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EXECUTIVE MESSAGE

Dear Policyholders,



When you choose MLMIC as your medical professional liability (MPL) insurer, you have accessed the most experienced malpractice legal defense system in New York State. However, as is the nature of insurance, and as we manage the tools to defend you, we work toward the goal that you never face a claim or lawsuit. Our commitment to providing applicable and actionable risk management services is born of decades of experience and data collected as the largest MPL insurer in New York State.

We are proud of our resources and service level, but *if a tree falls in the forest and no one accesses the webpage that discusses it, did the tree make a sound?* I overstate the issue. MLMIC.com has been well-accessed and well-used, but all things can be improved. Our ever-growing list of publications (including current and past issues of *The Scope*), CME courses, webinars, podcasts, case studies, legislative reports, and more, all offering practical guidance for safely providing care in today's litigious healthcare environment, can now be found on the newly designed MLMIC.com. In a nutshell, the goal of the redesign was to provide more streamlined access to this content as well as MPL insurance information for current and prospective policyholders. Did we succeed?

This issue of *The Scope* addresses the proliferation of the use of prescription weight loss drugs and provides a case study that covers diagnostic error, communication issues, and supervision requirements. While the first covers the ongoing evolution of pharmacology, anticipates liability traps, and offers tips in risk management, the second offers an opportunity to learn from history and the misfortune of others.

I hope that you find these articles helpful as you continue to provide the best of care to your patients, and please let me know what you think of our new website.

Warmest regards,

A handwritten signature in black ink, appearing to read "Tom Gray". The signature is fluid and cursive, written over a light gray rectangular background.

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Weight Loss Medication Trends — **Panaceas...or Pitfalls?**

Societal beauty standards put pressure on individuals to strive for a specific body shape. The influence of these standards has created a population vulnerable to the advertising of products that appear to promise the way to the ideal body shape. As celebrities and social media influencers go public with their use of Ozempic® and Wegovy® for weight loss, flocks of patients from this vulnerable population are running to their doctors asking for what appears to be a “quick fix” for their bodies.

The explosion in prescriptions of these drugs, along with post-marketing discovery of additional potential adverse reactions, has drawn a growing number of lawsuits. These lawsuits currently focus on manufacturers, but, as gatekeepers of these drugs, prescribers are also vulnerable to legal action. To mitigate the risk of being drawn into such lawsuits, providers must ensure that they engage in well-documented informed consent discussions with their patients and that their prescribing practices meet current standards of medical care. This means prescribing only for appropriate candidates and engaging in continuous management and monitoring of their patients' experience with these drugs.

These lawsuits currently focus on manufacturers, but, as gatekeepers of these drugs, prescribers are also vulnerable to legal action.

“Ask Your Doctor if this Medication is Right for You”

The catchphrase at the end of most drug advertisements — “Ask your doctor if this medication is right for you” — essentially shifts the onus for any injury arising from the drug to the “doctor.” This shifting of liability is consistent with legal precedent, particularly in states like New York that define prescribers as the “learned intermediary.” After manufacturers meet their obligation to conduct comprehensive testing and provide accurate information on potential adverse reactions, prescribers have a legal responsibility to accurately assess each patient's personalized risk of experiencing those reactions.

The media hype surrounding Ozempic® and Wegovy® suggests that these drugs are indicated as a “quick fix” for weight loss in any patient population. Providers need to educate patients that this is not true. Wegovy® is indicated for use as part of a more comprehensive long-term treatment plan for obesity¹, and Ozempic® is indicated only

as a treatment for type 2 diabetes.² Providers have a legal obligation to educate patients on the regulated indications for these drugs and to perform a thorough review of each patient's unique health history before deciding whether the drug is clinically indicated for the individual patient. While prescribing for nonapproved indications (prescribing off-label) is common, failing to ensure that a patient is an appropriate candidate for the drug as prescribed increases the risk of liability if the patient is injured.

Known Risks — A Moving Target

As with any treatment, providers must effectively communicate the risks, benefits, and alternatives of the drug before obtaining consent for treatment. Failure to obtain high-quality informed consent can give rise to legal action. Celebrities touting the success of these drugs do not necessarily disclose side effects. It is up to providers to educate their patients about all risks and potential side effects of these medications and discuss alternatives as well.

Of course, providers must inform patients of known risks, but what is “known” can become the subject of debate. Some providers are questioning whether to continue prescribing these drugs in the wake of lawsuits alleging that the manufacturers failed to warn of serious side effects. Safety information included in the manufacturer's product insert may be the best evidence of known risks, but post-marketing studies and adverse event reporting may show a trend that is not reflected in the FDA-approved labeling.

Some providers are questioning whether to continue prescribing these drugs in the wake of lawsuits alleging that the manufacturers failed to warn of serious side effects.

1 Wegovy® [package insert]. U.S. Food and Drug Administration website: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/215256s011lbl.pdf. Revised March 2024. Accessed July 30, 2024.

2 Ozempic® [package insert]. U.S. Food and Drug Administration website: https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/209637s020s021lbl.pdf. December 2017.

The Ozempic® lawsuits, which focus on gastrointestinal conditions, demonstrate that "known risks" can be a moving target. The initial package insert for Ozempic® did not warn of some gastrointestinal conditions at issue in the lawsuits, but the label was subsequently changed following post-marketing reports and trials that correlated Ozempic® with issues such as stomach paralysis.³ In fact, there have been six safety-related Ozempic® labeling changes approved by the FDA since the product was approved for marketing.⁴ Wegovy® has had three such changes.⁵ These post-marketing, safety-related label changes highlight the importance of keeping up to date with the latest clinical prescribing information and monitoring the results of post-marketing studies and adverse event reports.

In fact, there have been six safety-related Ozempic® labeling changes approved by the FDA since the product was approved for marketing.⁴

Even if the correlation between an adverse event and use of the drug has not reached the level necessary to prompt a change to the drug label, providers who prescribe this medication should stay up to date on post-marketing research and adverse event reports and use their clinical judgment to determine whether enough evidence of correlation exists to warrant informing the patient of such risks or prescribing the drug at all. If a label change is relevant to a particular patient, it will be important to update the informed consent discussion and assess whether, based on the patient's individual history, the medication remains an appropriate clinical modality to treat the patient's condition.

Mitigating the Risks of Off-Label Use

Ozempic® and Wegovy® are both being prescribed

for weight loss, but only Wegovy® has FDA approval for such use, and even that approval has parameters. Off-label prescribing may be the standard of care for certain medications, but providers should be particularly diligent documenting patient interactions and clinical decision making when prescribing drugs for off-label use. Off-label prescribing — prescribing for a nonapproved indication, dosages outside an approved range, or for a different clinical population — is not per se evidence of a deviation from the standard of care, but this practice will highlight the issue of clinical judgment in any malpractice action.

FDA approval and the correlating prescribing guidelines may be used in a malpractice action as evidence of the standard of care. A provider who prescribes outside of those guidelines will need to establish that the rationale for off-label use was personal to the patient and backed by peer-reviewed data.

FDA approval and the correlating prescribing guidelines may be used in a malpractice action as evidence of the standard of care.

Disclosing risks during the informed consent discussion becomes more complicated when a drug is prescribed for off-label use. The media hype around Ozempic® suggests that the drug is FDA approved for weight loss. As a result, patients are asking their providers to prescribe Ozempic® for this indication. It may be prudent to inform the patient that Ozempic® is not FDA approved for weight loss but is commonly prescribed for that indication.

If a provider decides that Ozempic®, rather than a drug approved for weight loss, is right for the patient, the provider should explain to the patient the rationale for off-label use and why an FDA-approved medication was not selected. It will

³ Ozempic® [package insert]. U.S. Food and Drug Administration website: https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/2096371bl.pdf. December 2017.

⁴ Ozempic® [package insert]. U.S. Food and Drug Administration website: https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/2096371bl.pdf. December 2017.

⁵ Wegovy®. Safety-related Labeling Changes Approved by FDA Center for Drug Evaluation and Research (CDER). U.S. Food and Drug Administration website: <https://www.accessdata.fda.gov/scripts/cder/safetylabelingchanges/index.cfm?event=searchdetail.page&DrugNameID=2711>. Accessed July 30, 2024.

be particularly important for the prescriber to document the discussion in the patient's medical record, especially the patient's understanding of the provider's rationale for choosing the nonapproved drug over the approved drug. Documenting the well-reasoned choice and the patient's consent will go a long way in a legal action to proving that the patient understood the risks of the off-label use and knowingly decided to move forward.

Patient Management

All prescribers of Ozempic® and Wegovy® must be in the position to continuously monitor the patient's overall health to ensure the drugs are working safely and effectively for the patient's condition. Because these drugs are intended for indefinite use, the patient-provider relationship will need to continue beyond the initial prescribing phase. Failure to properly monitor and manage a patient's use of these drugs can result in delayed diagnosis of an adverse event, leading to allegations of malpractice.

Physicians from a number of specialties, such as psychiatry and plastic surgery, are prescribing Ozempic® and Wegovy® for weight loss. While

these physicians have prescribing authority, the indications for these drugs may not be within their general scope of practice. The prescribing provider should be in a position to monitor long-term changes in a patient's overall health and adjust the treatment plan, including the use of the prescribed drug, if necessary. Although patients may not want the "burden" of ongoing and regular medical management, the necessity for such management should be part of the informed consent discussion. Providers should discontinue prescribing either of these drugs for any patient who fails to adhere to the treatment plan, including regularly scheduled appointments. Providers who do not regularly treat obesity but believe Ozempic® or Wegovy® may benefit a patient should consider referring the patient to the appropriate specialty.

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Conclusion

Many patients are eager to experience the weight-loss success from Ozempic® and Wegovy® plugged by celebrities and social media influencers. However, these drugs are not clinically appropriate for weight loss in all populations. It is up to providers to educate their patients that these drugs are not a beauty treatment. Providers must ensure that Ozempic® and Wegovy® are prescribed only for appropriate candidates as part of a more comprehensive continuous and monitored treatment plan. Fulfilling this duty will support not only patient safety but also a strong defense to any claim that a provider's prescribing practices deviated from standard of care and contributed to a patient's injury.



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CASE STUDY:

Medical and Legal Expertise Fail to Prevent Excessive Verdict



Initial Treatment

A 43-year-old, married father of three and soldier in the U.S. Army presented to the emergency room (ER) of a MLMIC-insured hospital with complaints of muscle pain in his right calf, problems with ambulation, and tingling, swelling, and bruising of the toes. He was initially triaged by the nursing staff. A history of injury to his foot during barefoot combat training two weeks prior was noted. He had seen his primary medical physician one week prior and was prescribed Motrin and physical therapy, which he did not undertake.

At the ER, the patient was seen by a MLMIC-insured physician assistant (PA), who was supervised by a MLMIC-insured ER physician. An ultrasound was negative for deep vein thrombosis (DVT), and circulation, motion, and sensation appeared to be intact. The patient next underwent an X-ray of the right foot, the results of which were

negative for fracture or dislocation. The patient was subsequently diagnosed with tendonitis of the foot, prescribed ibuprofen, and was advised to ice the area and follow up with an orthopedist and podiatrist, for which referrals were provided. He was discharged home on crutches.

The patient next underwent an X-ray of the right foot, the results of which were negative for fracture or dislocation.

Three weeks later, the patient presented to another hospital with complaints of severe pain in his right fourth toe with discoloration of the toes that had begun three weeks prior. He had been seen at his Army clinic, where a dermatologist performed a biopsy of the fourth toe to rule out vasculitis. The patient returned one week later for suture removal and was referred to a vascular surgeon. However,

he did not wait to be seen and proceeded to the hospital, where he underwent a venous ultrasound that revealed a non-occlusive DVT within the right popliteal vein. The patient also underwent an arterial ultrasound that revealed a right popliteal artery occlusion. A further right lower extremity angiogram found the distal superficial femoral artery (SFA) and the popliteal artery to be completely occluded. As a result, thrombolysis was begun. After two days, it was apparent that there were no changes from the previous angiograms.

The patient was subsequently seen by a vascular surgeon. Catheters could not pass into the popliteal vessel, and a decision was made to attempt a bypass revascularization for limb salvage; however, the bypass would not remain patent. After the procedure, the patient became hypoxic and was brought to the ICU and noted to have heterozygous mutation in Factor V Leiden, a blood clotting disorder, as well as heparin-induced thrombocytopenia (HIT).

The following day, the patient's right foot was cold and mottled, and two days later, his calf was noted to be cold and the right foot non-viable. The next day, he underwent exploration of the right calf, where it was found that the muscles were dead. An above-the-knee amputation was performed.

The next day, he underwent exploration of the right calf, where it was found that the muscles were dead.

Post-op, the patient was seen by the vascular surgeon with complaints of phantom pain, but his condition had improved. He was referred for rehabilitation with the use of an above-the-knee prosthetic. Subsequently, the patient was seen by a gastroenterologist due to elevated liver enzymes, which were attributed to the muscle injury. In addition, he underwent platelet treatment and was prescribed Coumadin.

The Lawsuit

The patient brought a lawsuit against the MLMIC-insured PA and ER physician, their professional entity, and the hospital. The plaintiff alleged that our insureds failed to diagnose a right lower extremity ischemic occlusion, which resulted in the above-the-knee amputation of his right lower leg.

The plaintiff alleged that our insureds failed to diagnose a right lower extremity ischemic occlusion, which resulted in the above-the-knee amputation of his right lower leg.

In addition, the patient claimed he was active prior to the incident and did household chores as well as outside activities. He testified that, subsequent to this incident, he could no longer perform chores or mow the lawn and claimed he could not drive (though he was never advised that he could not do so). Further, the patient claimed memory issues that prevented him from handling the household finances.

Expert Review

The case was reviewed by specialists in nursing, emergency medicine, vascular surgery, radiology, and hematology, and a decision was made to proceed to trial. The reviewers found that there were benign radiological findings with no DVT or fractures and that the patient was discharged with appropriate instructions. The patient likely had partial arterial occlusion of the right lower extremity when he presented to the hospital. Despite collateral flow that made the diagnosis difficult, the tests, films, and follow-up care were appropriate.

Although the PA and ER physician failed to document the pulses when the patient was initially seen in the ER, those pulses were present on subsequent examination. In addition, the patient was seen in the orthopedic clinic and by a dermatologist, but neither diagnosed lower extremity ischemia.

A venous ultrasound ruled out a DVT, and diagnosis of the occlusion that led to the amputation was performed after this ultrasound. MLMIC's vascular surgery expert found no deviations from the standard of care and believed the patient had a partial occlusion of the popliteal artery due to trauma and was dissecting when the patient was first seen in the ER. However, the patient showed no symptoms of arterial occlusion, thus, no additional studies were ordered. The imaging was interpreted correctly.

The only weakness of the patient's care was the failure to obtain an arterial Doppler study during the first ER visit to rule out arterial injury. However, the radiology expert advised that he would not order an arterial ultrasound in the wake of a negative venous ultrasound that showed the vessels to be patent. It was likely the occlusion was not present when the patient was initially seen in the hospital and, as such, would not have been detected had an arterial ultrasound been ordered. The hematology expert opined that the vascular injury and the Factor V Leiden deficiency and HIT likely contributed to the failure of the bypass.

It was likely the occlusion was not present when the patient was initially seen in the hospital and, as such, would not have been detected had an arterial ultrasound been ordered.

The Trial

This matter proceeded to trial under COVID restrictions, where masks were required in the Supreme Court. As such, it was difficult for counsel to "read" any expressions or reactions by the jurors during the trial. It was up to the plaintiff's counsel to prove the claim that the patient had a traumatic popliteal dissection or occlusion when initially seen in the hospital.

The plaintiff's counsel presented a video of our insured PA, depicting a contentious deposition during which the plaintiff's counsel attacked

his character. The defense counsel countered this testimony by stating that the witness was comfortable in the ER, not the courtroom.

The plaintiff's counsel then presented an Emergency Medicine expert. While this physician argued that arterial occlusion should have been a consideration and it was a departure from the standard of care to not order an ultrasound or CT angiogram when there was a negative venous ultrasound, he conceded that pulses were present later and, thus, would have been present during the earlier ER visit.

He was shown the reports of the ultrasounds and angiograms performed on the patient, none of which showed dissection.

The plaintiff's counsel also called a vascular surgeon, who testified that the plaintiff had a popliteal artery dissection that would have been diagnosed with an arterial ultrasound or CT angiogram and concluded that the failure to do so resulted in the loss of the limb. However, he conceded that he would not be called to see a patient in the ER unless a vascular issue was identified. He was shown the reports of the ultrasounds and angiograms performed on the patient, none of which showed dissection.

The plaintiff's counsel then produced a video of the prosthetist, who discussed the patient's prosthetic needs, and a pain management specialist, who discussed the patient's complaints of pain in his hand and shoulders from wheeling his chair and pain in his hips, foot, and back due to the difference in his gait with the prosthetic. A psychologist also discussed the patient's post-traumatic stress disorder due to combat, though it was suggested that it was actually from the amputation. A Vocational Rehabilitation expert and Life Care Planner also testified as to the plaintiff's damages.

The plaintiff and his wife were the last to testify, and they described their lives before and after the amputation. This testimony was emotional and had no mention of the medical care provided.

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TIP

Patient Safety and Medication Management

Prescription Medications and Patient Safety

The Risk

Medication errors result in a significant portion of medical liability claims. Patient harm can result from known risks, adverse or allergic reactions, drug interactions, and errors in prescribing. Careful attention to detail in prescribing and monitoring the use of medications promotes patient health and safety.

Recommendations

1. Physicians must discuss the indications, risks, benefits, and alternatives of prescription medication with their patients and document these discussions in the medical record.
2. The patient's allergy history should be reviewed prior to prescribing.
3. Allergies/sensitivities should be documented in a highly visible and pertinent part of the record.
4. Medication reconciliation should be performed on a routine basis, including the use of herbal supplements and over-the-counter drugs. Patients should be encouraged to bring a list of medications or actual prescription bottles to their visit(s) to facilitate this process.
5. Written consent should be obtained for high-risk medications such as allergy shots, joint injections, fertility medications, chemotherapy, etc.
6. The blood levels/side effects of certain medications should be monitored with laboratory and/or diagnostic tests as indicated. Test results should be reviewed and adjustments made as necessary.
7. Discontinuance of or a change in medication(s) should be documented in the medical record, including the rationale for the change.
8. Patient visit intervals should be established for the continuance of prescription medications.

Medical and Legal Expertise Fail to Prevent Excessive Verdict (continued)

At the conclusion of the plaintiff's case, requests by the defense to dismiss the case were denied by the judge.

The defense counsel first produced MLMIC's radiology expert, who testified that there was no occlusion or dissection of the artery when the patient was seen in the ER, which was supported by the images, and said that the occlusion occurred weeks later as the pulses were still palpable. It appeared that the jury listened intently to this witness' testimony but appeared disinterested during the plaintiff's cross-examination of the witness.

The emergency medicine physician was next to testify and described what occurred when the patient first presented to the ER, her review of the PA's treatment, and the conclusion that the care was appropriate. She supported the PA, describing his care for his patients.

It appeared that the jury listened intently to this witness' testimony but appeared disinterested during the plaintiff's cross-examination of the witness.

MLMIC then produced a vascular surgery expert, who testified that popliteal dissection is rare and usually the result of a traumatic knee injury. He disputed that there was a dissection and opined the occlusion occurred some three weeks after the patient's initial visit to the hospital.

The last witness was the ER expert, who supported his opinions using entries from the patient's medical record and the six "p's" of arterial occlusion — pain, paralysis, paresthesia, pulselessness, poikilothermia, and pallor. He agreed that an arterial ultrasound was not indicated and that a DVT ultrasound was appropriate, as DVT was suspected due to the patient's complaints of calf pain. The expert felt that the diagnosis of tendonitis was reasonable, as traumatic popliteal dissection is rare.

At the close of the defendants' case, motions to dismiss were made, and the Court reserved decision.

Summations

Summations ensued. The defense counsel suggested that no proof was offered that earlier action may have salvaged the patient's leg and that sympathy should not sway the jurors, as they are required to follow the law.

In contrast, the plaintiff's emotional summation suggested that the jury award "one to two million for past pain and suffering" and "several times that" for future pain and suffering. The jury then received the case.

The Verdict

During deliberations, the jury requested information provided by the Life Care Planner and the Economist, in addition to a calculator. At that point, a decision was made to discuss the case with the defendants, and consents to settle the case were secured. However, the plaintiff's counsel refused to engage in settlement discussions, and the jury subsequently returned an excessive verdict in favor of the plaintiff. They found negligence on the part of our insureds and suggested that this was a substantial factor in causing the plaintiff's injuries.

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The MLMIC-insured ER physician was found 20% liable and the PA 80% liable. Prior to trial, it had been stipulated that the professional entity and the hospital would be vicariously liable under Mdua in order to avoid separate questions posed to the jury against these defendants.

Post Verdict

Post-trial motions ensued, with the court denying most except the motion to set aside the award for future pain and suffering as excessive and ordering a new trial on that issue. However, a settlement was

eventually reached with the plaintiff, avoiding an appeal of the verdict.

A Legal and Risk Management Analysis

Here, although the case was deemed defensible, sympathy for the plaintiff prevailed, and an excessive verdict was rendered against the insureds. The ER physician never treated the patient but was responsible for supervising the PA.

PAs provide a number of benefits to the facilities that employ them: they allow such practices to service more patients by performing many of the same functions as a physician; they free up the time of physicians to treat conditions that may be beyond the capabilities and qualifications of PAs; and they can increase patient satisfaction by allowing more time to be spent with patients and by seeing them more quickly. Due to these advantages, the use of PAs has grown tremendously, but it is important for physicians to understand the malpractice risk: when a PA is sued, the licensed physician will most likely be named for a claim of negligent supervision.

This licensed physician is medically responsible for the medical services performed by the PA¹, as well as the overall care of the patient.

A PA is a dependent practitioner who must work under the direct supervision of a licensed physician. This licensed physician is medically responsible for the medical services performed by the PA,¹ as well as the overall care of the patient. A PA may perform any service that is within the expertise of the supervising physician. They are not registered in a particular specialty and may perform any function assigned to them, in any healthcare setting, that is appropriate to the education, training, and experience of the registered PA and within the ordinary practice of the supervising physician.²

Vicarious liability is defined as imputed liability that holds a person responsible for the actions or liability of others, such as employees.³ Therefore, employers are responsible for the actions of their PAs if the PA causes harm or injury through negligence while in the scope of their employment. Under this legal theory, employers do not have to be present or even aware of the patient encounter.

As proven in this case, both the PA and the supervising physician can be held liable for a patient's injuries. If the supervising physician approves the PA's conduct, as the ER physician testified to in this case, and the PA breaches the duty of care they owe the patient, then the physician may be held directly liable for the negligent actions without ever seeing the patient themselves. Further, in this matter, the professional entity and the hospital stipulated that they were vicariously liable under *Mduba*. In *Mduba*, the court held that a hospital could be vicariously liable for the negligence of an ER doctor, even if they were an independent contractor, since "the decedent entered the hospital for hospital treatment," the hospital held itself out as a provider of hospital services, and patients were entitled to assume that the doctors who treated them were doing so on behalf of the hospital.⁴

If the supervising physician approves the PA's conduct, as the ER physician testified to in this case, and the PA breaches the duty of care they owe the patient, then the physician may be held directly liable for the negligent actions without ever seeing the patient themselves.

Since the use of PAs is becoming so commonplace, it is important to be aware of effective ways to

1 10 NYCRR §94.2(f)

2 NYS Public Health Law §3703, Education Law §6542, 10 NYCRR §94.2(b)

3 *Black's Law Dictionary 11th Edition*, 2019

4 *Mduba v. Benedictine Hosp.*, 52 AD2d 450, 384 N.Y.S.2d 527 [3rd Dept. 1976]

minimize a supervising physician's risk of liability. Such measures include:

1. Every practice or hospital employing PAs should have comprehensive protocols and policies that outline which conditions PAs may address independently and which require consultation with a supervising physician.
2. Protocols and policies should be discussed with PAs to confirm that they understand and will comply with them. Both supervising physicians and PAs should sign a document to confirm their understanding of, and agreement with, the terms of employment, including compliance with all policies and protocols.
3. Supervising physicians must be readily available and approachable. PAs should always have reliable contact information for supervising physicians. Additionally, PAs should never be afraid to approach supervising physicians with questions and/or concerns, no matter how trivial they may seem.
4. Meetings should be regularly scheduled between supervising physicians and PAs to discuss cases and how they were managed.
5. Supervising physicians should regularly check the work habits of PAs.
6. Supervising physicians should perform and document periodic evaluations of all PAs.

7. PAs must document in the patient's medical record any recommendations made by supervising physicians after any consultation.
8. All continuing education activities should be attended by both PAs and supervising physicians.
9. Physicians need to be diligent in hiring, training, and supervising PAs. PAs must have the education, training, and certification required by law, and physicians should verify these from a primary source. A criminal background check should also be performed, and all references checked.

As discussed, while a PA can be beneficial to your practice, physicians need to cautiously decide what the practice needs, how the PA will be used and supervised, and how much autonomy the PA will have within the practice/facility. These decisions will affect patient experience and malpractice risk.



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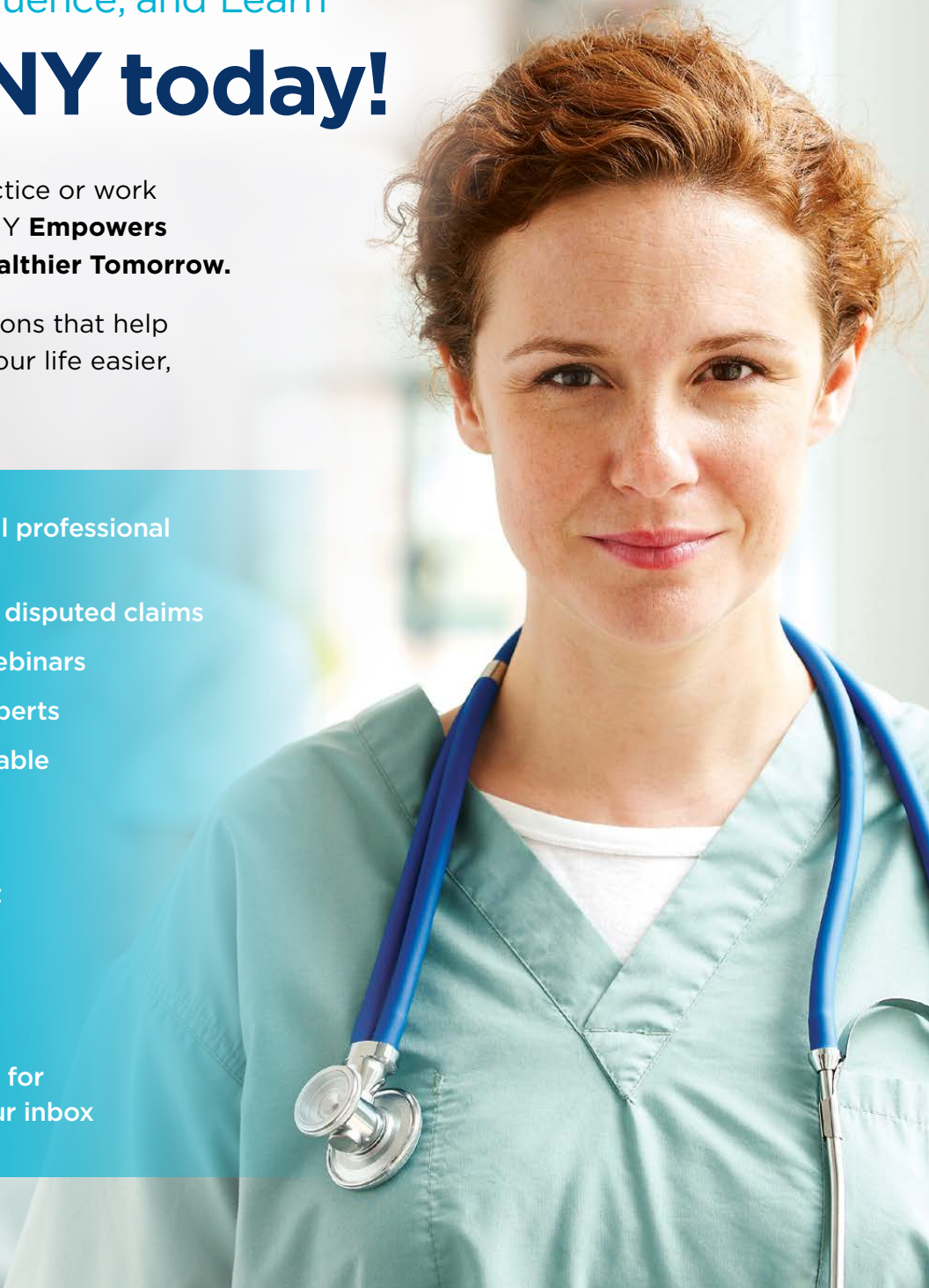
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