Learning from Medical Malpractice Claims Involving Pediatric Providers to Improve Practice
Karen Wilkinson, MN, ARNP, LNCC, CNLCP

Speaker Disclosure
Karen Wilkinson certifies that, to the best of her knowledge, no affiliation or relationship of a financial nature with a commercial interest organization has significantly affected her views on the subject on which she is presenting.

Learning Objectives
• Identify how malpractice cases are litigated and settled pre-trial.
• Recognize areas of risk for malpractice claims in nurse practitioner practice.
• Identify common fact patterns in pediatric-related litigation and apply knowledge to case examples to transfer learning to daily practice.
Adverse Outcomes and Patient Harm

- Even when excellent NP care is provided, patient comorbidities or system failures can result in an inadequate patient outcome.
- Understanding the conditions that lead to a litigation claim helps NP providers develop techniques to mitigate risk and minimize the potential for litigation.

Headline-Grabbing Study Brings Attention back to Medical Errors

- Medical Malpractice is now the third leading cause of death in the United States.
- Common types of cases in the field of medical malpractice include birth injuries, emergency room errors, failure to diagnose, misdiagnosis, anesthesia errors, medication errors, surgery errors, and improper treatment.
- Analyzing the death rate from preventable medical errors over an eight-year period of time, Johns Hopkins researchers demonstrated that more than 250,000 people per year die in the United States as a result of medical malpractice.* That means that 4.5-10% of all deaths in America are due to preventable medical malpractice. And those are just the deaths. Even more people are injured by medical malpractice and prescription drug side effects every year.


DOWNRIGHT SCARY STATISTICS!!!!

- IOM of "To Err Is Human" in 1999 – between 44,000 and 98,000 people die every year as a result of medical errors.
- FDA in 2005 – at least one death/day, and 1.3 million people injured each year due to medication errors.
- IOM in 2006 – medication errors harm as estimated 1.5 million Americans/year, resulting in about $3.5 billion in extra medical costs.
Why Do Patients Sue?

- Money?
- Information?
- A bad patient relationship?
- To teach the doctor a lesson?

“So that this won’t happen to someone else.”


Some Basics of Litigation

- Medical Malpractice: deviates from SOC
  - 4 elements:
    - Duty of care
    - Duty was breached
    - Breach was proximate cause of the injury (causation)
    - Damages flowed from the injury
- Medical Negligence: failure to exercise SOC
- Standard of Care (SOC):
  - Degree of care that a reasonably prudent practitioner would have exercised under the same circumstances
  - Most often established by the testimony of medical experts conversant with standards of practice in a particular medical specialty
- Vicarious liability: assigns responsibility not solely to NP but also to employer or supervisor

Adverse Outcome/Patient Harm Litigation

- Service of the Complaint
- Complaint, Answer, and other Preliminaries
- Discovery stage
- Experts disclosed
- Pre-trial motions
- Actual trial OR Settlement
  - Forced settlements, verdicts
- National Practitioner Data Bank

What Happens “backstage”

Behind the curtain:

Pre-trial settlement:
- Settled
- Case not disclosed, nature of error and damages to plaintiff hidden, concealed, and embargoed
- Public or medical community don’t know error, lawsuits filed, of outcome

The Good News..... And the Bad.....

- Medical Providers DO win about 90% of cases that go to TRIAL.
- Reality is that about 95% of med mal lawsuits (that result in a payout) are settled WITHOUT trial.
  - Why? It’s either
    - case is indefensible or
    - risk of a jury trial is too great
- Pre-trial settlements almost always include a non-disclosure clause.
Case Example: Process

- Baby born 5/3/2017 6 lbs 7 oz
- 5/4/2017 discharged 6 lbs 4 oz
- 5/13/2017 NP well baby 6 lbs 9 oz
- Circumcision 5/14/2017 wt same
- Well child 5/17/2017 Dr. A wt same
- 6/10/2017 7 lbs 2 oz Dr. B
- 6/16/2017 same wt Dr. A
- 6/18/2017 apneic, cyanotic, pulseless, admitted ICU
- TAPVR diagnosed with surgical repair on 6/20/2017
- Complaint filed 1/11/2019
- Retained 6/8/2019
- Defendants Pediatric clinic and Chief MD, Dr. A, Dr. B, and NP
- 11/16/2019 Depos Plaintiff
- My expert report 1/16/2020
- 1/17/2020 Defense/Plaintiff expert disclosures – 13 experts
- 1/10/2020 Depos Defense
- 3/6/2020 NP settled
- Trial 11/24/2021 scheduled, settled 11/22/21 day one voir dire

Closed Claims- still have a cost: Indemnity payment, Incurred payment, Expenses

- Closed Claims with Expense Payments but no Indemnity Payout
  - Successfully defended on behalf of the NP, resulting in a favorable jury verdict
  - Withdrawn by the plaintiff during the investigation or discovery process
  - Dismissed in favor of the defendant NP by the court prior to trial

Cost still incurred
- Expense payment of attorney fees, expert witness fees and costs involved investigating the claim
- Average of 27 months to resolve cases with indemnity
- Settlement or payment is entered into the NPDB under NP’s name

National Practitioner Data Bank (NPDB)

- Collects information about health care professionals who have
  - Paid judgments
  - Enter into settlements
  - Had adverse action on their license or privileges to practice

- Requirement for all hospitals and health care facilities, professional health care societies, state licensure boards, insurance companies, (Federal agencies)

- Who has access:
  - State licensing boards, hospitals, professional societies, health care facilities for peer review, attorneys in special circumstances, individual

- What is reported:
  - Full name, home address, DOB, schools attended and graduation dates, place of employment, SSA license number and state
  - Name, title, phone number of official submitting report and relationship to practitioner
  - Dates of judgment or settlement or amount paid
  - Description of judgment, settlement, or action
What is Current Data Telling us?

The data for 2021 only includes reports through September 30th, 2021.
State by Practitioner Type:

More Data
**IOM Report “To Err is Human” Response**

- Clinton Administration instructed government agencies to implement techniques for reducing medical errors and create a task force to find new strategies for reducing errors.
- Congress launched patient safety hearings and the Agency for Healthcare Research and Quality (AHRQ)
- Produced a booklet telling consumers what they could do to improve the quality of their own health care.
- Created “Never Events” list as basis of mandatory reporting system.

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**We Can’t Fix the Human Part…**

- **The Problem:** We need to learn how to avoid preventable harm.
- **The Solution:** Most of our mistakes get ironed out in peer review, credentials, or quality committees.
- Our most egregious mistakes go not to a conference room but to a courtroom.
- If lawsuits represent our most egregious mistakes, learning from them is the lowest hanging fruit in the patient safety.

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**Why Haven’t We Improved?**

- Tejal Gandhi MD, MPH – CEO of National Patient Safety Foundation (NPSF):
  - The lack of knowledge about mortality from medical mistakes is the tip of the iceberg.
  - All errors that result in injury, regardless of their severity, violate the basic promise in medicine to do no harm.
  - “It would be great if I could say, ‘Here’s the current rate of medical error, and here’s how it’s changed from 5 years ago,’ [but] I can’t give you that data because we don’t have it, because we don’t have a comprehensive, nationwide system for reporting or capturing all types of medical errors that happen not just in hospitals, but also in primary care offices, nursing homes, and many other settings where patients receive care.
  - No reliable, up-to-date estimate of the total number of medical errors that take place across all areas of the health care system. (In 1999, the IOM estimated that as many as a million people were injured annually by medical errors.)

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**Culture of Safety**

- Every year, more than 12 million patients experience a diagnostic error during an outpatient visit. It’s estimated that half of these could cause harm.
- Progress in patient safety is happening:
  - April 2011, the Department of Health and Human Services launched the Partnership for Patients initiative to reduce preventable hospital-acquired conditions and hospital readmissions. Federal partners include the Centers for Medicare & Medicaid Services, AHRQ, and CDC.
  - AHRQ’s interim estimates for 2014 indicated a 17% drop in hospital-acquired conditions such as adverse drug events, catheter-associated urinary tract infections, central line-associated bloodstream infections, pressure injuries, and surgical site infections since 2010, resulting in approximately 87,000 fewer deaths.
  - PBG a tremendous amount of work needs to be done in the realm of patient safety. For example, diagnostic errors are an area that hasn’t improved much.

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*Singh H et al. Jtq Qual Saf. 2014;39[7]:727-731*
Analyzing Medical Malpractice

- The 2016 National Academies of Sciences report, *Improving Diagnosis in Health Care*, recommended that health care providers work directly with their malpractice insurers to learn about diagnostic failure.
- Essential to bringing about change necessary to prevent similar injuries
- Turns data into credible evidence for what failed, why, and changes in vulnerabilities
- Crico 2018 CBS Benchmarking Report: Medical Malpractice in America: A 10-Year Assessment with Insights
- CNA/NSO Nurse Practitioner Claim Report


- Guide to Identifying and Addressing Professional Liability Exposures
  - Database and Methodology
  - Limitations/Definitions
  - Part 1: Professional Liability Data and Risk Control Strategies
  - Part 2: Additional datasets of license protection incidents or claims
- Data Analysis
  - Claims that:
    - Involved NP, NP practice, or NP student
    - Closed between Jan 1, 2012 and Dec 31, 2016
    - Claim resulted in indemnity payment of $10,000.00
  - Limitations:
    - Only closed claims involving NPs, NP practices, NP students insured by CNA through NSO
    - Only closed claims paid by CNA on behalf of its insured excluding those paid by employers, other insurers, or third parties
- Risk Control Recommendations
  - Risk Control Self-assessment

Analysis of Frequency and Severity by Specialty
Severity by Location

The three locations with the highest frequency of closed claims are physician office practice, NP office practice, and aging services facility, skilled nursing.

Severity of Allegations

<table>
<thead>
<tr>
<th>Allegation category</th>
<th>Percentage of closed claims</th>
<th>Total paid indemnity</th>
<th>Average paid indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td>21.5%</td>
<td>$26,628,755</td>
<td>$285,365</td>
</tr>
<tr>
<td>Assessment</td>
<td>9.2%</td>
<td>$6,456,275</td>
<td>$174,757</td>
</tr>
<tr>
<td>Medication</td>
<td>15.4%</td>
<td>$196,605,274</td>
<td>$233,246</td>
</tr>
<tr>
<td>Treatment and care management</td>
<td>3%</td>
<td>$17,307,457</td>
<td>$209,303</td>
</tr>
<tr>
<td>Communication</td>
<td>0.2%</td>
<td>$500,000</td>
<td>$200,000</td>
</tr>
<tr>
<td>Scope of practice</td>
<td>4.2%</td>
<td>$7,753,000</td>
<td>$144,230</td>
</tr>
<tr>
<td>Abuse/patient rights/professional conduct</td>
<td>1.8%</td>
<td>$600,000</td>
<td>$112,000</td>
</tr>
<tr>
<td>Equipment</td>
<td>0.3%</td>
<td>$150,000</td>
<td>$50,000</td>
</tr>
<tr>
<td>Documentation</td>
<td>0.1%</td>
<td>$500,000</td>
<td>$50,000</td>
</tr>
<tr>
<td>Supervision of others</td>
<td>0.3%</td>
<td>$150,000</td>
<td>$50,000</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>0.2%</td>
<td>$100,000</td>
<td>$100,000</td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td>100%</td>
<td>$44,618,281</td>
<td>$248,471</td>
</tr>
</tbody>
</table>

Comparison of 2012 and 2017 Claim Distribution by Allegation Category

- Review state NP practice act
- Know organization P&P
- Job description or contract
Analysis of Frequency and Severity by Allegation Category

- Diagnosis
- Monitoring
- Assessment
- Treatment and Care Management
- Scope of Practice
- Medication
- Communication
- Abuse/patient rights/professional conduct
- Equipment
- Documentation
- Supervision of others
- Confidentiality

Severity of Allegations

<table>
<thead>
<tr>
<th>Allegation category</th>
<th>Percentage of closed claims</th>
<th>Average paid indemnity</th>
<th>Average paid settlement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td>11.3%</td>
<td>$610,919</td>
<td>$600,000</td>
</tr>
<tr>
<td>Monitoring</td>
<td>4.9%</td>
<td>$11,000,314</td>
<td>$10,000,000</td>
</tr>
<tr>
<td>Treatment and care management</td>
<td>11.3%</td>
<td>$610,919</td>
<td>$600,000</td>
</tr>
<tr>
<td>Medication</td>
<td>3.3%</td>
<td>$500,000</td>
<td>$400,000</td>
</tr>
<tr>
<td>Communication</td>
<td>4.2%</td>
<td>$1,500,000</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Supervision of others</td>
<td>1.5%</td>
<td>$600,000</td>
<td>$100,000</td>
</tr>
<tr>
<td>Documentation</td>
<td>6.3%</td>
<td>$700,000</td>
<td>$500,000</td>
</tr>
<tr>
<td>Supervision of others</td>
<td>0.3%</td>
<td>$600,000</td>
<td>$0</td>
</tr>
<tr>
<td>Equipment</td>
<td>0.3%</td>
<td>$100,000</td>
<td>$100,000</td>
</tr>
<tr>
<td>Supervision of others</td>
<td>0.3%</td>
<td>$600,000</td>
<td>$0</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>0.3%</td>
<td>$100,000</td>
<td>$0</td>
</tr>
<tr>
<td>Overall</td>
<td>100%</td>
<td>$249,013,201</td>
<td>$249,013</td>
</tr>
</tbody>
</table>

Most common settings are physician and nurse practitioner offices

Diagnosis Related Allegations (32.8%)

- Subcategories
- Most common settings are physician and NP offices
- Subcategories: Failure to Diagnose (20.7%)
- Common thread is lack of sound documentation supporting the decision-making process of NP
  - Failure to write diagnosis or incomplete documentation
- Failure to identify and report observations, abnormal findings, or positive diagnosis
  - Failure to complete laboratory and/or radiology tests as ordered
- Failure to place patient on appropriate treatment plan
- Confirmation of diagnosis test results and further treatment for testing needed
- Remind patient to seek emergency treatment if a condition worsens
- Patient education efforts and materials
Illness/Injuries Related to Failure to Diagnose

<table>
<thead>
<tr>
<th>Illness/Injuries</th>
<th>Percentage of Cases</th>
<th>Total paid</th>
<th>Average paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to diagnose infection/abscess/sepsis</td>
<td>5.7%</td>
<td>$7,356.50</td>
<td>$2,557.00</td>
</tr>
<tr>
<td>Appendicitis, sepsis, osteomyelitis</td>
<td>1.9%</td>
<td>$1,085.50</td>
<td>$891.77</td>
</tr>
<tr>
<td>Other</td>
<td>3.2%</td>
<td>$999.00</td>
<td>$999.00</td>
</tr>
</tbody>
</table>

Failure to Diagnose: Infection

- **History:**
  - 13 year-old with left leg pain

- **Case facts:**
  - Seen by NP day 1 with x-ray
  - Learning point #1
  - Seen by another NP day 2 with labs and a CT scan
  - Learning point #2, #3
  - Day 4 to another medical center in critical condition

**What can we learn here?**
- Red flags that signal serious illness in children - tachycardia
- WITD - WORST
  - WORST thing
  - Gather information
  - Tell appropriate party
  - Document

Failure to Diagnose

**Cause of failure to diagnose**

- Failure to timely recognize/take action in a patient with symptoms of serious illness
- Inadequate management of medical condition
- Failure to timely obtain critical laboratory or radiographic study
- Failure to obtain appropriate consultation for a condition that requires consultation
- Failure to order appropriate admission
- Failure to provide and document any emergency and complete patient care and physical exam
- Failure to identify and promptly treat potential complications
- Failure to avert or to recognize and treat an avoidable event

- 9/6 of adverse events

- 7/6 of adverse events

- 5/6 of adverse events
Failure to order appropriate tests to establish diagnosis case

- History: 10 month-old with fever, vomiting, and diarrhea
- Case facts:
  - Seen by NP who diagnosed pharyngitis and acute gastritis
  - Learning point #1
  - 8 hours later infant arrives to emergency department
  - Learning point #2, #3

What can we learn here?
- Keep IMPORTANT DIAGNOSES in your DIFFERENTIAL - sepsis
- INFORM patients of the concerning diagnoses in your differential
- Prevent communication breakdowns between medical personnel
- Up to date Problem Lists/Visit problem list at every contact with patient

Failure to Diagnose

- Case: 5-year-old, developmental delay struck by a pick-up truck
- Case facts:
  - Diffuse abrasions and mild burns
  - X-rays ordered, discharged
  - Days later right leg pain

What can we learn here?
- Communication with parents of children with developmental disability is critical
- When patient is discharged, return precautions and follow-up instructions are critical
- Advise a patient even though negative x-rays now, if pain is not improving, recheck

Failure to consider/assess complaints: Pediatric MVC

- History:
  - 5-year-old, developmental delay struck by a pick-up truck
- Case facts:
  - Diffuse abrasions and mild burns
  - X-rays ordered, discharged
  - Days later right leg pain

Complaint: ED failed to respond to concerns about right leg pain
Severity of Allegations

<table>
<thead>
<tr>
<th>Allegation category</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>15.7%</td>
<td>$2,047,300</td>
<td>$494,300</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>22.9%</td>
<td>$24,850,715</td>
<td>$366,263</td>
</tr>
<tr>
<td>Assessment</td>
<td>12.9%</td>
<td>$4,546,275</td>
<td>$241,571</td>
</tr>
<tr>
<td>Medication</td>
<td>20.3%</td>
<td>$71,443,574</td>
<td>$353,340</td>
</tr>
<tr>
<td>Treatment and care management</td>
<td>20.3%</td>
<td>$11,099,457</td>
<td>$500,000</td>
</tr>
<tr>
<td>Communication</td>
<td>0.0%</td>
<td>$600,000</td>
<td>$200,000</td>
</tr>
<tr>
<td>Scope of practice</td>
<td>4.1%</td>
<td>$1,755,000</td>
<td>$166,230</td>
</tr>
<tr>
<td>Misadjudication (judgmental conduct)</td>
<td>19.5%</td>
<td>$665,000</td>
<td>$110,000</td>
</tr>
<tr>
<td>Equipment</td>
<td>0.3%</td>
<td>$75,000</td>
<td>$15,000</td>
</tr>
<tr>
<td>Documentation</td>
<td>0.3%</td>
<td>$30,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Supervision of others</td>
<td>0.3%</td>
<td>$40,000</td>
<td>$40,000</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>0.3%</td>
<td>$10,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Overall</td>
<td>100%</td>
<td>$69,015,261</td>
<td>$240,471</td>
</tr>
</tbody>
</table>

Medication Prescribing Frequency

- Improper prescribing/managing most frequent

Improper Prescribing/Managing: Gentamicin Case

- History:
  - 17 year-old with abscess and fistula complications
- Case facts:
  - Surgical drainage, started on TPN, Gentamicin
  - Learning point #1
  - PICC line placed, discharged on Gentamicin
  - Learning point #2, #3
  - Returned to hospital after one month, still on Gentamicin

What can we learn here?
- Patient education about medications/risks
- Miscommunication risk even higher when dealing with outpatient/home care
- When discharging patients, confirm all orders and follow-up
Practice Tips for Medication Prescribing

- Review current allergy information
- Learn about medication allergies, side effects, and interactions
- Discontinue medications causing cautioned side effects
- Discuss the patient's condition, medications, and care needs with the collaborating or supervising physician as needed, and document these discussions.
- Use caution when prescribing anticoagulants, antibiotics, and psychoactive medications, as well as other known toxicity-prone drugs
- Order and follow-up with all indicated monitoring tests and emphasize the importance of keeping follow-up appointments
- Avoid verbal orders except in emergency situations
- Consult with a pharmacist as needed, documenting all communications
- When deviating from package insert, always document the reason
- Remain current regarding clinical practice, medications, biologics, and equipment related to the diagnosis and treatment of illnesses and conditions encountered in one's specialty
- Rule out pregnancy
- Politely decline suggestions or recommendations from patients that could jeopardize their safety

Analysis of Frequency and Severity by Allegation

<table>
<thead>
<tr>
<th>Category</th>
<th>Frequency</th>
<th>Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring</td>
<td>infrequent</td>
<td>highest severity</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>most frequent</td>
<td>second-highest average severity</td>
</tr>
<tr>
<td>Assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment and Care Management</td>
<td>decreased slightly in terms of frequency and severity since the 2012 report from 29.5% versus 22.3%</td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scope of Practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervision of others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confidentiality</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medication Claims by Illness/Injury

- Costliest: ear injury/hearing loss
- Death/addiction: 19.6%
Improper or timely management of other non-surgical wound

- History:
  - 16 year old at detention center

- Case facts:
  - Thigh pain, low fever, abscess
    - Learning point #1
  - NP ordered pain meds, culture, antibiotic
    - Learning point #2, #3
  - Returned to health room with increasing size and increased pain

What can we learn here?
- Reassess patient when indicated
- Document key clinical information after reassessing
- Document with clinical encounters and communication with care
Improper technique or negligence in performance of a treatment of test: infant hip assessment

**History:**
- 8/31/2010 birth stable hips, home Dr. A
- 9/3/2010 2 week well child, Dr. A
- 10/1/2010 1 month well child, NP
- 11/3/2010 2 month well child, NP
- 12/28/2010 4 month well child, NP
- 3/2/2011 6 mos well child, NP
- 4/3/2011 ecchymosis visit, NP #2
- 4/21/2011 rash visit, NP #2
- 6/1/2011 9 mos well child, NP
- 6/29/2011 dermatitis visit, NP
- 8/21/2011 12 mos well child, NP
- 11/30/2011 15 mos well child, NP
- 2/28/2012 18 mos well child, NP
- 9/5/2012 2 yr well child, NP
- 3/13/2013 2.5 yr well child, NP
- 4/12/13 Hives visit, NP
- 9/11/2012 3 yr well child, NP
- 11/13/2014 4 yr well child, and concerns
- 12/20/2014 Orthopedics referral
- 1/16/2015 Orthopedic MD, referred to orthopedic surgeon
- 1/26/2015 Orthopedic surgeon visit
- 1/27/2015 MRI ordered, NP
- 3/5/2015 Osteotomy, tenotomy
- 3/31/2016 Surgery #2

**What can we learn here?**
- Document clinical encounters and communication with care
- Avoid repetitive copy and paste

### Frequency and Severity by NP Office Practice Claims

#### NP Office Practice Claims by Allegation

<table>
<thead>
<tr>
<th>Allegation</th>
<th>Percentage</th>
<th>Total paid</th>
<th>Average paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment and care management</td>
<td>46.7%</td>
<td>$1,308</td>
<td>$295</td>
</tr>
<tr>
<td>Medication</td>
<td>28.5%</td>
<td>$1,518</td>
<td>$615</td>
</tr>
<tr>
<td>Documentation</td>
<td>3.9%</td>
<td>$1,618</td>
<td>$259</td>
</tr>
<tr>
<td>Insults / unprofessional conduct</td>
<td>2.8%</td>
<td>$1,538</td>
<td>$496</td>
</tr>
<tr>
<td>Misrepresentation</td>
<td>0.9%</td>
<td>$2,738</td>
<td>$2,738</td>
</tr>
<tr>
<td>Total</td>
<td>92.4%</td>
<td>$1,548</td>
<td>$420</td>
</tr>
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</table>

#### NP Office Practice Claims by Injury

<table>
<thead>
<tr>
<th>Injury</th>
<th>Percentage</th>
<th>Total paid</th>
<th>Average paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malpractice</td>
<td>39.8%</td>
<td>$1,208</td>
<td>$305</td>
</tr>
<tr>
<td>Malpractice</td>
<td>40.5%</td>
<td>$1,208</td>
<td>$305</td>
</tr>
<tr>
<td>Death was second most frequent injury</td>
<td>1.9%</td>
<td>$9,238</td>
<td>$9,238</td>
</tr>
</tbody>
</table>

- Most common office related claims involve medication
- Majority related to prescribing/management of controlled drugs
- Costliest claims relate to diagnosis
References

- Clapper TC, Chen P. Debunking the myth that the majority of medical errors are attributed to communication. J Am Board Fam Med. 2012;25(4):412-8.

Questions?

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