Chart Cosignature: What Is Best for Patient Care?

In the early years of the PA profession, cosigning PA chart entries was a way for physicians to demonstrate they were overseeing PA practice. But 50 years of collaboration between physicians and PAs has shown that decisions about patient care and chart review are best tailored to the needs of individual practices or institutions. Requiring physicians to cosign every PA-written order or chart entry removes a clinical team's discretion to decide what works best for their practice, imposes an unnecessary burden, and hinders the efficiency of care delivery.

As practices and institutions strive to increase efficiency and fully utilize providers, and as technology changes care delivery, many aspects of healthcare systems are being reevaluated. Simultaneously, PA laws and regulations, including those relating to physician cosignature, are being modernized to reflect the transformation in clinical care models.

CHART COSIGNATURE AND OVERSIGHT

The majority of states do not require chart cosignature by physicians, while a few require a small fraction of charts—typically 10 percent—to be cosigned.

The Joint Commission, which accredits the majority of hospitals in the United States, recommends that each accredited organization determine the necessity for cosignature. One relevant standard states, "The hospital defines the types of entries in the medical record made by nonindependent practitioners that require countersigning in accordance with law and regulation."[1] Another standard states that the medical staff defines when a medical history and physical exam must be "validated and countersigned."[2]

AAPA's "Guidelines for State Regulation of PAs" states,

> The PA/physician team model continues to be relevant, applicable and patient-centered. The degree of collaboration of the practicing PA should be determined at the practice level in accordance with the practice type and the experience and competencies of the practicing PA. State law should not require a specific relationship between a PA, physician, or any other entity in order for a PA to practice to the full extent of their education, training and experience. Such requirements diminish team flexibility and therefore limit patient access to care, without improving patient safety.[3]

According to the National Practitioner Data Bank, a federally maintained database of malpractice payments and disciplinary actions against healthcare providers, PAs have a remarkably low rate of malpractice payments.[4] PAs not only have a low incidence of malpractice payments compared with physicians, but a comprehensive study of private insurance data found that PA-physician teams experienced a lower rate of malpractice litigation than physicians alone.[5]

FLEXIBILITY IS KEY

Licensed healthcare facilities, institutions, and group practices should establish practice policies that best suit the needs of the patients they serve. Some employers may decide to have physicians review other team members' chart entries if there is a demonstrated patient benefit. Other employers will leave the choice up to the team, itself. For instance, a PA seeing a complex patient may elect to discuss the patient with a physician and ask the physician to review the note. Or a physician new to a team may choose to review a portion of chart entries until they are comfortable in their new role.

Inflexible cosignature requirements diminish the quality and efficiency of care. If a physician is required to cosign orders, he or she has less time for patient care.

ELECTRONIC HEALTH RECORDS

Electronic health records (EHRs) are increasingly replacing paper charts. When state law, facility guidelines, or physician preferences call for chart cosignature, physicians should be able to meet the requirement by using appropriate notations in the EHR. Facilities or practices should ensure that the design, implementation, and utilization of EHR systems does not burden the PA with extra steps to notify the responsible physician and allows physicians to cosign records quickly and conveniently, when required. It is also essential that the system does not override the PA's name and lose the PA's contribution to the care provided, if a physician signature is required.

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FOR MORE INFORMATION

The AAPA website contains additional information about PA scope of practice, team practice, PA prescribing, and more.

REFERENCES

1 Joint Commission. Comprehensive Accreditation Manual 2016. Record of care, standard RC.01.02.01, EP 2. Oakbrook Terrace, IL: Joint Commission Resources; July 2019.

2 Joint Commission. Comprehensive Accreditation Manual 2016. Record of care, standard MS.03.01.01, EP 10. Oakbrook Terrace, IL: Joint Commission Resources; July 2019.

3 American Academy of PAs. Guidelines for State Regulation of PAs. Updated May 2017. https://www.aapa.org/download/35030/ Accessed September 6, 2019.

4 US Department of Health and Human Services. National Practitioner Data Bank. https://www.npdb.hrsa.gov/. Accessed September 6, 2019.

5 Ledges M, Victoroff M, Ginde AA. PAs and malpractice. *Med Econ*. 2011;88(19):34-6, 41-2.