care services similar to physicians. (11)
• According to the American Midwifery Certification Board, as of January 2012 there are 12,622 CNMs and 73 CMs (certified midwives) in the US, and since 1991, the number of midwife-attended births has more than doubled. CNMs and CMs attended 313,516 births in 2009, according to
the National Center for Health Statistics, representing 11.3% of all vaginal births, or 7.6% of all US births. (12)

- The American Association of Nurse Anesthetists (AANA) 2011 Practice Profile Survey reports that around 40,000 CRNAs deliver more than 33 million anesthetics to patients each year in the US. (13)
- In the past few years, there have been notable legislative changes in many states that have expanded the scope of practice and prescriptive authority for advance practice nurses (APNs). (14)

There is no doubt that these trends related to MLPs will continue for the foreseeable future, so it’s in the best interest of every physician to remain as informed as possible about this changing landscape.

II. Midlevel Provider Liability

Clearly, there are significant benefits associated with utilization of MLPs. Research shows midlevel providers:

- Provide high quality, cost-effective care
- Improve efficiency and patient access to healthcare
- Facilitate communication between the patient and healthcare team
- Receive high patient satisfaction marks
- Can address projected PCP shortages
- Allow physicians more time to manage complex medical cases
- Provide enhanced patient education
- Allow for broader cross-coverage and after hours on-call

Overall, MLP involvement in lawsuits is relatively infrequent, and using MLPs may actually reduce physicians’ overall liability risk. One 2009 analysis of 1991-2007 data from the National Practitioner Data Bank (NPDB) showed that PAs were 12 times less likely to make malpractice payments than physicians, and APNs were 24 times less likely. (15)

However, there are some specific medical-legal risks for physicians who work with MLPs that need to be considered:

- Supervising/collaborating physicians will usually be named as co-defendants in malpractice suits involving MLPs, even when the MLP is the primary caregiver and the supervising physician has had no contact with the patient
- “Inadequate supervision” on behalf of the physician will usually be alleged in malpractice suits involving MLPs
- In addition to malpractice liability concerns, failure to comply with state requirements for supervision of MLPs can result in disciplinary licensure actions, monetary fines and even criminal charges for the physician.
Legal Doctrine for Physician Liability Related to MLPs

Direct liability is the physician’s responsibility for his or her own actions. However, the doctor also may be held directly liable for the acts or omissions of a MLP if he or she is negligent in selecting or supervising the MLP.

Negligent selection may be alleged when a supervising physician fails to use reasonable care to assure MLP competence or confirm proper training and certification and the MLP causes an injury. In other words, if the MLP causes an injury and the plaintiff can show that the supervising physician knew (or should have known via reasonable diligence) that the MLP had the potential to practice in a dangerous or reckless manner and that hiring the MLP caused the injury, the physician may be found directly liable for the plaintiff’s injury.

In negligent supervision claims, the acts of the doctor (and not necessarily those of the MLP) are at issue. Supervising physicians who fail to respond, are unavailable or who provide inadequate training, quality assurance or oversight (or who don’t maintain adequate documentation of such oversight) may be held directly liable for plaintiff injury.

Vicarious liability can be found when the physician is held indirectly liable for the wrongful acts of the MLP. The plaintiff usually employs the doctrine of respondeat superior, Latin for “let the master answer”, to make this type of claim. To successfully pursue respondeat superior allegations, it must be shown 1.) the MLP committed a negligent act, and 2.) the physician was in a position to control the activity of the MLP. Physician liability under respondeat superior may be affected by the nature of the contractual relationship between the physician and MLP (i.e., whether an employer-employee or a principal-agent relationship exists, who hired or could terminate the MLP’s services, who pays the MLP’s wages, etc).

It is beyond the scope of this article to address liability nuances specific to the practice of each different type of MLP or each type of setting. In general, the clinical liability and patient safety concerns for physicians and MLPs in a given practice setting will be similar. Liability exposure for the physician may shift somewhat depending on whether the physician “supervises” or has a “collaborative agreement” with the MLP, which can vary from state to state and also from one practice site to another. As one attorney author puts it: “Instead of the direct supervisory role, the collaborative practice agreement provides for a transition of responsibilities between different health care providers with differing scopes of practice.” (16)

It is also beyond the reach of this article to discuss specific state-to-state variations in MLP scope of practice, prescriptive authority and physician supervision requirements. As of 2010, the board of nursing had sole authority for APN scope of practice in 24 states, with no statutory or regulatory requirements...
for physician collaboration, direction or supervision; 20 states had sole board of
nursing authority with a physician collaboration requirement; 3 states had sole
board of nursing authority with a physician supervision requirement; and in 4
states, APN scope of practice is authorized by both the board of nursing and the
board of medicine. (Washington, D.C. was counted as a state by this reference).
(17)

The scope of prescriptive authority for APNs varies from state to state also: as of
2010, 14 states allow NPs to prescribe (including controlled substances)
independent of any required physician involvement; 35 states allow NPs to
prescribe (including controlled substances) with some degree of physician
involvement or delegation of prescription writing; and in 2 states NPs can
prescribe (excluding controlled substances) with some degree of physician
involvement or delegation of prescription writing. (18)

It is imperative that all physicians working with MLPs consult their own state
licensure boards to ensure they are complying with current state regulations
regarding these matters. Local and state medical societies and MLP professional
organizations are also good sources of information.

Common Claim Areas for MLPs

Lawsuits involving MLPs typically involve one or more of these allegations:

- Inadequate examination/assessment
- Diagnostic error or delay
- Inappropriate or inadequate treatment
- Failure to monitor condition
- Medication errors
- Failure to consult with or refer to a physician when indicated
- Failure to practice within the designated scope of practice
- Deviation from written protocols
- Documentation errors

Unfortunately, in a litigation situation, all of these allegations can be (and usually
are) tied to negligent physician supervision, which typically means the physician
will also be a named defendant in lawsuits involving MLPs.

MLP liability is also tied to specialty and practice setting, much like physician
liability. To cite an example: According to the most recent report published by
PIAA, which reviewed 1985-2011 claims data, the Ob/Gyn specialty had the most
paid claims and highest total indemnity of any specialty, including the most
payments of $1 million or more. The five most prevalent medical conditions for
Ob/Gyn claims reported when the alleged incident occurred were pregnancy,
breast cancer, brain damaged infant, symptoms involving the abdomen or
pelvis, and back disorders; MLPs manage many patients with these types of
conditions on a regular basis. (19)
Nurse Practitioner Liability Considerations

A comprehensive NP claims review was published in 2009 by CNA HealthPro which analyzed statistical data from CNA's claims files on medical malpractice lawsuits brought against NPs 1998-2008. Some key findings emerged from review of 707 open and closed claims (out of a total of 1799 reported claims):

- **Ultimate average indemnity payments** for NPs increased from just under $100,000 in 1998 to nearly $200,000 in 2008.
- **Claims by specialty**: Adult/geriatric medicine and family and pediatric/neonatal medicine continued to have the most claims in the database, accounting for 84.3% of CNA open and closed claims. The pediatric/neonatal specialty had the highest average severity. Although these claims were only 4.7% of the closed claims, their average paid indemnity was $318,150.
- **Claims by location**: Medical care offices experienced the highest number of open and closed claims. The highest severity claims occurred at freestanding urgent care centers (based on a small sample) and from inpatient hospital services.
- **Claims by injury**: Wrongful death was the injury alleged in 40.5% of open and closed claims. An infection, abscess, or sepsis was the injury most frequently related to a death. Cardiac condition was associated with 22.1% of the closed claims that resulted in death. Categories of injuries with an average paid indemnity over $150,000 (in closed claims) included fetal/infant birth-related brain injury, brain injury other than birth-related, paralysis, cancer, loss of organ or organ function, wrongful death, cardiac condition and dislocation.
- **Claims by allegation**: Diagnostic-related allegations, such as incorrect diagnosis or failure to diagnose, accounted for 39% of open and closed claims, treatment for 28% and medication errors 18%. The remaining 15% was comprised of assessment, monitoring and “other”. The allegation that an NP provided services outside of the designated scope of practice (as defined by statute, regulation, or protocol) was infrequent, but resulted in the highest average severity among the closed claims. (20)

**Case Study: Weak Handoff Communication Causes Error in Patient’s Coumadin Therapy**

**Facts**: A 46 year old obese female underwent aortic heart valve surgery for aortic insufficiency with left sided ventricular enlargement on June 6.

During the post-operative hospital stay, the attending cardiologist periodically adjusted the patient’s Coumadin dose over three days. The cardiologist increased the dose each day, beginning with 5 mg/day, then 7.5 mg/day and finally 10 mg/day by the third day.
Starting on Friday, June 10, three different practitioners covered for the cardiologist. On that day, one of the nurse practitioners rounded on all of the inpatients that would likely be discharged during the weekend, including the subject patient. After visiting her, the nurse practitioner called the Coumadin clinic nurse to inform her that the patient would be discharged on a Coumadin dose of 10 mg/day.

On Saturday, another cardiologist from the same practice saw the patient in the hospital and reduced the Coumadin to 2.5 mg/day based on his assessment of the clotting studies, which showed increasing INRs. The patient was discharged on Sunday on a 2.5 mg/day dose. When she reported to the Coumadin clinic on Monday, her INR was 3.49. (Target INR range is typically 2.0-3.0 or 2.5-3.5, depending on the condition being treated.)

The Coumadin clinic nurse phoned the results to the attending cardiologist without realizing that the patient’s Coumadin discharge dose had decreased. The nurse instructed the patient to continue taking the 10 mg dose, and return to the clinic in a week. The actual hospital discharge orders with the lower dose of Coumadin were never communicated to the attending cardiologist’s office.

A week later at the recheck visit, the patient’s INR measured 18. The attending cardiologist immediately admitted the patient to the hospital for monitoring. He also terminated the Coumadin, and ordered vitamin K administration and a head CT to rule out intracranial bleeding. The CT came back normal.

The patient remained stable until Tuesday, June 21, 10:05 PM. At that point, she became diaphoretic and tachycardic, and went into cardiac arrest. Full resuscitative measures were initiated. The resuscitation efforts failed, and the patient was pronounced dead at 11:45 PM. An autopsy was performed. The medical examiner concluded that the patient died of cardiac tamponade resulting from an accumulation of hemorrhagic fluid in the pericardium as a result of anticoagulant usage.

**Disposition:** The case settled for very large amount.

**Risk Management Commentary:**

- Avoid verbal communication of orders unless absolutely necessary. Use written instructions and written orders. If verbal orders are unavoidable, then implement a “read back” policy to decrease the likelihood of an error.

- Develop a policy and procedure for documenting and communicating discharge instructions to the physician that will follow the patient once they arrive home.
• Provide the patient with a written copy of discharge instructions, along with verbal instructions for reinforcement. A copy of the instructions should be retained in the hospital medical record and a copy should be sent to the office where the patient will be following up.

• On-call communications between healthcare providers should always be documented in the patient’s chart.

• When multiple providers follow patients, it is crucial to update the medication and problem lists at each visit and communicate any changes to the attending physician.

• There should be a verbal or in-person hand-off process between off-going and oncoming providers. If the Friday nurse practitioner and Saturday physician had discussed the patient case, the Saturday physician may have been more alert to ensuring the office was aware of the dose change.

• Be especially careful when patient care handoffs occur outside of office hours. The last communication from a hospital provider to the Coumadin clinic nurse occurred on Friday; there was no clear mechanism in place to ensure the office was made aware of any further changes that may have occurred over the weekend.

Nurse Anesthetist Liability Considerations

According to the American Association of Nurse Anesthetists (AANA):

“Anesthesia outcomes are affected by factors such as provider vigilance, attention, concentration and organization, not whether the anesthesia professional is an anesthesiologist or a CRNA or whether the CRNA is supervised...regardless of whether a state requires nurse anesthetists to be supervised by a physician, nurse anesthetists are always independently responsible for their actions.” (21)

The AANA also notes:

• Forty states do not have a supervision requirement concerning nurse anesthetists in nursing or medical laws or regulations. Even taking into account state hospital licensing regulations, there are still 33 states that do not require physician supervision of CRNAs.

• The laws of every state permit CRNAs to work directly with a physician or other authorized healthcare professional (for example, dentists and podiatrists) without being supervised by an anesthesiologist.

• Whether a surgeon will be held liable for the negligence of the anesthetist or anesthesiologist depends on the facts of the case, not on the nature of the license of the anesthesia professional.
According to an analysis of 1994-2004 NPDB data, 8297 anesthesia related malpractice payments were made on behalf of physicians (82%), nurses (12.2%), and dentists (5%). The most common anesthesia malpractice payments (provider type unidentified) included death (35%), quadriplegia, brain damage or lifelong care (13%), minor permanent injury (10%), significant permanent injury (9.7%), and minor temporary injury (9.4%). The leading causes for anesthesia malpractice payments were monitoring issues (1183), followed by improper technique (845), intubation (803), agent use or selection (390), and positioning (425). (22)

According to the 2012 PIAA claims review report, the following “medical misadventures” are specified when the insured defendant is an anesthesiologist:

• Intubation problems
• Errors in agent use or selection
• Problems with patient monitoring in surgery
• Problems with patient monitoring in recovery
• Failure to delay case when indicated
• Lack or improper performance of preoperative evaluation
• Problems with administration of blood or fluids
• Improper supervision of others

The report also noted that the most frequent location of an alleged incident within an institution continues to be the operating room, accounting for about 31% of claims.

**Case Study: Patient Succumbs to a Preventable Anesthesia Respiratory Event**

**Introduction:** Adverse outcomes associated with respiratory events continue to constitute the single largest class of injury in closed claims study reports published by the American Society of Anesthesiology. The reports found that, in about half of the claims related to esophageal intubation, breath sounds had been auscultated and documented, but no other methods to confirm endotracheal (ET) tube placement had been employed. Thus, relying on breath sound auscultation alone to confirm ET tube placement can lead to the erroneous conclusion that the intubation was successful.

**Facts:** This case involves the death of a 29 year old female patient, married with two young children, who underwent an ERCP under general anesthesia. An anesthesiologist and CRNA were both present during induction. As per protocol, the patient received pre-oxygenation with 100% oxygen prior to intubation. The endotracheal intubation was completed without incident.

*The anesthesiologist and CRNA confirmed endotracheal tube placement by auscultation of breath sounds and by monitoring the patient's expired carbon dioxide (CO2) tracing. Following induction and intubation, the surgical team*
turned the patient to a prone position for the procedure. After repositioning, neither the anesthesiologist nor the CRNA checked the endotracheal tube position or listened to breath sounds. At this time, the anesthesiologist and CRNA observed that the CO2 monitor did not display any expired CO2.

The anesthesiologist asked the surgeon to pass a suction catheter through the endotracheal tube to look for gastric secretions to determine if the endotracheal tube was in the esophagus versus the trachea. Suddenly, the patient's heart rate began to drop rapidly and the patient went into cardiac arrest. All attempts to resuscitate the patient failed and the patient was pronounced dead after 30 minutes of cardiopulmonary resuscitation.

The anesthesia team believed that their equipment had malfunctioned. They did not trust the CO2 monitor, which they had turned on and off several times during the events. After the patient’s death, the hospital sent the medical equipment for testing, and all the equipment was found to have been functioning normally.

The plaintiff's estate did not file suit against the hospital or surgeon. Only the anesthesia team was named, and negligence was alleged on behalf of both the physician and CRNA.

**The Plaintiff’s Allegations:**

- The anesthesia team failed to verify endotracheal tube placement at induction or after repositioning.

- The anesthesia team failed to visually or physically assess the patient for any signs of distress.

- No attempt was made to manually ventilate the patient while the equipment was being checked.

**Disposition:** This case settled for a substantial amount of money.

**Risk Management Commentary:**

The major errors made in this case were that the anesthesia team failed to auscultate both sides of the chest after re-positioning the patient, and did not trust the monitors.

- Correct positioning of the endotracheal tube or laryngeal mask should be verified by both clinical assessment and measurement of the amount of CO2 in the expired gas.

- Resources for the treatment of potential anesthesia complications during surgery should be immediately available.
• **Alarms on monitoring equipment should never be disabled, and should be audible.**

• **In addition to preventative maintenance checks, anesthesia departments should conduct pre-use system checks at least before the first case every day.**

**Nurse Midwife Liability Considerations**

According to the American College of Nurse Midwives, the vast majority of midwives in the U.S. are certified nurse-midwives (CNMs) and certified midwives (CMs). CNMs are licensed and have prescriptive authority in every state and CMs are licensed in five states, with prescriptive authority in one state. Approximately 82% of CNMs have a master's degree, and a graduate degree has been required for entry to midwifery practice as a CNM/CM since 2010.

Published research has demonstrated that midwifery care is typically safe and effective, receives high levels of patient satisfaction and is cost-effective. Midwifery care has also been shown to be associated with lower rates of cesarean birth, lower rates of labor induction and augmentation, significant reduction in the incidence of third and fourth degree perineal tears, lower use of regional anesthesia, and higher rates of breastfeeding. (23)

Little data exists regarding nurse midwife claims analysis. In 2009, 1340 CNMs and CMs responded to a survey about malpractice liability. Some findings included:

- 32% had been named in a lawsuit at least once.
- Median number of years in practice when the event leading to a lawsuit occurred was 6.
- The majority of midwifery lawsuits involved hospital births and were settled prior to going to court.
- Three variables were statistically significant for involvement with litigation: the midwife's age, the number of births attended, and the ACNM region of practice in the United States. (24)

Per PIAA claims data from 1985-2011, of the 12,447 Ob/Gyn paid claims in the database, 4461 are attributed to “improper performance of a procedure”. The most prevalent condition linked with improper performance is “managing pregnancy”, which accounted for 39% of the claims paid in relation to this type of misadventure.

However, out of a total of 178,362 claims involving a list of 26 different types of “associated personnel”, “nurse midwife” was # 23 on the list, making up only 0.32% of the total, as compared to #1 “other MD” (47%) and #2 “nurse” (7.06%). Further, in the breakdown of claims by “type of institution”, “birthing center” accounted for only 0.010% of the institutions identified in 267,713 claims (#15 of
out of 16). These data tend to support the opinion that nurse midwives safely and effectively manage lower risk pregnancies, despite working in a traditionally high risk specialty. However, lawsuits related to childbirth for any practitioner do tend to be high severity and have some of the largest payments.

Lawsuits involving childbirth and newborn brain injury usually include allegations related to faulty team member communication and failure to follow chain of command. If there is a physician-midwife team, both will likely be named as defendants. Because of the team nature of managing labor and delivery, and because labor sometimes occurs over many hours with personnel changes, it is especially critical for all team members to have excellent communication skills and agreed-upon nomenclature to describe fetal heart monitor strips, assessments, etc.

**Case Study: Lack of Midlevel Supervision Contributes to Shoulder Dystocia Claim**

**Facts:** A 29-year-old female patient G2, P1 presented with a past history of shoulder dystocia in her first delivery. Her EDC (estimated delivery date) was April 24. At her next prenatal visit on April 5th, she was seen by a CNM (certified nurse midwife). At that time she weighed 226 lbs, and the clinical assessment estimated the fetal weight to be over 8 lbs.

The patient was admitted on April 13th at 6 AM for pitocin induction. The attending OB physician (Dr. "A") examined her at 8 AM, then turned the induction over to the CNM and left the hospital.

At 11:30 AM, Dr. "A" signed out to his partner, Dr. "B", due to a family emergency. Dr. "A" allegedly asked Dr. "B" to cover the call from 2 PM until he returned the next morning. However, Dr. "A" did not advise the patient, CNM or hospital nursing staff of his emergency. In contrast, Dr. "B" claims that Dr. "A" asked that he assume the call coverage only at 4 PM, so Dr. "B" left the hospital to go to a previous social commitment.

The patient's labor progressed uneventfully until 2:05 PM when she began pushing, and the CNM noted shoulder dystocia. The CNM attempted to contact Dr. "A" but the doctor didn't respond to cell phone calls or return pages. The CNM then made three attempts to turn the baby, and finally delivered the posterior arm by reaching under the axilla and sweeping the arm over the chest.

The baby delivered rapidly after this maneuver. The female infant weighed 9 lbs. 10 ozs. The shoulder dystocia complication caused severe Erb's Palsy. Documentation confirmed that the patient intended the CNM to deliver the baby, but she had specifically requested that Dr. "A" be immediately available since she had a shoulder dystocia history.
**Disposition:** This case settled for a substantial amount.

**Risk Management Commentary**

- **Delivery arrangements:** Dr. "A" failed to comply with delivery arrangements, which was particularly significant given the patient’s high risk for shoulder dystocia. If a physician promises to be present during the delivery, or immediately available, then either he or another physician should be present. Since this patient was high risk, the physician should have been primarily responsible for her delivery, not the CNM.

- **Communication breakdowns:** Verbal handoffs and orders increase the potential for miscommunication and errors. Both doctors differed on whether call was to begin at 2 or 4 PM. A change in call status should be communicated to both staff and the hospital to ensure that a physician can be reached. If verbal orders must be given, then the receiver should be asked to repeat back the order, instructions or coverage summary.

- **Midlevel staff supervision:** The supervising physician must utilize collaborative practice agreements or protocols (per state regulations), monitor the midlevel staff for competency, and ensure that the midlevel staff follows the protocols as written.

- **Midlevel staff compliance:** The CNM needs to follow the agreed treatment plan, call and update the attending physician during induction and document the telephone calls in the medical record. When the CNM encountered the problem, she attempted one call to the attending physician and decided to proceed with the delivery without placing a stat page for any physician in the hospital to come to the delivery.

- **Conflicting testimony:** A student CNM observing the delivery hurt the defense when she contradicted the testimony of the delivering CNM. Be aware of anyone present during treatment or delivery and whether it is appropriate to have the individual present during an emergency situation.

**Physician Assistant Liability Considerations**

The Physician Insurers Association of America conducted a national review of closed claims (1985–2004) that involved PAs. Findings revealed:
- The average indemnity payment was $174,871 (unadjusted to present value), which was higher than that for physicians.
- 42% of claims involving PAs resulted in an indemnity payment.
- In most cases, indemnity payment was made on behalf of a PA or other PE by the supervising physician’s policy or that of the physician’s professional association.
Most of the PA malpractice claims involved diagnostic error. The most prevalent medical condition involved in claims was acute myocardial infarction, most often due to a failure to diagnose. The majority of claims and the greatest number of paid claims were made in general and family practice, while the highest average indemnity payment was made in neurosurgery ($379,314). (25)

Another review looked at claims and suits brought against Colorado-licensed PAs insured by CO-PIC from 2002 to 2009; there were 34 claims against PAs over an 8-year period, a majority involving primary care and emergency medicine/urgent care. Other findings:

- PAs experienced 5.8 claims/suits per 1,000 provider years, whereas the doctors' rate was nearly seven times higher at 38.2.
- In the 27 cases (79% of the total) where both the PA and the supervising doctor were named in a claim or suit, the physician had also examined the patient nearly 50% of the time.
- Supervising doctors evaluated the patient or were consulted by the PA in two-thirds of all cases that ended in a monetary settlement or that went to trial. (26)

The report concluded: “This high rate of direct supervision in cases the plaintiff pursued to litigation suggests that PAs are involved in litigation for generally the same reasons as physicians. Direct supervision does not appear to protect against malpractice litigation risk.”

Another point to keep in mind: Overall, PAs are more likely than APNs to perform invasive procedures and assist physicians with surgery as part of their normal scope of practice, so this should be a particular area of attention. While hospitals and other regulated and/or accredited facilities typically require all medical staff, including MLPs, to be properly credentialed to perform procedures, this doesn’t relieve the supervising or collaborating physician’s responsibility to ensure MLP competence, as previously discussed.

It is therefore important to ensure that all MLPs who perform procedures, regardless of practice setting, have adequate training and interval competency validation. Also be sure to thoroughly document training and competency evaluations.

**Case Study: Inadequate Wound Infection Management Leads to Lawsuit**

**Facts:** A woman presented to a plastic surgeon with considerable excess skin and trunk fat. She had previously had liposuction surgery. She signed a surgical consent for a belt lipectomy and liposuction of the back and inner thighs. A total of 7,480 grams of tissue was removed from the abdomen; four JP drains were placed. The patient was discharged from the surgical center the following day.
Six days post-operatively the patient called with general questions and to report that one of the drains was putting out less than 30 cc’s of fluid. The office nurse instructed her to discontinue the use of her pain medications and use muscle relaxants instead. She also instructed the patient to use bikers’ shorts to help alleviate the swelling in her legs. The nurse offered the patient an appointment for the drain removal, but the patient stated that she was too sick to go to the office. Later the patient claimed she asked if someone from the office could come to her home to remove the drain.

Nine days post-operatively the patient called with complaints of a temperature of 101 degrees and generalized body aches. The plastic surgeon’s physician assistant (PA) spoke with her and called in a prescription for Ciprofloxacin 500 mg BID. The plastic surgeon was out of town. No supervising physician had been assigned to the PA during the surgeon’s absence.

The following day the patient called the PA again with similar complaints of a 101 degree temperature and body aches. She was instructed to follow up the next day at her regularly scheduled appointment with the surgeon.

On the 10th post-op day, the plastic surgeon saw the patient in the office for her first scheduled post-operative visit. He removed all of the wound dressings, and documented that the drain looked good, and no wound separation was noted. However, there was an area of infraumbilical necrosis with ecchymosis. The central portion of the umbilical incision, and extending downward, was blistered, with dark skin noted above the closure lines. The patient's temperature was within normal limits, although she had reported having had temperatures of 101 degrees. One drain was removed.

Because of the skin discoloration, the surgeon wanted her to return to the office in two days for further follow-up. The patient returned as instructed. The surgeon documented the incision looked somewhat improved, but there was a large area in the center of the abdomen that was necrotic, with surrounding areas of redness and tender to the touch. All drains were intact. The patient reported that her temperatures had not been elevated.

On the 12th post-op day the patient returned with an elevated temperature. The plastic surgeon admitted her to the hospital on an emergent basis for re-exploration of the surgical site. Upon opening the wound, he found pus and extensive necrotizing fasciitis involving much of the abdominal wall fat.

The diagnosis was necrotizing fasciitis of the abdomen, flanks, left breast and axilla after belt lipectomy.

The patient subsequently underwent numerous debridements and skin grafts, and was eventually discharged from the hospital with 16 days of home health care.
Allegations: The plaintiff claimed that the plastic surgeon and the PA failed to diagnose and treat a surgical wound infection that she developed following her belt lipectomy, resulting in the development of necrotizing fasciitis, and leading to multiple additional surgeries, treatments and pain and suffering.

Disposition: The case was mediated on behalf of both the plastic surgeon and the physician’s assistant with a substantial payment to the patient/plaintiff.

Risk Management Commentary:

This case had been scheduled for trial because it was felt that our policyholders had reasonable expert support. Then a plaintiff's expert identified, and dated, a photograph showing necrotic tissue to the day when the plastic surgeon first saw her. Based on that photograph, it was alleged that the patient should have been sent to the hospital, and the surgeon concurred.

Under state laws, PAs are not allowed to practice without a supervising physician. When a supervising physician is going to be unavailable, a back-up on-call physician, preferably in the same specialty, should be made available to the PA. If none are available, then a referral to the ER may be appropriate.

III. The Physician-Midlevel Partnership: Minimizing Risk and Maximizing Benefits

Risk Management Strategies for Physicians Working with MLPs

Due Diligence

- Rigorously verify MLP education and professional credentials with outside sources prior to hire, and periodically thereafter.

- Get authorization to check credit and criminal background, query the NPDB, check all references….and ensure that this process is well-documented.

- As appropriate to the practice setting and scope of practice, require up-to-date clinical certifications such as advanced cardiac life support, pediatric advanced life support, etc. All clinical staff should, at a minimum, maintain CPR and first aid certification.
Role Expectations

- Have realistic expectations regarding the capabilities of an inexperienced MLP or one that comes to you from a different practice background; he/she will require closer monitoring and will be less productive initially.

- Expect a new or inexperienced MLP to consult with you fairly frequently; investigate the situation more closely if this is not happening.

- Ensure that all members of the healthcare team understand the appropriate role of the MLP. Asking MLPs to perform tasks typically handled by nurses and other office staff will decrease MLP productivity and may also undermine the MLP’s morale. Conversely, expecting MLPs to function exactly as a physician would can impact patient safety and team functioning negatively.

Clinical Competence

- Use a skills checklist to determine what areas need additional monitoring, and provide time for necessary training.

- MLPs must keep their knowledge and skills current and maintain continuing education requirements. If possible, provide a continuing education allowance, and encourage learning activities alongside other practice providers.

- Verify clinical competence in areas/procedures appropriate to the setting and document this verification on a regular basis, typically annually.

Regulations

- Be knowledgeable about current state regulations regarding the MLP’s scope of practice and prescriptive authority; you will be held responsible along with the MLP for ensuring compliance with the regulations.

- Administrators should also be knowledgeable about state requirements for MLPs, and be able to access pertinent documentation if necessary.

- Require MLPs to use their title when introducing themselves to patients and family members. Consider use of name badges with professional titles clearly visible.

Teamwork
• Encourage collaboration. Being a willing mentor and encouraging questions will lessen the risk of MLP errors such as delayed diagnoses, medication mismanagement, etc.

• Be accessible.

• Ensure physician coverage when you are unavailable.

• Give feedback.

Medical Record Documentation

• EMRs should allow for proper authentication of entries made by MLPs.

• Know and comply with facility, state and federal requirements for co-signing MLP documentation.

• MLPs should always document consultations with physicians, and physicians should document all significant discussions about patient care.

Practice Protocols

• Understand state requirements for collaborative agreements, protocols, QA activities, face-to-face meetings, etc. Make sure these activities are being documented and are kept well-organized.

• Practice protocols should be clear and to the point. Avoid unnecessary verbiage or detail—in a lawsuit, you will be held accountable for, and limited to, whatever these protocols say. They should also be clinically up to date, practical, achievable and make sense for your practice setting and patient population. Lastly, they should be readily accessible, neat and well-organized. Juries make judgments about clinical competence based in part on whether or not defendants in a lawsuit come across as organized and conscientious in other matters. Good protocols encourage good practice and can be invaluable in defense of a lawsuit.

• Protocol pitfalls: too much information (creates an unrealistic standard of care); not enough information (creates an appearance of careless supervision); out of date content (this can significantly impact the defensibility of a lawsuit); sloppy, disorganized (undermines credibility).

• Date and archive revisions to protocols and keep on file for at least seven years—they may be requested in a lawsuit.

• Written guidelines should cover exam, treatment, delegation, supervision, how often the physician should see the MLP’s patients, patients’ right to
access the doctor and medical record documentation review/co-signatures.

- Agree upon a consistent plan for dealing with pain management and narcotic medications and monitor MLP prescription practices. Complications (and subsequent litigation) related to narcotic pain management are increasing rapidly.

- If you utilize MLPs to perform procedures, make sure patients and family members understand who will be performing the procedure, and make sure documentation related to informed consent reflects this understanding.

**Professional Liability Insurance**

- Notify your professional liability insurer immediately when MLPs are added or leave.

- Be sure that professional liability insurance includes coverage for MLPs. Require that non-employed MLPs carry professional liability insurance with coverage limits at least equal to your own or that of the practice.

**Remember: You may delegate responsibility, but you retain liability!**

**Risk Management Recommendations for MLPs**

- Diligently screen for diseases known to have high morbidity and mortality, such as diabetes, heart disease, and cancer.

- Maintain a high index of suspicion for the most frequently-encountered high-liability symptoms and conditions: chest pain (think myocardial infarction); complaints related to abdomen and pelvis (think appendicitis, colorectal cancer, aortic aneurysm, ectopic pregnancy); lung and breast cancer; meningitis (particularly for pediatric patients); and asthma (particularly diagnosis and medication management). (PIAA Executive Summary 2012 report)

- Remember that the most prevalent and expensive medical misadventure for general/family practice and internal medicine is error in diagnosis, according to PIAA 1985-2011 claims review data. Acute myocardial infarction was the medical condition cited most often in claims against general/family practitioners when there was an alleged diagnostic error, and the most prevalent condition related to alleged diagnostic error mentioned for internists was lung cancer.
• Utilize available clinical practice guidelines or protocols when establishing a diagnosis and providing treatment, and document the justification for deviations from guidelines or protocols.

• Seek timely consultation and advice regarding patients with recurring complaints and/or signs and symptoms that do not respond to the prescribed treatment.

• Document consultations with physicians and other healthcare providers in the medical record.

• Document the decision-making process that led to the diagnosis and treatment plan.

• Notify patients when screening is due and follow up if patients do not respond, documenting all communication.
IV. Additional Information/Links

Federation of State Medical Boards
http://www.fsmb.org/

National Council of State Boards of Nursing—Campaign for APRN Consensus
https://www.ncsbn.org/aprn.htm

American Association of Colleges of Nursing
http://www.aacn.nche.edu/

American Academy of Physician Assistants
http://www.aapa.org/

PA professional organizations
http://www.theagapecenter.com/Organizations/Specialties/Physician-Assistant.htm

Organizations that interact with physician assistants
http://www.pac.ca.gov/about_us/paorgs.shtml

Association of Family Practice Physician Assistants
http://www.afppa.org/

CNA / NSO Nurse Practitioner 2012 Liability Update

CAN / NSO Risk Control Self-Assessment Checklist for Nurse Practitioners

Legal Analysis & Advice for NPs by Carolyn Buppert, NP, JD
http://www.buppert.com/

American College of Nurse Practitioners
http://www.acnpweb.org/i4a/pages/index.cfm?pageid=1

American Academy of Nurse Practitioners
http://www.aanp.org/AANPCMS2
V. References


