The Importance of Protocols and Supervision When Utilizing Advanced Practice Providers

By Jamie Wyatt, JD

Given the ever-increasing physician shortage and high demand for appointments, it is common for a patient to receive treatment from an advanced practice provider (APP) when seeking medical care. Appointments with an APP often give a patient the opportunity to be treated sooner for a problem. The continued projection of lower numbers of physicians practicing medicine and its impact on meeting our needs due to population growth and aging is a real concern. [1] According to the Association of Medical Colleges (AAMC), the physician shortage will be up to approximately 86,000 by 2036 [2].

Many physician offices are turning to a more collaborative care approach. While this approach allows a physician to treat a larger patient population, reduce costs, and minimize administration burdens, it is not without inherent risks. When more providers are

involved with care in a collaborative team approach, the risk of liability exposure increases resulting in communication failures, inadequate protocols, and allowing too much autonomy to an APP. Allegations a physician may face in a lawsuit when an APP provides care are often for vicarious liability and negligent supervision. The closed claim review below is an example of the pitfalls that can occur when an APP is given too much autonomy due to minimal supervision and the absence of proper protocols.

This claim began with the treatment of a 22-year-old male who had a history of mental health illness. He presented to the Dr. Strobl's* office with 5-month-old labs showing minimally elevated TSH (Thyroid Stimulating Hormone) of 6.24 (N1 0.30-4.90) and complaints of sleep issues, weight loss, fatigue, and low testosterone symptoms consistent with hypothyroidism. The patient saw Nurse Practitioner Bower.* NP Bower evaluated the patient and noted in the record that he had abnormal thyroid function tests. He documented this based on the patient's old labs and the patient's assertion that he had hypothyroidism. Nurse Practitioner Bower ordered labs, which included a complete thyroid panel, an ultrasound, and thyroid uptake scan. The thyroid evaluation showed a TSH of 1.00 (N1 0.30-3.04), Anti-Thyroid antibodies 29.9 (N1 28-60), Free T4 1.03 (N1 0.58-1.54), Free T3 2.67 (N1 2.30-4.20) all of which were normal despite his discharge diagnosis of hypothyroidism. A follow up appointment was scheduled for 3-4 weeks. When the patient returned for his follow up appointment, NP Bower ordered a thyroid scan and a radioactive iodine uptake test (RAIU) due to "unspecified acquired hypothyroidism", despite a lack of documentation to support this finding. Dr. Strobl signed off on this order. Following this test, there was a report generated from the medical facility that performed the study, but it never made its way into the provider's chart. Instead, the medical chart contained a dictated note from NP Bower stating the test showed it to be "abnormal consistent with Graves Disease". The Thyroid Scan Report results obtained at 4 hours were 12% uptake (NI 5-15%), and 24 hours of 44.5% uptake (NI 10-30%), or a slight increase in uptake at 24 hours suggesting elevated thyroid. Our expert noted that this kind of increase, while consistent with Graves' Disease, is not sufficient for its diagnosis. There were significant red flags that should have caused Dr. Strobl to step in and evaluate. Unfortunately for the patient, Dr. Strobl never saw him. A few weeks later, NP Bower issued an order for I-131 thyroid ablation treatment that was countersigned by Dr. Strobl, who authorized the treatment based on the erroneous diagnosis of Graves' Disease made by the NP. The patient underwent a radioiodine ablation. Post ablation, he was seen multiple times with worsening complaints of palpitations, anxiety, fatigue, overeating, and nausea. When he became truly hypothyroid, NP Bower started thyroid replacement therapy. Following this, the patient never returned and went to a subsequent treater who noted that the patient's thyroid tests were all normal and documented in his notes that "[o]n the basis of this he was diagnosed with Graves' disease and treated with I-131." Suffice it to say, this subsequent treater would not make a good defense witness for NP Bower or Dr. Strobl.

The complaint was filed alleging the patient was wrongfully and negligently diagnosed with Graves' Disease and treated with radioiodine I-131, which caused permanent damage to his thyroid. The plaintiff alleged that the radioiodine ablation caused him to develop complications, including permanent hypothyroidism mandating continuous follow up care

and daily medication to correct low thyroid hormone condition. The plaintiff also alleged that he developed cardiac arrhythmia, cognitive deficits, and other conditions that impacted his ability to continue his education.

There were several weaknesses in the case that were difficult to overcome and led to settlement of the lawsuit. These weaknesses primarily centered around the absence of written policies and protocols outlining the scope of practice and delineating Dr. Strobl's relationship with NP Bower. The depositions supported the plaintiff's theory that there was no meaningful supervision. Plaintiff's IT expert noted that the audit trail revealed that Dr. Strobl devoted 8 seconds to review documentation relating to the initial presentation of the patient. The witness further testified that Dr. Strobl devoted a total of 3 minutes over a span of 7 months to chart review for this patient. Dr. Strobl never saw the patient, nor did he intervene when put on notice that NP Bower was ablating a thyroid. Dr. Strobl did not participate in any of the actual care that led to the final diagnosis of any condition in this case. The plaintiff's attorney argued that a physician's education, knowledge, and expertise must be used to diagnose serious conditions such as Graves' Disease. The plaintiff's attorney argued the purpose of supervising a nurse practitioner was to assure compliance with the standard of care. Further, the plaintiff's attorney made the argument that the physician had no clear boundaries set with NP Bower, which allowed him to provide treatment outside the scope of his expertise. There was no real oversight of NP Bower's work other than the obligatory checking of the box as to the chart review. The medical records failed to support the clinical diagnoses or justify the management recommended and carried out by NP Bower, making defensibility of the case difficult. To add to the defensibility issues, Dr. Strobl testified in his deposition that he never saw the patient or consulted on his labs and scans. When questioned by the Plaintiff's attorney about protocols, it was clear that Dr. Strobl did not know that according to his office protocols, he was required to see the patient on the first visit based on his complaints of thyroid issues. Further, to avert liability, Dr. Strobl stated that NP Bower should have known to come to him to discuss the encounters, but that he had a pattern of acting of his own accord. While this testimony was true based on all accounts, the attempt to deflect liability only increased it because Dr. Strobl acknowledged this dynamic existed and had taken no action to prevent it. Following depositions, Plaintiff's counsel had enough proof to support his claim of no meaningful oversight. The case's posture changed from defending the care to mitigating damages.

Physicians responsible for collaborating with or supervising the care provided by APPs can implement strategies to ensure appropriate oversight and compliance with state board requirements. Below are some major takeaways...

Major takeaways that may assist you in your collaborative efforts and mitigate risk:

1. **Establish Clear Protocols and Guidelines.** Start with the law. To minimize liability risks and maximize patient safety, the physician must establish a system for meaningful and effective collaboration/supervision. The starting place for determining the required level of collaboration/supervision is the applicable state

statute and regulations. Many statutes specify the role of the supervising physician. Some state boards determine the scope of practice of APPs, but others are more flexible. If statutes set forth guidelines, these are often just the minimum requirements for supervision. Evidence-based treatment protocols are typically required to outline the scope of practice, standard of care for the patient population, and include a formulary of approved medications. These clinical protocols should be agreed on, paying attention to symptoms or conditions requiring physician consultation. Set out the consultation method and access to physician consultation. Establish emergency procedures and referral for conditions/treatment outside the scope of APP. Avoid the temptation to delegate beyond the APP's education, knowledge, and competence. Finally, once protocols are established, make sure all parties know them.

2. **Regular Review.** Most states require protocols be reviewed at least every other year. Engage in a regular scope of practice review and medical record review. Most state boards set minimum record review requirements and remote site visits if applicable.
3. **Education and Comprehensive Training.** Provide ongoing education and training to enhance clinical skills, knowledge, and proficiency. Be aware that an APP should have similar practice experience/scope as a physician. This includes any specialized skills, procedures, or training. On the job procedure training is generally not acceptable; some states require board approval prior to training the APP for a new skill or procedure. Have on-going competency validation and a quality assurance plan. The minimum quality assurance standards are often set by the boards.
4. **Effective Communication.** It is important to foster open communication and establish a healthy culture. Be approachable and always ensure availability during the APPs' clinical schedule. Convey your expectation that the APP will contact you or another physician for cases requiring specialized expertise. Provide regular feedback and guidance to foster clinical decision-making. Discuss case concerns and treatment plans. If you see an issue with care, point it out and make it a teachable moment. Most state board rules require time-sensitive physician consultation or review in specific circumstances. Such include: upon a patient request, when controlled substances are prescribed, after an adverse outcome, and when the treatment plan falls outside the protocols.
5. **Documentation.** Your documentation is crucial if there is an allegation of negligent supervision. You should ensure updated documentation of the collaboration/supervision agreement. Document any changes to scope of practice, protocols, and roles. Take the time to discuss documentation requirements and expectations with the APP. Emphasize timely, accurate, and thorough documentation by all parties. Remember that in an audit, investigation, or lawsuit, the metadata is likely discoverable. Be aware of your duties and avoid "signing off" on medical records without the appropriate review.

By following these tips, physicians can better demonstrate diligent collaboration with APPs and mitigate the risk of negligence claims. SVMIC is here to assist you with these and

other risk issues. We have Claims and Risk attorneys available at 1-800-342-2239 or ContactSVMIC@svmic.com.

*All names were changed

1, 2. “New AAMC Report Shows Continuing Projected Physician Shortage.” AAMC, 26 Mar. 2024, www.aamc.org/news/press-releases/new-aamc-report-shows-continuing-projected-physician-shortage.

3.Optimizing Advanced Practice Providers in Healthcare.” An MGMA Research and Analysis Report, October 2020, OptimizingAdvancedPracticeProviders_R-A.pdf (mgma.com)