

# THE SCOPE

**MEDICAL EDITION**

**ISSUE 20**

FIRST QUARTER 2025

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## EXECUTIVE MESSAGE

# Dear Policyholders,



Thanks for picking up our first *The Scope — Medical Edition* of 2025! While this might seem a bit dramatic, know that 2025 marks MLMIC Insurance Company's 50th year of providing medical professional liability (MPL) insurance coverage in New York State. Born of a national crisis in MPL insurance cost and availability, MLMIC has been the steady partner with healthcare organizations and providers in a state where stability and experience are requirements for success.

This said, MLMIC's stability has little effect on the continuing change in the delivery of healthcare. Physician shortages have impacted access to care by making it more difficult to find a primary care physician or see a specialist, and wait times and crowds in ERs have increased. The healthcare industry is reacting, in part, by enlarging the roles of physician assistants and nurse practitioners. As with every change in healthcare, there are ripple effects. From our perspective, how will these changes impact quality of care? Will there be a measurable change in treatment outcomes? And, most importantly, how can we work with our policyholders to mitigate any risks associated with these changes?

MLMIC's depth of experience and close relationship with our insureds allows us to anticipate changing risks while we monitor the data provided by case development. This edition's feature article and case study illustrate this point well. As we offer information and recommendations to deal with change, our "Tips" and "Open Bar" offer practical advice related to common issues that you may encounter.

Have you come across any new healthcare setting practices, trends, or patient concerns that you feel MLMIC should address? Please reach out to me at any time, and we'll make sure that your peers are alerted and provided with the best direction and advice possible.

Warmest regards,

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

**Tom Gray, Esq.**

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# Leveraging Opportunities: The Expanding Roles of Nurse Practitioners and Physician Assistants



While the number of physicians licensed in the United States has grown over 20% since 2010 to over 1 million,<sup>1</sup> our rapidly aging population has demand for their care outpacing supply. **The AAMC projects a possible shortage of over 85,000 physicians by 2036.<sup>2</sup>**

To address this, academic medical centers, health systems, and office practices are now using the skills and training of physician assistants (PAs) and nurse practitioners (NPs)\* to help boost revenue and productivity, allowing physicians to focus their efforts on managing the care of those patients with more complex diagnoses. It is projected that two-thirds of the healthcare providers joining the U.S. workforce by 2030 will be NPs or PAs,<sup>3</sup> and NPs and PAs now provide primary care to more patients than physicians do, especially in rural areas.

## Incorporating NPs and PAs Into Your Practice

An obvious benefit of having these qualified professionals as part of a healthcare team is that they may be integrated more quickly than physicians. While NPs and PAs are not meant to replace physicians but to enhance and optimize workflow through “top of the license” initiatives, the quality of care and patient satisfaction ratings of these providers for routine patient presentations have been shown to be comparable to physicians (AJMC, 2019).

Having physicians focus on patients who present with more complex diagnoses allows NPs and PAs to see those patients who are more “time consuming” to treat, including those who require:

- Additional education.
- Coaching on lifestyle changes.
- Preoperative/discharge visits.

## New State Regulation for Physician Assistants

In November 2024, significant legislation was signed into law that will change the way PAs practice and will improve access to care for New Yorkers. The law came into effect on February 22, 2025.

Notably, under this new law, a physician in private practice may now supervise or employ up to six PAs (an increase from four) and a physician in practice for the Department of Corrections may supervise or employ up to eight PAs. The law also states that hospitals may employ an unlimited number of PAs, provided they work under the supervision of a hospital physician and within the physician’s scope of practice (a change from the prior limit of six PAs per one physician).<sup>4</sup>

This new law also expands PAs’ role to prescribe non-patient-specific regimens (which may be administered by a registered nurse), to write inpatient orders for durable medical equipment, and to supervise radiologic technologists administering contrast media.<sup>5</sup>

## Professional Liability Claims Data

Allegations from direct patient care, as well as supervision issues, have led to an increase in medical malpractice litigation in New York State. The nationwide data, however, indicates that:

- There is not an increase in the proportion of medical professional liability (MPL) claims involving PAs or NPs.

\* **Editor’s note: While PAs and NPs receive different and specialized education, training, and licensing, they can and do serve in similar roles and settings, including primary care.**

1 Federation of State Medical Boards (2023, July 20). *FSMB Physician Census Identifies 1,044,734 Licensed Physicians in U.S.* <https://www.fsmb.org/advocacy/news-releases/fsmb-physician-census-identifies--1044734-licensed-physicians-in-u.s/>

2 Association of American Medical Colleges (2024, March). *The Complexities of Physician Supply and Demand: Projections From 2021 to 2036.* <https://www.aamc.org/media/75236/download?attachment>

3 Davies, M (2022, August 22). *Amid a Physician Shortage, 51% of Primary Care Providers Are Nurse Practitioners and Physician Assistants.* Value Penguin. <https://www.valuepenguin.com/primary-care-providers-study>

4 Chapter 520 of the NY Laws of 2024.

5 Chapter 520 of the NY Laws of 2024; Chapter 476 of the NY Laws of 2024.



- PAs and NPs are associated with one or more contributing factors in approximately 8% of all medical professional liability claims, and they are named as defendants in 2%.
- The percentage of MPL cases involving a physician defendant dropped by 38% from 2012 to 2021.
- The average indemnity payment is less for cases with only a PA or NP involved, compared to cases with just a physician defendant.<sup>6</sup>
- MLMIC/MedPro data from 2012-2021 shows the percentage of cases with NPs or PAs in primary service roles involve a consistently high clinical severity outcome. As the number of PAs and NPs is growing — and these providers are likely taking on more complex cases — the average cost to resolve such high-severity cases is increasing rapidly. However, consideration of the high costs to resolve these cases must also be given to social inflation effects and plaintiff attorneys being selective with the cases they are taking. Big monetary relief cases, or “nuclear verdicts,” may be attributing to the higher indemnity payments reflected in the data.

It is also worth noting that removal of physician supervision restrictions on experienced NPs has

reduced physicians' liability to some extent. A 2017 study found that enacting less-restrictive scope-of-practice laws for NPs decreased the number of payments made by physicians in NP cases by as much as 31%.<sup>7</sup>

### Liability Considerations for Physicians

Physicians working with PAs and NPs — whether in hospital, residential, outpatient, or other settings — should be aware of the additional liability risks they may pose.

When patients treated by a PA or NP experience an untoward outcome, the plaintiff will often include the supervising physician in a suit, even if that physician never saw the patient.

- A physician may be liable for the negligence of a PA or NP they employ if there was a failure in the screening and hiring process, such as failing to verify qualifications or experience.
- A physician responsible for supervising a PA or in a collaborative relationship with a less experienced NP (<3,600 hours) may be liable for the negligence of the PA or NP for failure to supervise or follow the terms of a written practice agreement.

6 Tremont, H (2023, December 18). *A Sea Change in U.S. Care Delivery*. CRICO. <https://www.rmfi.harvard.edu/News-and-Blog/Newsletter-Home/News/2023/SPS-December-2023-Sea-Change>

7 McMichael BJ, Safriet BJ, Buerhaus PI (2018, June). The Extraregulatory Effect of Nurse Practitioner Scope-of-Practice Laws on Physician Malpractice Rates. *Medical Care Research and Review*, 75(5), 312-326. doi: 10.1177/1077558716686889.

- Based on the concept of vicarious liability, or “respondeat superior” (translating to “let the master answer”),<sup>8</sup> a physician who supervises or employs a PA or NP can be held liable for their negligent acts or omissions performed within the scope of their employment.<sup>9</sup> In other words, if an advanced practice provider, working under the supervision of a physician, is found to have negligently caused harm to a patient, the physician is also liable. This type of liability differs from the failure to supervise type mentioned above because there is no need to show any separate failure or negligence on the physician’s part.

In one case (full details [here](#)), a physician, PA, and NP were all treating the same patient at the same practice.<sup>10</sup> When the patient was diagnosed with prostate cancer, he sued the physician, not the NP who had treated the patient much more frequently and failed to follow up on an elevated PSA level. The patient alleged that it was the *physician* who failed to properly treat him, and that the physician failed to track the patient’s medical condition and failed to adequately supervise professional office staff, leading to the delayed diagnosis.

## Risk Management Strategies

While there are differences in how PAs or NPs practice at the top of their licenses, risk management strategies and best practices are similar.

Be sure to **address any administrative team-related vulnerabilities** when leveraging use of these professionals. It’s important to establish criteria for employment, as well as verifying education, training, and certifications in accordance with state laws. In addition, perform a criminal background check, verify references and credentialing, and check professional liability coverage. Ensure that any coverage purchased on behalf of these providers limits exposure to the physicians’ current practice

and distinguishes it from any additional jobs that they may have outside of the practice.

**It’s important to establish criteria for employment, as well as verifying education, training, and certifications in accordance with state laws.**

While a physician expected to supervise or collaborate with a PA or NP may or may not be directly involved in hiring decisions, it is important to **be aware of new professionals** and to promptly raise any concerns about the conduct of, or quality of care being provided by, a PA or NP. Additionally, providing orientation that is commensurate with the specialty/experience of the practitioner is crucial.

**Have a solid mentorship and onboarding program** to allow PAs and NPs to feel comfortable as part of the healthcare team. This is essential, especially since some NPs and PAs are fast-tracked through education programs without having significant clinical experience. NP programs are not standardized, and many students complete their coursework entirely online.<sup>11</sup>

**Put written protocols in place** that define each provider’s role, as well as their scope of practice. The protocols should address the main types of patients the PA and NP will see, identify patients that may need to periodically be seen by a physician, and specify the types of illnesses or conditions that should only be managed by a physician. In addition to establishing which provider should see which patient, it is also important to determine circumstances when the NP or PA should seek consultation with the supervising or collaborating physician, whether it be for a new or complex problem, a worsening condition, or a critical test result.

**Continued on page 16**

8 JUSTIA (2024, October). *Vicarious Liability in Personal Injury Lawsuits*. <https://www.justia.com/injury/negligence-theory/vicarious-liability-respondeat-superior/>

9 Paterick, TE (2024). What Is the Medical and Legal Risk of Physicians Supervising Advanced Practice Providers? *Healthcare Administration Leadership & Management Journal*, 2(4), 164-167

10 Richman D, Smeltz T (2024, February 10). *Case Study: Vicarious Liability Relating to Advanced Practice Providers*. MLMIC. <https://www.mlmic.com/blog/vicarious-liability-for-advanced-practice-providers/>

11 <https://www.beckershospitalreview.com/nursing/the-shortfalls-of-np-education-report.html>

## RISK MANAGEMENT TIP

Communication and the Physician–Patient Relationship

# Managing Patient Noncompliance

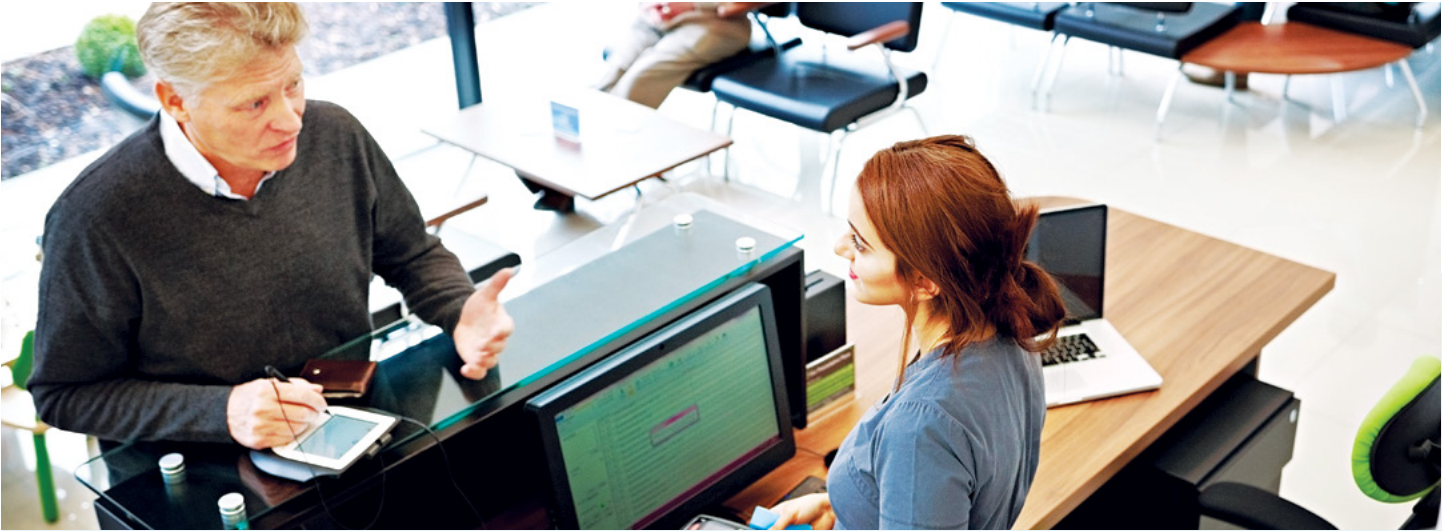
### The Risk

Patient noncompliance is one of the most difficult challenges for healthcare providers. Noncompliance may include missed appointments and failure to follow a plan of care, take medications as prescribed, or obtain recommended tests or consultations. The reasons given by patients for noncompliance vary but may include denial that there is a health problem, the cost of treatment, fear of the procedure or diagnosis, and not understanding the need for care. Physicians and other healthcare providers need to identify the reasons for noncompliance and document their efforts to resolve the underlying issues. Documentation of noncompliance helps protect providers in the event of an untoward outcome and allegations of negligence in treating the patient.

### Recommendations

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1. Establish an office policy to notify providers promptly of all missed and cancelled appointments. We recommend that this be done on a daily basis.
2. Formalize a process for follow-up with patients who have missed or cancelled appointments, tests, or procedures. This process should include recognition of the nature and severity of the patient's clinical condition to determine how vigorous follow-up should be.
  - Consider having the physician make a telephone call to the patient as a first step when the patient's condition is serious.
  - If the patient's clinical condition is stable or uncomplicated, staff should call the patient to ascertain the reason for the missed or cancelled appointment.
  - All attempts to contact the patient must be documented in the medical record.
  - If no response or compliance results, send a letter by certificate of mailing outlining the ramifications of continued noncompliance.
3. During patient visits, emphasize the importance of following the plan of care, taking medications as prescribed, and obtaining tests or consultations.
4. Seek the patient's input when establishing a plan of care and medication regimen. Socioeconomic factors may contribute to the patient's noncompliance.



5. To reinforce patient education, provide simple written instructions regarding the plan of care. Use the teach-back method to confirm that patients understand the information and instructions provided.
6. With the patient's permission, include family members when discussing the plan of care and subsequent patient education in order to reinforce the importance of compliance.
7. When there is continued noncompliance, patient discharge from the practice may be necessary. The attorneys of MLMIC's Legal Department are available to discuss patient noncompliance and the discharge of a patient.

MLMIC Risk Management Department • (518) 786-2815 • [RMC@mlmic.com](mailto:RMC@mlmic.com)



## AM Best Update

MLMIC Insurance Company is pleased to announce that **AM Best**, the preeminent credit rating agency for insurance companies, has again "affirmed MLMIC's Financial Strength Rating of A+ (Superior) and its Long-Term Issuer Credit Rating of "aa-" (Superior)."

Per AM Best, "these ratings reflect MLMIC's balance sheet strength, which AM Best assesses as strongest, as well as its adequate operating performance, limited business profile, and appropriate enterprise risk management."

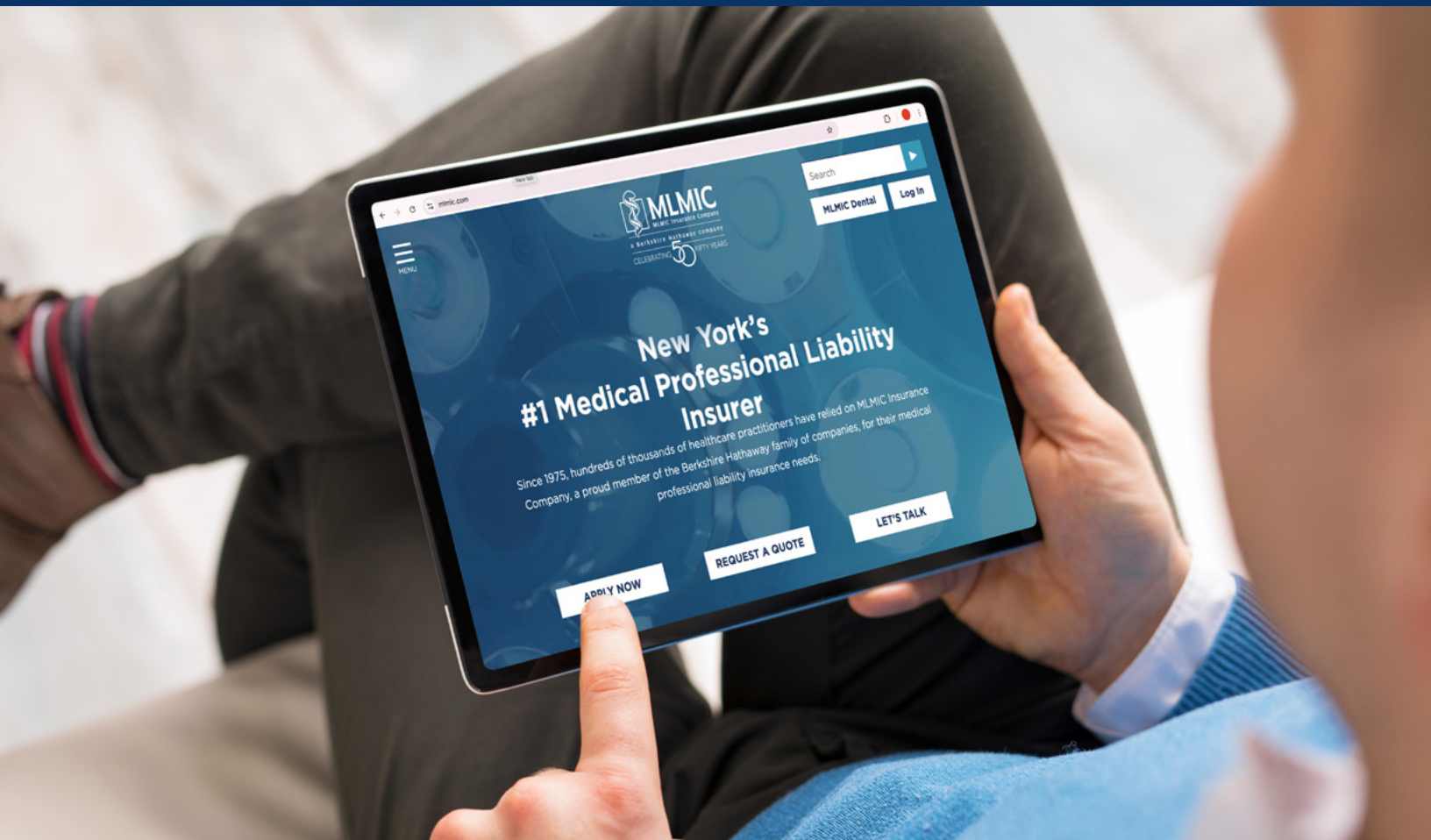
For more information: [AM Best Press Release](#) | [MLMIC Acknowledgement](#)





# Introducing MLMIC's New Website:

## A Hub for Policyholder Support and Resources



We're excited to announce the launch of our newly redesigned website! As New York's #1 medical professional liability carrier, and as we approach our 50th anniversary, we are even more dedicated to offering superior service to our policyholders.

This new site enhances the user experience and provides a streamlined, more intuitive way to access the critical resources you need. Whether you are a current insured or looking for coverage, our new site has you covered!



## Let's take a look at some of the features:

### User-Friendly Navigation

The redesigned [homepage](#) makes it easier to explore various sections of the website. Whether you're a physician, a group practice, or a hospital, the layout is tailored to guide you smoothly through our services. From coverage options to reporting claims, everything is just a click away!

### Does Your Coverage Put You at Risk?

Try our [physician liability estimator](#). Answer a few basic questions to determine if your current medical professional liability policy is giving you the coverage you need to minimize your risk exposure. You may be surprised!

### Request a Quote

Whether you're looking for medical malpractice insurance quotes for independent physician coverage or representing a large group or hospital, there are many factors to consider when calculating specific costs. Our new website simplifies requesting a [quote](#) either by completing an online form or speaking with a MLMIC representative. When you're ready to join the MLMIC family, check out our ["Apply Now"](#) page, which contains all our applications, as well as our policy administrator designation form.

### Preferred Savings Programs

Our expanded [Preferred Savings Programs](#) page allows users to explore various ways to lower their insurance premiums. MLMIC works with groups and organizations throughout the state to help qualifying New York physicians obtain medical professional liability insurance at a lower cost. Qualifying physicians can save up to 30% on their premiums!

We invite all our policyholders and new visitors to explore our revamped website and discover how MLMIC continues to innovate in providing the best insurance and risk management solutions to New York's healthcare community.

Visit the site today at [MLMIC.com](https://www.mlmic.com) to check out our exciting new features!

### Policyholder Portal

Every policyholder has a dedicated, [secure login](#) area where they can access policy information and renewal documents, take advantage of our CME+ educational programs, make a premium payment online, and download certificates of insurance. This all-in-one access point is designed for your convenience and efficiency. Everything you need is available 24/7!

### Risk Management Resources

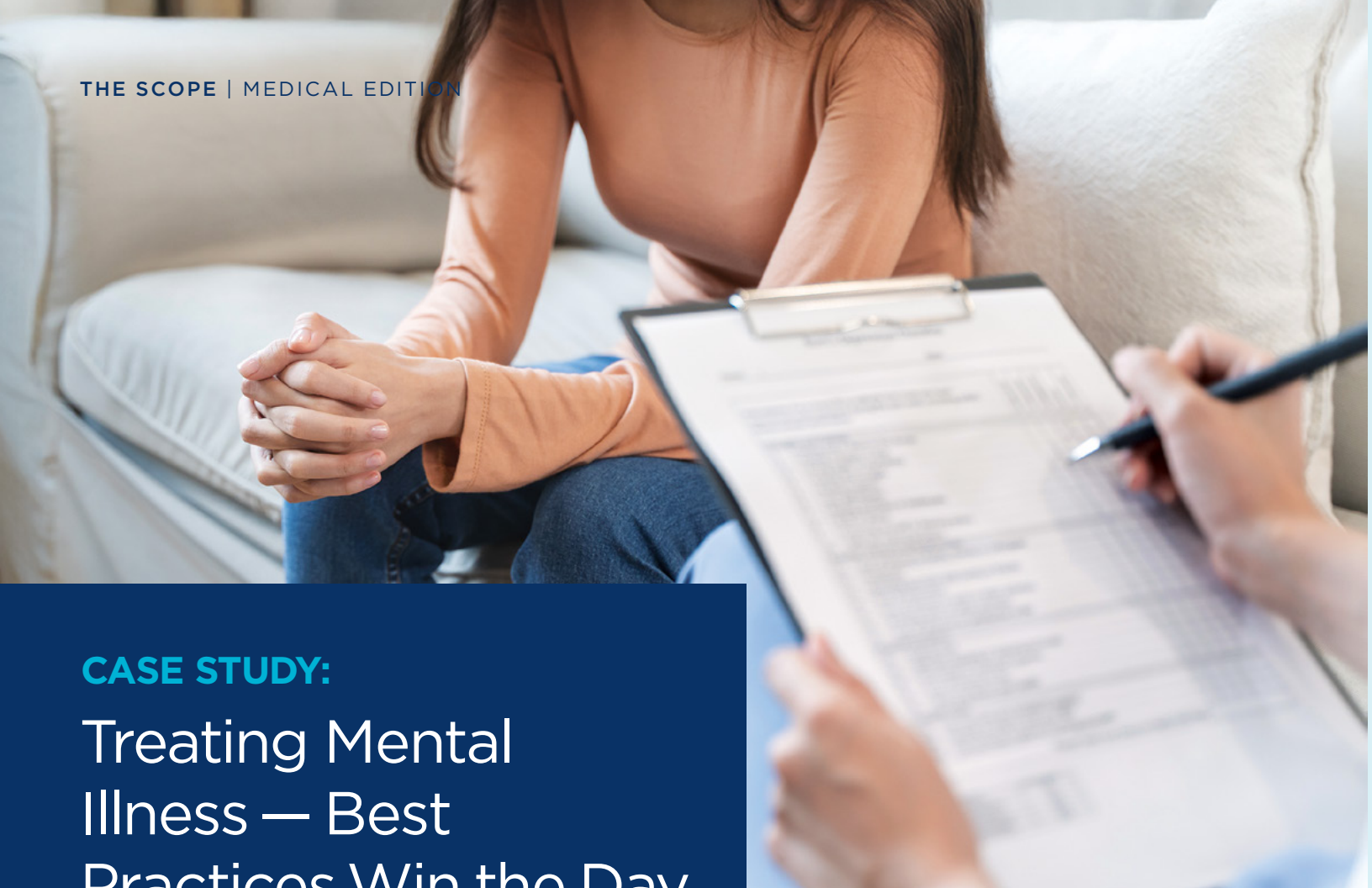
One standout feature is our expanded [risk management section](#). Policyholders can now access comprehensive resources, including CME educational programs, proactive risk management courses, and publications in one consolidated location. These tools are invaluable for healthcare practitioners in New York looking to stay informed about best practices and the latest developments in risk management. Learn more about our policyholder exclusives on this page as well, such as MLMIC's Analytics Reports and Consultative Services.

### Mobile Optimization

We know that many healthcare providers are constantly on the move. The new website is fully optimized for mobile devices, ensuring you can easily manage your account, access educational resources, and obtain support from any location.

### Enhanced Support Options

With updated support features, policyholders can quickly connect with MLMIC representatives via phone or email. We aim to deliver service like no other by personally assisting our insureds.



**CASE STUDY:**  
Treating Mental  
Illness — Best  
Practices Win the Day

The 25-year-old female patient in this case had a tumultuous family life, alternating between residing with her family and with other relatives. She suffered a mental breakdown at age 16, requiring admission to a psychiatric hospital, which was attributed to her social history. Thereafter, she was treated by a psychiatrist for bipolar disease.

While attending a university, the patient continued weekly treatments with counselors on campus. In her junior year, she was admitted to the hospital as she had not been taking her prescribed medications for several weeks. She was discharged and returned to campus but left school before the end of the semester due to severe stress. She continued to seek counseling and inpatient treatment at various hospitals and facilities and attended outpatient counseling sessions.

### **Hospital Admission**

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The patient was subsequently admitted to the emergency department (ED) of a MLMIC-insured hospital with suicidal ideation, having attempted to set papers on fire outside the counseling facility prior to a session. Police were called, and she informed them that she was suicidal, wanted to kill herself, and had a plan in place to do so. She was initially seen by a nurse practitioner, who noted that the patient presented with suicidal ideation. The

patient denied drug and alcohol abuse and raised no medical concerns.

**She was initially seen by a nurse practitioner, who noted that the patient presented with suicidal ideation.**

The patient was then seen by a social worker. The patient was noted to have a history of borderline personality disorder and reported that her case manager was not available that day, thus triggering her to act out and try to start a fire. She denied suicidal/homicidal ideation or intent to harm herself at that time and demonstrated no sign of psychosis. She was future oriented, with plans to see her therapist, attend a medical appointment, and keep an appointment with her psychiatrist the following week.

The patient was next evaluated by a psychiatrist, who noted her borderline personality disorder, anxiety, schizophrenia, depression, and multiple prior ED visits. She appeared to have a history of seeking shelter in the hospital when she was experiencing life challenges. The patient admitted that she wished to be hospitalized but denied being suicidal. She stated she had become upset when her case worker had left on vacation.

The patient was noted to be on medications, including several trials. Her physical exam was within normal limits, and she was diagnosed with borderline and dependent personality disorder. The patient was pleasant during her interview, and there were no signs of psychosis. The plan was to discharge her with follow-up at an outpatient clinic. Care was coordinated between the hospital and psychiatric counseling services for her to attend a counseling session upon discharge.

After discharge from the ED, the patient attempted to arrange for transportation without success. She contacted a family member, who advised that the patient was no longer welcome in their home. In addition, she attempted to contact some agencies for housing but could not get in contact with

anyone to assist her. At that point, the patient went to a wooded area, where she threw herself down an embankment. As a result, she suffered two broken legs, a spinal fracture, and a fractured pelvis.

The patient was brought via ambulance back to our insured hospital but was later transferred to another hospital, where she underwent multiple surgeries and remained during her rehabilitation. After four months, the patient was discharged to a psychiatric facility and later discharged to live independently.

### **Lawsuit Filed...and Verdict Reached**

The patient brought a lawsuit against the MLMIC-insured hospital and psychiatrist, along with the nurse practitioner and social worker. She claimed negligence in the failure of the hospital and their employees to admit her due to suicidal ideation. In addition, it was claimed that her discharge plan was deficient as the hospital failed to contact her family and ensure that she would be returned to a safe environment. The plaintiff's counsel made a demand of \$5 million.

**He felt that the post-discharge events where the patient felt rejected triggered the suicide attempt.**

MLMIC's psychiatric expert opined that the standard of care was met as the patient was not suicidal during her admission to the ED and concluded that the patient had a borderline personality disorder with heightened reactivity and impulsiveness. He felt that the post-discharge events where the patient felt rejected triggered the suicide attempt.

During her examination in the ED, the patient was found to be rational and future oriented, with intention to continue with future treatment, thus demonstrating that she was not suicidal. The standard of care for borderline personality disorder would have been to avoid inpatient hospitalization as these patients do not fare well in an institutional environment.



Prior to trial, the hospital, nurse practitioner, and social worker moved for summary judgment and were successfully dismissed from the lawsuit. When the case proceeded to trial against the psychiatrist, the plaintiff did not present as overly sympathetic but had significant, documented injuries.

### **The patient also exhibited a lack of impulse control, as her suicide attempts revealed.**

The plaintiff's expert testified to departures by the psychiatrist in his evaluation and assessment of the patient and his decision to discharge her. MLMIC's psychiatry expert testified that the standard of care was met in that our insured properly evaluated the patient, determined that the patient was not suicidal, and made an appropriate plan for discharge. The patient's attempt at suicide was sudden and unpredictable and emerged from a series of events that developed after her discharge.

At the conclusion of testimony, a decision was made to enter into a high/low agreement. The jury received the case and, after deliberations, returned a verdict in favor of the defense. However, as MLMIC had entered into a high/low agreement, we were required to pay the "low" of \$350,000.

### **A Risk Management and Legal Analysis**

Bipolar disorders are very difficult for physicians to treat. The patient in this case had all the symptoms of this condition, including emotional instability, a history of unstable relationships, and difficulty trying to maintain relationships. She also felt a lack of worth and was unable to regulate her emotions and maintain relationships due to her lack of emotional control. This was exemplified by her negative relationship with her family. The patient also exhibited a lack of impulse control, as her suicide attempts revealed. Her view of life was altered, as she felt that "everything in her life was bad." Unfortunately, due to this often-expressed belief, an

attempted suicide can be construed as an attention-seeking mechanism. However, interestingly, the patient was able to maintain herself for some time in college before her condition seemed to exacerbate.

People diagnosed with bipolar disorder tend to be unable to control their emotions and have mood swings. They often feel anxious and empty and without self-worth. The National Institute of Mental Health, part of the National Institutes of Health, confirms this by describing a person with this disorder as having an inability to control emotions, feelings of anxiety, and no feelings of self-worth. Relationships with other individuals are often perceived as all good or all bad. Therefore, since this patient had a distorted image of herself, she would be likely to engage in impulsive behavior, such as attempting suicide.

This patient visited the ED frequently and had attempted suicide several times. Her inability to sustain any type of relationship with her family eliminated the potential for obtaining key support. Therefore, to the professionals in the ED, her frequent mood swings and other behaviors fit the pattern of a typical bipolar patient. Although these patients can and do participate in some behavioral therapy, bipolar patients present treatment difficulties to providers as medications are not typically used unless the disorder is associated with depression, as with this patient.

## What Is a “High/Low” Agreement?

In the event of a malpractice suit, a “High/Low” is when MLMIC enters into an agreement with the plaintiff’s counsel prior to a verdict where both parties agree to accept a settlement amount within certain parameters, irrespective of the eventual verdict amount.

If a verdict were to be returned in favor of the defendant practitioner (a defense verdict), MLMIC would still pay the “Low.” If the verdict were returned in favor of the plaintiff (a plaintiff’s verdict), but the amount awarded was higher than the agreed upon “High,” we would only pay the “High” number. Any amount returned in favor of the plaintiff that is between the “High and Low” would be the award paid.

**Example:** MLMIC enters a “High/Low” agreement of \$50k/\$900k. If the plaintiff’s verdict is \$35k, MLMIC would pay \$50k. If the plaintiff’s verdict is \$1 million, MLMIC would pay \$900k. If the verdict is \$600k, MLMIC would pay \$600k.

**High/Low agreements protect policyholders’ personal assets** as MLMIC will only agree to a maximum settlement amount that is within the policyholder’s limits of coverage.

Contact [MLMIC](#) for more information.

From a legal perspective, the psychiatrist’s choice of treatment, proper examination of the patient, and documentation in the ED record were able to overcome the arguments of the plaintiff’s attorney, whose main allegation was that the patient was not properly evaluated. In addition, there was an allegation that this patient did not have the cognitive ability to care for herself and that the psychiatrist, as part of his examination, did not evaluate her for suicidal risk.

Documentation of his findings was key in successfully defending against the plaintiff’s claims, resulting in a verdict that was favorable to the defendant. The plaintiff’s argument was not supported by the documentation, which clearly indicated that the patient was told to return to the ED if she had a recurrence of suicidal ideation.

The patient, appropriately, was also given an appointment to be seen by a therapist and was cognitively evaluated as to

whether she was able to care for herself.

Documentation of risk is always necessary when dealing with a psychiatric patient. Finally, the patient was placed on Effexor, an antidepressant medication. This was also reasonable treatment given the symptoms the patient was experiencing. Despite all the appropriate handling of the patient’s condition, she attempted suicide after leaving the ED.

When a psychiatrist chooses a course of treatment within the range of medically acceptable choices, based upon a proper examination and evaluation, the doctrine of professional medical judgment insulates the psychiatrist from liability.<sup>1</sup>

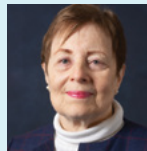
**As exemplified in this case, progress notes clearly reflected that the patient was both properly evaluated and treated for a suicide risk.**

Thorough documentation is always beneficial to defend against allegations in a medical malpractice lawsuit. As exemplified in this case, progress notes clearly reflected that the patient was both properly evaluated and treated for a suicide risk. The patient denied suicidal ideation, planning, or intent. The fact that she later attempted suicide does not necessarily change the defensibility of this case, since suicide attempts are often unpredictable.

It is very likely that the outcome of this litigation would not have been favorable to the defense if the documentation had not been thorough, reasonable, and appropriate. Psychiatric cases are difficult to evaluate in a busy ED, but in this case, because of good documentation of an appropriate examination, the defense was able to prevail.



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<sup>1</sup> Dumas v. Adirondack Med. Ctr., 89 A.D.3d 1184 (3d Dept. 2011). Durney v. Turk, 42 A.D.3d 335, 336 (1st Dept. 2007).

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**MLMIC's Open Bar** is a monthly FAQ covering trending issues in healthcare that are derived from questions received by the seasoned, New York-based healthcare attorneys of **MLMIC's Legal Hotline**.

**January 17, 2025**

## **Preparation in Advance of Retirement**

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Retirement may be looked at both with anticipation and, at times, sadness. Many professionals have practiced in their specialty for a long time and may be looking forward to making changes geographically and/or spending more time with family. Other times, retirement may be thrust upon you by illness or economic reasons.

Regardless of why you intend to retire, there are some important questions to consider.

1. Are you going to be selling your practice to another professional, or are you just closing your doors?
2. Do you have a partner or another licensed professional who is interested in continuing the practice and caring for your patients?

[CLICK HERE TO CONTINUE READING >](#)

**December 20, 2024**

## **How to Properly Discharge a Difficult Patient from Your Practice**

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Two of the most common questions we receive from providers and physician practices are:

1. Should we discharge a difficult or noncompliant patient?
2. How should we appropriately discharge the patient?

The most common reason for discharging a patient is that the patient is a difficult patient. In legal parlance, this is commonly referred to as a serious breakdown or disruption in the physician-patient relationship. It may arise from disruptive behavior on the telephone or in the office; rude, lewd, or abusive behavior directed at providers or staff; or conduct in the waiting room that is upsetting to other patients. If this type of conduct occurs, it should be documented, along with documentation of practice advice to the patient that this conduct will not be tolerated.

A similar but distinct reason for discharging a patient is noncompliance with your treatment recommendations or failing to keep scheduled appointments. This type of noncompliance should also be documented in the medical chart. These two types of patient misbehavior share the same result: They make it difficult or impossible for the provider to continue to see and effectively treat the patient in the office setting. As such, they often make patient discharge the most reasonable course of action.

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*Leveraging Opportunities: The Expanding Roles of Nurse Practitioners and Physician Assistants (continued)*

Supervising/collaborating physicians are required to **conduct periodic reviews** of a sample of records at a minimum of every 90 days for inexperienced NPs with less than 3,600 hours of experience. While not required under state law, consider the same process for PAs and independent NPs with whom you maintain an employment relationship, and maintain documentation of the reviews performed. Supervision involves more than just signing charts and should be a regular ongoing activity.

**Supervision involves more than just signing charts and should be a regular ongoing activity.**

Keep lines of communication open among providers to support a culture of safety, and take the time to schedule routine staff meetings, not only for problem identification and resolution but also as a way to foster ongoing education. As part of this ongoing education, consider having all physicians, PAs, and NPs partake in the same continuing education opportunities, and take the time to review the content of the education as a team. Promoting

interactive relationships further ensures that providers are working at the top of their license.

### Moving Forward

Overcoming the primary care shortage will likely involve coordinated, team-based efforts from physicians, PAs, and NPs. Communication and collaboration among these professionals will be essential to providing safe and effective healthcare in any practice environment. So, let the “Do No Harm” include “Don’t be afraid to ask questions.”



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