

AI-04718 FMEA New MD

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Perform an FMEA of a new internal medicine MD in Hernando, FL as co-physician of a 65 yof pre-retirement MD. I want to see all the possible failure modes and effects to produce a better training model.

FMEA: New Internal Medicine MD Joining a Small Practice in Hernando, Florida ⇄

Scenario: A newly hired Internal Medicine physician joins an established practice as co-physician to a **65-year-old female physician approaching retirement**. The objective is to identify how the transition could fail, what those failures could do to patients and the practice, and how to design a training system that prevents them.

This is a **prospective risk analysis**, not an assessment of any particular physician. The risks apply to the interaction between the new physician, senior physician, staff, technology, clinical workflows, business model, and local healthcare environment.

Core principle: Do not train only for “Can the new physician diagnose and treat?” Train for **“Can the physician reliably deliver safe, coordinated, sustainable care inside this specific practice?”**

A useful foundation is the six-domain competency model: patient care, medical knowledge, practice-based learning, communication, professionalism, and systems-based practice. ABIM identifies these as core internal medicine competency domains. (ABIM)

1. FMEA Methodology

What is being analyzed?

Process: Transitioning from an established solo/primarily senior-led internal medicine practice to a reliable two-physician practice.

Primary objective: Safe patient care + successful physician integration + continuity after retirement.

FMEA scoring

Score	Severity — S	Occurrence — O	Detectability — D
1	Negligible effect	Rare	Almost certain detection
2–3	Minor inconvenience / low clinical impact	Uncommon	High likelihood of detection
4–6	Moderate clinical, operational, or financial impact	Occasional	Moderate detection
7–8	Major patient harm, serious disruption, or substantial loss	Frequent	Low likelihood of detection
9–10	Catastrophic harm, death, major regulatory event, or practice failure	Very frequent / systemic	Failure likely to remain hidden until harm occurs

RPN = Severity × Occurrence × Detectability

- **1–39:** Monitor / improve as practical
- **40–99:** Priority improvement
- **100–199:** High-priority mitigation
- **200+:** Critical — address before or immediately after independent practice

These thresholds are practical training thresholds, not a universal regulatory standard. A low RPN must never override a catastrophic failure mode.

2. System-Level Fault Model

The practice succeeds only if several subsystems work together.

The five systems that must remain healthy

System	What must work
Clinical system	Diagnosis, treatment, escalation, follow-up, preventive care
Information system	EHR, medication list, results, referrals, records, inbox
People system	Physician–physician trust, staff roles, communication, escalation
Business system	Scheduling, billing, payer rules, staffing, cash flow, contracts
Succession system	Transfer of knowledge, patient relationships, ownership/leadership continuity

The central FMEA concern

The senior physician may be the undocumented operating system of the practice.

If the practice depends on her memory, judgment, relationships, preferences, and informal workarounds, the new physician may appear competent while the practice remains fragile.

3. Executive FMEA Summary — Highest-Risk Failure Modes

These are the failure modes I would address first.

Priority	Failure mode	Primary effect	S	O	D	RPN	Priority
1	New MD practices beyond verified competence	Patient harm, delayed escalation	10	4	7	280	● Critical
2	Missed abnormal labs,	Delayed diagnosis/treatment	10	5	6	300	● Critical

	imaging, or referrals						
3	Incomplete medication reconciliation	Adverse drug event, hospitalization	9	5	6	270	● Critical
4	Senior physician's knowledge is not transferred	Unsafe decisions, continuity failure	8	8	6	384	● Critical
5	No clear emergency/escalation protocol	Delayed treatment of unstable patient	10	4	7	280	● Critical
6	Poor handoff between physicians	Duplicated or omitted care	9	5	6	270	● Critical
7	EHR/inbox workflow not mastered	Results, refills, messages missed	9	6	6	324	● Critical
8	Senior physician remains the hidden bottleneck	Burnout, delayed decisions, failed succession	7	8	5	280	● Critical
9	New MD cannot manage practice workload	Access problems, rushed care, errors	8	6	5	240	● Critical
10	Credentialing, payer, or billing gaps	Revenue loss, inability to practice	7	4	5	140	● High
11	Patient resistance to new physician	Attrition, poor continuity, low trust	6	7	4	168	● High
12	No measurable competency assessment	Weaknesses remain hidden	8	6	8	384	● Critical

Important: RPN is a prioritization aid. For example, a missed cancer diagnosis may have a lower occurrence than an administrative error, but its severity demands robust controls regardless of the calculated score.

4. Detailed FMEA — Clinical Care

A. Patient Assessment and Diagnosis

ID	Process	Failure mode	Possible causes	Effect on patient/practice	S	O	D	RPN	Preventive controls	Training verification
C01	Initial evaluation	Incomplete history	Rushed visit, unfamiliarity with patient, poor structure	Missed diagnosis, inappropriate plan	9	5	5	225	Standard history template; high-risk prompts	Direct observation of complex cases
C02	Physical exam	Inadequate or incorrectly focused exam	Time pressure, overreliance on prior notes	Missed clinical findings	8	4	6	192	Condition-specific exam checklists	Observed examinations with feedback
C03	Differential diagnosis	Anchorin g on prior diagnosis	Trusting historical labels, premature closure	Wrong or delayed diagnosis	9	5	6	270	Diagnostic pause; "What else could this be?"	Case-based diagnostic reasoning
C04	Clinical deterioration	Fails to recognize unstable patient	Inexperience, normalization of abnormal vitals	Delayed emergency treatment	10	4	7	280	Red-flag protocol; escalation criteria	Simulation: chest pain, sepsis, stroke, respiratory distress
C05	Diagnostic testing	Orders inappropriate or insufficient tests	Knowledge gap, defensive medicine, local practice	Missed disease, unnecessary cost, false positives	8	5	6	240	Evidence-based testing pathways	Chart review and rationale audit

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C06	Test interpretation	Misinterprets lab/imaging results	Inexperience, unfamiliar reference ranges, cognitive overload	Incorrect treatment or missed disease	9	4	6	216	Result review standards ; specialist consultation	Case-based interpretation assessment
C07	Follow-up	Does not close diagnostic loop	Assumes patient will follow up, unclear ownership	Delayed diagnosis	10	5	7	350	Closed-loop tracking; assigned result owner	Audit abnormal -result closure
C08	Uncertainty	Fails to communicate diagnostic uncertainty	Overconfidence, fear of appearing weak	Patient misunderstanding, delayed escalation	8	4	6	192	Safety-net instructions; explicit return precautions	Review patient instructions

Training insight

The dangerous trainee is not necessarily the one who lacks knowledge. It is the one who **does not recognize when knowledge is insufficient**.

B. Medication Management

ID	Failure mode	Possible causes	Effects	S	O	D	RPN	Key controls
C09	Medication reconciliation incomplete	Multiple prescribers, outdated EHR, patient uncertainty	Duplicate therapy, omissions, adverse drug event	9	6	6	324	Reconcile every new patient, transition, and high-risk visit
C10	Drug-drug interaction missed	Polypharmacy, unfamiliarity	Toxicity, bleeding,	9	4	6	216	Interaction checker +

		with regimen	arrhythmia, renal injury					pharmacist consultation
C11	Renal/hepatic dosing error	Failure to review kidney/liver function	Drug toxicity or treatment failure	9	4	6	216	Dose-adjustment protocols
C12	Allergy or adverse reaction overlooked	Incomplete record, inaccurate allergy list	Serious reaction	10	3	6	180	Allergy verification and reaction description
C13	High-risk medication monitoring missed	No tracking ownership	Harm from anticoagulants, insulin, opioids, immunosuppressants, etc.	10	4	7	280	High-risk medication registry and monitoring schedule
C14	Inappropriate prescribing	Habit, pharmaceutical influence, patient pressure	Harm, cost, poor outcomes	8	5	5	200	Evidence-based prescribing review
C15	Refill request treated as routine	No clinical review, staff routing error	Continued unsafe therapy or missed deterioration	8	5	6	240	Refill protocol with escalation criteria
C16	Medication changes not communicated	Patient, pharmacy, caregiver, specialist not informed	Conflicting regimens, nonadherence	8	5	6	240	Closed-loop communication; written instructions

Critical training requirement: The physician must demonstrate the ability to reconcile medications for an older patient with multiple chronic conditions, multiple prescribers, and incomplete records—not merely pass a pharmacology test.

C. Chronic Disease and Preventive Care

ID	Failure mode	Possible causes	Effects	S	O	D	RPN	Key controls
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C17	Chronic disease not risk-stratified	Treating all patients similarly	High-risk patient receives insufficient follow-up	8	5	6	240	Registry and risk tiers
C18	Diabetes, hypertension, CKD, CHF, COPD, etc. not monitored	No disease registry, inconsistent visits	Progression, hospitalization	9	5	6	270	Condition-specific care protocols
C19	Preventive screening overdue	No recall system, unclear responsibility	Missed early detection	8	6	7	336	Preventive-care registry and outreach
C20	Vaccination gaps	Unclear ownership, incomplete records	Preventable infection	7	5	6	210	Immunization reconciliation
C21	Social determinants overlooked	Time pressure, insufficient history	Nonadherence, avoidable deterioration	7	5	7	245	Screening and referral pathways
C22	Goals of care not discussed	Avoidance, unclear timing, cultural/family complexity	Unwanted care, conflict during crisis	8	4	7	224	Structured advance-care-planning workflow
C23	Geriatric risks overlooked	Falls, cognition, frailty not assessed	Injury, medication harm, loss of independence	8	5	7	280	Geriatric screening prompts

For an older adult-heavy internal medicine practice, the new physician should be trained not just in disease treatment but in **polypharmacy, cognition, falls, frailty, function, caregiver dynamics, and goals of care.**

5. Detailed FMEA — Care Coordination and Transitions

This is one of the most important sections for a community practice.

Research on internal medicine training emphasizes that transitions of care are high-risk and that effective handoffs require prioritized information, action plans, and contingency planning. ([PubMed Central \(PMC\)](#))

ID	Failure mode	Causes	Effects	S	O	D	RPN	Preventive controls
T01	Hospital discharge summary not reviewed	No assigned owner, delayed records	Readmission, medication error	9	5	7	315	Discharge queue with 48–72-hour review target
T02	Post-discharge follow-up not scheduled	Scheduling gap, unclear responsibility	Deterioration, readmission	9	5	6	270	Follow-up appointment before discharge/within defined timeframe
T03	Specialist referral not completed	Insurance, patient confusion, no tracking	Delayed diagnosis/treatment	9	5	7	315	Referral tracking dashboard
T04	Specialist recommendations not incorporated	Records unavailable, no review	Conflicting or incomplete care	8	5	7	280	Referral result reconciliation
T05	Physician-to-physician handoff incomplete	Verbal assumptions, no standard format	Omitted tasks, duplicated care	9	5	6	270	Standard handoff: status, risks, pending tasks, contingency
T06	Coverage physician unaware of high-risk patients	No risk list, poor sign-out	Delayed response	9	4	7	252	Daily/weekly high-risk patient list
T07	Patient assumes "someone else is handling it"	Ambiguous ownership	No action occurs	9	6	7	378	Every pending task has one named owner
T08	Outside records not	Fragmented healthcare	Repeated tests,	7	6	6	252	Records-request

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	obtained	system	incomplete decisions					workflow
T09	Emergency department visit not known to practice	No notification integration	Missed follow-up	8	5	8	320	ED notification and reconciliation process
T10	Home health/hospital communication fails	Poor coordination, unclear contacts	Unsafe home care, patient distress	8	4	7	224	Defined communication pathway

BKM: The “No Orphan Task” Rule

Every pending clinical task must have:

- 1. Task description
- 2. Patient
- 3. Responsible person
- 4. Due date
- 5. Expected result
- 6. Escalation trigger
- 7. Completion evidence

If a task has no owner, it is not a task—it is a future failure.

6. Detailed FMEA — EHR, Inbox, Documentation, and Technology

The EHR is not merely a documentation tool. It is a **clinical control system**.

ID	Failure mode	Causes	Effects	S	O	D	RPN	Controls
E01	EHR access unavailable on first day	Credentialing, IT delay	Cannot safely practice	7	4	4	112	Pre-start access checklist
E02	New MD does not understand inbox	No training, unclear routing	Missed results/messages	9	6	7	378	Supervised inbox training
E03	Abnormal result routed incorrectly	Misconfigured pools, wrong provider	Delayed treatment	10	4	8	320	Result-routing validation

E04	Notes incomplete or delayed	High workload, unfamiliar templates	Poor continuity, coding issues	7	6	5	210	Documentation standards and audits
E05	Copy-forward propagates errors	Template misuse	Incorrect clinical information	8	5	7	280	Copy-forward review training
E06	Medication list not updated	Workflow omission	Unsafe prescribing	9	6	6	324	Medication reconciliation hard stop/standard
E07	Patient portal message not escalated	Staff uncertainty, unclear protocols	Delayed care	9	5	7	315	Message triage rules
E08	Results reviewed but not communicated	Assumes patient sees portal	Patient unaware of important findings	8	5	7	280	Communication documentation
E09	EHR shortcuts bypass safety checks	Efficiency pressure	Errors become invisible	8	4	8	256	Audit high-risk shortcuts
E10	Downtime procedure unknown	No downtime training	Inability to access records or document safely	8	3	8	192	Downtime drills and paper backup
E11	Privacy/security breach	Poor access hygiene, improper disclosure	Patient harm, legal/regulatory exposure	9	3	7	189	HIPAA/security training
E12	Clinical decision support ignored	Alert fatigue	Missed interaction or contraindication	8	5	8	320	Alert governance and high-risk alert review

Required EHR competency demonstration

The new physician should complete a supervised scenario involving:

- A new patient with 12 medications
- An abnormal lab result
- A pending imaging study
- A referral requiring follow-up
- A patient portal message describing worsening symptoms
- A discharge summary from a hospital
- A refill request for a high-risk medication

Pass condition: All tasks are correctly prioritized, assigned, documented, communicated, and closed.

7. Detailed FMEA — Emergency and Acute Care

A community internal medicine practice must have a clear boundary between **office management** and **emergency stabilization/escalation**.

ID	Failure mode	Causes	Effects	S	O	D	RPN	Controls
A01	Chest pain not escalated appropriately	Atypical presentation, anchoring	MI, death	10	3	7	210	Chest pain protocol, ECG capability, EMS criteria
A02	Stroke symptoms not recognized	Inadequate screening, delayed triage	Loss of treatment window, disability	10	3	7	210	Stroke recognition and EMS protocol
A03	Sepsis or serious infection underestimated	Older patient presentation, subtle symptoms	Shock, hospitalization, death	10	4	7	280	Sepsis red flags and escalation
A04	Respiratory distress managed too long in office	No defined threshold	Respiratory failure	10	3	7	210	Vital signs, oxygen, EMS protocol
A05	Syncope/arrhythmia risk missed	Incomplete history, no ECG review	Injury, sudden death	10	3	7	210	Syncope pathway
A06	Hypoglycemia/hyperglycemia	Diabetes complexity	Neurologic injury,	9	4	6	216	Point-of-care testing

	emia mishandled		hospitalization					and protocol
A07	Patient deteriorates while waiting	Triage failure, understaffing	Delayed intervention	9	4	7	252	Waiting-room escalation process
A08	Staff do not know when to interrupt physician	Hierarchy, unclear escalation	Delayed care	9	4	8	288	"Stop-the-line" authority
A09	Emergency equipment unavailable or expired	Poor maintenance	Delayed stabilization	10	2	6	120	Daily/weekly equipment checks
A10	New MD hesitates to call for help	Ego, fear, uncertainty	Preventable deterioration	10	4	8	320	Explicit escalation culture

Training principle: "Knowing when to seek assistance" is a high-priority clinical capability in internal medicine. ([PubMed Central \(PMC\)](#))

8. Detailed FMEA — Physician-to-Physician Relationship

This scenario has a unique risk: the senior physician is both **clinical mentor and pre-retirement stakeholder**.

The relationship can be a powerful asset—or a hidden failure source.

ID	Failure mode	Causes	Effects	S	O	D	RPN	Controls
P01	Roles and authority unclear	Informal arrangement, no written agreement	Conflicting decisions, staff confusion	8	7	6	336	Written governance and role matrix
P02	Senior MD continues to make every decision	Difficulty letting go, habit, patient dependence	New MD never develops autonomy	7	8	5	280	Progressive delegation plan
P03	New MD makes unilateral changes too quickly	Desire to modernize, insufficient context	Staff resistance, patient disruption	7	6	5	210	Change-control process

P04	Clinical disagreement becomes personal	Different styles, generational differences	Poor teamwork, unsafe compromise	8	5	7	280	Structured disagreement protocol
P05	Senior MD avoids difficult feedback	Protect relationship, fatigue	Competency gaps persist	8	6	8	384	Scheduled direct feedback
P06	New MD hides uncertainty	Fear of judgment	Unrecognized clinical risk	9	4	8	288	Psychological safety and escalation norm
P07	Senior MD's undocumented preferences dominate	"This is how we do it"	Inconsistent practice, poor adaptability	6	8	6	288	Standardize essential processes; document local exceptions
P08	Senior MD becomes unavailable unexpectedly	Illness, family emergency, retirement acceleration	Practice disruption	8	4	7	224	Contingency and cross-coverage plan
P09	Patient loyalty remains exclusively with senior MD	Long-standing relationships	New physician underutilized; succession fails	6	8	5	240	Structured warm handoffs
P10	New MD is treated as subordinate indefinitely	Cultural dynamics	Low engagement, attrition, unsafe silence	7	5	6	210	Defined co-physician authority
P11	Succession/ownership assumptions differ	No written business agreement	Legal/financial conflict	9	4	8	288	Attorney-reviewed agreement
P12	Retirement date is vague or repeatedly delayed	Emotional/financial uncertainty	No reliable transition plan	7	7	6	294	Milestone-based transition schedule

The key question

Is the senior physician training a successor—or hiring an assistant?

Those are different operating models.

9. Detailed FMEA — Staff, Workflow, and Team Dynamics

ID	Failure mode	Causes	Effects	S	O	D	RPN	Controls
W01	Staff do not know which physician handles what	Informal routing	Delays, duplicate work	7	7	5	245	Responsibility matrix
W02	Staff bypass new MD and ask senior MD everything	Habit, trust imbalance	Bottleneck, poor autonomy	6	8	5	240	Routing rules and coaching
W03	Staff resist new workflows	Fear, fatigue, unclear benefit	Low adoption, errors	6	7	5	210	Involve staff in redesign
W04	Front desk fails to identify urgent symptoms	Inadequate triage training	Delayed care	9	4	7	252	Symptom escalation script
W05	Medical assistant misunderstands physician orders	Communication gaps	Wrong test, missed follow-up	8	5	6	240	Read-back / closed-loop communication
W06	Lab/specimen process error	Labeling, transport, handling	Wrong or delayed result	8	3	6	144	Specimen verification
W07	Staff turnover during transition	Stress, uncertainty, workload	Loss of operational knowledge	7	6	6	252	Retention plan and cross-training

W08	No backup coverage for key roles	Single-person dependency	Workflow stops	7	6	5	210	Cross-training matrix
W09	Team avoids reporting near misses	Blame culture	Repeated errors	9	4	9	324	Nonpunitive safety reporting
W10	Physician workload overwhelms staff	Poor scheduling, unrealistic volume	Burnout, errors, turnover	8	6	5	240	Capacity planning and daily huddles

A strong onboarding program should establish community, role clarity, efficient workflows, mentoring, and professional support rather than treating orientation as a one-time checklist. ([PubMed Central \(PMC\)](#))

10. Detailed FMEA — Patient Experience and Continuity

ID	Failure mode	Causes	Effects	S	O	D	RPN	Controls
X01	Patient does not trust new MD	No introduction, communication mismatch	Nonadherence, attrition	7	7	5	245	Senior MD warm handoff
X02	New MD appears rushed or impersonal	High volume, unfamiliar workflow	Low satisfaction, poor disclosure	6	6	5	180	Visit structure and communication coaching
X03	Patient receives conflicting advice	Physicians differ without alignment	Confusion, unsafe care	8	5	6	240	Shared clinical standards
X04	Cultural/language needs not addressed	Lack of interpreter process	Misunderstanding, inequity	8	4	7	224	Qualified interpreter access
X05	Patient cannot access physician	Poor portal/phone workflow	Delayed care, frustration	7	6	6	252	Access standards and triage

	appropriately							
X06	Continuity breaks during senior MD retirement	No patient transition plan	Patient loss, care disruption	8	7	6	336	Panel transition schedule
X07	Patient expects senior MD to remain available indefinitely	Unclear communication	Delayed care, conflict	6	7	5	210	Transparent transition messaging
X08	Complaints not analyzed	No feedback loop	Repeated service failures	6	5	8	240	Complaint review and corrective action

11. Detailed FMEA — Business, Compliance, and Practice Operations

Clinical competence alone does not guarantee a successful physician partnership.

ID	Failure mode	Causes	Effects	S	O	D	RPN	Controls
B01	Credentialing incomplete	Delayed paperwork, payer issues	Physician cannot bill/practice fully	7	4	5	140	Credentialing tracker
B02	Malpractice coverage unclear	Contract omission	Financial/legal exposure	9	3	7	189	Verify policy and tail coverage
B03	Employment/partnership agreement ambiguous	Informal negotiation	Dispute over compensation, ownership, exit	9	4	8	288	Healthcare attorney review
B04	Compensation model misunderstood	RVU, collections, overhead unclear	Conflict, dissatisfaction	7	5	5	175	Written compensation model

B05	Billing/coding errors	New payer mix, unfamiliar EHR	Denials, lost revenue, compliance risk	7	5	6	210	Coding audit and training
B06	Documentation insufficient for billing	Time pressure, poor templates	Denials, audit exposure	7	5	5	175	Documentation standards
B07	Payer network mismatch	Credentialing gap	Patients cannot be seen/billed properly	7	4	5	140	Payer verification
B08	Practice volume exceeds safe capacity	Growth pressure, unrealistic targets	Burnout, errors, patient dissatisfaction	8	6	5	240	Capacity and scheduling model
B09	Financial performance not monitored	No dashboard	Unsustainable practice	7	5	7	245	Monthly financial review
B10	Retirement transition creates revenue shock	Senior MD leaves abruptly	Cash-flow and staffing crisis	8	4	6	192	Transition financial model
B11	HIPAA/privacy process failure	Inadequate training, shared access	Regulatory and reputational harm	9	3	7	189	Privacy/security controls
B12	No business continuity plan	Single physician dependency	Practice closure or disruption	9	4	8	288	Emergency succession plan

Florida-specific operational items to verify

These should be included in the onboarding checklist and confirmed with the practice's attorney, credentialing team, and compliance advisor:

- Florida medical licensure and applicable practice requirements
- DEA registration, if prescribing controlled substances
- Hospital privileges or referral relationships, if applicable
- Malpractice coverage and tail coverage
- Payer credentialing and participation

- HIPAA, OSHA, CLIA-waived testing, and applicable practice policies
- Medical record retention and release procedures
- Controlled-substance prescribing and monitoring procedures
- Telehealth requirements, if telehealth is offered
- Ownership, employment, compensation, and retirement-transition agreements

These are **verification items**, not assumptions about what the practice currently does.

12. Detailed FMEA — Physician Development and Training System

This is the category that determines whether the other risks are detected early.

ID	Failure mode	Causes	Effects	S	O	D	RPN	Controls
T01	Training is informal only	"Shadow me and you'll learn"	Major gaps remain hidden	9	7	8	504	Structured competency curriculum
T02	No baseline competency assessment	Assumes residency equals practice readiness	Training not individualized	8	6	8	384	Baseline assessment before independent practice
T03	New MD is evaluated only by senior MD	Single-observer bias	Blind spots remain	8	5	8	320	360° feedback from staff, peers, patients where appropriate
T04	No direct observation after onboarding	Trust replaces verification	Unsafe habits persist	9	5	8	360	Periodic chart review and observed encounters
T05	Feedback is delayed or vague	Conflict avoidance	Errors repeat	8	6	8	384	Weekly structured feedback
T06	Training focuses on knowledge, not workflow	Traditional orientation	Physician knows medicine but cannot operate system	8	7	7	392	Workflow-based EPAs
T07	No remediation	Fear of conflict,	Weaknesses become	9	4	9	324	Written improve

	pathway	unclear standards	patient risks					nt plan
T08	Competency is assumed after a short orientation	Business urgency	Premature autonomy	10	5	8	400	Entrustment decisions based on evidence
T09	No simulation of rare high-risk events	Low frequency of emergencies	Poor response under stress	10	3	8	240	Simulation and drills
T10	No measurement of workload sustainability	Focus on productivity only	Burnout, turnover, errors	8	6	7	336	Workload, quality, and wellness dashboard
T11	No continuing education plan	Practice demands overlooked	Clinical knowledge drift	7	5	7	245	Annual learning plan
T12	No succession-readiness assessment	Retirement treated as a date, not a capability	Practice remains dependent on senior MD	9	7	8	504	Formal succession scorecard

The most important training failure

“The new physician seems fine” is not a competency assessment.

A better model uses observable activities, direct observation, feedback, and progressive entrustment. Internal medicine education frameworks use EPAs—activities a physician must be trusted to perform safely—as a bridge between knowledge and real practice. (PubMed Central (PMC))

13. The Training Model: From New Hire to Reliable Co-Physician

The “Observe → Assist → Perform → Verify → Entrust” model

Stage	New physician role	Senior physician role	Release criterion
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1. Observe	Learn patients, workflow, EHR, local practice	Explain reasoning and hidden workflows	Can describe process accurately
2. Assist	Participate in visits, documentation, care coordination	Coach and correct	Performs components safely
3. Perform with supervision	Conduct visits and manage tasks	Review selected cases and decisions	Consistent safe performance
4. Perform with audit	Manage defined patient panel	Review dashboards and high-risk cases	Reliable independent execution
5. Co-lead	Own clinical and operational responsibilities	Transition authority	Practice functions without constant senior intervention
6. Succeed	Maintain continuity after retirement	Exit or advisory role	No critical dependency on senior physician

Important: “Independent” should not mean “never asks for help.” It means the physician can recognize limits, escalate appropriately, and reliably close the loop.

14. Suggested 12-Month Competency Curriculum

Phase 0 — Pre-Arrival: 30–60 Days Before Start

Objective: Prevent administrative and system failures before the first patient.

Required activities

- Credentialing, licensing, payer, malpractice verification
- EHR account, prescribing, lab, imaging, referral access
- Review practice policies
- Review patient population and panel characteristics
- Review emergency equipment and escalation procedures
- Review staffing structure and role matrix
- Review compensation and employment agreement
- Identify senior physician’s responsibilities and hidden dependencies
- Establish baseline clinical competency assessment
- Establish training calendar and feedback schedule

Exit gate: Physician can legally and operationally practice with required access and knows how to summon help.

Phase 1 — Days 1–30: Learn the Practice

Focus: Workflow, patients, documentation, and safety.

Competency	Training activity
EHR	Supervised chart navigation, orders, inbox, results
Medication reconciliation	Perform 10–20 supervised reconciliations
Patient flow	Observe front desk, MA, triage, lab, checkout

Clinical documentation	Review sample notes and complete supervised notes
Referral process	Submit, track, and close referrals
Emergency response	Participate in office emergency drill
Physician relationship	Daily debrief with senior MD
Patient introductions	Senior MD performs warm handoffs

Assessment: Direct observation + chart review + workflow demonstration.

Phase 2 — Days 31–60: Supervised Clinical Ownership

Focus: The new physician begins owning care while the senior physician verifies.

Required activities

- Conduct a defined number of supervised visits
- Manage chronic disease follow-up
- Perform medication reconciliation
- Review labs and imaging
- Communicate results
- Complete referrals
- Participate in hospital discharge follow-up
- Conduct difficult conversations
- Manage urgent same-day cases under supervision
- Begin managing a small patient panel

Assessment: Weekly review of selected cases and closed-loop tasks.

Phase 3 — Days 61–90: Progressive Autonomy

Focus: Reliable independent work with targeted review.

Required activities

- Manage a defined panel
- Independently handle routine visits
- Demonstrate safe management of common acute complaints
- Manage inbox according to protocol
- Demonstrate appropriate escalation
- Complete documentation on time
- Demonstrate care coordination
- Participate in quality-improvement review
- Conduct patient transition visits from senior MD

Assessment: Entrustment decision for each major activity—not a single global “pass/fail.”

Phase 4 — Months 4–6: Co-Physician Integration

Focus: Two-physician operating model.

Required activities

- Share clinical coverage
- Establish physician-to-physician handoff standard
- Define panel ownership
- Lead a staff huddle
- Review quality dashboard
- Manage a clinical improvement project
- Participate in financial/operational review
- Identify remaining senior physician dependencies
- Conduct formal 360° feedback

Assessment: Can the practice operate safely if the senior MD is absent for two weeks?

Phase 5 — Months 7–12: Succession Readiness

Focus: Sustainability and retirement transition.

Required activities

- New MD owns an increasing percentage of the panel
- Senior MD transitions from primary decision-maker to advisor
- Patient transition plan implemented
- New MD participates in hiring/training decisions
- Practice policies documented
- Emergency coverage plan tested
- Business continuity plan tested
- Quality metrics compared against baseline
- Retirement readiness review

Assessment: Can the practice operate safely and financially with the senior physician absent or retired?

15. Entrustable Professional Activities for This Specific Role

Instead of evaluating the physician only by “clinical knowledge,” define activities that the new MD must be trusted to perform.

EPA	Activity	Example entrustment question
EPA 1	Conduct a complete outpatient internal medicine encounter	Can the physician independently evaluate and manage a typical patient safely?
EPA 2	Recognize and escalate an unstable patient	Can the physician identify when office care is inappropriate?
EPA 3	Perform medication reconciliation	Can the physician identify discrepancies and high-risk interactions?
EPA 4	Close the loop on abnormal results	Can the physician ensure abnormal results lead to appropriate action?
EPA 5	Coordinate referrals and transitions	Can the physician ensure no patient falls through the system?

EPA 6	Manage a chronic disease panel	Can the physician maintain reliable longitudinal care?
EPA 7	Perform safe handoffs	Can the physician transfer responsibility without omissions?
EPA 8	Manage inbox and patient communications	Can the physician triage, respond, and escalate safely?
EPA 9	Communicate difficult information	Can the physician explain uncertainty, risk, and next steps?
EPA 10	Work effectively with staff	Can the physician use the team rather than becoming the bottleneck?
EPA 11	Practice within legal, ethical, and professional boundaries	Can the physician recognize and manage conflicts appropriately?
EPA 12	Participate in quality improvement	Can the physician identify a system failure and improve it?
EPA 13	Operate during senior physician absence	Can the physician maintain safe continuity?
EPA 14	Lead a practice transition	Can the physician sustain the practice after retirement?

These activities combine clinical knowledge with communication, systems-based practice, and patient safety—the real requirements of community internal medicine.

16. The “Senior MD Knowledge Transfer” FMEA

This deserves its own analysis because it may be the most consequential succession risk.

What the senior physician may know that is not in the EHR

- Which patients are medically fragile
- Which patients minimize symptoms
- Which families require special communication
- Which patients have transportation or financial barriers
- Which specialists are responsive
- Which hospitals provide reliable care
- Which patients are at risk of nonadherence
- Which medications have caused prior problems
- Which abnormal findings require immediate attention
- Which workflows depend on one particular staff member
- Which payer or referral processes routinely fail
- Which patients are likely to deteriorate after discharge
- Which patients should never be allowed to “wait and see” without follow-up

Failure mode

Tacit knowledge is lost when the senior physician retires.

Effect: The new physician inherits charts but not the practice’s clinical memory.

BKM: The Patient Continuity Transfer

For every high-risk or complex patient, create a structured transition record:

Field	Example content
Patient risk level	High / medium / routine
Active diagnoses	Key chronic and acute conditions
Current medications	Verified list
Baseline status	Functional and clinical baseline
Known red flags	Symptoms or changes requiring urgent action
Pending items	Labs, imaging, referrals
Specialist network	Relevant contacts
Patient preferences	Communication and care preferences
Social barriers	Transportation, caregiver, cost
Senior MD’s clinical pearls	Relevant, documented, clinically justified
New MD confirmation	Reviewed and accepted
Follow-up date	Next review

Do not transfer undocumented personal opinions as facts. Distinguish between objective information, clinical judgment, and patient preference.

17. FMEA Controls: The Practice’s Safety Architecture

A high-quality training model should not depend on memory alone.

The seven control layers

Layer	Control	Purpose
1. Standardize	Protocols, templates, checklists	Reduce variation
2. Assign ownership	Named physician/staff owner	Prevent orphan tasks
3. Verify	Direct observation, chart review	Detect competency gaps
4. Escalate	Clear red flags and authority	Prevent delayed intervention
5. Track	Dashboards, registries, queues	Make invisible work visible
6. Learn	Near-miss review, feedback, QI	Prevent recurrence
7. Resilience	Cross-training, backup, succession	Continue safely under disruption

18. Recommended Daily, Weekly, and Monthly BKM

Daily — 10–15 Minute Clinical Operations Huddle

Participants: Both physicians + key staff.

1. Which patients are high risk today?
2. Which patients are waiting for urgent results?
3. Which discharges require follow-up?
4. Which referrals are overdue?
5. Which patients need physician-to-physician discussion?
6. Are there staffing or capacity problems?
7. Is there anything that could harm a patient today?

Weekly — Physician Competency and Case Review

Review 5–10 cases:

- One complex diagnostic case
- One medication-risk case
- One abnormal-result case
- One transition-of-care case
- One difficult communication case
- One case involving uncertainty or escalation

Discussion format:

What happened → What was the risk → What was done → What could fail → What will we standardize?

Monthly — Practice Safety and Succession Review

Domain	Questions
Clinical	Any adverse events, near misses, delayed diagnoses?
Results	Are abnormal results closed on time?
Referrals	Are referrals completed and reviewed?
Medications	Any reconciliation or monitoring gaps?
Patient experience	Complaints, access, continuity?
Operations	Volume, staffing, wait times, documentation?
Financial	Collections, denials, overhead, cash flow?
Succession	What still depends on senior MD?
Training	Which competencies are verified?
Wellness	Is workload sustainable?

19. Metrics That Should Be Measured

Leading indicators — detect risk before harm

Metric	Why it matters
% abnormal results reviewed within target	Detects result-management risk

% abnormal results with documented action	Detects closure failure
% referrals tracked to completion	Detects care coordination gaps
% medication reconciliations completed	Detects prescribing risk
% charts completed within policy	Detects documentation backlog
% high-risk patients with updated care plans	Detects chronic-care risk
% new MD cases directly observed	Detects training blind spots
% competency EPAs verified	Detects premature autonomy
Number of unresolved inbox items	Detects information-system overload
Number of tasks without assigned owner	Detects orphan-task risk
Number of near misses reported	Detects learning culture
Senior MD dependency count	Measures succession progress

Lagging indicators — detect harm after it occurs

- Avoidable hospital readmissions
- Medication errors
- Delayed diagnoses
- Missed abnormal results
- Patient complaints
- Referral failures
- Staff turnover
- Physician burnout
- Patient attrition
- Revenue decline
- Malpractice claims

Best practice: Do not use productivity alone as the success metric. A physician can see many patients while the system accumulates hidden risk.

20. The 30-60-90-Day Readiness Scorecard

Domain	30 Days	60 Days	90 Days	Evidence
Clinical assessment	Observes and performs with help	Manages routine cases	Manages defined panel safely	Direct observation
Acute care	Knows escalation protocol	Handles urgent cases with supervision	Recognizes and escalates independently	Simulation + cases
Medication safety	Learns reconciliation	Performs reliably	Manages high-risk medication monitoring	Chart audit
EHR	Navigates system	Manages supervised inbox	Independently closes loops	EHR audit

Care coordination	Learns referral process	Tracks referrals/discharges	Owens transitions reliably	Tracking dashboard
Communication	Observed patient interactions	Receives feedback	Consistent patient-centered communication	Observation / feedback
Teamwork	Learns roles	Participates in huddles	Works effectively with staff	360° feedback
Professionalism	Understands policies	Demonstrates reliability	Handles conflict/escalation appropriately	Feedback
Practice operations	Learns business workflows	Understands capacity and billing	Participates in operational decisions	Review
Succession	Understands senior MD role	Takes partial ownership	Demonstrates continuity without senior MD	Absence simulation

Readiness decision

- **Green:** Independent within defined scope
- **Yellow:** Independent with targeted review
- **Red:** Requires additional supervision or remediation

No physician should be released to independent responsibility solely because 90 days have elapsed.

21. The “Two-Week Senior MD Absence” Test

This is one of the best practical tests of whether the onboarding model is working.

Scenario

The senior physician is unavailable for two weeks due to illness, family emergency, or planned leave.

Evaluate whether the new physician and team can:

- Manage scheduled patients
- Triage urgent calls
- Review abnormal results
- Process refills
- Handle hospital discharges
- Complete referrals
- Contact specialists
- Manage emergencies appropriately
- Handle staff questions
- Maintain documentation
- Maintain patient communication
- Escalate appropriately when outside competence
- Keep the practice operational

Pass criterion

The practice does not need the senior physician's constant intervention to remain safe and functional.

This is a **resilience test**, not a test of whether the new physician knows everything.

22. Top 15 Training Controls I Would Implement First

If I were designing this practice's onboarding program, I would prioritize these:

1. **Written co-physician role and authority matrix**
 2. **Baseline competency assessment**
 3. **Structured 30-60-90-day onboarding plan**
 4. **EHR/inbox/result-management training**
 5. **Medication reconciliation standard**
 6. **Abnormal-result closed-loop protocol**
 7. **Referral and transition-of-care tracking**
 8. **Emergency escalation protocol**
 9. **Weekly case review with direct feedback**
 10. **Senior MD tacit-knowledge transfer program**
 11. **Warm patient introductions**
 12. **Standard physician-to-physician handoff**
 13. **Monthly quality and safety dashboard**
 14. **Written remediation and escalation process**
 15. **Two-week senior MD absence test**
-

23. Final Risk Interpretation

The practice's greatest risks are not limited to medical knowledge.

The highest-risk failure modes are likely to arise from:

1. Hidden dependency on the senior physician

The practice may appear stable because one experienced physician compensates for weak systems.

2. Premature autonomy

The new physician may be clinically capable but not yet reliable in the specific practice environment.

3. Information-loop failure

Results, referrals, medication changes, and discharge tasks may fall between people.

4. Ambiguous authority

Two physicians may have different assumptions about who decides, who owns the patient, and who is accountable.

5. Succession without operational transfer

The senior physician retires, but the practice's knowledge, relationships, and workflows have not been transferred.

The central BKM

Train the physician. Standardize the system. Verify the work. Transfer the knowledge. Test the absence. ↻

A successful co-physician transition is not achieved when the new MD can perform routine visits alone. It is achieved when the physician can **reliably manage patients, recognize limits, coordinate care, work with the team, close clinical loops, and sustain the practice without hidden dependence on the retiring physician.**

That is the difference between **hiring a doctor** and **building a resilient medical practice.**