How PAs Can Avoid Malpractice: Go Back to Practice Basics

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INDIANAPOLIS — Two days after her father was admitted to the hospital from his nursing home with methicillin-resistant *Staphylococcus aureus* (MRSA), a woman presented to urgent care with fever, chills, chest discomfort, body aches, and mild tachycardia. The physician assistant recorded "no wheezing or rhonchi, positive mild congestion" before diagnosing an upper respiratory infection and prescribing azithromycin "just in case" a secondary bacterial infection developed.

Soon afterwards, the woman was admitted in respiratory distress with a diagnosis of influenza and MRSA pneumonia. She died a few days later.

Dr Jeffrey Nicholson

"The PA should have tested for influenza and ordered a chest X-ray and, if that was positive for pneumonia, sent the patient to the ER for IV antibiotics and admission," Jeffrey G. Nicholson, PA-C, PhD, MEd, said in a session about avoiding malpractice at the American Academy of Physician Associates 2022 annual meeting. "There was no complete history taken, no further questioning about her MRSA exposure, no MRSA-covering antibiotic prescribed."

Common Errors

The details vary, but Nicholson has heard versions of this story hundreds of times before. As founder and president of the medico-legal consulting firm PA Experts in Milwaukee, Wisconsin, he's testified as an expert witness in dozens of malpractice trials and seen clear trends emerge in terms of clinical mistakes.

Some of the more common situations that lead to malpractice cases in Nicholson's experience include missed diagnoses, especially:

- Appendicitis
- Ileus/bowel obstruction
- Postoperative infection

These missed diagnoses often result from an insufficient workup or physical exam, or not referring the patient to an appropriate specialist promptly or at all.

Other common errors include:

- Failure to accurately assess the severity of the patient's condition
- Delayed review of diagnostic tests and reporting results to the patient
- Failure to formulate and document a differential diagnosis
- Providing a proper level of documentation

- Practicing outside one's training or comfort level
- Poor communication with the patient, either in not sharing information or treating them disrespectfully

But errors like these can be avoided when PAs focus on the basics of good practice, Nicholson said.

Take a Thorough History

For example, if the PA cited earlier had delved into her patient's MRSA exposure more thoroughly, the case could have had a very different outcome. "I really do believe, as we teach our students, that 90% of our diagnosis comes from our patient's history," he said. "A well-done medical history focuses our diagnostic workup and our differential diagnosis."

During the presentation, Nicholson referred to the tried-and-true mnemonic OLDCARTS several times:

- Onset
- Location
- Duration
- Character
- Aggravating factors
- Relieving factors
- Treatments tried
- Symptoms associated

"If it's a possible life- or limb-threatening condition, you must complete OLDCARTS for each symptom," he said. "If you do that, you will get a good historical picture of what's going on with the patient and it will aid you tremendously in coming to the correct diagnosis."

Refer When Needed

Nicholson also reminded attendees of the importance of maintaining a good relationship with their supervising physician. "This relationship is absolutely paramount," he said. "Don't be afraid to admit when you don't know something. You are not expected to know everything."

Nicholson sees too many PAs who don't have their diagnostic tests like EKGs or other imaging studies over-read by the supervising physician or a radiologist when warranted. "Get them involved whenever you're uncertain about a particular patient presentation," he said.

Communicate Clearly and Respectfully

In Nicholson's experience, patients are less likely to sue when they think their PA cares about them, kept them informed, and were honest at all times. "If you dismissed their concerns or didn't tell them all the possible diagnoses or potential treatments, that to me is not a compassionate provider," he said. "We need to educate our patients about what we're thinking and why, and to be their advocates within the healthcare system. We need to be on our patient's side, not on the side of the healthcare system that pushes back against patients too often."

Attendee Barbara Regis, PA-C, MS, of Premise Health in Seattle, Washington, agreed with Nicholson's suggestions about focusing on the basics of good practice, including documentation. "We all need to remember that if you didn't document it, it didn't happen," she said. "Being thorough in your charting with every patient is absolutely vital."

Regis, who also does some medical consulting, also appreciated Nicholson's emphasis on thoroughly investigating patient complaints that could have potentially have life-threatening consequences, like new-onset headaches.

"If you've got a patient who presents with a migraine, discuss ordering a CT, even if they've previously seen a specialist who didn't order a scan," she said in an interview after the session. "Get one clean scan in the chart because if something happens to that patient after they see you, like a ruptured aneurysm, you'll be the one called in."

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