Liability on the Increase for PNPs and their Fellow Pediatric-focused APRNs: How to Decrease Risk

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Wilkinson Legal Nurse Consulting

Disclosures

• I hereby certify that, to the best of my knowledge, no aspect of my current personal or professional situation might reasonably be expected to affect significantly my views on the subject on which I am presenting.
• I will not discuss off label use and/or investigational use of agents or treatments in my presentation.

Learning Objectives

• Discuss guidelines for malpractice prevention for pediatric nurse practitioners and identify reasons why patients sue
• Discuss practical medical malpractice prevention in everyday practice
• Identify the various defenses to professional liability suits
• Evaluate whether liability insurance is practical for your individual practice and discuss different types of medical liability insurance

Legal Risk

• APRN practice has increased legal vulnerability
• The medical malpractice myth
  -- Medical malpractice premiums are skyrocketing, clinics are closing, providers are leaving the field or practicing in fear, billions of dollars are being wasted on defensive medicine, medical malpractice litigation is exploding, plaintiffs and greedy lawyers sue at the drop of a hat, and juries award eye-popping sums to undeserving claimants
• Reality based on research is telling us
  -- Real problem is too much medical malpractice
  -- Real cost is lost lives, extra medical expenses, time out of work and suffering of tens of thousands of people every year, the vast majority of whom do not sue

Medical Errors

• Patient safety
  -- IOM report 1999
• Poor outcomes

Malpractice Claims on the Rise?

• On the rise for all health care providers
• Rise is slow
• NPDB records can be used to explore trends of provider malpractice and adverse actions, size of malpractice awards, time lapse between an act or omission and their reporting, or judgment
National Practitioner Data Bank

- Monitors medical malpractice and adverse actions
- Medical malpractice payments
- Adverse licensing and clinic privileging
- Professional society membership actions
- DEA actions
- Medicare/Medicaid exclusion

Malpractice Severity of Injury Classification

<table>
<thead>
<tr>
<th>Code</th>
<th>Severity of Injury</th>
<th>NAC Interpretation</th>
<th>No. (%)</th>
</tr>
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<tbody>
<tr>
<td>01</td>
<td>Involuntary Injury</td>
<td>Negligent/Temporary</td>
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<tr>
<td>02</td>
<td>Malignant Malpractice</td>
<td>Serious/Permanent</td>
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<tr>
<td>03</td>
<td>Minor Temporary Injury</td>
<td>Negligent/Temporary</td>
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<tr>
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<td>10</td>
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<td>Death</td>
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<td>12</td>
<td>Certified Causation</td>
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<td>Total</td>
<td></td>
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Number of Malpractice Claims

<table>
<thead>
<tr>
<th>Year</th>
<th>Total (AA+MR)</th>
<th>AA</th>
<th>MR</th>
<th>Total (AA+MR)</th>
<th>AA</th>
<th>MR</th>
<th>Total (AA+MR)</th>
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<td>2013</td>
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Malpractice Allegation Groups for Physicians, PAs, and NPs

<table>
<thead>
<tr>
<th>Malpractice Allegation</th>
<th>Total Claims</th>
<th>Percentage of Claims</th>
<th>Total Paid</th>
<th>Average Paid</th>
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<tr>
<td>Diagnosis related</td>
<td>35,693</td>
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<td>Surgery related</td>
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<td>Treatment related</td>
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<td>Obstetrics related</td>
<td>8,257</td>
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<td>Medication related</td>
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<td>Monitoring related</td>
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<td>Other miscellaneous</td>
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<tr>
<td>Equipment/product related</td>
<td>650</td>
<td>0.6%</td>
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Malpractice Counts and Rates

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<tr>
<th>Year</th>
<th>Total Providers</th>
<th>Physician</th>
<th>PA</th>
<th>NP</th>
<th>Physician</th>
<th>PA</th>
<th>NP</th>
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<th>PA</th>
<th>NP</th>
<th>Physician</th>
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<th>NP</th>
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<td>62,960</td>
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<td>12,475</td>
<td>113</td>
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<tr>
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<td>96,000</td>
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<tr>
<td>2008</td>
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<td>71,950</td>
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<td>2010</td>
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<td>2011</td>
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<tr>
<td>2012</td>
<td>817,850</td>
<td>83,640</td>
<td>125,600</td>
<td>9,362</td>
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<tr>
<td>2013</td>
<td>832,466</td>
<td>88,110</td>
<td>136,800</td>
<td>9,656</td>
<td>164</td>
<td>180</td>
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<td>1.9</td>
<td>1.3</td>
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<tr>
<td>2014</td>
<td>844,340</td>
<td>91,670</td>
<td>153,600</td>
<td>9,477</td>
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<td>2.1</td>
<td>1.2</td>
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</table>

CNA HealthPro Nurse Practitioner Claims Analysis 1998-2008

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Percentage of Claims</th>
<th>Total Paid</th>
<th>Average Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatrics</td>
<td>1.0%</td>
<td>$1,050,000</td>
<td>$525,000</td>
</tr>
<tr>
<td>Women's health (obstetrics)</td>
<td>2.5%</td>
<td>$2,185,000</td>
<td>$437,000</td>
</tr>
<tr>
<td>Emergency medicine</td>
<td>3.5%</td>
<td>$1,915,292</td>
<td>$273,613</td>
</tr>
<tr>
<td>Adult medical/pediatric care</td>
<td>52.0%</td>
<td>$26,977,252</td>
<td>$253,359</td>
</tr>
<tr>
<td>Women's health (gynecology)</td>
<td>5.0%</td>
<td>$2,357,833</td>
<td>$235,783</td>
</tr>
<tr>
<td>Occupational health</td>
<td>0.5%</td>
<td>$225,000</td>
<td>$225,000</td>
</tr>
<tr>
<td>Behavioral health</td>
<td>6.5%</td>
<td>$2,643,750</td>
<td>$205,365</td>
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<tr>
<td>Family practice</td>
<td>23.5%</td>
<td>$6,904,296</td>
<td>$146,900</td>
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<tr>
<td>Aesthetics/cosmetics</td>
<td>4.5%</td>
<td>$467,500</td>
<td>$51,944</td>
</tr>
<tr>
<td>Overall</td>
<td>100%</td>
<td>$44,370,490</td>
<td>$221,852</td>
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### Severity by Allegation Category

<table>
<thead>
<tr>
<th>Allegations related to</th>
<th>Percentage of closed claims</th>
<th>Total paid indemnity</th>
<th>Average paid indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring</td>
<td>1.5%</td>
<td>$965,000</td>
<td>$321,667</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>43.0%</td>
<td>$21,573,135</td>
<td>$250,850</td>
</tr>
<tr>
<td>Medication prescribing</td>
<td>16.5%</td>
<td>$7,680,197</td>
<td>$232,127</td>
</tr>
<tr>
<td>Treatment and care management</td>
<td>29.5%</td>
<td>$13,005,408</td>
<td>$220,431</td>
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<tr>
<td>Equipment</td>
<td>3.5%</td>
<td>$640,000</td>
<td>$91,429</td>
</tr>
<tr>
<td>Abuse/patient rights/professional conduct</td>
<td>1.5%</td>
<td>$271,250</td>
<td>$90,417</td>
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<tr>
<td>Communication</td>
<td>0.5%</td>
<td>$27,500</td>
<td>$27,500</td>
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<tr>
<td>Scope of practice</td>
<td>0.5%</td>
<td>$12,000</td>
<td>$12,000</td>
</tr>
<tr>
<td>Overall</td>
<td>100%</td>
<td>$44,370,49</td>
<td>$221,852</td>
</tr>
</tbody>
</table>

### Diagnosis-Related Analysis

<table>
<thead>
<tr>
<th>Allegation sub-category</th>
<th>Percentage of closed claims</th>
<th>Total paid indemnity</th>
<th>Average paid indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to diagnose</td>
<td>30.0%</td>
<td>$15,120,548</td>
<td>$252,009</td>
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<tr>
<td>Delay in establishing diagnosis</td>
<td>13.0%</td>
<td>$6,452,587</td>
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<tr>
<td>Overall</td>
<td>43.0%</td>
<td>$21,573,135</td>
<td>$250,850</td>
</tr>
</tbody>
</table>

How does this happen?
- Context
- Availability
- Premature closure
Differential Diagnosis is KEY....

### Severity of Failure to Diagnose Claims by Cause of Failure

<table>
<thead>
<tr>
<th>Cause of failure to diagnose</th>
<th>Percentage of closed claims</th>
<th>Total paid indemnity</th>
<th>Average paid indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to obtain/ref for immediate emergency treatment</td>
<td>3.0%</td>
<td>$2,795,000</td>
<td>$464,833</td>
</tr>
<tr>
<td>Failure to obtain consultations to establish diagnosis</td>
<td>9.0%</td>
<td>$6,386,250</td>
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<td>Failure to perform/document a timely or complete history and physical examination</td>
<td>1.5%</td>
<td>$580,540</td>
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<tr>
<td>Failure to order appropriate tests to establish diagnosis</td>
<td>10.0%</td>
<td>$3,633,555</td>
<td>$181,698</td>
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<tr>
<td>Failure or delay in obtaining/addressing diagnostic test results</td>
<td>3.5%</td>
<td>$1,249,803</td>
<td>$378,543</td>
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<tr>
<td>Failure to timely order/obtain diagnostic test or consultation at patient's request due to lack of insurance coverage of funds</td>
<td>1.0%</td>
<td>$225,000</td>
<td>$112,500</td>
</tr>
<tr>
<td>Failure to assess the need for medical intervention</td>
<td>1.0%</td>
<td>$165,000</td>
<td>$82,500</td>
</tr>
<tr>
<td>Wrong/insufficient information provided or recorded</td>
<td>0.5%</td>
<td>$70,000</td>
<td>$70,000</td>
</tr>
<tr>
<td>Failure to notify patient/family/healthcare team of patient's condition</td>
<td>0.5%</td>
<td>$10,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Overall</td>
<td>30.0%</td>
<td>$15,120,548</td>
<td>$252,009</td>
</tr>
</tbody>
</table>

### Dangerous Means Risk

- Always keep important diagnoses in mind and document differential.
- Inform patients of concerning diagnoses in your differential and alert them to patterns of clinical progression that warrant return or immediate emergency department evaluation.
  - That Appendicitis Case
    - Abdominal pain - no young male with abdominal pain should go without a genital exam for testicular torsion or female assessed for ovarian torsion
    - How many intussception cases actually present with triad of symptoms – 15%
    - If thinking meningitis–should still treat with antibiotics and not wait while waiting for the CT scan
  - UTIs come with concomitant risk of bacteremia- 10-15% risk
- The greatest risk of liability is in poor history and exam skills
- Keep IMPORTANT DIAGNOSES in your DIFFERENTIAL
- INFORM patients of the concerning diagnoses in your differential

### Negligence and Standard of Care

- State law determines how negligence is defined
- Standard of Care is the “yardstick” for measuring malpractice
- Not the same as quality of care
- It is “ordinary care” or “acceptable practice”
  - Standards come from medical experts, medical literature, practice guidelines, policies and procedures, state and federal regulations
- Malpractice occurs when the standard of care is violated
- Practice must meet a reasonable, prudent standard of care

### Theories of Liability

- General Negligence Theory
- Four legal elements of malpractice
  - Duty of care owed to the patient
  - Breached the standard of care
  - Patient suffered an injury
  - Patient’s injury was caused by provider’s mistake
- Standard of care for NP should be that of a reasonable and prudent NP acting in like or similar circumstances
  - Similar locality rule
What is Malpractice?

- Negligence vs. malpractice
- Res ipsa loquitur
- Vicarious liability – Respondeat superior
- Corporate liability
- Unintentional tort - Negligence
- Intentional torts
  - Spoliation of evidence
  - Battery, assault, false imprisonment
  - Fraud
  - Concealment

- Other actions
  - Lack of informed consent
  - Negligent Infliction of Emotional Distress (NIED)
  - Wrongful death
  - Loss of consortium

Avoiding Malpractice

- Become familiar with the law, statutes, rules, regulations, standards, and practice guidelines that govern APN practice.
- Refer patients when required or care exceeds your capabilities or practice restrictions.
- Stay current and know your competence level and work to improve it.
- Be compassionate and professional.
- Become active in a state or national organization that promotes APN practice.

Most Common Lawsuits

- Failure to:
  - DIAGNOSE or “rule out”
  - “Top twelve” “missed” pediatric conditions: viral illness diagnosed as bacterial illness, medication side effects, psychiatric disorders, appendicitis, otitis media, intussusception, developmental dysplasia of the hip, pneumonia, meningitis, testicular torsion, bronchiolitis, fracture
  - follow up
  - “own it”
  - To inform and advise
- Violations of standard of care
- Communication breakdowns between medical personnel
- Failure to fully inform and advise patients
- Patient “fell through the cracks”
- Putting profit before people

Who Sues NPs and Why

- Develop good relations with your patients
- 3 categories of malpractice actions
  - Patient’s unhappiness with his/her underlying disease
  - Lack of communication between the patient and healthcare professional
  - Procedure related
- Situational categories
  - Accountability
  - Explanation
  - Standard of care
  - Compensation

Know Red Flag Complaints and Conditions

- Red Flags that Signal Serious Illness in Children
  - Parental concern and PNP impression that illness is serious
  - Infection: meningial irritation, petechial rash, seizures, unconsciousness
  - Respiratory/circulatory: cyanosis, SOB, tachypnea, poor perfusion
- Developmental Red Flags
  - Birth to 3 months
  - 4-6 months
  - 6-12 months
  - 12-24 months
Know Risk Factors

- Infectious disease endemic to geographic area
- Age and gender specific risks
- Incorporate into plan
- Positives of history that predispose a patient for specific diseases
  - Hypovolemic shock

Rule Out the Worst Thing First

- **Document** process that led to diagnosis and treatment plan
  - Algorithm/system for rule-out process
  - WIT-D
    - WORST thing
    - Gather INFORMATION
    - TELL appropriate party
    - DOCUMENT
- Rule out appendicitis before viral gastroenteritis

Avoiding that Missed Appendicitis

- Monitor serially
- Exams
- Diagnostic testing
- Documenting
- Tell the patient/parent

Up to Date Problem Lists and Medication Lists

- Medication list up-to-date and in consistent place in medical record
- Problem list up-to-date in chart
- Visit problem list at every contact with patient

Revisit Unresolved Problems

- Seek timely consultation
- 2 steps for red-flag complaints
  - Scheduled follow-up
  - Check in with patient

Follow Diagnostic Tests and/or Referrals

- For diagnostic tests, procedures, or referrals, be able to answer “yes” to these questions:
  - Was it done?
  - Are results on record?
  - If abnormal, was the condition, symptom or finding followed up to a definitive diagnosis or rule-out?
- Diagnostic tests can be time bombs
- Disarming the time bombs
Audit for Mistakes or Omissions

- Why audit?
  - Note conforms to "documentation guidelines for evaluation and management for level of visits billed"
  - Note demonstrates standard of care has been met
  - Pertinent negatives
  - Referrals
  - Abnormal findings
  - Transcription of notes
  - Patient non-compliance

Prescribe Carefully

- Common prescribing errors
  - SCRIPT
    - Side effects
    - Contraindications
    - Right medication
    - Interactions
    - Precautions
    - Transmittal
    - Drug samples
  - Suicidal patients
  - Discontinue medications causing cautioned side effects
  - Patient consent
  - Deviating from package insert
  - Ask, listen, and alter plan as necessary
  - Rule out pregnancy
  - Ensure follow-up

Consistent Medical Opinions/Advice

- Unnecessarily establishing a duty to a patient
- If you chose to give advice, you need to go through the steps of the medical decision-making process
- Individual gets medical advice only if 5 conditions are met
  - Registered with practice
  - Reviewed hx, past med history, family hx, allergies, and meds
  - Documented results of hx/exam and documented
  - Follow-up planned and responsibility assigned

If They Don’t Need it, Don’t Offer it

- Take the minimalist approach and avoid:
  - Prescription errors
  - Side effects
  - Drug interactions
  - Compliance problems
  - Risk of an unknown pregnancy
  - Risk of an overdose

Documentation

- Documentation is the best defense but.....
- Document, document, document... correctly
  - Precisely and thoroughly
  - No "one-size-fits-all" notes
- Document timing of findings-this is crucial
- Reduce risk with documentation of:
  - Informed consent or informed refusal
  - Follow-up instructions
  - Following up with patient’s test results

Impact of EHR on Malpractice Claims

- Increased inaccuracy
- Safety and usability
- Adherence to workflow and compliance
- Inexperience data overload, and resistance
- Dependency on technology
- Not activating evidence based protocols
- Documented but not done
Liability and your EHR

- Inconsistency
  - EHRs can:
    - Increase patient safety
    - Improve outcomes
    - Provide legible and accurate records
    - Use CPOE, decision support, alerts, reminders, tracing
  - OR EHRs can:
    - Decrease patient safety and contribute poor outcomes
    - Create unrealistic expectations of patients, lawyers, and juries
    - Present new liability and litigation risks

Email

- Establish guidelines
  - Do not replace office visits
  - Not for use in emergencies
  - Established turn-around time
  - Types of transactions
  - Print and document in patient chart
- Patient consent

Apology Laws/Tort Reform

- Benefits of disclosure
  - Patient safety-systems improvement
  - Patients and families want to know
  - May be less likely to sue
  - Preserve trust and confidence
  - Reduce providers' anxiety and guilt
- Apologies and Hearsay
  - Federal Rules of Evidence 801(c), 802, 801 (d)(2)
  - "A statement other than one made by the witness while testifying, offered as evidence to prove the truth of the matter asserted"
  - "Hearsay" is inadmissible unless an exception to the hearsay rule applies
  - "Admission by party Opponent" exception is admissible

Apology Laws—What They Protect

- 37 states have apology laws protecting voluntary disclosures
  - 29 protect sympathy, regret, and condolence
  - 8 protect admissions of fault as well as sympathy
- "admission of fault" laws
  - "Any and all statements...expressing apology. Fault, sympathy...made by a health care provider...shall be inadmissible."

Malpractice Insurance

- Facility/employer provided
- Contract considerations
- Types of policies
  - Claims made
  - Occurrence
  - Extent of coverage
- Choosing a policy

Winning Defense Strategies

- Differential diagnosis is a process
- Medical treatment involves risk
- Patients and situations are unique
- What is known at the time
- It's more complicated than that
- Standard of care does not mean perfect care
- Confusing guidelines and standards
Conclusion

• The rules and systems discussed take time and attention.
• There is no immediate gratification. The rewards are invisible—measured only by the avoidance of adverse events.
• In clinical medicine, the parallel concept would be preventative care so apply some of these concepts to your everyday habits.
• The clinician who adopts systems to decrease potential litigation is being smart, not altruistic. These activities will not be a waste of time.

References


