LNP 102
Analyzing Nurse Practitioner Liability: Uncovering the Risks
Carolyn Buppert

Pat: Welcome to Legal Nurse Podcasts. This is Pat Iyer and I have with me today Carolyn Buppert who is an attorney who focuses on legal issues affecting nurses, advanced practice clinicians and their employers. Her clients include hospitals, health systems, insurers, physician and nurse practitioner practices, visiting nurse agencies, nursing homes, hospices, schools of nursing and a national certification organization.

She practiced as a nurse practitioner for 16 years before focusing exclusively on legal matters. Carolyn is also an author and you may have encountered some of her books and columns. She has written just in the last three years several books and instructional CDs. They include the "Nurse Practitioner's Business Practice and Legal Guide" a 2017 publication, "Frequently Asked Legal Questions That Keep Nurses Awake At Night", "Billing Physician Services Provided By Nurse Practitioners", "Negotiating Terms of Employment" and "Avoiding Malpractice". This was all in the last three years.

She is a frequent contributor to the *Journal of Nurse Practitioners* and Medscape.com. She lectures extensively on legal issues regarding the scope of practice, compliance prescribing malpractice, privacy and reimbursement issues. She lives in Boulder, Colorado which in my experience have some of the finest restaurants in the state of Colorado.

Welcome to the show, Carolyn.

Carolyn: My pleasure. I'm happy to be here.

Pat: I see that you started as a nurse, then became a nurse practitioner and then went into law as an attorney. Tell us about the transition from being a nurse to becoming an attorney. What caused you to make that move in your life?

Carolyn: I actually started out straight out of college as a writer and editor. For most of the 10 years after college I worked as a writer and editor for medical institutions. I then decided I wanted to be a healthcare provider and went to nursing school.

In my 20's I was interested in the law, but I really wasn't interested in working all day and then going to school all night which was what was going to be necessary. After I became a nurse and then went to graduate school to become a nurse practitioner I got so used to working and going to school all the time. It no longer seemed onerous to work all day as a nurse practitioner and go to law school at night.

That's what I did pretty quickly after getting out of graduate school as a nurse practitioner. I got a day job at Johns Hopkins and then I had to run over to the law school at 5:30 and be there until 9:30. That was a grind, but somehow as I got older it didn't seem like as much of a grind. I'm very glad that I now combine all three things, writing, nursing and law. It's worked out quite well.

Pat: There's such an emphasis in the legal world on how well you write and can express yourself. Those three pieces intertwine very nicely.

Carolyn: Definitely.

Pat: I know that you focused a great deal in your practice on some of the legal risks that are affecting nurse practitioners and other advanced practice people. Let's talk about some of the specific issues that they face as it comes to liability.

Carolyn: Just like with any other kind of healthcare provider, especially physicians, nurse practitioners always have the threat of malpractice hanging over their heads. My role is I don't do litigation. I have in the past, but I don't do litigation regarding malpractice. I try to inform nurse practitioners through talks I give and writings about what they need to know to avoid malpractice.

I have been for the last 20 years collecting cases against nurse practitioners, as much as I can find out about those cases, analyzing them trying to figure out what went wrong and then translating all of that into either articles or talks about how nurse practitioners can avoid malpractice. It's sort of like here is what went wrong in this

situation and what we can learn from that to avoid that happening in the future.

Pat: What are some of the common threads that you see in terms of why nurse practitioners are named as defendants?

Carolyn: Any studies that have been done on this say that the most common reasons nurse practitioners are sued is for missing a diagnosis or not diagnosing in a timely manner and lack of follow-up, and often lack of follow-up leads to the delay in the diagnosis. Those are the two common things and those are the same reasons that primary care physicians are sued, I am told.

Pat: Have you seen any difference in terms of the frequency with which nurse practitioners are named as defendants in the last decade or so?

Carolyn: I'm only going on survey data from sources such as NSO, which insures nurse practitioners. They have white papers on nurse practitioners and malpractice. If you look at their graphs, the line is going up over the years of suits against nurse practitioners. It's not a dramatic rise and it's consistent with the increase in numbers of nurse practitioners that have happened over the years.

I don't know that the percentage is growing or if it is it's growing alarmingly. Nurse practitioners are still sued infrequently, but less frequently than physicians by far. One way to sort of judge how bad it is or how good it is, is what's the premium for insurance. It's still relatively inexpensive for nurse practitioners to buy their own malpractice insurance policies, so I don't see it as a problem. No one wants to be the one sued, but I don't see it as a burgeoning threat. It's just a gradual rise and consistent with a rise in the numbers.

Pat: Do you have any theories about why nurse practitioners would be sued with less frequency than physicians?

Carolyn: For one thing there's the public perception that the nurse practitioners aren't really doing much on their own. That's changing, but the public perception in the past has been the physician is running the show and that's who we should sue. Second of all, nurse practitioners aren't

viewed as deep pockets. Physicians probably are and I'll leave it at that. Those are the main two I think that come to mind.

Pat: Another factor that might influence this is something that I learned when I was doing a presentation in Japan at the International Counsel of Nurses. There was a great deal of research that was shared about patient satisfaction and outcome with nurse practitioners compared to primary physicians. What I took away from that was that across the board on all parameters, patients tended to be more satisfied with the care that they got, in the communication and the patient teaching from the nurse practitioner when compared against a primary care physician.

Carolyn: Yes, Pat that is another reason I've often heard. I don't have any data to prove it, but I've often heard that because nurse practitioners supposedly spend more time than physicians they are sued less often. I've heard that and again I don't have any personal data to support it, but it could very well be true.

Pat: I know in reading those verdicts that you've been tracking for 20 years you've seen trends and patterns. Are there any red flags that come up from looking at those cases that are the things that you've seen more frequently or the hot spots that our listeners should be aware of?

Carolyn: Yes - breast complaints. There are quite a number of cases over the years of missed breast cancer. Either there is a lump that maybe an ultrasound is done, but a biopsy isn't done and it turns out to be cancer.

There's this one case that stuck in my mind where a young lady in her early 30's came in to a nurse practitioner complaining of a breast rash. The nurse practitioner evaluated it and thought it was a mastitis that could be treated with topical antibiotics. The nurse practitioner said, "Put this ointment on and if it doesn't go away in two weeks see a dermatologist." The patient did not see a dermatologist. The patient came back six months later complaining about something else and neither the nurse practitioner nor the patient brought up the breast rash.

The patient came back again another three months about yet another complaint and again the breast rash was not brought up by either party. About three months after that the patient comes back again with lumpy breast and it turns out that the breast rash was in fact Paget's disease and it had been untreated. The patient died 18 months after that of this problem and the family sued the nurse practitioner.

That's an example of a breast case. That one is complicated because the patient came back several times and yet no one brought up the breast rash.

Should the patient have brought it up? Yes, but should the nurse practitioner have revisited that problem? Yes. Was it not on the problem list?

The take home that I give for that case is you got to have a good problem list or somehow make sure that you address a previous problem and was it resolved. If it wasn't resolved, do something about it so that's one.

There are a number of cases I see against nurse practitioners and physicians where a patient comes in with chest pain, often a younger patient, a 40-year-old let's say and has chest pain. The practitioner doesn't evaluate the patient for an MI or heart attack. They think it's musculoskeletal so it turns out it is a heart attack and then the patient will sue for that later on.

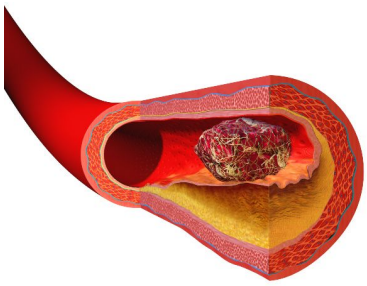
The third sort of red flag is the complaint of be lower abdominal pain and there are just so many things that could be that there are things missed. It could be just constipation. It could be a viral gastroenteritis, neither which are life threatening. It could also be an ectopic pregnancy in a female or appendicitis and a number of other things. It's those number of other things and appendicitis that often go missed.

Those three things, breast lump or breast complaint, chest pain and lower abdominal pain I think are the areas that practitioners should have their antenna go up when they hear that as a chief complaint to rule out the worst things first.

Pat: They all have some catastrophic outcomes associated with them if the warning signs are missed or misdiagnosed or ignored. I could see why

those cases would really raise red flags. I've seen a number of cases that came into my legal nurse consulting business involving chest pain that was misdiagnosed as epigastric pain or completely dismissed with some horrible outcomes.

Carolyn: Right, so the trick to being a great practitioner is to know these areas that are red flag areas. When the person comes in complaining of that, you just get right on it knowing that the odds are it could be nothing but this could be catastrophic if it's something.



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Pat: I wanted to move on and talk about prescriptive privileges for nurse practitioners and some of the prescribing errors that you have seen. Is

it true now that nurse practitioners have prescribing privileges in all 50 states in the United States?

Carolyn: Yes, the mechanism can be different in different states and they can have the authority to prescribe different classes of medications, but they have the ability in all 50 states. Yes, they have the authority.

Pat: I have become aware as our show has gained more listeners that we have listeners in 18 to 20 countries around the world. Could you explain for the non-Americans does a nurse practitioner who has prescribing privileges have to have a physician review that prescription before it's handed to the patient?

Carolyn: In no state does a nurse practitioner have to run each prescription by a physician. Each state has its own law regarding the authority of nurse practitioners to diagnose, treat and prescribe. In some states nurse practitioners can diagnose and prescribe without any connection to a physician. They may choose to consult with a physician, but they don't have to. In other states there needs to be a written agreement between the physician and the nurse practitioner about what exactly the nurse practitioner can do. Those written agreements often cover making medical diagnosis, ordering medical therapies and prescribing.

I don't believe there's any state where a physician has to cosign and no state where the nurse practitioner has to run every prescription by a physician. In some states there are requirements such as the physician has to review a certain small percentage of the charts randomly to see what was going on and then supervise. Each state is different, but in all states nurse practitioners can prescribe.

Pat: Thank you for that clarification. That's really good background information. One other question along those lines is it's my understanding that nurse practitioners who are considered advanced practice nurses at this point are being prepared in Master's programs. There was some talk a few years back about wanting the basic preparation to include a Doctoral degree as well. Is there any update on that movement?

Carolyn: There was a goal of having the doctorate be the entry level by 2015, but clearly we're past that. The doctorate is still optional. A nurse

practitioner with a Master's degree is not going to be required to get a doctoral degree. There are some programs where the initial advanced degree is a doctorate, but it's not mandatory and I don't see that happening. Again, each state has its own rules and no state has made it mandatory for a nurse practitioner to have a doctorate.

Pat: Thank you, I appreciate that updated information.

I know that we talked in the past about doing a SCRIPT analysis when it comes to prescribing errors. Could you take us through those steps and what that means?

Carolyn: That's just a little reminder to nurse practitioners when they're prescribing for each time they prescribe that these things should run through their head.

- S – are there side effects that I need to talk to the patient about
- C – are there contraindications for this patient
- R – is this the right medication
- I – are there any interactions with the patient's other medications that I should be aware of
- P – are there any precautions for this patient
- T – have I transmitted this prescription in a clear way

In other words there are cases where the whole malpractice lawsuit is based on somebody not writing clearly and pharmacist has mistaken the prescription for something else.

Ideally prescribers are familiar with the medicines they write and hopefully they aren't writing for thousands of types of medicines. They usually have an arsenal of medications they use frequently. The first three times you write for a medication - hopefully at least in your head if not going to the PDR or Epocrates - you go through this analysis and then after a while you're going to sort of memorize it.

When I was still working as a nurse practitioner, but also working as a lawyer, but working less as a nurse practitioner I wasn't prescribing as

often as when I had been full time. I made myself every time I wrote a prescription go to the PDR and look up these things and go over it with the patient. It takes a little extra time, but it saves you. It saves you and the patient from some bad outcomes.

Pat: It reminds me of a day about a year ago when my husband was meeting his gerontologist for the first time at Johns Hopkins. The doctor was considering putting my husband on a different medication for his diabetes and he went to the computer. He was reviewing the medication on the screen and talking about the benefits and the side effects. As we drove away my husband said, "Shouldn't he have known that medication? Why was he looking it up?" I said, "He was being very careful and very cautious. He was making sure that he was clear on whether this was the right drug for you."

Carolyn: Right - good for that doctor. I don't know if you saw but there was an article in the Chicago Tribune a couple of days ago. The Chicago Tribune sent out fake patients who were reporters with prescriptions. It was something like they were given two prescriptions which had bad interactions with each other. The objective was to see if the pharmacist told the patient anything about it. The whole article is about the percentages in various pharmacy chains where the pharmacists did not mention it.

In real life there are two checks and balances. One is the prescriber needs to be checking for interactions and the second thing is the pharmacist needs to be checking for interactions.

Pat: Have you seen in your practice any alarming prescribing errors or more commonly occurring alarming errors?

Carolyn: I don't think the bases of that many lawsuits involving prescribing errors by nurse practitioners. I know that having talked to insurers of nurse practitioners they are worried about prescribing. I guess certainly the threat is there, but here are two cases that I find interesting that have to do with prescribing.

In the first one the nurse practitioner was seeing a new patient. The patient had just gotten out of a mental institution and was on several psych meds. The patient comes to the community clinic and the nurse

practitioner is talking about renewing the psych meds. The patient talked to the nurse practitioner out of discontinuing at least one of the psych meds. Didn't like the side effects, didn't need it, etc. The nurse practitioner did not have the benefit of the records from the psych hospital, but the nurse practitioner discontinued at least one of the psych meds. The patient came back a week or two weeks later and assaulted people in the clinic, having had a breakdown.

In this case not only did the patient sue the nurse practitioner, but the people who were assaulted sued. It was a horrible case and the take home message there is don't be discontinuing medications based on what the patient wants if the patient really needs the medication. This nurse practitioner didn't have access to old records, but clearly before discontinuing psych meds if you want to prevent problems you want to talk to the previous provider or get those records. Discontinuing psych meds is not a good idea generally.

That was one thing and then another case a patient came to a clinic, saw a family nurse practitioner about blood pressure and a few things. The patient was also seeing a psych nurse practitioner at that same clinic. The psych nurse practitioner put the patient on Lamictal or Lamotrigine. A couple of weeks go by and the patient comes back to see the family nurse practitioner. The patient was having some problems with a rash and a couple of other problems. I can't remember what, but it turns out those problems were related to the psych med that the psych nurse practitioner had prescribed.

The family nurse practitioner didn't pick up on the side effects of that medication. The patient ended up getting Stevens-Johnson syndrome and had to be hospitalized in intensive care all based on the side effects to the psych medicine. The patient survived, but sued the clinic and the family nurse practitioner for not picking up on the side effect. The family nurse practitioner testified that she didn't believe she was responsible for medicines that were not prescribed by her. That did not make the judge happy. The judge said, "You must certainly are. (a) You should have known about the side effect. (b) Yes, you are responsible for picking up on the side effects and medications prescribed by other people."

What we learned from that case is yes, you are responsible if you're a family practitioner for picking up on side effects of medications prescribed by some other practitioner. We learned that psych medicine has certain side effects you have to be aware of if that patient is on that.

Those aren't the common prescribing errors. When I think of common prescribing errors, I think of somebody choosing the wrong medication or having too big a dose. It's more complicated than that.

Pat: It certainly is. I remember working on a case with the same medication with Lamictal that was given to a teenage boy. The question was he was outside of the age range for being the appropriate patient for that drug. He was too young and he ended up with a rash and lost most of his skin. He survived it, but a lot of scarring. He was critically ill for a long time, huge damages.

Carolyn: Yes and if we have time I'll give you one more short case.

Pat: Sure.

Carolyn: That reminds me of yet another prescribing case which I felt was very instructive.

A teenage girl at 15 comes into an emergency room with abdominal complaints. I forget what was done exactly, but she was then referred to her primary care provider who was a nurse practitioner. In treating and starting off with the abdominal complaints the nurse practitioner prescribes Paxil for depression for the girl. A long story short the girl three weeks later tried to hang herself. She was unsuccessful in killing herself, but did suffer brain damage and required around the clock care for three years plus she eventually died.

The family sued the nurse practitioner and the basis of the suit was if you look at the warnings under Paxil it says, "Don't prescribe this for adolescents unless there is a major depression." There was no documentation in the record that there was any screen applied or a depression screen. There was no evidence that the nurse practitioner had suspected major depression. If the nurse practitioner had

suspected major depression, she should have referred her to a psychiatrist or inpatient care or so on.

At any rate it was kind of a slam dunk case against the nurse practitioner when you got a warning that says, "Don't prescribe except for major depression" and there was no documentation of major depression. The same kind of age related precautions that perhaps if that nurse practitioner had done the SCRIPT analysis like we talked about earlier she would have come up with a reason not to prescribe that medication or prescribe it but immediately hook the patient up with a specialist.

Pat: And such a tragic outcome too.

Carolyn: Yes.

Pat: How can our listeners find out more about you, Carolyn?

Carolyn: My website is the best way and it's www.Buppert.com and through that there's a way to contact me if someone has a question.

Pat: I so appreciate the time that you spent with us today. It's been really instructive talking to you. I know that we could have talked about cases and stories for a long time and not exhausted the amount of knowledge that's stored in your head about these issues. I really appreciate you sharing your expertise with our group.

Carolyn: It's my pleasure, Pat. It seems like we kind of built on each other. Both of us have some experience in this area, so it's been my pleasure. Thank you.

Pat: Thank you, Carolyn.

This has been Legal Nurse Podcasts. We have been talking with Carolyn Buppert about nurse practitioner liability issues, as well as some other common medical malpractice concerns and red flags. Stay tuned for our program next week. We will be back with an interview in a week from today. We appreciate the comments, the attention and the listeners who have been part of this show.

> As we wrap up, remember to order your copy of *Analyzing Cardiac Risk Cases* now, and get a 25% discount by using the code Listened. The link is http://lnc.tips/cardiacrisk - check it out.

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LNP 103

Nurse Practitioners: Expanding Role, Expanding Liability

New York became the 18th state to no longer require experienced nurse practitioners to have a written practice service agreement with a physician. Experienced nurse practitioners (who have more than 3,600 hours of practice) are even more independent. Nurse practitioners' expanding liability accompanies their expanding role.

I'm Pat Iyer. In this edition of *Iyer's Insights,* I share tips on analyzing nurse practitioner liability.

As patients receive insurance as a result of the Affordable Care Act (an estimated 1.1 million in New York alone), the availability of nurse practitioners expands choices of care. When compared to physicians, the care delivered by nurse practitioners is equal in quality.

Often patients are more satisfied by care they receive from a nurse practitioner.

But advanced practice comes with a price. At my LNC business I saw an increase in the requests from attorneys for nurse practitioner expert witnesses. At first, I had a few names in my database. By the time I sold the company, I had several subgroups of nurse practitioners according to their specialty. With an expanded role, nurse practitioners have expanded liability.

The number of suits against nurse practitioners is rising.

A study reported in the *Journal for Nurse Practitioners* supports what I saw. The top allegations are consistent with the advanced nurse practitioner role.

Most common allegations against nurse practitioners

In a study of over one thousand cases recorded in the National Practitioner Data Bank, reported by Kenneth Miller, the top allegation was "diagnosis related". The allegations are broadly divided into

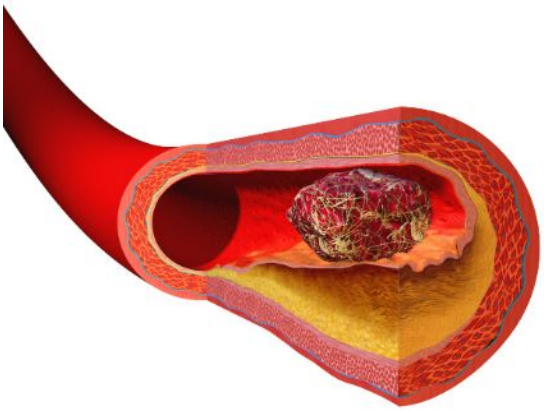
- Failure to diagnose
- Delay in diagnosis
- Improper performance
- Failure to recognize a complication

- Wrong or misdiagnosis

According to Diedrich Healthcare, diagnosis related allegations are also the single largest category of complaints against physicians.

Nurse practitioners' expanding liability – tips for LNCs
Legal nurse consultants helping attorneys with medical malpractice cases involving nurse practitioners will encounter these nuances:

- There are several subspecialties within the nurse practitioner world. Make sure you match the defendant's specialty if you supply a nurse practitioner expert.
- Some physicians who sign the collaborative agreements with nurse practitioners have been known to drop their malpractice coverage, and in effect leave the nurse practitioner holding the bag. Talk to the attorney about the physician's coverage.
- Many physicians remain hostile to the idea of nurse practitioners becoming more independent. They argue that removing the requirement for physician oversight will weaken patient safety and quality of care. Opposing counsel may elicit such testimony from a physician witness.
- The National Practitioner Data Bank data showed the only .008% of the nurse practitioner cases went to court. The remainder either were yet to be resolved or resulted in settlement.



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Let's continue.

Analyzing Nurse Practitioner Medical Records

Many nurse practitioners chart using electronic medical records both in the office and in the healthcare setting. As a legal nurse consultant, you are in an ideal position to identify problems with medical records. In this podcast, I cover two: copying and pasting and missing records.

You are looking at medical records generated by a nurse practitioner. As you read the records, you think, "I've read this note before." When a nurse practitioner

copies a note from the prior office visit, this innocent seeming practice can result in confusion, embarrassment, misinformation and medical errors.

ECRI Institute and Copying and Pasting in Medical Records

Recent studies focused on the drawbacks of electronic medical records. They identified copying and pasting in medical records as the source of errors. ECRI Institute compiles a database of patient safety events.

With more than 300,000 event reports, ECRI is in an ideal position to spot trends. One of the top 10 concerns is data integrity failures with health information technology systems – errors caused by electronic medical records.

ECRI points out that the integrity of data in health IT systems can be compromised by copying and pasting in medical records by putting older information into a new report. Other sources of errors include

- Data entry errors
- Missing or delayed data delivery
- Inappropriate use of default values
- Use of both paper and electronic systems for patient care (hybrid records)
- Patient/data association errors (patient data from a medical device is mistakenly associated with another patient's record)

CRICO

An insurance company called CRICO collected data in a large database of 275,000 open and closed claims. In a study released in 2014, it found 147 cases in which electronic health records were a contributing factor. These were the top issues:

- Incorrect information in the electronic health record in 20% of cases
- Hybrid health records/EHR conversion issues in 16%
- Systems failure – electronic routing of data in 12%
- **Pre-populating/copy and paste in 10%**
- Failure of system design to meet the need in 9%
- EHR (user) training and/or education in 7%
- Lack of integration/incompatible systems in 7%
- EHR-related user error (other than data entry) in 7%

You need a critical eye when evaluating medical records. The attorney relies on you to read the record and see if it makes sense. Copying and pasting in medical records is easily detected when it refers to events, like surgery, as taking place in the future, when they have already occurred. It is also easily detected when page after page of notes are identical or there is obvious erroneous information in the record. It is harder to detect when there are scattered pieces that were duplicated that could possibly be correct.

Always read records carefully, putting together the whole picture of the patient. Question information that does not seem right.

It just may be that the nurse practitioner was taking a shortcut. The attorney relies on you as a legal nurse consultant to point out potential problems and weak spots that could be caused by copying and pasting in medical records.

Missing Medical Records

How do you know as a legal nurse consultant that there are missing medical records? Are the medical records complete? The attorney relies on you to detect missing medical records.

Although a copy of a certified medical record is supposed to be compared by the medical records custodian with the original, it is common for LNCs to detect there are missing medical records.

This often happens because of inattention during the process of copying the record, a task that is frequently subcontracted out to a records duplication service. Or it could be that not all of the records were printed.

How to detect the fact there are missing medical records

1. If you are working for a plaintiff attorney, and the plaintiff obtained medical records, compare the set the facility or nurse practitioner supplied with the one the plaintiff received. The nurse practitioner may have withheld records from either the plaintiff or the plaintiff attorney.

2. Use medical record dividers to separate the sections of the record. You can do this either physically (with paper or plastic coated divers) or electronically using

a documents manipulation program like Adobe Acrobat. First look to be sure that entire sections are not missing medical records.

3. Electronic medical records are usually numbered in the lower right corner with numbers like "1 of 346." Look for gaps in the numbers.

4. Review copies of nurse practitioner office billing and compare with the dates of the evaluations. Sometimes providers try to conceal the details of an office visit but forget that the billing records verify the patient was seen that day.

5. If possible, go the healthcare provider who produced the medical records and view them on site. A legal nurse consultant may do with a letter authorizing him or her to act as a representative of the attorney. If the records are to be reviewed on site, this should be promptly done.

Handwritten records are eventually put on microfilm and are more difficult to read than a hard copy. Each time I have gone into a hospital to read original medical records, someone in the risk management department watched me looking at the original medical records and then eventually got bored and left me alone.

Medical records are often key to analyzing the liability of nurse practitioners. Use your skills in reading, interpreting and summarizing medical records.

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