

AI-04725 PRA New Internal Medicine MD in FL

Perform a comprehensive PRA 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.

Comprehensive PRA: New Internal Medicine MD in Hernando, Florida

Scenario

A new internal medicine physician joins an established outpatient practice in **Hernando County, Florida**, working as a **co-physician with a 65-year-old female physician who is approaching retirement**.

The objective is not merely to determine whether the new physician possesses sufficient medical knowledge. The objective is to identify **every important way the physician–practice system could fail**, understand the effects of those failures, and build a training and onboarding model that prevents patient harm, operational disruption, legal exposure, and an unsuccessful physician transition.

Important distinction: This is a prospective **Process Risk Assessment (PRA)** using FMEA-style analysis. It is a training and safety-planning tool, not a determination that a particular physician is unsafe or incompetent. Actual competency decisions should be based on credentials, references, observed practice, chart review, supervised evaluation, and applicable professional requirements.

1. Executive Risk Model

The new physician is entering a system with **five simultaneous transitions**:

Transition	Primary risk
Clinical transition	New physician must safely manage the practice's patient population
Knowledge transition	Established physician's tacit knowledge may not be documented or transferred
Relationship transition	Patients may resist, distrust, or misunderstand the new physician
Operational transition	EHR, staff, referrals, labs, billing, and workflows may be unfamiliar
Ownership / succession transition	Retirement timing, responsibility, finances, and governance may be unclear

Core risk statement

A clinically capable new physician can still fail if the surrounding system does not reliably transfer knowledge, define authority, support escalation, protect continuity, and detect errors early.

Conversely:

An excellent practice can experience preventable harm if a new physician is permitted to operate beyond verified competence or without adequate integration into the practice's safety systems.

2. PRA Methodology

This assessment uses a healthcare-adapted FMEA framework.

Risk scoring

Each failure mode receives three provisional ratings:

Factor	Scale	Meaning
Severity (S)	1–10	Consequence if the failure reaches the patient or practice
Occurrence (O)	1–10	Likelihood of the failure occurring
Detectability (D)	1–10	Difficulty of detecting the failure before harm; 10 = difficult to detect
RPN	$S \times O \times D$	Relative prioritization score

RPN is not a clinical truth or a legal threshold. A low-frequency event with catastrophic consequences may deserve priority even if its RPN is modest.

Severity guide

Score	Clinical / operational consequence
1–2	Minimal inconvenience; no meaningful harm
3–4	Minor delay, rework, or low-level patient dissatisfaction
5–6	Moderate clinical deterioration, avoidable resource use, or significant workflow disruption
7–8	Serious patient harm, hospitalization, major financial/legal exposure, or substantial continuity failure
9	Potential permanent disability, life-threatening event, or major practice failure
10	Death, catastrophic patient harm, or irreversible systemic failure

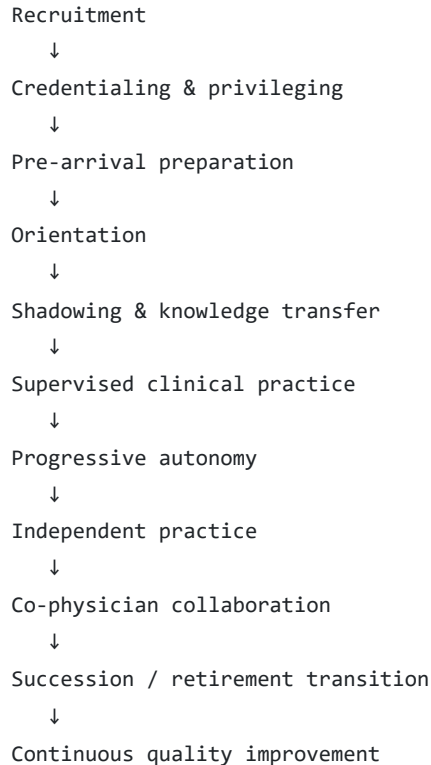
Prioritization bands

RPN	Suggested action
300+	Immediate mitigation and competency gate
200–299	High-priority mitigation before independent practice
100–199	Structured training, monitoring, and process controls
<100	Manage through standard onboarding and routine monitoring

Important: Any failure mode with **S = 9 or 10** should receive review regardless of RPN.

3. System Boundary: What Is Being Assessed?

The PRA covers the entire physician lifecycle:



Stakeholders

- New internal medicine MD
 - Established 65-year-old physician
 - Patients and families
 - Nurses and medical assistants
 - Front-desk and scheduling staff
 - Practice manager / administrator
 - Billing and coding personnel
 - Referral coordinators
 - Laboratory and imaging partners
 - Pharmacies
 - Hospitals and specialists
 - EHR / IT support
 - Credentialing organizations
 - Malpractice carrier
 - Practice owner / partners
 - Successor physician or future practice leadership
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4. Master Failure-Mode Register

The following is a **comprehensive training-oriented register**, organized by risk domain. It is intentionally broad: some failure modes are clinical, some administrative, and some are latent system conditions that make clinical errors more likely.

Ratings are illustrative starting estimates. The practice should recalibrate them using its actual patient volume, staffing, EHR, specialty mix, incident history, and physician experience.

DOMAIN A — Credentialing, Licensing & Scope of Practice

ID	Failure mode	Potential effect	Likely causes	Existing / desired controls	S	O	D	RPN
A1	Florida license not active or verified	Unauthorized practice; patient risk; regulatory exposure	Incomplete verification, expiration, administrative error	Primary-source license verification before start	9	2	2	36
A2	DEA registration unavailable or inappropriate	Inability to prescribe controlled substances; unsafe workaround	Registration delay, incorrect address, scope mismatch	Verify DEA status and prescribing workflow	8	3	2	48
A3	Board certification / eligibility misunderstood	Misrepresentation; inappropriate patient expectations	Poor credential review	Verify training, certification, and permitted representations	7	2	3	42
A4	Hospital privileges not established	Inability to admit or manage patients appropriately	Credentialing delay	Confirm privileges, admitting arrangements, and coverage	8	4	3	96
A5	Malpractice coverage has gaps	Uninsured exposure; delayed start	Policy exclusions, tail/claims-made	Confirm coverage, limits, retroactive	9	3	4	108

			misunderstanding	date, tail requirements				
A6	Scope of practice exceeds verified training	Unsafe procedures, prescribing, or clinical decisions	Pressure to fill service gaps	Written scope and privilege matrix	9	4	5	180
A7	Licensure history or restrictions overlooked	Regulatory and patient-safety risk	Incomplete due diligence	Primary-source and professional-reference checks	9	2	5	90
A8	Required payer enrollment incomplete	Claims denied; patients redirected; revenue disruption	Delayed enrollment	Medicare, Medicaid, commercial payer enrollment checklist	6	5	2	60
A9	NPI / CAQH / taxonomy data incorrect	Billing failures and credentialing delays	Data mismatch	Reconcile all provider identifiers	5	4	3	60
A10	No defined clinical escalation authority	New physician practices beyond support level	Ambiguous co-physician roles	Written escalation and coverage policy	9	5	6	270

Training controls

Before the first patient:

- Verify Florida licensure through the Florida Board of Medicine.
- Confirm DEA and controlled-substance prescribing requirements where applicable.
- Verify board status and training history.
- Confirm malpractice policy and coverage structure.
- Establish written clinical privileges and exclusions.
- Define who can authorize, review, or co-sign clinical decisions.
- Confirm hospital admission, transfer, and after-hours coverage pathways.

Florida's Board of Medicine provides licensing and credentialing requirements, and physician practice should remain within the physician's verified training and authorized scope. ([Florida Board of Medicine](#))

DOMAIN B — Practice Governance & Co-Physician Relationship

This domain is especially important because the new physician is not simply joining a large organization. The physician is entering an existing professional ecosystem led by a physician approaching retirement.

ID	Failure mode	Potential effect	Likely causes	Controls	S	O	D	RPN
B1	Roles and responsibilities undefined	Duplication, omissions, conflict	Informal assumptions	Written role charter	8	6	6	288
B2	Established physician retains all decision authority	New physician cannot develop autonomy; bottleneck	Control concerns, habit	Decision-rights matrix	6	6	5	180
B3	New physician assumes authority too quickly	Unsafe decisions; disruption	Overconfidence, inadequate orientation	Progressive autonomy gates	9	4	6	216
B4	No agreement on patient ownership	Missed follow-up; conflicting plans	Panel boundaries unclear	Explicit panel and cross-coverage rules	8	5	6	240
B5	No agreement on after-hours coverage	Delayed urgent care; burnout	Coverage assumed rather than designed	Written call schedule and escalation	9	5	5	225
B6	Disagreement over clinical management unresolved	Delayed treatment; staff confusion	No conflict pathway	Second-opinion / escalation protocol	8	4	6	192
B7	Retirement timeline not explicit	Abrupt transition; patient abandonment risk	Avoidance of difficult conversations	Succession roadmap with milestones	8	5	7	280

B8	Tacit knowledge remains with retiring physician	New MD misses hidden risks and patient preferences	Knowledge not documented	Structured knowledge-transfer program	8	7	8	448
B9	Financial expectations unclear	Conflict, turnover, loss of trust	Ambiguous compensation / buy-in	Written agreement reviewed by professionals	7	5	5	175
B10	New physician becomes dependent on senior MD	Fragile practice; delayed independent judgment	Excessive rescue behavior	Deliberate autonomy development	7	5	7	245
B11	Senior physician disengages prematurely	Unavailable expertise during transition	Fatigue, retirement planning	Minimum transition availability agreement	8	4	6	192
B12	Senior physician continues practicing despite impairment or fatigue	Patient harm; impaired judgment	Health, fatigue, reluctance to step back	Fitness-for-duty and coverage safeguards	10	2	7	140
B13	Personality conflict becomes operational conflict	Staff polarization; patient experience decline	Poor communication	Structured conflict resolution	6	5	5	150
B14	No shared clinical philosophy	Inconsistent care and patient confusion	Different thresholds and habits	Agree on evidence-based practice standards	7	6	6	252
B15	No exit / emergency succession plan	Practice collapse if either physician	Planning omission	Business continuity and emergency	9	3	8	216

Critical insight

B8 — Tacit knowledge transfer failure — is one of the highest-risk items in the entire PRA.

The retiring physician may know:

- Which patients underreport symptoms
- Which patients frequently miss appointments
- Which family member is the real care coordinator
- Which patients have unreliable medication histories
- Which specialists respond quickly
- Which hospitalists are dependable
- Which patients require earlier follow-up
- Which patients have subtle cognitive decline
- Which patients have unresolved diagnostic questions
- Which patients have difficult social circumstances
- Which patients have historically deteriorated after a specific pattern
- Which referrals are pending but not visible in a standard task list
- Which patients should not be lost during transition

This knowledge must be converted from **memory** → **structured information** → **shared workflow**.

DOMAIN C — Patient Population & Clinical Complexity

A new general internist may be clinically strong but unfamiliar with the practice's specific patient population.

ID	Failure mode	Potential effect	Causes	Controls	S	O	D	RPN
C1	Underestimates prevalence of multimorbidity	Incomplete assessment; unsafe prioritization	New population unfamiliar	Patient-mix analysis and case review	8	6	6	288
C2	Unfamiliar with local geriatric population	Falls, delirium, polypharmacy, frailty missed	Different demographic profile	Geriatric medicine training	9	6	6	324
C3	Misses atypical presentations in older adults	Delayed diagnosis	Anchoring on classic symptoms	Diagnostic reasoning and red-flag training	9	5	7	315

C4	Fails to identify high-risk chronic disease patients	Preventable hospitalization	No risk stratification	High-risk registry	9	5	7	315
C5	Inadequate knowledge of local referral resources	Delayed specialty care	New geography/network	Referral directory and escalation pathways	7	6	4	168
C6	Misjudges socioeconomic barriers	Nonadherence, missed care	Assumes access	Social-needs screening and care navigation	7	6	7	294
C7	Fails to account for health literacy	Misunderstanding of treatment	Communication mismatch	Teach-back and plain-language standards	8	5	6	240
C8	Does not recognize caregiver burden	Medication and care-plan failure	Patient seen without caregiver context	Caregiver assessment	7	5	7	245
C9	Inadequate awareness of local infectious / environmental risks	Delayed diagnosis or prevention	Geographic unfamiliarity	Regional clinical orientation	6	3	6	108
C10	Does not recognize cognitive impairment	Unsafe self-management	Time pressure, subtle presentation	Cognitive screening and collateral history	9	5	7	315

Hernando County-specific considerations

The training model should investigate the actual practice population rather than assume it. Depending on the practice's location and patient mix, this may include:

- Older adults and Medicare patients
- Multiple chronic conditions
- Cardiovascular disease
- Diabetes

- Chronic kidney disease
- COPD and asthma
- Heart failure
- Polypharmacy
- Falls and frailty
- Cognitive impairment
- Depression and anxiety
- Cancer survivorship
- Caregiver-dependent patients
- Transportation and access barriers
- Patients transitioning between hospitals, skilled nursing facilities, and home

Do not use county demographics as a substitute for the practice's own data. Extract actual patient-panel characteristics during onboarding.

DOMAIN D — Clinical Assessment & Diagnostic Reasoning

This is the central clinical risk domain.

ID	Failure mode	Potential effect	Causes	Controls	S	O	D	RPN
D1	Incomplete history	Missed diagnosis or contraindication	Time pressure, poor structure	Standardized history framework	8	6	6	288
D2	Incomplete physical examination	Missed clinical findings	Overreliance on prior records	Problem-oriented exam standards	8	5	7	280
D3	Anchoring on prior diagnosis	Wrong diagnosis persists	Premature closure	Diagnostic timeout / differential checklist	9	6	7	378
D4	Failure to consider dangerous alternatives	Delayed emergency treatment	Narrow differential	Red-flag training and escalation	10	4	8	320
D5	Premature closure after reassuring initial test	Missed serious disease	Overreliance on negative result	Safety-net and reassessment rules	9	5	8	360
D6	Inadequate interpretation	Delayed workup	Knowledge gap or	Case review and	9	5	7	315

	n of abnormal findings		cognitive overload	decision support				
D7	Failure to reconcile conflicting data	Incorrect treatment	Fragmented records	Structured data reconciliation	8	5	7	280
D8	Failure to recognize clinical deterioration	Delayed escalation	Inadequate vitals review, pattern recognition	Deterioration criteria	10	4	8	320
D9	Overtesting without clinical question	False positives, unnecessary procedures	Defensive practice, uncertainty	Test-indication review	6	6	5	180
D10	Undertesting or delayed testing	Missed disease	Cost concerns, overconfidence	Evidence-based diagnostic pathways	9	4	7	252
D11	Failure to communicate diagnostic uncertainty	Patient misinterpretation; delayed follow-up	Overconfidence or poor communication	Documented uncertainty and safety net	8	5	7	280
D12	No explicit follow-up plan for unresolved problem	Patient lost to follow-up	Visit ends without ownership	Closed-loop follow-up	9	6	8	432
D13	Failure to reassess after treatment	Persistent or worsening illness	No scheduled reassessment	Condition-specific follow-up rules	8	5	7	280
D14	Failure to recognize need for emergency transfer	Catastrophic delay	Clinic attempts to manage unstable patient	Emergency transfer protocol	10	3	7	210

D15	Overconfidence in unfamiliar clinical scenario	Unsafe management	Inadequate escalation	"Pause and ask" culture	9	4	8	288
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High-risk diagnostic scenarios for competency assessment

The new physician should demonstrate safe reasoning in cases such as:

- Chest pain with atypical symptoms
- Dyspnea with multiple possible causes
- Syncope
- New neurologic deficit
- Sepsis or occult infection
- GI bleeding
- Acute kidney injury
- Hyperkalemia
- Severe hyperglycemia
- Hypoglycemia
- New anemia
- Unexplained weight loss
- Abnormal chest imaging
- New atrial fibrillation
- Heart failure exacerbation
- Pulmonary embolism risk
- Delirium
- Falls with anticoagulant use
- Medication-induced hypotension
- Abnormal troponin interpretation
- Persistent symptoms despite a prior reassuring workup

DOMAIN E — Chronic Disease Management

Internal medicine practices often fail not because of one dramatic diagnostic error, but because chronic disease management becomes fragmented.

ID	Failure mode	Effect	Causes	Controls	S	O	D	RPN
E1	Incomplete problem list	Important disease omitted	Poor record review	Problem-list reconciliation	7	5	6	210
E2	Inaccurate medication list	Wrong treatment, interaction, overdose	Multiple prescribers	Medication reconciliation every transition	9	6	7	378

E3	Duplicate medications	Adverse drug event	Brand/generic duplication	Pharmacist / EHR duplicate checks	8	4	6	192
E4	Failure to monitor high-risk medications	Toxicity or treatment failure	Lab tracking gaps	Medication monitoring registry	9	5	8	360
E5	Diabetes care gaps	Complications, hospitalization	Missed A1c, renal, eye, foot monitoring	Diabetes registry	8	6	6	288
E6	Hypertension undertreatment or overtreatment	Stroke, kidney disease, falls	Poor measurement or follow-up	BP validation and titration protocol	8	6	6	288
E7	CKD progression not recognized	Renal failure, medication toxicity	Trend not reviewed	eGFR / albuminuria monitoring	9	5	7	315
E8	Heart failure care gap	Hospitalization, death	Weight/symptom changes missed	HF action plan and registry	10	4	7	280
E9	COPD / asthma control failure	Exacerbation, hospitalization	Inhaler errors, poor assessment	Inhaler technique and action plan	8	5	6	240
E10	Anticoagulation mismanagement	Stroke or major bleeding	Poor reconciliation, procedures	Anticoagulation safety process	10	4	7	280
E11	Statin / cardiovascular prevention gap	Preventable cardiovascular events	Risk not reassessed	Prevention checklist	8	5	6	240
E12	Cancer screening gap	Delayed diagnosis	No registry or unclear responsibility	Preventive-care registry	8	6	8	384

E13	Osteoporosis / fracture risk missed	Fracture, disability	Risk not assessed	Age/risk-based screening	8	5	7	280
E14	Vaccination gaps	Preventable infection	Records fragmented	Immunization reconciliation	7	5	5	175
E15	Polypharmacy not addressed	Falls, delirium, hospitalization	No deprescribing process	Medication review for high-risk patients	9	6	7	378
E16	No shared chronic-care goals	Conflicting treatment priorities	Disease-centered care	Shared decision-making	7	5	6	210
E17	Failure to identify care gaps inherited from prior MD	Patients assume care is complete	Trust in historical workflow	Transition chart audit	8	6	8	384

DOMAIN F — Medication Management & Prescribing

Medication safety deserves its own PRA because it crosses nearly every workflow.

ID	Failure mode	Effect	Causes	Controls	S	O	D	RPN
F1	Wrong patient selected in EHR	Wrong prescription	Similar names, workflow error	Two-identifier verification	10	3	7	210
F2	Wrong medication selected	Adverse drug event	Look-alike/sound-alike names	Search verification and medication review	9	4	7	252
F3	Wrong dose	Toxicity or treatment failure	Unit/concentration confusion	Dose-range checks, indication review	9	4	7	252

F4	Wrong route or frequency	Harm or treatment failure	Template error	Structured prescribing	8	3	7	168
F5	Allergy not verified	Allergic reaction	Inaccurate or outdated record	Allergy reconciliation	10	3	8	240
F6	Renal dosing not adjusted	Toxicity	eGFR not reviewed	Renal-dose decision support	9	5	8	360
F7	Drug interaction missed	Bleeding, arrhythmia, toxicity	Multiple prescribers	Interaction review	9	5	7	315
F8	Duplicate therapy	Overdose or adverse effect	Fragmented care	Medication reconciliation	8	4	7	224
F9	Medication discontinued without coordination	Disease destabilization	Poor communication	Closed-loop medication changes	8	4	7	224
F10	High-risk medication monitoring missed	Toxicity	No owner for labs	Monitoring registry and alerts	9	5	8	360
F11	Controlled-substance prescribing process failure	Patient harm, regulatory exposure	Poor documentation or monitoring	Controlled-substance policy	9	3	7	189
F12	Prescription sent to wrong pharmacy	Delay, medication access problem	Pharmacy selection error	Verify pharmacy with patient	6	5	4	120
F13	Refill approved without clinical review	Unsafe continuation	Refill automation without guardrails	Refill protocol and exception queue	8	6	8	384
F14	Patient misunderstands instructions	Nonadherence, overdose	Complexity, language, literacy	Teach-back and simplified instructions	8	6	7	336

F15	Medication reconciliation after hospital discharge fails	Readmission , adverse event	Transition-of-care gap	Post-discharge medication reconciliation	10	5	8	400
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DOMAIN G — Laboratory, Imaging & Diagnostic Result Management

This is one of the most important outpatient risk domains because **the test may be performed correctly while the overall process still fails.**

ID	Failure mode	Effect	Causes	Controls	S	O	D	RPN
G1	Test ordered but never completed	Delayed diagnosis	Patient access, scheduling failure	Order tracking	8	6	8	384
G2	Result received but not reviewed	Missed diagnosis	Inbox overload	Result acknowledgment queue	10	5	8	400
G3	Abnormal result reviewed but no action	Disease progression	Unclear ownership	Action-required result workflow	10	5	8	400
G4	Critical result not escalated	Catastrophic harm	Poor notification process	Critical-result escalation policy	10	3	8	240
G5	Result routed to wrong physician	Delayed care	Provider assignment error	Routing validation	9	4	8	288
G6	Patient not informed of result	Delayed treatment; loss of trust	No communication owner	Closed-loop patient notification	9	6	8	432
G7	Patient assumes	Missed abnormality	Poor communication	Explicit result policy	8	6	7	336

	"no call = normal"		expectations					
G8	Imaging recommendation not followed	Delayed cancer or disease diagnosis	Incidental finding lost	Incidental finding registry	10	4	9	360
G9	Outside test result not integrated	Duplicate testing or missed information	Fragmented records	External-record reconciliation	8	5	8	320
G10	Wrong patient/test association	Wrong treatment	Identity or interface error	Two-identifier verification	10	2	8	160
G11	Lab trend not recognized	Delayed deterioration	Single-value review	Trend dashboard / chronic disease registry	8	5	8	320
G12	Test ordered without follow-up interval	Open loop	No explicit plan	Every order includes follow-up ownership	8	6	7	336

Closed-loop result standard

Every clinically meaningful test should have:

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Order placed
↓
Test completed
↓
Result received
↓
Result reviewed
↓
Clinical interpretation documented
↓
Patient notified
↓
Action / referral / repeat test
↓
Completion verified
↓
Loop closed

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A result sitting in an inbox is not a completed clinical process.

DOMAIN H — Referral & Care Coordination

ID	Failure mode	Effect	Causes	Controls	S	O	D	RPN
H1	Referral not placed	Delayed specialty care	Order omission	Referral checklist	8	5	7	280
H2	Referral placed but not scheduled	Delayed diagnosis/treatment	Access, insurance, patient barriers	Referral tracking	8	6	8	384
H3	Urgent referral treated as routine	Clinical deterioration	Priority not communicated	Urgency classification	10	4	8	320
H4	Specialist report not received	Fragmented care	Fax/interface failure	Referral closure process	8	5	8	320
H5	Specialist recommendation not acted upon	Disease progression	No ownership	Care-plan reconciliation	9	5	8	360
H6	Referral sent to inappropriate specialist	Delay and patient burden	Inaccurate referral selection	Referral directory	6	4	5	120
H7	Patient unable to access referral	Unmet medical need	Transportation, cost, network	Barrier escalation	8	6	7	336
H8	Referral duplicated	Cost, confusion, delayed care	Poor visibility	Shared referral registry	5	4	4	80
H9	Abnormal finding not included in referral	Incomplete evaluation	Poor clinical summary	Referral quality template	8	4	7	224
H10	No follow-up after specialist visit	Treatment plan not integrated	Responsibility ambiguity	Specialist-report review queue	8	5	8	320

DOMAIN I — Transitions of Care & Hospital Interface

Internal medicine patients often move between outpatient, emergency, inpatient, rehabilitation, and home settings.

ID	Failure mode	Effect	Causes	Controls	S	O	D	RPN
I1	Hospital discharge summary not received	Medication and follow-up errors	Interface failure	Discharge-document tracking	9	5	8	360
I2	Post-discharge visit not scheduled	Readmission or deterioration	No transition workflow	Follow-up within appropriate clinical window	9	5	7	315
I3	Medication changes not reconciled	Adverse event	Multiple lists	Post-discharge med reconciliation	10	5	8	400
I4	Pending hospital tests not tracked	Missed diagnosis	Discharge summary incomplete	Pending-results registry	10	4	9	360
I5	SNF / rehab communication failure	Care-plan errors	Fragmented systems	Transition checklist	8	5	8	320
I6	Patient does not understand discharge instructions	Nonadherence, deterioration	Complex instructions	Teach-back	8	6	7	336
I7	New physician unaware of recent hospitalization	Incorrect management	Incomplete chart review	Recent-utilization flag	8	5	7	280
I8	No clear responsibility for follow-up	Open-loop care	Shared panel ambiguity	Named clinician ownership	9	5	8	360
I9	Emergency department	Missed deterioration	Data delay	ED notification	9	4	8	288

	visit not recognized	n		process				
I10	Hospice / palliative transition poorly coordinated	Unwanted or inconsistent care	Goals not reconciled	Goals-of-care documentation	9	4	8	288

DOMAIN J — Geriatrics, Cognitive Health & Vulnerable Patients

Because the practice may include a substantial older-adult population, this domain should be a **mandatory competency track**, not an optional lecture.

ID	Failure mode	Effect	Causes	Controls	S	O	D	RPN
J1	Delirium mistaken for dementia	Missed acute illness	Inadequate baseline assessment	Delirium screening and baseline cognition	9	5	8	360
J2	Dementia not recognized	Unsafe medication / self-management	Brief visit, subtle symptoms	Cognitive assessment	9	5	8	360
J3	Falls risk not assessed	Fracture, disability	No falls screening	Falls-risk protocol	8	6	7	336
J4	Orthostatic hypotension missed	Falls, syncope	Incomplete vitals	Orthostatic assessment when indicated	8	5	7	280
J5	Frailty overlooked	Poor outcomes, overaggressive care	Disease-centered focus	Frailty assessment	8	5	7	280
J6	Elder abuse / neglect not recognized	Ongoing harm	Lack of privacy or awareness	Safeguarding training	10	2	9	180
J7	Capacity incorrectly assumed	Invalid decisions or	Cognitive bias	Capacity assessment framework	9	3	8	216

		unsafe consent						
J8	Surrogate decision-maker unclear	Delayed or inappropriate care	Documentation gap	Advance-directive / surrogate review	8	5	8	320
J9	Goals of care not updated	Treatment inconsistent with preferences	No structured conversation	Advance-care planning	9	4	8	288
J10	Driving safety concerns missed	Injury risk	Sensitive topic avoided	Functional and safety screening	8	3	9	216
J11	Caregiver burnout not recognized	Medication / care failure	Patient-only focus	Caregiver assessment	7	5	7	245
J12	Inappropriate medication burden continues	Falls, delirium, hospitalization	Inertia	Deprescribing review	9	6	7	378

DOMAIN K — Preventive Care & Population Health

ID	Failure mode	Effect	Causes	Controls	S	O	D	RPN
K1	Cancer screening not tracked	Delayed cancer diagnosis	No registry	Screening dashboard	9	5	8	360
K2	Immunization status inaccurate	Preventable infection	Fragmented records	Immunization reconciliation	7	5	5	175
K3	Cardiovascular risk not reassessed	Preventable events	Reliance on historical plan	Risk-based review	8	5	7	280
K4	Osteoporosis screening gap	Fracture	No age/risk protocol	Preventive-care registry	8	5	8	320

K5	Smoking status not updated	Missed counseling / screening	Template autopilot	Structured social history	6	5	5	150
K6	Alcohol / substance risk missed	Harm, interactions	Inadequate screening	Validated screening where appropriate	7	4	7	196
K7	Depression / suicide risk missed	Severe harm	No screening or poor response	Screening + safety escalation	10	3	8	240
K8	Social isolation / food insecurity missed	Poor disease control	Narrow medical focus	Social determinant screening	7	5	7	245
K9	Preventive recommendations not individualized	Overtreatment or undertreatment	Checklist without context	Shared decision-making	6	5	6	180

DOMAIN L — EHR, Documentation & Information Management

ID	Failure mode	Effect	Causes	Controls	S	O	D	RPN
L1	New physician unfamiliar with EHR	Errors, slow throughput	Insufficient training	Role-specific EHR simulation	7	7	5	245
L2	Wrong patient chart opened	Wrong orders/documentation	Similar names, workflow	Patient identifiers	10	3	7	210
L3	Copy-forward inaccurate information	Wrong clinical decisions	Template dependence	Copy-forward audit	8	6	8	384

L4	Important history buried in notes	Missed information	Poor documentation structure	Problem-oriented summary	7	6	7	294
L5	Assessment and plan incomplete	Poor continuity; legal exposure	Time pressure, poor habits	Documentation standard	8	6	6	288
L6	No clear follow-up interval	Delayed care	Incomplete plan	Required follow-up field	8	6	7	336
L7	Clinical reasoning not documented	Poor handoff / defense	Notes focus only on orders	Reasoning and risk documentation	7	5	7	245
L8	EHR inbox unmanaged	Missed results, refills, messages	Volume, unclear ownership	Daily inbox protocol	10	6	8	480
L9	Tasks assigned to wrong person	Delayed action	Routing ambiguity	Task ownership rules	9	5	8	360
L10	Telephone messages not triaged correctly	Delayed urgent care	Staff training gap	Nurse triage algorithm	9	5	7	315
L11	Patient portal message overlooked	Delayed treatment	Inbox overload	Response-time standards	8	6	7	336
L12	Documentation completed late	Missing information, billing errors	Workflow inefficiency	Same-day or defined completion standard	6	6	5	180
L13	Privacy breach	HIPAA exposure, patient harm	Inappropriate access or communication	Access control and privacy training	9	3	7	189
L14	EHR downtime	Missing records,	Technical failure	Downtime procedures	8	3	6	144

	disrupts care	delayed treatment		and backups				
L15	Clinical decision support ignored indiscriminately	Missed safety alerts	Alert fatigue	Alert governance and meaningful review	8	6	8	384
L16	AI-generated documentation contains errors	Incorrect record or plan	Unverified automation	Human verification and approved-use policy	8	4	8	256

Critical observation

L8 — Unmanaged EHR inbox — may be the single highest RPN in the entire system.

A physician can perform excellent face-to-face visits while failing through:

- Unreviewed lab results
- Unanswered patient messages
- Unprocessed refill requests
- Unacknowledged hospital notifications
- Unclosed referrals
- Unreviewed imaging
- Unassigned tasks

The practice must treat the **inbox as a clinical care environment**, not an administrative afterthought.

DOMAIN M — Patient Communication, Trust & Continuity

The new physician's success depends partly on whether patients accept the transition.

ID	Failure mode	Effect	Causes	Controls	S	O	D	RPN
M1	Patients not informed about physician transition	Confusion, mistrust	Poor communication plan	Formal transition communication	6	6	4	144
M2	Patients perceive new physician as replacement	Complaints, attrition	Poor framing	Patient-centered introduction	6	5	5	150

	without choice							
M3	New physician dismisses established patient preferences	Loss of trust, nonadherence	Communication mismatch	Shared decision-making	7	5	6	210
M4	New physician criticizes prior physician in front of patients	Trust erosion, conflict	Poor professionalism	Professional transition standard	7	3	6	126
M5	Senior physician undermines new physician	Confusion, reduced authority	Unresolved disagreement	Unified communication policy	7	4	6	168
M6	Patient receives conflicting treatment plans	Medication error, confusion	Poor physician communication	Shared plan documentation	9	5	7	315
M7	Language / cultural needs not accommodated	Misunderstanding, poor adherence	Lack of resources	Interpreter and communication policy	8	4	6	192
M8	Patient cannot reach appropriate clinician	Delayed care	Unclear access model	Access and triage design	8	6	7	336
M9	Patient complaints not analyzed	Recurring failures	Defensive culture	Grievance review process	6	5	8	240
M10	Patient abandonment during transition	Harm, legal exposure	Poor panel transfer	Continuity and notice protocol	10	3	8	240

Patient-transition training

The new physician should learn to say, in substance:

"Dr. ___ and I are working together to ensure continuity of your care. I will take the time to understand your history, your priorities, and the treatment plan that has worked for you. When something is uncertain, we will review it together and make sure you have a clear follow-up plan."

The actual wording should reflect the physicians' authentic relationship and practice arrangement.

DOMAIN N — Clinical Workflow & Throughput

ID	Failure mode	Effect	Causes	Controls	S	O	D	RPN
N1	Schedule exceeds new physician's safe capacity	Rushed care, errors, burnout	Revenue pressure	Graduated patient volume	9	6	6	324
N2	Visit types not matched to physician capability	Inadequate care	Scheduling assumptions	Visit-complexity matrix	8	5	6	240
N3	Same-day urgent slots unavailable	Delayed urgent care	Overbooked schedule	Protected acute capacity	8	5	6	240
N4	New physician spends excessive time on low-value tasks	Reduced clinical capacity	Poor delegation	Role and delegation design	6	7	4	168
N5	Staff do not understand new physician preferences	Delays, errors	No workflow alignment	Standard operating procedures	6	7	4	168
N6	Rooming process incomplete	Missing data, delays	MA training gap	Rooming checklist	7	5	5	175

N7	Abnormal vitals not escalated	Missed deterioration	Unclear thresholds	Vital-sign escalation protocol	9	4	7	252
N8	Inadequate time for complex patients	Incomplete assessment	Productivity expectations	Complexity-adjusted scheduling	9	6	6	324
N9	No protected learning / review time	Slow development, errors	Training treated as extra	Scheduled protected time	7	7	5	245
N10	Staff bypass physician due to accessibility problems	Unsafe informal decisions	Poor communication	Clear clinical access pathways	8	5	7	280
N11	Workflow varies by physician without clear rules	Staff errors, patient confusion	Unstandardized processes	Standardize critical processes; allow clinical flexibility	7	6	6	252
N12	Productivity metrics override safety	Overbooking, poor care	Misaligned incentives	Balanced scorecard	9	4	7	252

DOMAIN O — Nursing, MA, Front Desk & Team Interface

A new physician does not operate alone. Many failures originate at the interfaces between team members.

ID	Failure mode	Effect	Causes	Controls	S	O	D	RPN
O1	Staff do not know physician's escalation preferences	Delayed care	No orientation	Team briefing	8	6	6	288

O2	Unlicensed staff perform tasks beyond competency	Patient harm	Poor delegation	Competency-based delegation	9	3	7	189
O3	Staff fail to escalate abnormal symptoms	Delayed diagnosis	Fear, ambiguity	Nurse triage protocol	9	5	7	315
O4	Staff misunderstand verbal orders	Wrong treatment	Communication failure	Read-back for critical orders	9	4	7	252
O5	Front desk mishandles urgent calls	Delayed emergency care	No triage routing	Call-triage decision tree	10	3	8	240
O6	Staff route messages to wrong physician	Delayed care	EHR configuration	Routing audit	8	5	7	280
O7	Staff conceal errors due to fear	Errors recur	Blame culture	Just culture and reporting	9	4	9	324
O8	Staff do not understand new physician's documentation needs	Missing information	No standard	Rooming and documentation alignment	6	6	5	180
O9	Physician delegates without confirming completion	Open-loop tasks	Assumption	Closed-loop delegation	8	5	8	320
O10	Staff turnover during transition	Workflow instability	Retirement uncertainty	Cross-training and retention plan	7	5	6	210
O11	Team conflict	Delays and errors	Unresolved interpersonal	Team huddles	7	5	6	210

	affects patient care		al problems	and escalation				
O12	No backup for critical staff role	Workflow collapse	Single point of failure	Cross-training	7	5	7	245

Key principle

If a task is delegated, the responsibility for ensuring the task is appropriately delegated and completed must remain explicit.

The exact legal scope of delegation depends on Florida law, licensure, training, and practice policy. The practice should not assume that "someone on staff will handle it" is a safe control.

DOMAIN P — Billing, Coding, Compliance & Financial Operations

These failures may not immediately harm a patient, but they can threaten the practice's sustainability and create downstream clinical problems.

ID	Failure mode	Effect	Causes	Controls	S	O	D	RPN
P1	Incorrect coding	Denials, audits, revenue loss	Documentat ion/coding mismatch	Coding education and audits	5	6	4	120
P2	Upcoding	Refunds, penalties, legal exposure	Incentive pressure, misunderstanding	Compliance review	8	3	7	168
P3	Undercodin g	Revenue loss	Incomplete documentat ion	Coding feedback	5	6	4	120
P4	Missing documentat ion for billed service	Denial or audit exposure	Time pressure	Documentat ion standard	6	5	5	150
P5	Preventive and problem-oriented services improperly combined	Billing issues	Coding confusion	Billing education	5	4	4	80

P6	Payer enrollment incomplete	Unpaid services	Administrative delay	Enrollment tracker	6	5	3	90
P7	Referral / authorization failure	Care delay and financial loss	Staff process gap	Authorization workflow	7	5	6	210
P8	Patient financial expectations unclear	Complaints, unpaid balances	Poor communication	Financial policy	5	6	4	120
P9	Practice expenses increase during transition	Financial stress	Staffing, technology, low volume	Financial dashboard	6	5	4	120
P10	Physician compensation disagreement	Conflict, turnover	Unclear contract	Written agreement and review	7	5	5	175
P11	Retirement liabilities or obligations misunderstood	Financial dispute	Poor succession planning	Professional legal/accounting review	8	4	6	192
P12	Fraudulent or inappropriate billing not detected	Legal and financial exposure	Weak controls	Compliance audits	9	2	8	144

DOMAIN Q — Legal, Regulatory, Privacy & Patient Safety

Florida physician-office risk management deserves explicit attention. Florida law includes requirements related to adverse incidents in physician office settings, and the applicable reporting obligations depend on whether an event meets statutory definitions and the practice's circumstances. The practice should use its risk manager, counsel, and current Florida requirements rather than rely on an informal interpretation. ([Florida Healthcare Risk Management](#))

ID	Failure mode	Effect	Causes	Controls	S	O	D	RPN
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Q1	Adverse event not recognized as reportable	Regulatory exposure; delayed corrective action	Poor incident knowledge	Incident-reporting training	9	3	8	216
Q2	Incident not reported internally	Repeated harm	Blame culture, unclear process	Nonpunitive reporting process	9	4	8	288
Q3	Incident not reviewed for system causes	Recurrence	No RCA/PRA process	Structured incident review	9	4	9	324
Q4	Patient notification mishandled	Trust/legal harm	Poor communication	Risk-management protocol	9	3	8	216
Q5	Informed consent inadequate	Patient dispute; legal exposure	Generic forms, poor discussion	Procedure-specific consent process	8	4	7	224
Q6	Privacy breach	Patient harm, penalties	Improper access or communication	HIPAA/privacy training	9	3	7	189
Q7	Chaperone / sensitive-exam process inconsistent	Patient distress, complaints	No policy	Standardized sensitive-exam policy	6	3	6	108
Q8	Documentation altered improperly after event	Legal and clinical harm	Poor documentation knowledge	Documentation integrity policy	9	2	8	144
Q9	Patient complaint escalates without review	Reputational and legal harm	Defensive response	Grievance process	7	4	7	196
Q10	Malpractice event not escalated to carrier	Coverage / legal complications	Unclear reporting	Carrier notification protocol	9	2	8	144

Q11	Staff not trained in emergency response	Delayed resuscitation	Inadequate drills	BLS/CPR and emergency drills	10	3	7	210
Q12	Emergency equipment unavailable or untested	Preventable death	Maintenance failure	Emergency equipment checklist	10	2	7	140

Florida's physician-office adverse-incident rule requires systematic review of incident reports, identification of contributing factors and trends, and implementation of corrective action and education when indicated. ([Justia Regulations](#))

DOMAIN R — Emergency Preparedness & Acute Deterioration

An outpatient practice must be able to recognize when it has crossed from **routine outpatient management** into **emergency stabilization and transfer**.

ID	Failure mode	Effect	Causes	Controls	S	O	D	RPN
R1	Chest pain not triaged urgently	MI or death	Atypical symptoms, poor triage	Chest-pain protocol	10	3	8	240
R2	Stroke symptoms not recognized	Permanent disability	Inadequate screening	Stroke recognition protocol	10	2	8	160
R3	Sepsis not recognized	Shock, death	Subtle presentation	Sepsis red flags and escalation	10	3	8	240
R4	Anaphylaxis response delayed	Death	Emergency kit unfamiliarity	Emergency drills	10	2	7	140
R5	Hypoglycemia / severe hyperglycemia mishandled	Seizure, coma, death	Poor protocol	Glucose assessment and treatment pathway	9	3	7	189
R6	Syncope not appropriately evaluated	Missed arrhythmia / serious disease	Reassurance bias	Syncope algorithm	9	4	7	252
R7	Respiratory distress not escalated	Respiratory failure	Inadequate vitals / assessment	Respiratory emergency protocol	10	3	7	210

R8	Emergency transfer delayed by office logistics	Deterioration	No EMS workflow	EMS activation protocol	10	2	7	140
R9	Patient leaves before evaluation	Serious harm	Waiting time, misunderstanding	Elopement / urgent-care process	9	3	8	216
R10	Emergency documentation incomplete	Clinical and legal problems	Chaotic event	Emergency documentation template	7	4	6	168

DOMAIN S — Professionalism, Ethics & Physician Well-Being

ID	Failure mode	Effect	Causes	Controls	S	O	D	RPN
S1	New physician reluctant to ask for help	Preventable clinical error	Fear of appearing incompetent	Psychological safety	9	5	8	360
S2	Overconfidence / inability to recognize limits	Unsafe care	Poor self-awareness	Case-based assessment and feedback	9	4	8	288
S3	Senior physician reluctant to delegate	Transition bottleneck	Identity/control issues	Delegation plan	6	6	6	216
S4	Senior physician fatigued or burned out	Errors, poor communication	Retirement stress, workload	Workload review and coverage	9	4	7	252
S5	New physician overloaded by inherited complexity	Errors, burnout	Poor panel ramp-up	Workload ramp and protected time	8	6	6	288
S6	Feedback becomes	Learning failure	Poor feedback	Structured feedback	6	5	6	180

	personal		technique	model				
S7	Errors concealed	Repeated harm	Punitive culture	Just culture	10	3	9	270
S8	Boundary violations	Patient harm, legal exposure	Poor professional judgment	Professionalism training	9	2	8	144
S9	Conflicts of interest not disclosed	Trust and legal risk	Unclear policy	Conflict disclosure	7	3	7	147
S10	Physician does not maintain current knowledge	Outdated care	No CME/quality plan	Continuing education plan	8	4	7	224
S11	Moral distress or value conflict	Poor care, disengagement	Incompatible expectations	Ethics consultation pathway	7	3	7	147
S12	No process for physician impairment concerns	Patient harm	Avoidance	Fitness-for-duty / escalation policy	10	2	9	180

DOMAIN T — Succession, Retirement & Business Continuity

This domain makes this scenario different from ordinary physician onboarding.

ID	Failure mode	Effect	Causes	Controls	S	O	D	RPN
T1	Retirement date changes unexpectedly	Patient and financial disruption	Health, personal, financial factors	Scenario-based succession plan	8	5	7	280
T2	Senior physician becomes suddenly unavailable	Clinical continuity failure	Illness, family emergency	Emergency coverage plan	10	3	8	240
T3	Patient panel not	Missed follow-up	Informal transition	Panel transition registry	9	5	8	360

	formally transferred							
T4	Patients do not accept new physician	Attrition, delayed care	Trust/relationship loss	Gradual warm handoffs	7	6	6	252
T5	Critical patient knowledge not transferred	Missed risk	Tacit knowledge	High-risk patient dossiers	9	7	8	504
T6	Practice contracts unclear after retirement	Financial/legal conflict	Incomplete agreements	Legal/accounting review	8	4	6	192
T7	EHR ownership / access unclear	Loss of records or operational paralysis	Poor planning	Data-access and continuity plan	9	3	8	216
T8	Billing / payer enrollment tied to retiring physician	Revenue disruption	Provider-specific enrollment	Transition checklist	7	5	5	175
T9	Staff allegiance split	Workflow conflict	Long-term relationship with senior MD	Team transition plan	6	5	6	180
T10	No plan for unresolved clinical tasks	Results/referals lost	Task ownership unclear	Open-loop task inventory	10	5	9	450
T11	No plan for records, prescriptions, and patient access after exit	Patient abandonment / disruption	Incomplete continuity planning	Formal continuity plan	10	3	8	240

T12	New physician is not prepared for leadership	Practice instability	Clinical training only	Leadership and operations curriculum	7	6	6	252
T13	Practice's financial model depends on retiring MD's volume	Cash-flow stress	No transition forecast	Financial scenario modeling	7	5	5	175
T14	Retirement is treated as an event instead of a process	Poor transition quality	No staged milestones	12–24 month transition plan	8	6	7	336

5. Highest-Priority Failure Modes

A PRA should not treat every failure mode equally. The following are the most important to address before the new physician receives broad autonomy.

Tier 1 — Immediate safety priorities

Priority	Failure mode	Why it matters
1	T5: Critical patient knowledge not transferred	Hidden patient risks can disappear during succession
2	T10: Unresolved clinical tasks lost during transition	Pending tests, referrals, and abnormal results may never receive action
3	B8: Tacit knowledge remains with retiring physician	The new MD may inherit patients without inheriting the knowledge needed to manage them safely
4	L8: EHR inbox unmanaged	Results, messages, refills, and hospital notifications can silently fail
5	D12: No explicit follow-up plan	Outpatient harm frequently occurs through open loops
6	G6: Patient not informed of result	Patients may deteriorate while believing care is complete
7	F15: Post-discharge medication reconciliation failure	High-risk transition point for medication errors and readmissions

8	B1/B4: Roles and patient ownership undefined	Ambiguity causes both duplication and omission
9	D3/D5: Anchoring and premature closure	Common cognitive mechanisms behind diagnostic error
10	S1: New physician reluctant to ask for help	A strong physician can become unsafe when psychological safety is absent

Tier 2 — High-priority developmental risks

- Inadequate geriatric competency
- Polypharmacy and renal dosing errors
- Referral tracking failures
- Abnormal result follow-up failures
- Inadequate emergency recognition
- Excessive initial patient volume
- Inconsistent physician-to-physician treatment plans
- Poor staff escalation
- Lack of structured feedback
- Unclear after-hours coverage
- Failure to identify inherited care gaps
- Failure to prepare for sudden senior-physician unavailability

6. The Most Important Concept: Hidden Failure Modes

Many clinical errors are not caused by the obvious person at the end of the process.

Example: Missed cancer diagnosis

```

Patient presents
↓
Physician orders imaging
↓
Patient cannot schedule due to access problem
↓
No referral/order tracking
↓
Test never completed
↓
No alert for overdue test
↓
Patient assumes no news is good news
↓
Disease progresses

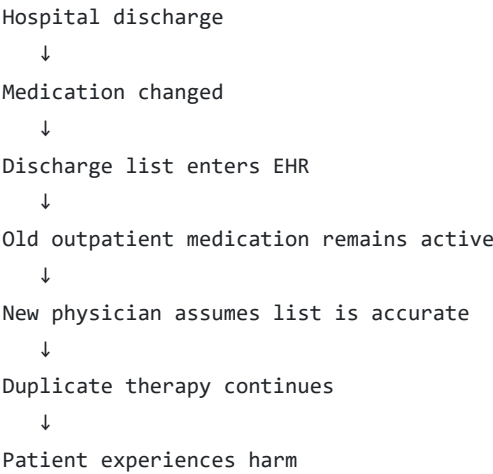
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Failure mode: "New physician missed the diagnosis."

Actual system failure chain:

- Access barrier
- No order tracking
- No overdue alert
- No patient communication standard
- No ownership
- No audit

Example: Medication adverse event



Failure mode: "Physician prescribed incorrectly."

Actual system failure chain:

- Incomplete transition data
- No medication reconciliation
- Copy-forward list
- No pharmacist review
- No high-risk medication trigger

PRA lesson

Train the physician, but redesign the system that surrounds the physician.

7. New Physician Competency Framework

A better onboarding model should not use only "shadow for two weeks, then start seeing patients."

Instead, use **competency domains + evidence + progressive autonomy**.

Competency architecture

Competency domain	What must be demonstrated
Clinical knowledge	Appropriate internal medicine knowledge for the practice's patient population

Diagnostic reasoning	Safe differential diagnosis, recognition of red flags, uncertainty management
Patient care	History, examination, treatment, follow-up, continuity
Medication safety	Reconciliation, prescribing, monitoring, deprescribing
Geriatrics	Cognition, falls, frailty, polypharmacy, goals of care
Transitions of care	Hospital discharge, SNF, specialist coordination
EHR proficiency	Documentation, inbox, results, referrals, orders, messages
Communication	Patient trust, difficult conversations, teach-back
Teamwork	Delegation, escalation, closed-loop communication
Professionalism	Ethics, boundaries, accountability, feedback
Systems thinking	Recognizing process failure and preventing recurrence
Practice operations	Scheduling, billing, compliance, workflow, business continuity
Leadership	Developing autonomy and eventually leading the practice

8. Training Model: 6-Phase Progressive Onboarding

Phase 0 — Pre-Arrival Risk Assessment

Suggested duration: 2–4 weeks before start

Objectives

- Verify credentials
- Understand practice population
- Map the practice's workflows
- Identify high-risk patients and open loops
- Establish expectations with the senior physician
- Configure systems and access

Required activities

Activity	Evidence of completion
Credentialing verification	Completed credentialing file
Malpractice and payer verification	Written confirmation
EHR access and security	Successful access test
Review practice policies	Signed acknowledgment
Review emergency protocols	Knowledge check
Review patient panel demographics	Population profile
Review open referrals and pending tests	Open-loop inventory
Review high-risk patient list	Risk-stratified registry
Meet staff	Orientation checklist

Define physician roles	Signed role charter
Define escalation pathways	Written escalation map
Establish feedback schedule	Calendarized reviews

Gate 0

Do not begin independent clinical practice until credentialing, access, emergency readiness, and role expectations are verified.

Phase 1 — Observation & System Immersion

Suggested duration: 1–2 weeks, adjusted to experience

The new physician observes not only clinical visits, but the entire practice system.

Observe:

- Patient check-in
- Rooming
- Medication reconciliation
- Physician visits
- EHR documentation
- Lab and imaging ordering
- Result review
- Referral placement
- Referral follow-up
- Prescription refills
- Patient portal messages
- Hospital discharge workflow
- Billing/coding
- Staff escalation
- Emergency response
- Physician-to-physician communication

Deliverable

Practice Process Map

Patient need → Entry → Assessment → Decision → Order
→ Result → Communication → Follow-up → Closure

Gate 1

The new physician can explain:

1. How a patient enters the practice
2. How urgent concerns are triaged
3. Who owns results
4. Who owns referrals
5. Who owns refill requests

6. How after-hours care works
 7. How emergencies are transferred
 8. How patient continuity is maintained
 9. How incidents are reported
 10. How the retiring physician's knowledge is being transferred
-

Phase 2 — Structured Knowledge Transfer

Suggested duration: 2–6 weeks, overlapping with observation

This is the most important phase for the co-physician scenario.

Build a "Practice Knowledge Transfer Dossier"

A. Patient population

- Major chronic disease distribution
- High-risk patient categories
- Common urgent presentations
- Frequent hospital systems
- Common specialists
- Common pharmacies
- Common access barriers

B. High-risk patient registry

For each patient, document only appropriate clinical information in the authorized system:

- Active major diagnoses
- Current treatment plan
- Recent deterioration
- Pending diagnostic questions
- Pending referrals
- Medication risks
- Relevant social / caregiver considerations
- Advance-care planning status when clinically relevant
- Next required follow-up
- Responsible physician

C. Practice-specific knowledge

- Common referral pathways
- Hospital discharge patterns
- Local specialist contacts
- Laboratory and imaging interfaces
- EHR shortcuts and traps
- Known workflow bottlenecks
- Staff competencies
- Emergency resources
- Recurring operational risks

D. "Top 100 patient transition review"

The number **100 is a suggested starting point**, not a fixed requirement. The actual number should depend on panel size and risk.

Prioritize:

- 1. Recent hospitalization
- 2. Active cancer evaluation
- 3. Pending abnormal imaging
- 4. Complex medication regimens
- 5. Anticoagulation
- 6. Heart failure
- 7. CKD
- 8. Frequent ED visits
- 9. Cognitive impairment
- 10. Unresolved diagnostic symptoms
- 11. Patients with imminent specialist follow-up
- 12. Patients with high dependence on the retiring physician

Gate 2

The new physician can safely explain the current plan and next risk for selected high-risk patients without relying exclusively on the retiring physician's memory.

Phase 3 — Supervised Clinical Practice

Suggested duration: 4–8 weeks, individualized

Progressive exposure

Step	Clinical activity
1	Observe complex visits
2	Conduct selected portions of visits
3	Conduct full visits with senior review
4	Write assessment and plan for review
5	Manage selected follow-up patients
6	Manage moderate-complexity patients with available consultation
7	Manage more complex patients with case review
8	Manage independent panel under monitoring

Case categories

Category	Examples
Low complexity	Stable hypertension, routine preventive care, stable uncomplicated chronic disease
Moderate complexity	Multiple chronic diseases, medication adjustment, abnormal labs

High complexity	Recent hospitalization, unstable chronic disease, diagnostic uncertainty
High-risk	Chest pain, syncope, acute neurologic symptoms, severe metabolic abnormality, suspected sepsis

Assessment methods

- Direct observation
- Chart review
- Case presentation
- Differential diagnosis assessment
- Medication reconciliation audit
- Documentation review
- Patient communication observation
- EHR inbox simulation
- Referral closure audit
- Emergency simulation

Gate 3

The physician demonstrates safe management of the defined patient categories and knows when to escalate.

Phase 4 — Progressive Autonomy

Suggested duration: 2–4 months

Autonomy should be **earned by demonstrated competence**, not granted solely because the physician has completed a time period.

Autonomy matrix

Activity	Initial status	Advancement criterion
Routine follow-up	Supervised	Consistent safe assessment and plan
Preventive care	Supervised / review	Complete preventive-care workflow
Medication refills	Protocol + review	Safe refill decisions and monitoring
Chronic disease management	Case review	Reliable monitoring and escalation
New diagnostic complaints	Direct review	Safe differential and safety net
High-risk patients	Senior consultation	Demonstrated recognition of complexity
Abnormal results	Review required initially	Closed-loop result management
Referrals	Review initially	Correct urgency and closure
Hospital follow-up	Review initially	Accurate transition reconciliation
After-hours calls	Defined escalation	Safe triage and disposition
Emergency stabilization	Protocol-based	Demonstrated emergency readiness

Gate 4

The new physician can independently manage the agreed scope while maintaining safety-netting, documentation, and escalation standards.

Phase 5 — Co-Physician Integration & Leadership

Suggested duration: Months 4–12

The goal is not merely to create a second clinician. It is to create a **reliable two-physician practice**.

Activities

- Joint case conferences
- Monthly quality review
- Shared clinical protocols
- Review of patient transition progress
- Staff feedback
- Patient feedback
- Financial / operational review
- EHR workflow optimization
- Cross-coverage drills
- Succession planning
- Leadership development

Gate 5

The practice functions safely even when one physician is unavailable.

Phase 6 — Succession Readiness

Suggested duration: Months 6–24, depending on retirement timeline

The new physician should be able to:

- Manage the majority of routine patient care
 - Manage high-risk patients with appropriate support
 - Handle urgent and after-hours workflows
 - Own result and referral closure
 - Understand the practice's financial and operational model
 - Lead staff meetings
 - Maintain quality and compliance systems
 - Manage physician coverage
 - Continue patient relationships
 - Execute an emergency succession plan
 - Assume appropriate leadership after retirement
-

9. Entrustment Model: Replace "Ready / Not Ready" With Graduated Authority

A useful model is based on **entrustable professional activities (EPAs)**.

Level	Description
Level 1	Observe only
Level 2	Perform with direct supervision
Level 3	Perform with indirect supervision readily available
Level 4	Perform independently within defined scope
Level 5	Supervise / teach others

Example: Managing an abnormal laboratory result

Stage	Expected behavior
Level 1	Observe result-review workflow
Level 2	Interpret result with senior physician
Level 3	Review and draft action plan; senior available
Level 4	Independently review, communicate, act, and close loop
Level 5	Improve the practice's result-management process

Example: New patient with multiple chronic diseases

Stage	Expected behavior
Level 1	Observe complete assessment
Level 2	Conduct history/exam with direct supervision
Level 3	Present assessment and plan for review
Level 4	Manage independently with escalation when needed
Level 5	Mentor another physician or improve the care pathway

10. Competency Assessment Matrix

Use **observed evidence**, not impressions.

Domain	Assessment method	Minimum evidence
Clinical reasoning	Case-based oral assessment	Recognizes dangerous alternatives
History / exam	Direct observation	Complete, relevant, efficient
Medication safety	Chart audit + simulation	Accurate reconciliation and monitoring
Chronic disease care	Registry review	Appropriate monitoring and follow-up
Geriatrics	Case simulation	Recognizes frailty, cognition, falls, polypharmacy
EHR	Practical simulation	Can manage orders, results, messages, referrals
Documentation	Chart review	Clear assessment, plan, follow-up, uncertainty

Communication	Observed encounter	Explains plan and uses teach-back
Emergency care	Simulation / drill	Recognizes, stabilizes, escalates
Teamwork	360-degree feedback	Staff can escalate concerns
Professionalism	Direct observation	Respectful, accountable, receptive
Systems safety	PRA exercise	Identifies latent failure modes
Leadership	Project evaluation	Improves a measurable workflow

11. The "No Silent Failure" Operating System

The practice should create explicit ownership for every clinically meaningful task.

Closed-loop ownership matrix

Process	Primary owner	Backup owner	Completion evidence
Lab result review	Named physician	Designated covering physician	Reviewed + action documented
Critical result	Physician / clinical escalation	Backup physician	Direct notification and action
Imaging result	Ordering physician	Coverage physician	Interpretation + follow-up
Referral placement	Referral coordinator	Backup staff	Referral accepted / scheduled
Referral result	Named physician	Backup physician	Specialist plan reviewed
Refill request	Assigned clinician / protocol	Backup clinician	Appropriate approval + monitoring
Portal message	Assigned team	Backup team	Response documented
Hospital discharge	Assigned physician	Coverage physician	Reconciliation + follow-up
Pending test	Named physician	Registry owner	Completion and result action
Patient complaint	Practice manager / physician	Escalation lead	Review and response
Incident report	Designated risk lead	Backup	Report, review, corrective action

Rule

Every order, result, referral, message, and clinical concern must have a named owner, a deadline or trigger, and a closure state.

12. Knowledge Transfer: Convert Tacit Knowledge Into Explicit Knowledge

The retiring physician's experience is an asset, but it can become a **single point of failure**.

Tacit knowledge categories

Category	Questions to ask
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Clinical risk	Which patients are most vulnerable to deterioration?
Diagnostic uncertainty	Which patients have unresolved diagnostic questions?
Medication risk	Which patients have difficult medication histories or adherence issues?
Communication	Which patients need special communication approaches?
Caregivers	Who coordinates care for dependent patients?
Specialists	Which referral pathways are reliable?
Hospitals	Which hospitals and hospitalists commonly manage the patients?
Operations	Where do tasks routinely get lost?
Staff	Who has which competencies and backup responsibilities?
Patient relationships	Which patients need a deliberate warm handoff?
Business	Which workflows, contracts, and revenue streams are critical?
Succession	What must be transferred before retirement?

Recommended artifact: Practice Risk & Knowledge Register



Do not maintain sensitive patient information in unsecured personal notes or informal spreadsheets. Use the practice's authorized EHR, registry, or approved secure system.

13. Training Scenarios: High-Value Simulation Set

A strong training model should include realistic cases that test the entire system, not just medical knowledge.

Scenario 1 — Abnormal imaging with no follow-up

Situation: A patient has an imaging study with a recommendation for additional evaluation. The result is in the EHR, but no follow-up is scheduled.

Test:

- Can the new MD identify the abnormality?

- Can the MD determine urgency?
- Can the MD communicate with the patient?
- Can the MD place the correct referral/order?
- Can the MD verify completion?
- Can the MD identify why the original process failed?

Failure modes tested: G3, G6, G8, G12, H1, H2, H5, T10.

Scenario 2 — Hospital discharge with medication discrepancies

Situation: A patient returns after hospitalization with five medication changes, an old medication list, and a pending test.

Test:

- Reconcile medications
- Identify contraindications
- Review discharge summary
- Identify pending results
- Establish follow-up
- Communicate the plan
- Assign ownership

Failure modes tested: F2, F6, F15, I1, I3, I4, I8.

Scenario 3 — New patient with atypical chest discomfort

Situation: An older patient presents with fatigue, nausea, and mild chest pressure.

Test:

- Avoid anchoring
- Assess risk
- Recognize atypical presentation
- Decide outpatient vs emergency disposition
- Document reasoning and safety net

Failure modes tested: C3, D3, D4, D5, D14, R1.

Scenario 4 — Polypharmacy and falls

Situation: An older adult reports two falls and dizziness while taking multiple medications.

Test:

- Medication reconciliation
- Orthostatic assessment when indicated
- Evaluate cognition and frailty
- Identify medication-related risk
- Create a safe deprescribing / monitoring plan
- Assess home and caregiver context

Failure modes tested: E15, J3, J4, J5, J12, F6, F7.

Scenario 5 — Patient refuses transition

Situation: A long-term patient says, "I only want to see Dr. ____."

Test:

- Demonstrate empathy
- Explain continuity plan
- Avoid undermining the senior physician
- Identify clinical continuity needs
- Escalate if care access is threatened

Failure modes tested: M1, M2, M3, M4, M5, M10, T4.

Scenario 6 — EHR inbox overload

Situation: The new physician inherits 80 inbox items, including refills, abnormal labs, specialist reports, and patient messages.

Test:

- Triage by clinical urgency
- Identify critical results
- Assign tasks correctly
- Close loops
- Avoid treating all items equally
- Build a sustainable inbox workflow

Failure modes tested: L8, L9, L10, L11, G2, G3, F13.

Scenario 7 — Senior physician suddenly unavailable

Situation: The established physician becomes unavailable for two weeks.

Test:

- Can the new physician identify patient ownership?
- Can the practice access records?
- Who handles urgent calls?
- Who reviews results?
- Who handles refills?
- Who manages hospital follow-up?
- Can staff operate without informal knowledge?

Failure modes tested: B11, B15, T2, T3, T7, T10, T11.

Scenario 8 — Staff fails to escalate urgent symptoms

Situation: A patient calls with shortness of breath. The message is placed in a routine queue.

Test:

- Does the front desk recognize the escalation trigger?
- Is the patient directed appropriately?
- Can the nurse triage?
- Is the physician notified?

- Is the outcome documented?

Failure modes tested: O3, O5, O6, R7, L10.

Scenario 9 — Conflicting physician plans

Situation: The senior physician prefers one medication strategy, while the new physician recommends another.

Test:

- Discuss evidence and patient goals
- Avoid conflicting instructions
- Establish one documented plan
- Communicate consistently
- Escalate unresolved disagreements

Failure modes tested: B6, B14, M5, M6, S6.

Scenario 10 — Unresolved diagnostic patient inherited at retirement

Situation: The senior physician has been following a patient with unexplained weight loss and anemia, but the diagnostic workup is incomplete.

Test:

- Identify unresolved clinical questions
- Review prior data
- Reconstruct the diagnostic timeline
- Determine urgency
- Create a closed-loop plan
- Communicate with the patient

Failure modes tested: B8, C4, D3, D6, D12, G3, T5.

14. Training Dashboard: How Do We Know the Model Is Working?

A training model must measure **process reliability**, not merely whether the physician "seems good."

A. Clinical safety indicators

Metric	What it measures
Critical-result response time	Emergency result handling
Abnormal-result closure rate	Results converted into action
Referral closure rate	Referrals completed and integrated
Pending-test closure rate	No unresolved diagnostic loops
Post-discharge follow-up completion	Transition reliability
Medication reconciliation completion	Medication safety
High-risk medication monitoring compliance	Toxicity prevention
Unplanned ED visits / hospitalizations	Contextual outcome signal

Incident reports	Detection and learning
Near-miss reports	Early warning system

B. Competency indicators

Metric	What it measures
Direct observation scores	Clinical performance
Chart review quality	Documentation and reasoning
Medication-error rate	Prescribing safety
EHR simulation score	Workflow proficiency
Emergency simulation score	Acute response
Escalation appropriateness	Self-awareness and judgment
Feedback responsiveness	Learning behavior
Independent-case complexity	Safe autonomy growth

C. Patient experience indicators

Metric	What it measures
Patient acceptance of new physician	Transition success
Continuity rate	Relationship retention
Patient complaints	Communication / access problems
Patient-reported understanding	Communication quality
No-show rate	Access and relationship issues
Portal response satisfaction	Responsiveness

D. Practice sustainability indicators

Metric	What it measures
Visit volume vs safe capacity	Workload balance
Staff turnover	Team stability
Claim denial rate	Operational integration
Revenue per clinical session	Financial sustainability
Physician workload	Burnout risk
Senior physician dependency	Succession readiness
Coverage resilience	Business continuity

15. Recommended 90-Day Training Plan

Days 1–14: Understand the system

Focus: Safety, people, workflow, patient population

- Credentialing and compliance verification
- EHR training
- Emergency procedures
- Observe full workflow
- Review practice policies
- Review patient population
- Meet staff and referral partners
- Review high-risk patient registry
- Map open clinical loops
- Establish daily physician huddle

Assessment: Written and practical orientation check.

Days 15–30: Begin supervised care

Focus: Clinical integration

- See selected patients with review
- Perform medication reconciliation
- Manage stable chronic disease
- Review labs and imaging with senior MD
- Practice referral workflows
- Conduct hospital follow-up visits
- Perform geriatric assessments
- Complete chart audits
- Participate in case conferences

Assessment: Direct observation + chart review + case simulation.

Days 31–60: Expand complexity

Focus: Independent decision-making with support

- Increase patient volume gradually
- Manage moderate-complexity patients
- Handle selected new patients
- Own result and referral closure
- Participate in after-hours workflow
- Practice emergency escalation
- Lead a small quality-improvement project
- Review patient-transition cases

Assessment: Competency matrix and entrustment review.

Days 61–90: Establish reliable autonomy

Focus: Safe independent practice

- Manage defined panel independently

- Review high-risk cases with senior physician
- Demonstrate EHR inbox reliability
- Demonstrate closed-loop care
- Participate in practice governance
- Develop cross-coverage plan
- Conduct a PRA of one practice workflow
- Review patient and staff feedback

Assessment: Formal 90-day readiness review.

16. Recommended 12-Month Development Plan

Month	Focus	Deliverable
1	Orientation and safety	Completed competency baseline
2	Supervised clinical care	Initial case portfolio
3	Progressive autonomy	90-day review
4	Chronic disease quality	Disease registry improvement
5	Geriatrics and polypharmacy	Geriatric case assessment
6	Transitions of care	Discharge workflow audit
7	Referral and result management	Closed-loop improvement project
8	Emergency readiness	Simulation / drill
9	Team leadership	Staff workflow improvement
10	Practice operations	Financial / operational literacy
11	Succession planning	Emergency continuity exercise
12	Annual competency review	Full reassessment and development plan

17. Specific Controls for the 65-Year-Old Pre-Retirement Physician

The established physician should not be treated as merely a supervisor. She is a **critical knowledge source, clinical partner, and transition risk factor**—both positively and negatively.

What the senior physician should transfer

Clinical knowledge

- High-risk patient profiles
- Unresolved diagnostic issues
- Complex medication decisions
- Patient-specific warning signs
- Longitudinal disease trajectories
- Specialist relationships
- Common complications
- Patients needing proactive outreach

Operational knowledge

- Staff strengths and limitations
- Referral workflows
- EHR workarounds
- Payer / billing issues
- Common scheduling bottlenecks
- Practice financial dependencies
- Emergency contacts
- Vendor and technology dependencies

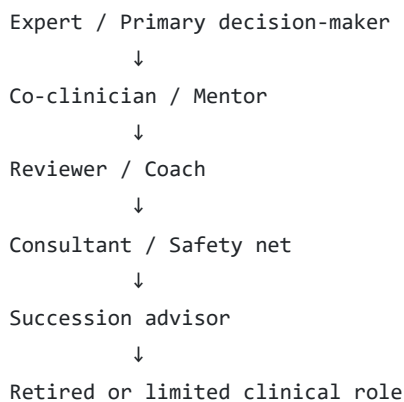
Relationship knowledge

- Patients who need warm handoffs
- Families involved in care
- Communication preferences
- Patients with mistrust or prior negative experiences
- Patients likely to resist transition

What the senior physician should avoid

- Becoming the only person who can solve difficult problems
- Retaining all high-risk patients indefinitely
- Correcting the new physician in front of patients unnecessarily
- Giving conflicting instructions to staff
- Using undocumented "tribal knowledge" as the primary safety system
- Increasing the new physician's workload faster than competency develops
- Treating retirement planning as a last-minute event
- Assuming the new physician has learned something because it was mentioned once

Senior physician's role should evolve



This evolution should be **planned**, not accidental.

18. Specific Controls for the New Physician

The new MD should be expected to develop five habits.

Habit 1 — Ask before guessing

"I am not certain. I will verify the diagnosis, consult the appropriate resource, or discuss this with my co-physician."

This is a strength, not a weakness.

Habit 2 — Every clinical action has a follow-up

For every significant order:

- Why was it ordered?
- What result is expected?
- Who reviews it?
- What happens if abnormal?
- When must it be completed?
- How is the patient informed?
- How is closure verified?

Habit 3 — Every complex patient has a prioritized problem list

Avoid treating every problem as equal.

1. Immediate threat
2. Active unresolved diagnostic issue
3. Unstable chronic disease
4. Medication safety
5. Preventive care
6. Long-term optimization

Habit 4 — Document uncertainty

A safe note can state:

- What is known
- What is uncertain
- What dangerous conditions were considered
- Why the current plan is appropriate
- What would trigger escalation
- When reassessment occurs

Habit 5 — Think in systems

When an error occurs, ask:

"What allowed this error to reach the patient?"

Not merely:

"Who made the mistake?"

19. PRA of the Training Program Itself

The onboarding program can also fail.

ID	Training-program failure mode	Effect	Control
TP1	Training is mostly lectures	Knowledge without performance	Simulation and observed practice
TP2	No baseline competency assessment	Training not individualized	Pre-start assessment
TP3	Training assumes prior experience equals current competence	Hidden gaps	Verify actual capability
TP4	No defined autonomy gates	Premature independence	Written entrustment criteria
TP5	Senior physician has no teaching time	Inconsistent transfer	Protected mentoring time
TP6	Feedback is vague	Slow improvement	Structured feedback
TP7	Feedback is only positive	Risks remain hidden	Balanced, evidence-based feedback
TP8	Feedback is punitive	Errors concealed	Just culture
TP9	No chart audit	Clinical errors remain invisible	Regular retrospective review
TP10	No EHR workflow assessment	Inbox failures after onboarding	Practical EHR simulation
TP11	No assessment of geriatric care	High-risk population gap	Mandatory geriatric module
TP12	No result/referral closure assessment	Open-loop failures	Closed-loop audit
TP13	Training ends after 90 days	Regression / unsupported autonomy	6- and 12-month reviews
TP14	No contingency plan for senior physician absence	Fragile system	Emergency succession exercise
TP15	Productivity pressure overrides training	Unsafe ramp-up	Protected training capacity

20. Recommended Governance Structure

A small practice does not need a large hospital bureaucracy, but it does need clear accountability.

Monthly Co-Physician Safety & Operations Meeting

Suggested agenda:

1. Patient safety events and near misses
2. Critical results and open loops
3. Referral backlog
4. Hospital transitions
5. High-risk patient review

- 6. Medication safety
- 7. Patient complaints
- 8. Staff escalation concerns
- 9. Workload and capacity
- 10. New physician competency progress
- 11. Succession milestones
- 12. Corrective actions

Use a simple action register

Issue	Risk	Owner	Action	Due date	Status
Abnormal imaging follow-up delayed	High	Physician A	Create tracking queue	Date	Open
Medication reconciliation inconsistency	High	Physician B	Audit 20 discharges	Date	In progress
Staff unclear on urgent calls	High	Practice manager	Implement triage protocol	Date	Open

21. Risk-Control Hierarchy

When a failure mode is identified, do not automatically respond with "train the physician."

Use the hierarchy of controls:

Control level	Example
1. Eliminate the hazard	Remove unnecessary manual handoff
2. Standardize the process	Every test requires a follow-up owner
3. Automate / engineer	EHR alerts, referral registry, task routing
4. Add verification	Second check for high-risk medication
5. Train	Teach diagnostic reasoning or workflow
6. Monitor	Audit results, incidents, and performance

Example

Failure: Abnormal test result not acted upon.

Weak intervention: "Remind physician to check results."

Stronger intervention:

- 1. Every result routed to a named clinician.
- 2. Critical results trigger escalation.
- 3. Abnormal results enter an action queue.
- 4. Unresolved results appear on a dashboard.
- 5. Patient notification is documented.
- 6. Closure is audited.

7. Physician receives training on the system.

22. What "Success" Should Look Like

After a successful transition, the practice should demonstrate:

Clinical

- Patients receive safe, evidence-based care.
- The new physician recognizes limits and escalates appropriately.
- High-risk patients are identified and actively managed.
- Medication reconciliation is reliable.
- Abnormal results and referrals are closed-loop.
- Emergency deterioration is recognized promptly.

Operational

- Staff know exactly who owns each task.
- EHR inboxes are managed consistently.
- Patient volume matches clinical capacity.
- Coverage is reliable.
- The practice does not depend on one physician's memory.

Relationship

- Patients understand the transition.
- The new physician has earned trust.
- The senior physician is respected without becoming an irreplaceable bottleneck.
- Conflicting treatment plans are rare and resolved professionally.

Succession

- The new physician can manage the practice's patient population.
 - High-risk patient knowledge has been transferred.
 - The practice can function during senior physician absence.
 - Retirement does not create a sudden continuity crisis.
 - The practice has a documented operational and clinical continuity plan.
-

23. Final Risk Perspective

The central risk is not simply:

"What if the new MD makes a medical mistake?"

The more complete question is:

"What if the practice allows a new physician to inherit patients, responsibilities, workflows, and undocumented knowledge without a reliable system for verifying competence, transferring information, escalating uncertainty, and closing clinical loops?"

That is the real PRA.

The five highest-value design principles

1. **Credential before autonomy.**
2. **Transfer knowledge before transferring responsibility.**
3. **Make every clinical task have an owner and closure mechanism.**
4. **Use progressive entrustment instead of a binary ready/not-ready decision.**
5. **Design the practice so it remains safe when either physician is unavailable.**

Bottom line

A successful onboarding model should produce **three outcomes simultaneously**:

A competent physician + a reliable care-delivery system + a resilient succession plan.

If any one of those is missing, the practice remains vulnerable.

Reference and implementation note

For implementation, the practice should align its PRA, incident reporting, credentialing, privacy, delegation, and succession processes with current Florida requirements, applicable payer rules, malpractice-carrier guidance, and professional standards. Florida's physician-office risk-management resources specifically identify incident review, corrective action, education, and systematic risk management as important components of practice safety. ([Florida Healthcare Risk Management](#))