Navigating the Storm: A Physician Associate's Guide to Medical Malpractice Litigation

Abstract

Medical malpractice lawsuits constitute a significant source of stress and professional uncertainty for physician associates (PAs). This comprehensive review details the medical malpractice litigation process, offering practical guidance for PAs facing such challenges. The article examines the four foundational elements required to establish medical negligence: duty of care, breach of standard of care, proximate causation, and resulting damages. Following the chronological progression of malpractice litigation—from the initial service of process through discovery, deposition, mediation, and potential trial—we place particular emphasis on deposition preparation and testimony strategies. Depositions often provide PAs with a critical opportunity to clarify their clinical decision-making beyond what is documented in the medical record, while also demonstrating their competence, compassion, and professionalism. By thoroughly understanding the legal process, the national provider database (NPDB), liability insurance, possible conflicts that may arise during the discovery and litigation process, and implementing evidence-based preparation techniques, PAs can navigate malpractice litigation more effectively, preserving their professional confidence and maintaining the quality of their clinical practice throughout these challenging proceedings. This article will also explore the current literature and malpractice trends as they relate to PAs and how the evolving landscape of PA modernization laws may be impacted. Lastly, legal theories of malpractice related to the physician-PA team, including vicarious liability, negligent supervision, and negligent credentialing, will also be discussed, and how evolving changes at the practice level may influence future litigation trends.

Introduction

Today, approximately half of the cases brought to appellate courts in the United States rely to some extent on medical evidence to ensure justice is served. Each trial is an adversarial proceeding where one party prevails, and another is defeated. Theoretically, the goal in all legal actions is the discovery of truth.[1] Before examining the specifics of the system and process, it is essential to understand the intended societal goals of malpractice litigation. These goals include deterring unsafe practices, compensating persons injured through negligence, and exacting corrective justice. Beyond these traditional objectives, malpractice litigation increasingly serves to provide acknowledgment and apology to injured parties, offer closure to affected families, and mandate corrective actions that improve patient safety systems. Pursuing these objectives, malpractice litigation serves multiple functions within the broader legal framework of society.[2]

Medical malpractice litigation remains a significant concern for many PAs across all disciplines and specialties. Despite the best efforts to provide quality patient care, the inherent complexities and risks in medicine leave clinicians vulnerable to allegations of negligence. Going through a medical malpractice litigation is a physically and emotionally demanding process that, unfortunately, some PAs must endure in their clinical careers. A thorough understanding of the medical malpractice process is essential for all healthcare providers, particularly those in high-risk specialties or settings.

Medical malpractice is legally defined as a healthcare provider's failure to meet the standard of care expected of reputable and careful practitioners under similar circumstances. When this failure causes patient harm, a lawsuit may be filed to recover damages for the injury or losses of

the patient or the patient's estate. For many providers, such allegations can be professionally and personally devastating, even when the claims lack merit.

This review will equip PAs with essential knowledge about medical malpractice litigation, with particular emphasis on navigating depositions—often the most consequential phase of the process. As most malpractice actions conclude before trial through the process of alternative dispute resolution, the deposition often represents the provider's best opportunity to directly influence case outcomes. Familiarity with the process and thorough preparation can significantly reduce anxiety and enhance the effectiveness of testimony.[3]

Understanding Medical Malpractice

Definition and Legal Framework

To prevail in a medical malpractice case, a plaintiff must successfully establish four essential elements, as noted in Table 1.

Table 1. Four Essential Elements in a Medical Malpractice Suit[3]

1. **Duty**: The existence of a provider-patient relationship that establishes a legal duty of care
2. **Breach of Standard of Care**: Failure to provide care that meets the expected standards of similarly qualified providers
3. **Proximate Causation**: Direct connection between the breach of care and the patient's injury
4. **Damages**: Actual harm or injury to the patient resulting from the breach

Medical malpractice represents a specific form of the legal theory of negligence. A plaintiff team (e.g., attorney and patient or the estate of the patient) to be successful before a judge or jury in a malpractice case, they must show by a preponderance of the evidence. As it is more likely than not that there is a greater than 50% probability that professional negligence occurred. This would be based on the evidence presented. The plaintiff's team must prove each element by the preponderance of the evidence to receive a successful judgment on their behalf.[4]

First Element: Duty

The first requirement in establishing a medical malpractice claim involves proving a provider-patient relationship that creates a legal duty of care. This relationship establishes the provider's obligation to conform to accepted standards of practice in treating the patient. The formal provider-patient relationship, or "privity," is essential because it establishes the legal framework for the standard of care obligations.

Second Element: Breach of Standard of Care

The standard of care refers to what a reasonable person with similar training and experience would do under the same or similar circumstances. Table 2 shows several factors that determine the care standard in a given situation.

Table 2. Factors that Determine the Standard of Care[3]

- Testimony from expert witnesses (a provider with similar credentials and experience)
- Adherence to or deviation from applicable laws and regulations
- Compliance with clinical practice guidelines or protocols

- Adherence to the healthcare system or institutional policies

Several vital principles clarify the legal understanding of the standard of care in malpractice cases. The development of recognized or known complications, even when unfortunate, does not inherently constitute negligence when proper care is provided. The law acknowledges that medicine entails inherent risks and does not demand perfect results from healthcare providers. Similarly, adverse outcomes alone—regardless of severity—cannot establish malpractice without evidence of deviation from acceptable standards. Ultimately, determining whether care meets appropriate standards in specific clinical situations should be based on the opinions of qualified expert witnesses with relevant training and experience, rather than solely on patient perception or general medical knowledge.

Third Element: Proximate Causation

Proximate causation requires the Plaintiff to demonstrate that their injuries directly resulted from the provider's negligent actions or omissions. The legal threshold for establishing causation is "a reasonable degree of medical certainty," which translates to "more likely than not" (greater than 50% probability). This causal relationship between the breach of the standard and the resulting injury must be established.[3] Proximate causation is established at the state level, not at the federal level, and may differ from state to state

Fourth Element: Damages

If the Plaintiff successfully proves duty, breach of the standard of care, and proximate causation, the defendant becomes liable for resulting damages. These damages may include medical expenses incurred for treatment necessitated by the negligent care, lost wages or diminished

earning capacity due to injury, compensation for pain and suffering endured, attorney's fees, associated with disability or disfigurement resulting from substandard care, and losses related to reduced quality of life or inability to engage in previously enjoyed activities. In particularly egregious cases involving willful misconduct or gross negligence, courts may also award punitive damages designed to punish the defendant and deter similar future behavior.[3] Twenty-six states have caps on non-economic damages, while economic damages are not capped.

The Medical Malpractice Litigation Pleadings Process

Service of Process

The formal initiation of a malpractice lawsuit begins with the service of process, wherein the defendant receives a complaint and summons. This complaint and summons must be initiated within a state-defined statute of limitations. Most states allow extended filing periods for minors, whereas adult windows typically range from 1 to 4 years, with the majority falling between 2 and 3 years. This legal notification formally announces the lawsuit, details specific allegations of negligence, specifies damages sought, and sets a deadline for the defendant's response (typically 20-30 days).[5]

Initial Response and Legal Representation

Healthcare providers should take immediate steps to protect their interests upon receiving notice of a lawsuit. First and foremost, providers must notify their malpractice insurance carrier immediately, as insurers typically assign defense counsel based on their approved attorney panels. After securing representation, providers have several initial response options, including filing an Answer (a formal response to admit or deny the allegations) or filing a Motion to

Dismiss (challenging the legal sufficiency of the complaint). It is crucial to understand that failure to respond within the specified timeframe may result in a default judgment against the provider, essentially conceding liability without the opportunity to present a defense. In situations where a provider has multiple malpractice carriers, such as a hospital umbrella policy and a personal policy, both must be notified. In some circumstances, a plaintiff may initiate a demand letter for payment for the alleged medical malpractice, which usually includes a condition of filing a complaint and summons if the complaint is not resolved.

After being served and learning of the initial complaint of alleged malpractice, the PA may be tempted to go into the medical record to review their care and make changes to the chart. The PA should avoid all temptations to review a patient's chart after being served and should at no time attempt to make any alterations or additions to the medical record associated with the alleged negligence. Any access to the record will be logged in the EMR (including date, time, and user). Plaintiff attorneys can subpoena audit trails to show when and why the provider accessed the chart. All requests should go through legal counsel or risk management. The consequences of altering the medical record can be interpreted as intent to conceal or falsify information, which may invalidate legal defenses, negatively affect the PA's professional credibility, and result in not only legal consequences but also compromise their professional credentials and employment due to ethical violations. These actions may also result in a PA employer facing disciplinary, monetary, and procedural penalties.

Discovery Phase

The discovery phase involves exchanging information between the parties and represents a critical period in the litigation process. Key discovery mechanisms include interrogatories, which

are written questions requiring written responses under oath from the opposing party; requests for production of documents, which are formal demands for medical records, policies, protocols, and other relevant documentation pertinent to the case; requests for admissions, which present written statements that the opposing party must either admit or deny, potentially narrowing disputed issues; and depositions, perhaps the most significant discovery tool, where oral testimony is taken under oath and recorded verbatim by a court reporter for future reference or use at trial. These complementary discovery methods collectively enable both sides to thoroughly investigate claims, assess the strength of their positions, and prepare effective litigation strategies. Once the pleadings are filed, many states will allow either party to move for judgment, enabling the rapid resolution of a case. Often, there is disagreement on the critical facts of the cases, which then results in the judgment not proceeding.[3]

Expert Witnesses

Both sides typically retain paid medical expert witnesses who serve multiple critical functions throughout the litigation process. These professionals meticulously review medical records and provide authoritative opinions on whether the standard of care was met in the case. They prepare detailed expert reports establishing whether the provider's actions conformed to or breached accepted medical standards for the same or similar circumstances. Beyond the standard of care assessments, experts may also provide crucial opinions on causation—determining whether the alleged breach directly caused the patient's injury—and the extent of damages suffered. Experts may also serve as medical professionals or legal consultants in their analysis of the case, providing an intellectual asset to the attorney teams and offering key knowledge on additional areas of the case. Given their specialized knowledge and credibility, expert witnesses typically

have a significant influence on case outcomes, with their testimony often proving decisive in settlement negotiations or trials.

Motion Practice

Attorneys may file motions throughout litigation to advance their client's position or limit the opposing party's claims. These include summary judgment motions, which request the court to render judgment without proceeding to trial based on ostensibly undisputed facts that demonstrate one party is entitled to prevail as a matter of law. Attorneys also commonly file motions to exclude evidence or testimony they consider inadmissible, prejudicial, or unreliable, which can significantly impact case presentation strategies. Settlement negotiations often occur during this phase of motion practice, as both sides assess the strength of their positions in light of judicial rulings on these preliminary legal matters, frequently leading to case resolution before trial.

The Deposition: A Critical Juncture

Significance of Depositions

The deposition of a healthcare provider defendant is frequently the most critical aspect of a medical malpractice lawsuit for several reasons that collectively impact the case trajectory and outcomes. Most malpractice cases conclude before trial through settlement negotiations, making the deposition the primary opportunity for the provider to directly influence case resolution through clear, professional, and credible testimony. Additionally, deposition testimony is preserved and can be used at trial, potentially years later, either to support the provider's defense or to highlight contradictions. During this sworn testimony, opposing counsel carefully evaluates

the provider's demeanor, expertise, and credibility—factors significantly influencing settlement decisions and jury perceptions if the case proceeds to trial. Perhaps most critically, any inconsistencies between deposition testimony and subsequent trial testimony can severely damage the provider's credibility, as plaintiffs' attorneys routinely use such contradictions to suggest unreliability or dishonesty to the jury.

A deposition involves providing testimony under oath outside of a courtroom, typically in an attorney's office, a neutral location, or virtually. The process is found in Table 3. While objections can be raised during depositions, they differ from courtroom objections in that no judge can immediately rule on them. The objections are noted in the record and may be addressed later if the case proceeds to trial.

Table 3. Deposition Process and Structure

1. **Swearing in**: A court reporter administers an oath to tell the truth
2. **Direct examination**: The Plaintiff's attorney questions the defendant
3. **Cross-examination**: The defendant's attorney may ask clarifying questions
4. **Re-direct**: The Plaintiff's attorney may ask follow-up questions
5. **Re-cross**: The defendant's attorney may ask additional questions (There may be additional attorneys in the room representing various parties who may also ask the defendant questions.)

Deposition Preparation

Adequate preparation represents the cornerstone of successful deposition testimony. Key preparation strategies include a thorough review of all relevant medical records and

documentation, which requires carefully examining them typically 1-2 days before the deposition to ensure details are fresh in the provider's mind. Case discussion with defense counsel is equally essential, allowing the provider to comprehensively review key events and develop a clear understanding of the specific allegations of negligence. A medical knowledge review ensures that the provider maintains confidence in discussing the clinical aspects central to the case, particularly regarding standard of care practices, differential diagnoses, and treatment rationales. Deposition etiquette preparation involves practicing the skill of providing concise, truthful answers that directly address the question without volunteering additional information that might create new avenues of inquiry. This technique requires practice but significantly enhances the effectiveness of testimony. Table 4 shows anticipated questions by the Plaintiff's attorney.[6]

Table 4. Anticipated questions:

- Personal and professional background
- Education, licensure, and certifications
- Hospital affiliations and professional associations
- Have you discussed the case with anyone other than your attorney (e.g., colleagues and your spouse)
- Previous malpractice claims or lawsuits
- Experience with the specific medical condition
- Details about patient encounters and treatment decisions
- Do you have an independent recollection of the case and encounter? What would be your usual practice?

Deposition Content Areas

Depositions typically focus on two broad categories of inquiry, found in Tables 5 and 6.

Table 5. A Focus on Personal and Professional Background.

● Professional qualifications and practice information
● Education and continuing education
● Licensure and board certification
● Hospital affiliations
● Teaching responsibilities
● Professional associations
● Publications and research
● Previous litigation experience
● Clinical experience with relevant conditions

Table 6. A Focus on Patient Care Details.

● Initial patient encounter circumstances and communications
● Information available before the first patient contact
● Chronology of each subsequent patient interaction
● History-taking and physical examination components
● Diagnostic testing was ordered, and the interpretation
● Differential diagnoses considered
● Treatment decisions and rationale
● Consultations and referrals

- Patient discharge or disposition instructions.
- Patient communications regarding diagnosis, treatment, and prognosis

Effective Deposition Conduct

During the deposition, providers should adhere to several key principles that collectively enhance the quality of testimony and personal credibility.[6,7,8,9]

1. A professional presentation begins with appropriate business attire (not clinical scrubs) and punctual arrival, establishing respect for the proceedings.
2. Careful listening to each question before responding ensures accurate understanding and prevents hasty or off-target answers. Never react emotionally or defensively.
3. Truthfulness remains paramount and providers must answer honestly even when responses seem unfavorable, as deception inevitably damages case outcomes.
4. Concision requires providing complete yet succinct answers without including extraneous information that could lead to new lines of questioning. Specificity in testimony means avoiding speculation or guessing—responding with "I do not know" or "I do not recall" when genuinely uncertain demonstrates integrity rather than weakness.
5. Maintaining calmness throughout questioning, particularly during challenging moments, prevents appearing defensive or antagonistic, which can negatively influence perception.
6. Requesting clarification when questions are ambiguous or complex demonstrates thoughtfulness and precision.

7. When addressing documentation questions, providers should be prepared to discuss medical record entries in detail while acknowledging that clinical practice sometimes includes actions not explicitly documented, such as one's usual practice.
8. Finally, providers should approach hypothetical questions cautiously, understanding that defense counsel may object to speculative scenarios beyond factual circumstances. Plaintiff attorneys use this tactic often. Approach this cautiously and provide concise and precise answers. Try to avoid answering hypothetical questions.

Mediation

Bringing a medical malpractice case to trial can be extremely expensive for all parties involved. The process of mediation involves negotiation with a third party acting as an intermediate between the plaintiff and defense contending parties. Once the discovery is near completion, attempts will be made with the mediator to settle the issue, removing the “toss the dice” approach of a jury trial. Some cases will go through a medical review panel rather than to trial. During the mediation proceedings, the plaintiff team will present a settlement demand. A settlement of claims is a quick and comparatively inexpensive way from which resolution of a dispute may be settled rather than going to trial. The PA, as a defendant, would work with the attorney and malpractice carrier and often will have an explicit say in the decision to mediate or settle. This dynamic may vary based on whether coverage is provided exclusively through the healthcare system’s umbrella policy or supplemented by the PA’s own professional liability insurance. Since a practice or healthcare system’s umbrella policy extends coverage to both the provider and the institution, a PA who maintains an individual policy provides independent representation and counsel exclusively advocating on their behalf. Conflicts may arise if there is

not alignment in the alleged medical negligence case. Malpractice carriers may elect to settle because the cost of continued litigation simply may exceed the settlement amount or an even larger payout if the case goes to trial and is ruled in favor of the plaintiff. Additionally, cases may settle to avoid public scrutiny. Nondisclosure agreements will be presented in these cases in an effort to put an end to the case in these circumstances, emphasizing the importance of PAs having their own policy and attorney representation.

National Provider Database

Because settlements are typically reportable to the National Practitioner Data Bank (NPDB), providers may be inclined to defend malpractice allegations through trial rather than accept a settlement, even when doing so carries greater risk. The NPDB is a federal, confidential information clearinghouse that was established under the Health Care Quality Improvement Act of 1986 and began data collection on September 1, 1990. The NPDB collects and disseminates reports about medical malpractice payments and certain adverse actions (e.g., licensure actions, clinical privileges restrictions) against health care practitioners, providers, and suppliers. *The AMA Journal of Ethics*[10] describes that the NPDB, at its core mission, is to "improve health care quality and protect the public by preventing practitioners with histories of adverse actions from moving across states or institutions unnoticed." Having a settlement reported to the NPDB, like an award of a medical malpractice claim against a PA, may adversely affect future employment, carrying increased pressure and stress for the PA, presenting significant importance to the strategy and quality of the defense team.

Liability Insurance and Limits

Most U.S. medical malpractice insurance policies have "per claim" and "aggregate" limits,

which are typically $1 million per claim / $3 million aggregate per year. This is the most common coverage configuration for physicians, PAs, and NPs. State Requirements: Many hospitals and state professional boards mandate minimum coverage, which is often the $1 million/$3 million standard, though some states have lower statutory minimums.

Medical malpractice insurance premiums are calculated by carriers to cover their anticipated financial losses (claims payments and defense costs), administrative expenses, and desired profit, as offset by investment income. Higher risk specialties: General Surgery, Orthopedic Surgery, Obstetrics/Gynecology, and Emergency Medicine, have consistently faced significantly higher premiums due to the higher potential for patient injury. Other factors include: a provider's claim history, hours worked, risk management education, geography (states with higher litigation according to NPDB, litigation climate, and those that have seen some premium hikes due to nuclear verdicts. PAs must have a thorough understanding of their liability coverage, policy limits, and associated financial risks. They should also be aware of whether their state imposes caps on non-economic damages. In cases where an excess verdict exceeds policy limits, the provider is personally responsible for the remaining amount. Without a separate individual policy—and particularly in states without damage caps—this exposure could be financially catastrophic, placing the PA's personal assets at risk.

Liability Insurance Policy Types

There are also two different policy types: claims-made and occurrence. Although claims made are less expensive up front, they often come with the requirement to purchase an expensive tail coverage or a nose coverage if there is a change in practice. Covers incidents that happen only while the policy is in force, and once the policy has been terminated, coverage no longer exists.

If you want coverage after the policy has been terminated, then tail coverage must be purchased. For example, if you had a claims-made policy in 2014 (which you terminated in 2016) and then were sued in 2017 for an incident in 2014, you would not be protected. This policy provides coverage for incidents and claims that are filed during the policy period only. You must keep up with your policy/policies to ensure that you do not have gaps in coverage. This policy is generally inexpensive at first, then gradually increases ("steps up") over time—about five years—to a "mature" premium. If an incident happened during the policy period, but the claim was filed after the policy expired, then the insurance will not cover that claim. Occurrence policies cover incidents that happen during the policy period without regard to when the claims are reported. Occurrence coverage protects for each policy period indefinitely. For example, if you had an occurrence policy in 2014 (which you terminated in 2016), and then are sued in 2017 for an incident in 2014, you will be protected. This policy provides coverage for incidents that happened during the policy period, no matter when the claim is filed. Premiums in the first few years are more expensive than claims-made policy premiums (until the claims-made policy reaches maturity). Over time, the total costs should even out if you consistently maintain your own policy.

Medical Malpractice Liability Disputes

Before a PA decides to obtain their own medical professional liability policy, it is important to investigate if their institutional policy allows for a "duty to defend" clause. If not, negotiation for such a clause is advisable to ensure appropriate representation of one's own self-interest. Disputes may occur when counsel representing a practice or health care system seeks to assign primary responsibility to the PA to shield the institution or supervising physician from vicarious

liability claims. This risk may become heightened when the PA maintains individual liability coverage and independent counsel separate from the organization's legal team. Additional risks and conflicts may stem from negligent supervision, systems or operational errors, and disagreements on the standard of care. Although this is not a common event, PAs can protect themselves from such an occurrence by strictly adhering to practice agreements, healthcare system bylaws, department policies, and delineation of privileges, thereby mitigating the risk. If the organization pushes for a quick settlement to limit costs, even when the PA disputes the claim, the PA's independent counsel retained through the PA's personal liability policy can intervene on their behalf to protect their professional and legal interests. Counsel may recommend going to trial to clear the PA's name, even if it risks a larger ultimate verdict, reporting to the NPDB, reputation, employability, and, in some circumstances, professional licensure.

Vicarious Liability, Negligent Credentialing, and Negligent Supervision

When both the PA and supervising or collaborating physician (SP) are named as co-defendants and share representation through the organization's defense team, a conflict of interest may arise, which may necessitate separate legal counsel to ensure independent advocacy for each party. There may be instances when finger-pointing may occur, and it becomes strategically advantageous for one provider to blame the other. Now, as PA professional practice laws evolve, this source of strategy may change in the coming years, but largely remains a plausible action in some cases, as the SP remains legally responsible for the PA's actions under vicarious liability. A SP's attorney may argue the PA acted outside the collaborative practice agreement, standard of care, or acted through negligent credentialing, attempting to sever the link for

vicarious liability. Conversely, the PA's attorney may argue the injury stemmed from a failure of the SP to properly supervise, delegate, or follow up. In a circumstance like this, *Cumis counsel* may apply. When a PA has their own individual liability policy, it helps ensure the PA's right to an independent defense counsel acting in their client's best interest.

Going to Trial

The Candello database, which includes over 425,000 malpractice cases from across the U.S. (representing approximately one-third of all U.S. medical malpractice claims annually), reveals that only about 5% of medical malpractice claims go to trial.[11] *Jena et al* reported that 55% of claims led to litigation. 4.5% of all claims resulted in a trial verdict, and among those that went to trial, about 80% favored the physician.[12] While most medical malpractice cases settle before trial, some proceed to court through a structured sequence of legal proceedings:

1. *Pre-trial preparation* involves several critical components: final witness preparation to ensure testimony readiness, development of trial exhibits for effective visual presentation of evidence, submission of motions in limine to exclude potentially prejudicial evidence, and participation in a pre-trial conference with the judge to address procedural matters.
2. *The trial process* itself follows a well-established progression. It begins with jury selection (voir dire), where attorneys question potential jurors to identify any biases they may have. This is followed by opening statements outlining each party's case theory.
3. *The evidentiary phase* includes the Plaintiff's case presentation, where they bear the burden of proving negligence, followed by the defense's case presentation, which challenges the Plaintiff's assertions.

4. *The trial* concludes with closing arguments summarizing each side's position. The judge then provides the jury with instructions on the applicable law before deliberations commence.
5. *Post-trial proceedings* include the announcement of the verdict, implementation of the judgment (including any monetary awards), and, in some cases, the initiation of appeals challenging procedural or substantive aspects of the trial.

Current literature on PA malpractice trends

In this groundbreaking article by *Depalma, et al*[13] in the *Journal of Medical Regulation* in 2023 in their study examined data from medical malpractice payment reports (MMPR) data from the National Practitioner Data Bank (NPDB) compared to the laws and regulations of states over 10 years (2010-2019) of states with permissive practice environments (with four or more permissive scope of practice reforms) compared to restrictive states (with three or fewer scope of practice reforms). The authors also found that there was no increased risk of PA medical malpractice reported occurrences and that removing barriers to PA Practice does not increase medical malpractice payments. The authors further concluded that through PA modernization practice reform, there would not only be fewer medical malpractice cases for PAs but also for physicians. *Hoffman et al*[14] found that healthcare providers have grown from 1.07 million (82% physicians, 10% NPs, 7.8% PAs) in 2012 to 1.34 million in 2020 (76% physicians, 15% NPs, 9% PAs) with a projection to 1.51 million in 2029 (71% physicians, 20% NPs, and 10.4% PAs). In their large and detailed database of approximately 1/3 of all claims in the US from 1/1/2012-12/31/2021 reviewed 65,724 medical malpractice cases and found that PAs were involved in 3097 cases. Despite a 94% growth of PAs/NPs with increased autonomy, responsibility, and direct patient

care since 2012 to 2021, MPL claims have remained flat. Over the same time, the proportion of MPL cases in which PAs/NPs had contributory involvement has remained < 9% and with population increases, medical professional liability (MPL) cases for PAs/NPs patients have been declining. At present, PA/NPs provide 25% of the healthcare to patients across the US, and with PAs projected to have a 20% employment growth (BLS Occupational Outlook Handbook, 2024–34)[15] it remains to be seen will this trend continue. During the COVID-19 global pandemic, in April 2020, CMS (Centers for Medicare & Medicaid Services) waived certain physician supervision requirements under Medicare, allowing more flexibility in how "direct supervision" could be satisfied (for example, via virtual presence), and regulatory federal Public Health Emergency (PHE) declarations were also enabled using various waivers and flexibilities across healthcare regulation. Each respective state also had its own version of a Public Health Emergency Order, allowing for an opportunity to study the impact of PAs practicing *without* designating a supervising physician *and* without preparing/signing prescriptive practice or scope guidelines.

Evidence-Based Medical Malpractice Liability

In their analysis of *Advanced Practice Provider and Physician Malpractice Risk*, *Hoffman et al*[14] found that breakdowns in the diagnostic process, communications, and avoiding known complications were the most identified errors. They further concluded that a collaborative team-based environment was the most successful and safe environment for patients. In the *JAAPA Podcast – PAs in Legal Medicine Parts 1 and 2*[16,17], board members and subject matter experts of *APALM*, Christopher Cannell DMSc, MPLC, PA-C; Amanda Mallory Spillman DMSc, MPLC, PA-C, Susan Ferrero MPLC, PA-C, and Adam Broughton, PA-C discussed that the best

ways PAs can mitigate risk in clinical practice: demonstrate great listening skills, perform detailed documentation with appropriate time stamps, provide detailed discharge instructions with comprehension from their patients established, empathetic and compassionate care, ensure sign outs are organized and performed with all parties understanding plans, know your guidelines for case discussions, procedures, and care models within your healthcare system, follow evidence based guidelines and scoring systems, follow up on incidental findings, check documentation for template errors or omissions. All the SMEs discussed the importance for PAs to refrain from going back into the medical record and making edits, as this action can be audited and place oneself at increased liability risk. PAs must follow system guidelines when it comes to peer review, medical executive review, and malpractice cases. Follow the recommendations of risk management, appointed attorneys, and know your state's apology laws. PAs must know the differences in liability insurance and coverage in practice and beyond. Having appropriate liability coverage and representation is essential, and without this, the financial outcomes could be catastrophic to the PA in a possible negative liability outcome.

Conclusion

Medical malpractice litigation represents one of the most challenging experiences healthcare providers may face during their careers. While the prospect of being sued can generate significant anxiety, understanding the legal process and preparing thoroughly can substantially improve outcomes and reduce personal stress.

The deposition phase represents a particularly critical juncture in the litigation process. As most cases conclude before trial, the deposition often provides the primary opportunity for healthcare providers to directly influence case outcomes. Thorough preparation, a professional demeanor, and truthful testimony are the foundational elements of an effective deposition performance.

By familiarizing themselves with the litigation process, working closely with defense counsel, and implementing the preparation strategies outlined in this review, PAs can navigate the challenges of medical malpractice litigation with greater confidence and effectiveness. While no provider is immune to litigation, proper preparation can transform uncertainty and apprehension into confidence and competent testimony.

The PA field continues to grow and is expected to grow another 20% or so in the next 10 years. PA modernization practice guidelines are changing and were studied from 2012 to 2019, with more permissive practice environments demonstrating improved MPL rates. This literature, combined with the safety and quality data coming out of the COVID-19 pandemic, has shown that the care provided by PAs is safe and high-quality. As the PA profession continues to grow, it is incumbent on PAs and healthcare systems administrators to follow proven evidence-based risk mitigation guidelines to decrease MPL risk.

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