

**APALM PRESENTS:  
MALPRACTICE OVERVIEW, REAL CASES  
& RISK MANAGEMENT STRATEGIES FOR  
PHYSICIAN ASSISTANTS**



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# GENERAL OBJECTIVES

What is PA malpractice?

Most common reasons PAs are sued?

My career chances of being sued?

What steps can I take to reduce my risk?

What kind of Insurance do I need?

# TALK OUTLINE

- I. MEDICAL MALPRACTICE DEFINED
- II. NATIONAL RISK DATA
- III. TRIAL CASE REVIEWS
- IV. RISK REDUCTION RECOMMENDATIONS
- V. MALPRACTICE INSURANCE
- VI. RESOURCES

# DISCLAIMER

- All information presented is not intended to be legal advice. There is no intention to give legal advice, and information presented should not be misconstrued as legal advice.
- Information presented is based on actual malpractice cases, real life experience, attorney interaction and research.

I.  
WHAT IS MEDICAL  
MALPRACTICE?

# MEDICAL MALPRACTICE DEFINED

Medical Malpractice is generally defined as Negligence on the part of the Physician, Allied Healthcare Provider or Hospital which causes Physical or Emotional Damage to the patient:  
Personal or Institutional.

# NEGLIGENCE REQUIRES...

- **Duty**
- **Breach**
- **Causation**
- **Injury or Damages**

# DUTY

**Provider to Patient  
Relationship**

**Health Care Institution to  
Patient relationship**

**Implied Contract**



# BREACH

## Standard of Care

### External / Internal

**(State and Federal Regs/Hospital Policies/Bylaws)**

# STANDARD OF CARE

“What a provider with similar credential, experience and training would be expected reasonably to know and do under same or similar circumstances.” GENERIC

“Exercising the degree of care, skill and judgment which a reasonable provider would exercise given the state of medical knowledge at the time of diagnosis or treatment.” WI JI-CIVIL 1023

# CAUSATION

- Cause In Fact – The provider's negligence caused the injury  
(eg: wrong med or dose caused death)
- Or a reasonable close connection existed between the provider's conduct and the patient's injury  
(eg: Inappropriate prescribing led to suicide attempt, DM pt. put on prednisone for PTA)

# INJURY & DAMAGES

## INJURY:

- Death – Disability – Deformity – Chronic or Severe Pain

## DAMAGES:

- Lost Wages – Out-of-Pocket Expenses – Attorney's fees - Lost Enjoyment of Life
- **(caps on non-economic damages)**

# THE LITIGATION PROCESS

Time Limits on Filing – see summary

Initial Review

Expert Review

Depositions

Mediation

Settlement versus Jury Trial?

# THE LITIGATION PROCESS

Caps on Non-economic Damages

Caps on Attorney Fees

Expert's Fees

Expert's Qualifications

Do you want to be an “expert”?

FAQs

II.

HOW DO PA'S COMPARE?  
WHAT IS OUR RISK?

PHYSICIAN ASSISTANT MEDICAL PRACTICE IN  
THE HEALTH CARE WORKFORCE:

A RETROSPECTIVE STUDY OF MEDICAL  
MALPRACTICE AND SAFETY COMPARING  
PHYSICIAN ASSISTANTS TO PHYSICIANS AND  
ADVANCED PRACTICE NURSES

Jeffrey G. Nicholson, MEd, MPAS, PA-C  
Dissertation June 25, 2008



# Does the Employment of Physician Assistants and Nurse Practitioners Increase Liability?

- Hooker, R. & Nicholson, J.
- *Journal of Medical Licensure and Discipline, Vol. 95, No. 2, 2009*

# QUESTION

Is the practice of medicine by  
PAs as safe as the practice of  
medicine by physicians?



## And also...

- Does the average cost of PA malpractice offset cost effectiveness?
- Is the rate and ratio of malpractice claims per provider the same for PAs as for physicians and APNs?
- Are the reasons for disciplinary action the same for PAs, physicians, and APNs?

# Data Source

## National Practitioner Data Bank

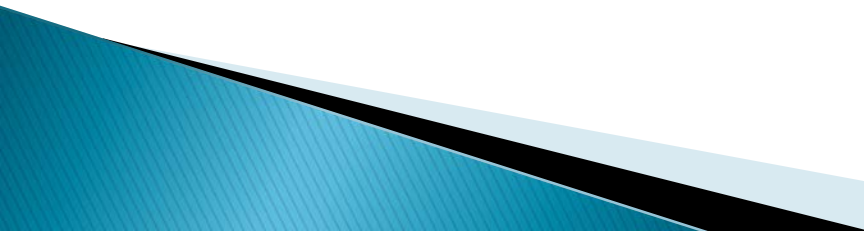
Federally mandated depository of malpractice claims and payments, and disciplinary actions against health care providers.

Health Care Quality Improvement Act 1986

## Sample

324,285 cases (physicians, PAs, APNs)  
logged between Jan. 1, 1991 - Dec. 31, 2007  
17 year sample

# National Practitioner Data Bank (NPDB)

- ▶ Established under **Title IV of Public Law 99–660 of the Health Care Quality Improvement Act of 1986**.
  - ▶ A **national registry of recorded actions**—required reports of malpractice payments, sanctions and adverse actions.
  - ▶ **Malpractice** refers to misconduct, unprofessional conduct, mismanagement, or negligence.
  - ▶ **Liability** refers to legal responsibility, accountability responsibility, or charge.
  - ▶ **Adverse actions** can involve licensure, clinical privileges, professional society membership, and exclusions from Medicare and Medicaid participation.
- 

# THE GOOD NEWS

PAs Fare Well  
by Comparison

# CONCLUSIONS

Based on malpractice incidence, malpractice payments and required reporting elements of adverse actions, PAs are safe providers of medical care when compared with physicians



# CONCLUSIONS

- PAs do not negate their cost effectiveness through the costs of malpractice – they may add cost savings over physicians
- The rate of malpractice incidence is at the same trajectory for PAs and physicians and at a lower trajectory than APNs

# CONCLUSIONS

- The ratio of malpractice claims per provider is much less for PAs and APNs than physicians.
- The reasons for disciplinary action are similar for physicians, PAs and APNs for required reporting elements.

# THE BAD NEWS

The COST to the health care system and to you and I as insured providers was over \$74 BILLION from 1991-2007, an average of \$4.4 billion/year.

# THE DETAILS

# Data Summary

Type of Provider	Total Entries	Malpractice Payments	Adverse Actions
Physician	320,034	245,267	74,767
PA	1,536	1,222	314
APN	2,715	2,608	107
TOTAL	324,285	249,097	75,188

Total entries  $\chi^2=576.67$ ;  $p<0.0001$   
Malpractice Payment field RECTYPE M AND P  $\chi^2=181.36$ ;  $p<0.0001$   
Adverse Action field RECTYPE A ND C  $\chi^2=565.66$ ;  $p<0.0001$

# Malpractice Payments Adjusted (\$'08)

	MEAN	MEDIAN
• MD	\$301,150,	\$150,821
• APN	\$350,540,	\$190,898
• PA	\$173,128,	\$80,003

17 Year Total    \$74.5 Billion !

# 17 Year Malpractice Payment Incidence Ratio

Ratio of payments per providers calculated as total payments in the 17 years per average number of providers over the 17 years. “17 year likelihood”

Physician	1:2.7	37%
PA	1:32.5*	3.1%
APN**	1:65.8	1.52%

\*12 times less than physicians \*\*APN data includes active and non-active providers

# 2005-2014 NPDB Study

- Physician payments per 1000: 11.2 – 19  
Ave: 13.75
- PA payments per 1000 PAs: 1.4 – 2.4  
Ave: 1.83
- NP payments per 1000 NPs: 1.1 - 1.4  
Ave: 1.26

Phys to PA ratio 1:7.5 7.5 times more,

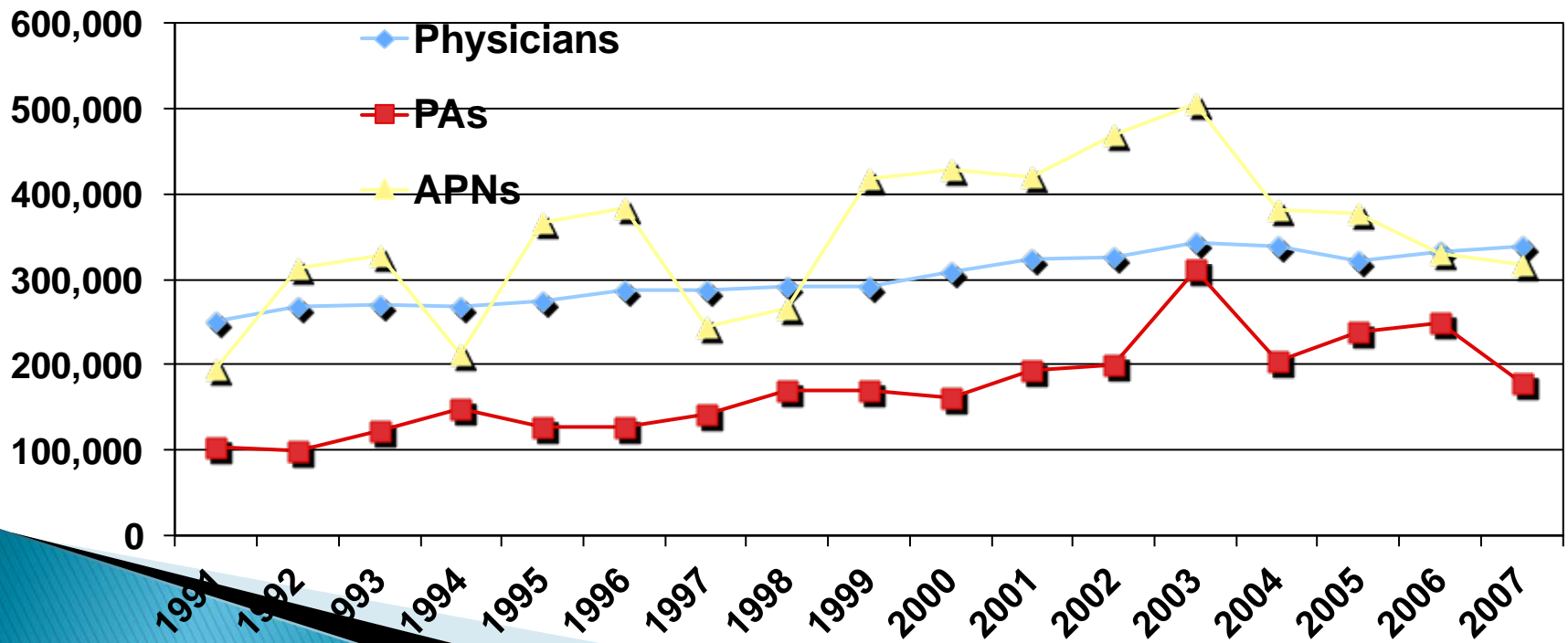
Phys to NP ratio 1:11 11 times more



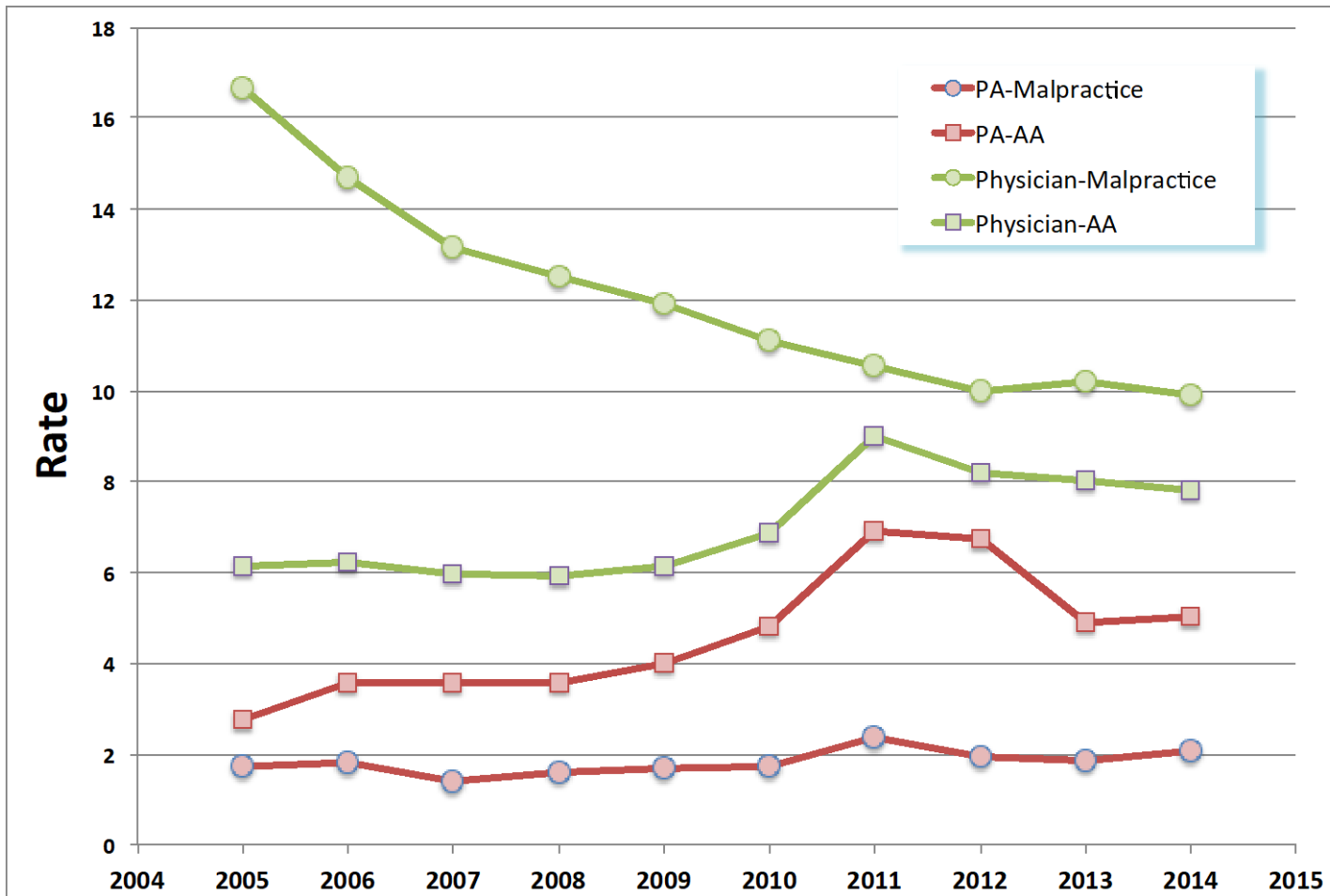
# 10 year “Likelihood”

- Physicians 13.75% for every ten years
- PAs 1.83% for every ten years worked
- NPs 1.26% for every ten years worked

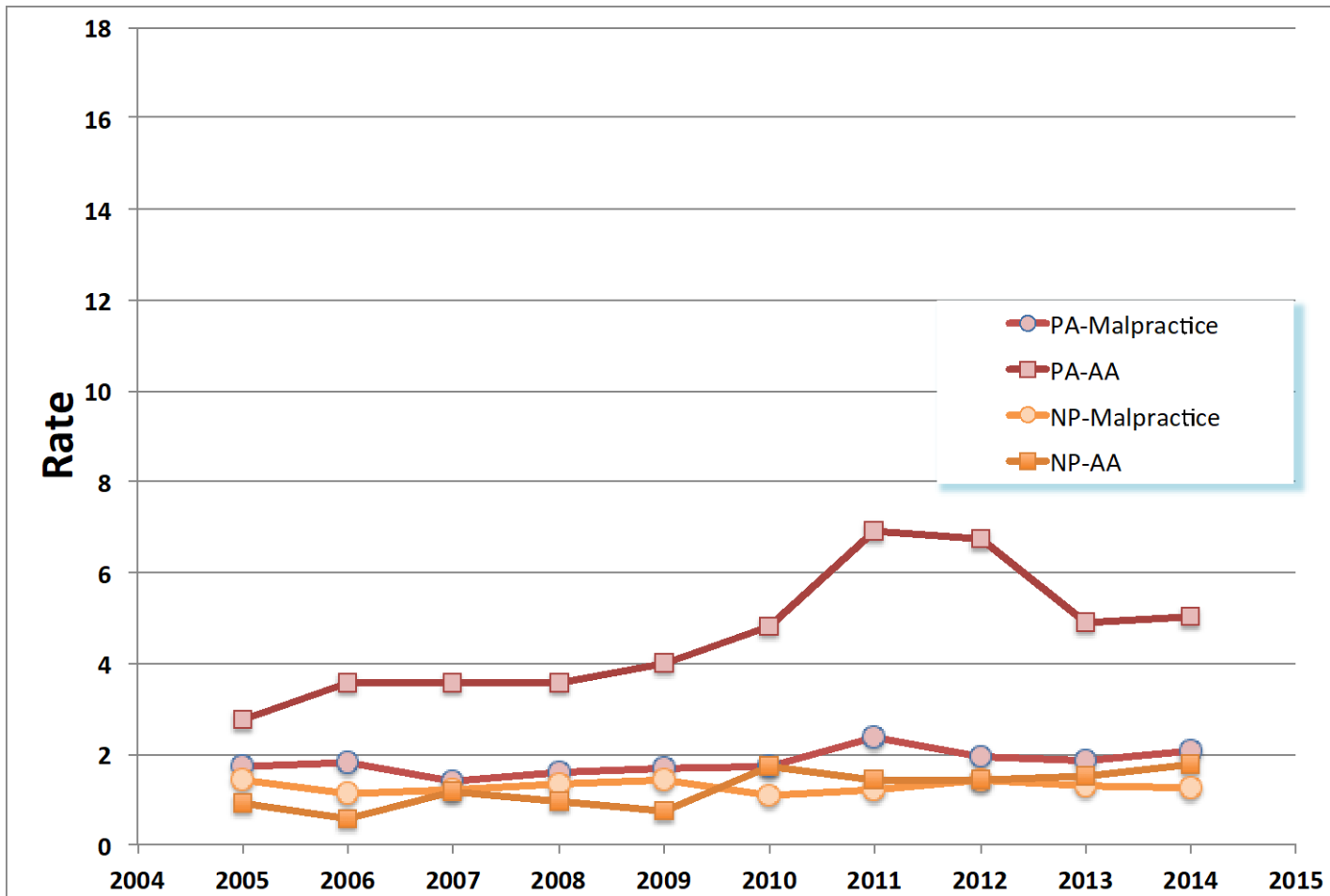
# Mean Malpractice Payment by Year 1991 to 2008



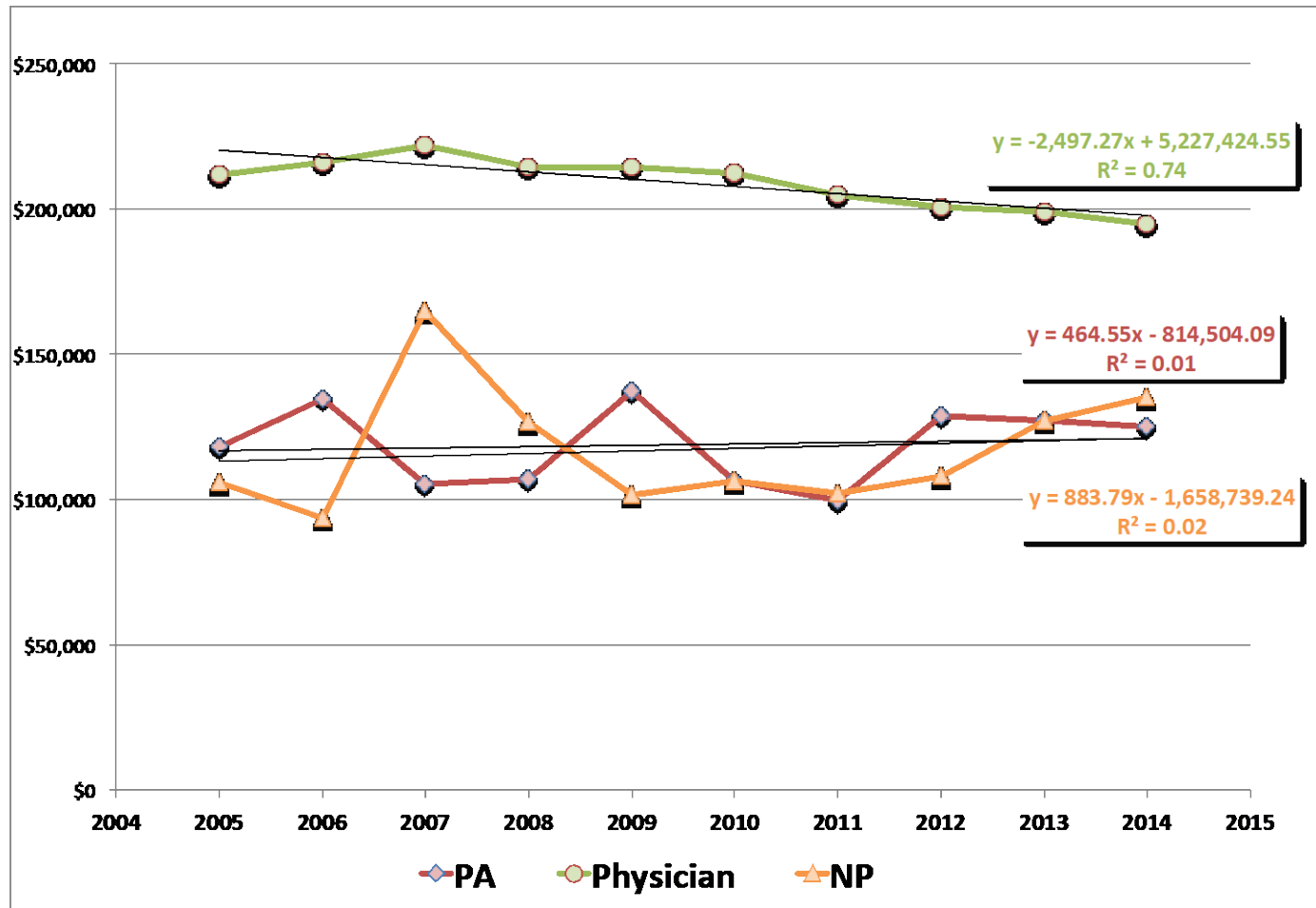
# PA and Physician Rates of Malpractice and Adverse Actions Per 1000 Providers



# PA and Nurse Practitioner Rates of Malpractice and Adverse Actions Per 1000 Providers



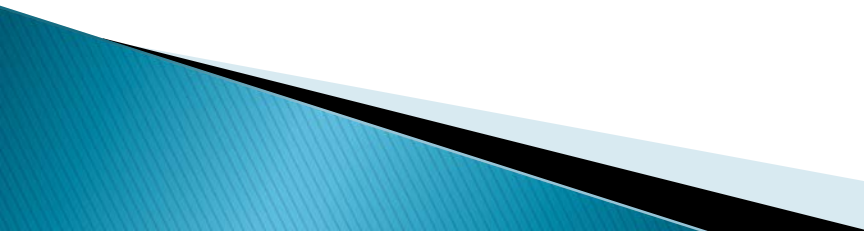
# Median Malpractice Payments



# Most Common Malpractice Allegations

<b>Malpractice Allegation</b>	<b>PA</b>	<b>Physician</b>	<b>NP</b>	<b>All</b>
Diagnosis Related	52.8%	31.8%	40.6%	32.2%
<b>Treatment Related</b>	<b>26.6%</b>	<b>19.6%</b>	<b>32.2%</b>	<b>19.8%</b>
Medication Related	9.3%	5.2%	12.8%	5.3%
<b>Surgery Related</b>	<b>4.0%</b>	<b>26.6%</b>	<b>1.8%</b>	<b>26.0%</b>
Monitoring Related	2.5%	3.1%	4.8%	3.1%
<b>Obstetrics Related</b>	<b>0.7%</b>	<b>7.6%</b>	<b>3.7%</b>	<b>7.4%</b>
Equipment/Product Related	0.5%	0.6%	0.3%	0.6%
<b>Anesthesia Related</b>	<b>0.4%</b>	<b>2.7%</b>	<b>1.1%</b>	<b>2.7%</b>
Behavioral Health Related	0.2%	0.4%	1.1%	0.4%
<b>IV &amp; Blood Products Related</b>	<b>0.1%</b>	<b>0.2%</b>	<b>0.1%</b>	<b>0.2%</b>
Other Miscellaneous	2.8%	2.3%	1.5%	2.3%

# Medical Error

- (1) Failure of a planned action to be completed as intended or use of a wrong plan to achieve an aim; the accumulation of errors results in accidents.
  - (2) Failure to complete a planned action as intended, or the use of an incorrect plan of action to achieve a given aim.
  - (3) The failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.
- 

# Risk by discipline 2005–2014

Physician 11.2 – 19 per 1000 (13.75 ave.)

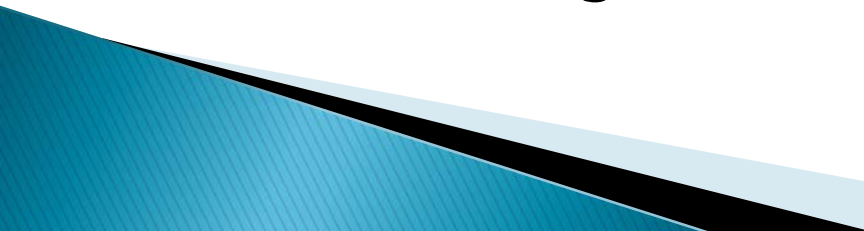
PA 1.40–2.4 per 1000 (1.83 ave.)

NP 1.1 – 1.4 per 1000 (1.26 ave.)

Risk 7.5 times higher for physicians than PAs and 11 times higher than NPs. Prior study 1998–2007 showed a much larger difference in physician to PA and NP risk.



# Conclusions 2005–2014

- ▶ Rate of physician malpractice payments has been declining, the rate of NP malpractice payments been steady, and the rate of PA malpractice payments has been slightly increasing.
  - ▶ Median payments for physicians slightly decreasing, PAs and NPs steady
  - ▶ Reasons for payments largely unchanged
  - ▶ PAs and NPs remain much less frequently sued than physicians, though the frequency gap may be narrowing
- 



III.

# CASE REVIEWS

# UC CASE\*

- 10 year old girl with a h/o anemia, renal failure, acute necrotizing glomerulonephritis
- Immune compromised – on prednisone and Cytoxan, hospitalized a month prior, doesn't look “sick”
- DX strep pharyngitis, Expired of sepsis less than a week later (**STOP – what do you think happened?**)

# ALLEGED DEVIATIONS

- Recognize severity of underlying illness
- Lab tests? – CBC, UA, BMP
- Communicate with child's PCP and/or Nephrologist
- More aggressive treatment
- Closer Follow Up

# PA ISSUES

- Need to recognize an underlying sick child who did not necessarily appear sick – CA, HIV, **History!**
- Need for communication
- Missing: “See your PCP or Nephrologist in the next 2 days.” That simple statement in the chart might have exonerated the PA - or at least placed greater percent settlement on mother.

# ER CASE

- 19 yr old AA, 1 week post partum, SOB, CP, tachycardia, tachypnea, crackles, 1430
- CXR, neb, IV fluids
- PA dx of pneumonia and staffed with MD who went off shift in 10 min, admit for pneumonia
- Hospitalist came down, did not read film

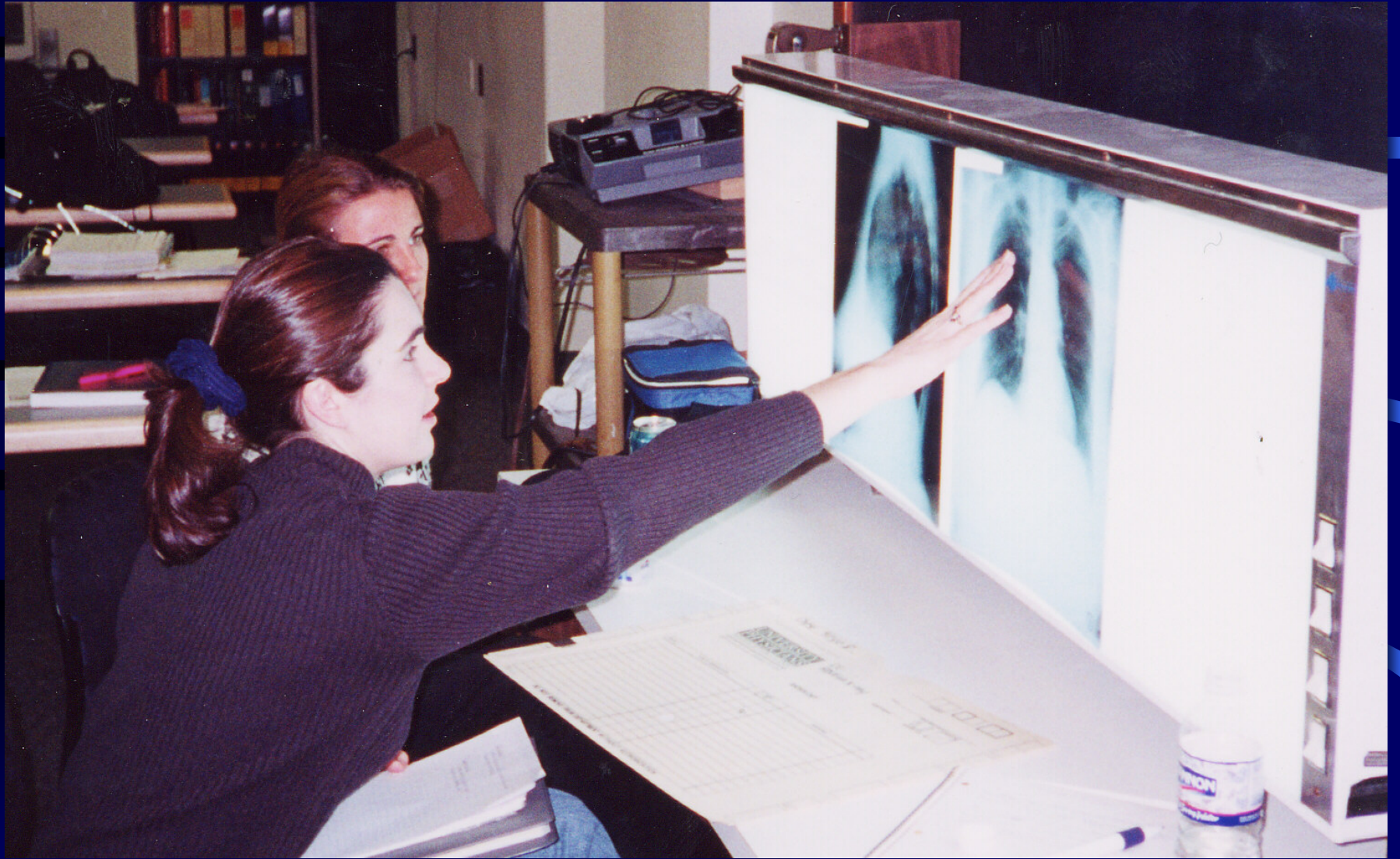
## ER CASE (cont.)

- Pt in ER all night waiting for room, deteriorating, no vitals or re-evaluation by RN or PA
- Chest film finally read by radiologist at 3am cardiomegaly/CHF/congestion, sent for CT
- Pt expired on way to CT of cardiac arrest, cardio-pulmonary failure; DX Post Partum cardiomyopathy



# ALLEGED BREACHES

- Severity of condition not recognized
- Wrong diagnosis, No differential
- Incomplete workup, UA, EKG, cardiac enzymes, d-dimer, BNP all not done
- Misread CXR by PA – no over-read by MD
- Inadequate PA supervision
- Inappropriate potentially harmful treatment
- **Institutional Negligence** – vitals, admission



# PA ISSUES

- Staffing with an MD going off shift
- Not continuing to care for your patient – allowing patient to “fall through the cracks”
- Not ensuring an over-read of the CXR by MD or radiologist in timely fashion
- PA inexperience or haste, haste, haste
- Where’s the communication with the RNs?
- Settled for \$5,350,000 in 2009!

# MAIN LESSONS

- PLEASE LEARN THE DIFFERENCE BETWEEN RONCHI , CRACKLES (RALES) AND WHEEZING!
- DON'T GIVE IV FLUIDS TO A PATINET IN HEART FAILURE
- BE SURE YOUR FILMS ARE OVERREAD BY SUPER PHYSICIAN

# FP CASE\*

- Well known 30 y/o male “chronic depression seems to be getting worse”
- Family h/o depression bro. suicide attempt
- Pt. expressed “suicide ideation at times” “has even thought of a method” but never acutely in the office
- Patient placed on Paxil, dose increased monthly

# FP CASE

- Pt. seen monthly in f/u, Paxil increased from 20, 30 to 40mg. Patient does not improve, legs ache, sees MD for sigmoidoscopy in between visits
- PA increases Paxil to “50mg for 3 days then 60mg” – above rec. dose.
- Pt. attempts suicide a week later – Dx SSRI intoxication syndrome

# ISSUES/ALLEGATIONS

- FP PA outside scope of practice
  - No psych training, no objective assessment of patient progress
- No referral to psychiatrist or communication with psychologist
- Exceeded max medication dose
- No notification or monitoring of side effects
- Failure to follow Penn. state regs of seeing MD every third visit (**external standard**)

# PA Issues/Recommendations

- Do not practice outside of your comfort zone
- S.I. even passively expressed is out of a FP realm
- Get other professionals involved, share the burden (and the blame), communicate with those already involved
- Know your meds, explain side affects



# ORTHO CASES\*

- 60 y/o woman total knee replacement
- Saw MD in follow up and placed on antibiotic for incision site purulent drainage
- Sees PA a few days later who sees no drainage & tells patient she doesn't really need the antibiotic and allows the patient to decide to take it or not
- Patient d/c'd med, infection ensues, ends with an above the knee amputation

# ISSUES/ALLEGATIONS

- PA contradicts supervising physician medical plan
- PA allows patient to make her own medical decision outside a layman's expertise
- PA does not discuss the change in plan with supervising MD

# ORTHO CASE II\*

- Missed post op knee infection, patient perceived as a “whiner” - pain out of proportion to expected – patient not taken seriously
- Nosocomial MRSA, eventual sepsis and death
- Allegations of missed diagnosis, treatment, uncaring, unprofessional conduct

# ORTHO CASE II\*

- Allegations of poor, incomplete PE
- Failure to appreciate severity (pain and swelling) out of the ordinary post op
- Infection not in written differential
- Patient was previously on clindamycin, failed to get **history** of prior MRSA?
- Used the word hysterical in documentation

# PA Issues/Recommendations

- Take your patients seriously
- Unexpected pain or unexpected course of treatment is a huge RED FLAG – get another opinion if necessary
- Respect your patients no matter how difficult it may be at times
- Avoid inflammatory comments in your note

# FP CASE II

- New grad PAs with a DO in FP. DO claimed to have pain management expertise
- PAs saw mainly pain follow ups – 120 -240 Percocets a month, pain contracts not used
- Multiple OD deaths over several years
- DO and wife office manager in jail



# PA ISSUES

- Need to verify supervising MD/DOs credentials
- No PA training or expertise in pain management - but neither did the doc!
- If uncomfortable in a practice get out!
- PAs will be held accountable in addition to supervising physician



# FP VA CASE

- Painless hematuria in a male repeatedly diagnosed as cystitis without objective UA findings of cystitis
- Procrastinated on referral to urology then took months for system approval
- Bladder CA diagnosis delayed 5 months by **both provider and institutional negligence**

# FP VA CASE LESSONS

- Continuing down the wrong path without diagnostic evidence
- Don't procrastinate to refer or order tests when your patient is not getting better
- Be your patient's advocate when there are system obstacles to quality care (approval delay), find a "work around"

# ER CHEST PAIN CASE\*

- PT seen for “HA”, c/o chest pain on the way back from CT for HA– tech told PA within earshot of MD
- PA went back and talked with patient for less than a minute and reported vague complaints to MD
- MD did an equally rudimentary look at the patient, initial enzymes nl.
- PT discharged and died of MI

# PA Issues/Recommendations

- No clear delineation of who is in charge and responsible – docs need to know when you are “washing your hands of this patient”
- Since neither was fully in charge after the expressed chest pain, neither went back to do a **fresh and full history and exam** – new complaint

# PA Issues/Recommendations

- History
- Risk Factors
- Quality of the PE
- Who is in charge?
- Communication with Supervising MD
- Can a PA testify about SOC of MD?
- Can you blame your Supervising MD?

# Compartment Syndrome

## UC Case\*

- PT fell backward, leg pinched between cart and wooden palette, ER, Dx muscle strain, crutches, Motrin
- Day later first UC visit
- Return in less than 24 hours to UC
- 3 visits in 3 days
- PT seen 4 times in UC over 3 weeks

# PA Issues/Allegations

- Failure to diagnose (leg pain sx not dx)
- Incomplete Physical – no NeuroVasc exam
- Failure to appreciate mechanism/history
- Failure to provide adequate treatment
- Failure to refer, Ignored MRI findings wk3
- Failure to meet state requirements, No...

Supervisory agreement on file

Chart co-signature

# OTHER COMMON CASES

- Missed ileus/bowel obstruction- film issue
- Missed appendicitis – very common
- Post op infections – very common MRSA
- Rudimentary physical exams –poor documentation
- Lack of sufficient work up or PE– (missed preterm labor)
- Lack of referral or timely referral



# COMMON THEMES

- Failure to appreciate severity
- Delay in reviewing diagnostic tests and getting back to patient
- Practicing outside of training or comfort level
- Failure to formulate or **document** differential diagnosis – my rec!

# COMMON CASE THEMES

- Failure to treat aggressively enough
- Failure to communicate with specialists
- Failure to ensure close follow-up
- Failure to request assistance from supervising MD
- Failure to provide continuity of care
- Failure to treat patients respectfully

# COMMON CASE THEMES

- Failure to clarify and document transfer of care (especially ED setting)
- “Are you taking over or am I still involved”
- Failure to get a “final” read on films by supervising MD or radiologist and timely
- Rushing /Haste
- Minimizing complaints or findings

IV.

# RECOMMENDATIONS

# LESSONS

- Relationships with supervising physicians and staff is tantamount
- Communication is key!
- Relationships with patients. “If they like you they won’t sue despite a poor outcome.”

**Failure to Diagnose**

**Referral**

**Examination**

**PITFALLS OF MEDICAL MALPRACTICE**

**SUPERVISION**

**Documentation**

**COMMUNICATIONS**

# RECOMMENDATIONS

- Document a differential or no one will know what your thinking – not the lawyers, not the “experts”, not even yourself a year later!
- Your diagnostic work-up must be adequate and appropriate for your differential (Don't be cheap to order tests but don't order out of malp. fear either - practice good medicine.)

# RECOMMENDATIONS

- Have your diagnostic tests – EKGs, imaging studies over read by your supervising MD or radiologist. Don't convince yourself you know more than you do. Know your limitations. (PP-Cardio case, psych case)
- Provide and document close follow up or next step instructions for every patient. (immunocomprised child case )



# RECOMMENDATIONS

- Believe your patients – don't dismiss their concerns when they come back (ortho knee case)
- Don't practice 'over your head.' We're not all experts at everything. (FP psych case)
- Know and follow your state regulations carefully (FP psych case, UC Comp Syn)

# RECOMMENDATIONS

- Clarify and document who is the responsible provider and when? (ER MI case)
- Be liberal with treatment – a \$4 antibiotic may keep your patient alive and prevent a damaged career (ortho sepsis cases)
- Balance what patient's want with good medicine, keep them 😊 !!

# RECOMMENDATIONS

- Help your institution/clinic/office become more efficient in lab turn around and in patient communication and follow-up - prevent system failures (ER post partum cardiomyopathy case, **cardiac echo case**)
- Determine who is responsible for what – lab results, patient calls, follow up times

# RECOMMENDATIONS

- Know your supervising docs credentials, training and reputation in the community (Narcotic prescribing abuses).
- Don't be afraid to leave a high liability situation – get out before you become implicated (Pain Management FP case).

# REVIEW BASED ON NPDB RESEARCH

- **Inadequate Supervision**
- **Inadequate Examination**
- **Untimely Referral**
- **Failure to Correctly Diagnose**
- **Lack of Documentation**
- **Poor Communication**



# Inadequate Examination

- **Always confirm & expand on the Chief Complaint : “OLD CARTS”.**
- **Do not accept someone else's triage information, but compare it with your own.**
- **You must always perform and document a complete physical examination for the history taken.**

# Failure to Diagnose

- **BE SURE TO MAKE A DIAGNOSIS!!**
- Know the difference between a symptom and a diagnosis, e.g. cough, nausea, abd. pain, emesis vs. pneumonia, bronchitis, gastroenteritis, appendicitis, etc.
- **IF YOU CAN'T MAKE A DIAGNOSIS, YOU MUST AT LEAST DOCUMENT A DIFFERENTIAL AND EXPLAIN WHAT FURTHER STEPS WILL BE TAKEN OR YOU HAVEN'T DONE YOUR JOB!**



# Lack of Documentation

- **Five years from now, if someone reads your record on a patient you saw today, will they get an accurate picture of your care or will what is missing in the record speak louder than what you noted?**
- **SOMEONE WILL SAY IF ISN'T IN THE CHART, IT NEVER HAPPENED**

# BIG TIP: OLDCARTS

- Onset, Location, Duration, Character, Aggravating factors, Relieving factors, Treatments tried, Symptoms associated.
- If its a life or limb threatening condition, you must complete OLDCARTS for every complaint or someone will say you are negligent in your duty. OLDCARTS is just the minimum to get you thinking thoroughly.

# BIG TIP: HISTORY

- “There is no such thing as a poor historian – just a poor history taker.”
- “90% of your diagnosis comes from the history!!”
- If you cannot get an adequate history from the patient, your duty obliges you to get it from family, bystanders, witnesses, EMTs, old records.

# BIG TIP: MEDICATION

- At end of note state:
- “The potential side affects and adverse reactions of all medications prescribed were thoroughly discussed with the patient and they verbalized understanding.”

# BIG TIP: FOLLOW-UP

- At the end of note state:
- “The patient was told to return, see their primary provider or go to the ER if not improving in the next 48 hours or if getting worse.”

# BIG TIP: Communication

- Your relationship with your supervising physician is tantamount.
- Don't be afraid to admit you don't know and ask for help – you are not expected to know everything.
- “The biggest compliment you can receive is...”

# BIG TIP: DIAGNOSIS

- Be sure your diagnosis is a diagnosis!!
- Not a restatement of a symptom, e.g. abdominal pain
- If impression is a symptom, then you **MUST** delineate differential diagnosis and next steps to rule them in or rule them out.
- Attorneys will crucify you if you don't "rule out the most life threatening conditions first" even if they are not common.

## BIGGEST PEARL!

Treat everyone as if  
they were your  
grandmother!



# Communication

- Although you will not find POOR COMMUNICATION listed anywhere as an official cause of MEDICAL MALPRACTICE CLAIMS, it underlies almost every malpractice action.
- Studies show contributing factor in 80%.

# GET ORGANIZED!

- PERSONAL RISK
  - Get back to patients, don't let results sit
- INSTITUTIONAL RISK
  - Look at the process of diagnostic studies and who communicates results
  - Who is responsible for making sure the study is done in a timely fashion and that results are communicated back to the patient in a timely fashion – YOU ARE!



# DOCUMENTATION

- “The witness whose memory never fades.”
- Critical, must be legible, thorough
- Includes emails
- Document all phone calls and emails
- Initial and date all documents you have reviewed – such as lab reports

# DOCUMENTATION (3 Purposes)...

- Reminds you of what you did and what you were thinking
- Tells other providers what you did and what you were thinking
- Serves as a legal record in case of litigation  
– USE IT TO PROTECT YOU not the other way around!!

# DOCUMENTATION

## DO NOT ALTER THE MEDICAL RECORD

- *If an error is made, SLIDE it!*
  - *Single Line through the words*
  - *Initial it*
  - *Date it*
  - *(don't write error next to it)*

# RECORD TAMPERING

- WILL CAUSE YOU TO LOOSE/SETTLE
- **Missing Medical Records**
- **Records Conflict With Patients Testimony**
- **Different Ink on Single Entry**
- **Different Handwriting**
- **Late Entries**
- **Long entries when normally short**
- **Handwriting too neat**
- **Late entry or out of sequence**
- **Additions to the chart**
- **Erased – Obliterated – Whited Out**

# Summary

Communicate – say you are sorry - be organized - don't be rushed - keep your cool- be polite and professional no matter what - be aware of shift changes, ER  
“pneumonia” case - again take your time, do not discharge with abnormal vitals signs  
– Saw II “torticollis” case



# Summary

Communicate with your supervising physician - insist on supervision and involvement when you are in over your head or uncomfortable – refer, refer, refer, **Back Surgery Case, UC Strep Throat case** – choose a good supervising physician and know their credentials **D.O. Case** -- document well - keep documentation professional - quote the patient – be sure your notes and the triage or nurse assessments are similar

# Summary

A \$4 antibiotic may prevent \$300K settlement! post surgical knee case, hip case, MRSA – document patient instructions and especially follow up instructions – exude a caring and compassionate attitude at all times – take frequent breaks – take care of yourself! ☺

# WHY PATIENTS DON'T SUE

- They know you care
- You kept them informed
- You were honest
- You apologized - “Sorry Works” but did not accept fault or assess blame
- They view their provider as a friend
- It's been too long (more than 3 years)
- It's too much trouble

VIII.

RESOURCES

# MORE INFORMATION

PA Malpractice, Expert Witnessing Websites:

[www.AAPALM.org](http://www.AAPALM.org)

ReachMD XM Radio

[www.PAexperts.com](http://www.PAexperts.com)

Summary of State Laws:

[www.mcandl.com/states.html](http://www.mcandl.com/states.html)

[www.ama-assn.org/resources/doc/arc/capsdamages.pdf](http://www.ama-assn.org/resources/doc/arc/capsdamages.pdf)

