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Urgent Care Center Emergencies:

Learning from Diagnostic Errors to Prevent and Mitigate Claims

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Urgent Care Center Emergencies:

Learning from Diagnostic Errors to Prevent and Mitigate Claims

INTRODUCTION

According to the American Academy of Urgent Care Medicine, urgent care involves providing immediate medical attention to outpatients for the treatment of both acute and chronic illnesses and injuries.¹ Urgent care practitioners are required to be proficient in evaluating and caring for any patient who arrives at an urgent care center (UCC) or clinic. This means that there is some overlap in their scope of practice with all other medical specialties that involve direct patient care.

A recent study by Kelly Wong et al. examined medical professional liability claims in emergency departments (EDs) and urgent care settings involving adult patients. Out of 6,779 closed claims, the majority (65.9%) were dropped, withdrawn, or dismissed. Settlements were reached in 22.8% of cases, with an average indemnity payment of \$297,709. Only 7.6% of cases went to trial, with the defendant prevailing in 92.6% of those cases. The remaining 7.4% resulted in jury verdicts for the plaintiff, with an average indemnity payment of \$816,909. The most commonly cited medical condition in paid claims was cardiac or cardiorespiratory arrest. Diagnostic errors were the most frequent medical mistake cited in closed claims. Death was the most commonly listed severity level in both closed and paid claims. Claims reporting major permanent injury had the highest paid-to-closed ratio, while those reporting grave injury had the highest average indemnity payment of \$686,239.²

The primary allegation in the following cases is failure to diagnose, which is a common claim in malpractice suits, including those in urgent care medicine. These cases also demonstrate failure to transfer patients to a higher and more appropriate setting for their medical emergency or failure to provide appropriate follow-up care.



Gaps in Diagnostic Workup:

Missed Traumatic Injuries Result in Death

In the following case the physician failed to perform an abdominal exam or order a CT scan to check for internal injuries after the patient presented to the UCC in 10/10 pain following a high-speed motor vehicle accident.



CASE ONE

Allegation: Negligent evaluation post-motor vehicle accident (MVA) and failure to identify traumatic injuries resulted in death.

A 35-year-old male arrived at the UCC in a private vehicle following a left-side impact high-speed MVA. The patient complained of 10/10 pain on the left side of his body involving his neck, shoulder, and ribs. His vital signs upon arrival included blood pressure of 114/75, heart rate of 57, respiratory rate of 17, and a temperature of 97.4°F. The defendant, a family medicine physician (FM), evaluated the patient. His review of systems was positive for nausea, joint pain, myalgia, and neck pain; and negative for dizziness, loss of consciousness, and headaches. On exam, the patient's head was normal and atraumatic; his pupils were equal, round, and reactive to light; and his extraocular movement was normal. Respiratory effort and breath sounds were also normal. The patient exhibited bony tenderness to palpation of the left lower ribs, dorsally, without any deformity. The FM also noted decreased range of motion, tenderness, swelling, and an obvious deformity of the left shoulder, as well as tenderness to palpation along the cervical spine. The patient was treated with ketorolac and ondansetron for his acute pain and nausea, and multiple x-rays were ordered.

The radiologist's interpretation of chest, cervical spine, and left shoulder x-rays included superior elevation of the clavicle with widening of the acromioclavicular distance to 13 mm and widening of the coracoclavicular distance to 20 mm. He did not identify any fractures on the cervical spine or chest x-rays. The patient was placed in a sling and referred to orthopedics for further treatment of suspected acromioclavicular joint separation.

Approximately seven hours later, 911 received a call from the patient's daughter saying he had collapsed at home. Emergency medical technicians arrived to find the patient supine on the floor without a pulse. Mechanical respirations were done en route to the community hospital, where spontaneous respirations were reestablished. The patient was transferred to a Level II trauma center. An exploratory laparotomy revealed multiple large lacerations to the anterior and posterior spleen with no active bleeding. The surgeon noted a large, old hematoma which had resulted in an estimated blood loss of 2000 cc. A splenectomy was performed. In the postanesthesia care unit (PACU) the patient was hemodynamically stable, but his prognosis was poor. Post-op spinal CT found no significant spinal abnormalities. A CT of the head revealed effacement of the gyri and sulci associated with effacement of the perimesencephalic cistern, cerebral edema, and bilateral subdural hematomas. Post-op CT of the abdomen and pelvis revealed a significant liver laceration involving the lateral segment of the left lobe of the liver. The patient thereafter declined and expired. The autopsy report listed the cause of death as "blunt force injuries of the head and torso."



DISCUSSION

None of the defense consultants were able to support the FM's care. The urgent care/emergency medicine expert believed the FM fell below the standard of care (SOC) because, in the context of a high-speed MVA and left rib tenderness, the patient should have been referred immediately for a CT of the abdomen and pelvis. According to the expert, this should be the case regardless of whether a rib/abdominal exam revealed abnormalities. Left lower rib pain following a high-speed MVA indicates spleen injury until definitively ruled out. Here we know the patient suffered a spleen injury. This expert further noted that he would not expect a patient to die from a spleen injury less than a day later, especially since he was taken to the operating room and the spleen was removed. He thought the death most likely was related to the patient's head injury. The expert was also critical of the FM's neurological evaluation as he only noted that a review of symptoms was negative for dizziness, loss of consciousness, and headaches. The expert further opined that ideally there would be a notation that the patient was alert and oriented, or a reference to his reflexes or movement. In his defense the FM testified that if there were noticeable neurological deficits they would have been noted. Furthermore, the FM independently recalled the patient being alert and oriented. Accordingly, the FM did not believe the SOC required any neurological imaging or an ED referral.

A second emergency medicine consultant believed the primary issue of concern in the case was the FM's failure to address the patient's complaint of left rib pain. The consultant asserted that at a minimum the SOC required an abdominal exam, which was not done. If it had been done and there were positive findings, the consultant opined that the SOC would further require the FM to send the patient to the ED. Since the FM did not document an abdominal exam, did not recall performing one, and could not testify to performing one by customary practice, the expert could not support the FM's care.

...even though the patient presented at urgent care with normal vital signs, no neurological impairment, and no abdominal pain, an ED trauma center would have performed head-to-toe CT scans because injuries to the liver and spleen can be asymptomatic.

A general and trauma surgeon consultant opined that even though the patient presented at urgent care with normal vital signs, no neurological impairment, and no abdominal pain, an ED trauma center would have performed head-to-toe CT scans because injuries to the liver and spleen can be asymptomatic. The expert believed the patient died from cardiac arrest due to hemorrhagic shock, which was caused by significant bleeding into the abdomen from the spleen laceration, and possibly liver laceration. He also opined that the 2000 cc hematoma found intraoperatively was significant and approximately 40% of one's total blood volume. The surgeon consultant stated that blood loss from the spleen can be variable and can progress either slowly or rapidly. He said the bleed likely started off slowly, resulting in normal vital signs at the UCC. This consultant further opined that if the patient's splenic injury had been diagnosed earlier he could have been transfused and may not have required surgery.

The neurosurgery expert opined that the patient's death was a direct result of his splenic injuries and that the UCC records showed no evidence of traumatic head injury or the need to refer the patient for a CT of the head. The expert stated that the CT performed after the splenic injury showed a prolonged period of anoxia and findings of a hypoxic injury rather than one caused by trauma. He also said that the patient went into hemorrhagic shock from the splenic injuries, then into cardiac arrest. The expert's opinion was that he likely had a severe anoxic/hypoxic brain injury by the time he was taken to surgery at the trauma center.

The recommendation was made to settle the case due to no SOC support and varying opinions on causation.



KNOWING WHEN TO REFER: RISK REDUCTION STRATEGIES

Patients may choose care from a UCC instead of an ED, primary care physician, or specialist for many reasons, including a UCC's greater convenience and lower cost. But UCCs are often only equipped to provide care for episodic, subacute illnesses and injuries. Although UCCs are not intended to treat medical emergencies, they should be reasonably prepared to properly handle emergencies or conditions that require care beyond the center's capabilities. Consider the following risk reduction strategies:

- Review the UCC's current scope of practice and define its scope of services.
- Evaluate the capability of the physical plant, staffing, equipment, information management, and clinical protocols to meet the needs of the target patient population.
- Use a systems-based approach to implement diagnostic and treatment protocols within the scope of services offered.
- Ensure appropriate clinical guidelines are in place for services offered.
- Identify clinical scenarios that require referral to a higher level of care and should therefore be categorized as emergent. Mechanism of injury should be considered regardless of clinical presentation in certain instances.
- Adopt policies and procedures for stabilization and transfer to higher-level facilities for patients whose needs exceed the UCC's capabilities.
- Include criteria for contacting 911 and/or arranging transport to an emergency facility for patients with life-threatening conditions.
- Develop transfer agreements with local and regional higher-level facilities.
- Connect to a network of medical specialists to facilitate timely referrals.

It is imperative that good UCC follow-up systems are in place to keep patients and their medical information moving effectively and safely throughout the care continuum. Having thorough, well-organized, and consistently utilized systems in place to support and communicate patients' healthcare needs can diminish patient injury and liability risks.



Knockout Punch:

How a “Fight Bite” Progressed to an Extensive Infection Requiring Joint Replacement

This case study involves a patient who suffered complications due to a misdiagnosis and improper treatment of a fight bite injury. The case highlights the importance of eliciting a thorough patient history to land on the proper diagnosis and avoid treatment delays. Further, it demonstrates the importance of documentation to aid in the defensibility of a claim when a resultant patient injury occurs.



CASE TWO

Allegation: Failure to identify a fight bite and initiate treatment with antibiotics caused infection and osteomyelitis, which eventually resulted in the need for a right middle metacarpophalangeal (MCP) joint replacement.

A 26-year-old male was involved in a bar fight in which he punched his opponent in the mouth with his right clenched fist, resulting in a bite wound known as a fight bite. After the fight he went home and noticed a small cut on his right third knuckle. He cleaned the area with soap, water, and peroxide and then fell asleep for the night.

**JUNE
23**

On June 23, 2017, approximately 12 hours after the fight, the patient presented to a UCC complaining of right-hand pain and swelling. The defendant, an FM, evaluated the patient. On exam he noted an abrasion, contusion, and swelling over the right third-finger MCP joint. He also noted intact sensation distally and the inability to form a fist. He ordered x-rays and suspected a possible nondisplaced proximal phalanx fracture of the third finger. The patient was treated with a splint and referred to an orthopedist for further care. He was advised to ice and use nonsteroidal anti-inflammatory drugs (NSAIDs) for pain, and was given a copy of his x-rays upon discharge.

**JUNE
24**

On June 24, 2017, the UCC received the radiologist's reading of the x-rays which noted dorsal soft tissue swelling and no definite fracture. The same day the patient was notified of the results and told to see an orthopedist if his pain persisted.

**JUNE
25**

On June 25, 2017, the UCC called the patient to follow up, and the patient reported continued pain and swelling. He was again advised to follow up with an orthopedist. Instead, the patient presented to an ED for further care.

The ED physician noted 8/10 worsening hand pain with associated redness and swelling since the patient hit his friend's tooth three nights prior. The record also noted that he had been seen at the UCC two days prior, assessed with a fracture, and that antibiotics had not been started. Vital signs revealed a temperature of 100°F, pulse rate of 84, and blood pressure of 143/90. On exam the ED physician identified significant edema and erythema from the proximal phalanges to above the wrist, and the inability to fully flex all fingers. X-rays identified diffuse dorsal subcutaneous edema and no fracture. Labs revealed white blood cell (WBC) count of 11.65 and normal lactic acid. A general surgeon evaluated him in the ED and admitted him with a diagnosis of rapid onset cellulitis from a fight bite. He began treatment with IV antibiotics and morphine. He also consulted plastic surgery for cellulitis, possible abscess, or tenosynovitis.

**JUNE
26**

On June 26, 2017, the plastic surgeon noted two puncture wounds, swelling, and erythema to the mid-forearm. He performed right hand and finger debridement which released 5 cc of purulent drainage. He identified a complete right middle finger extensor tendon laceration proximal to the MCP joint. He planned to allow the suspected infection to resolve prior to performing a tendon repair. Wound cultures from this surgery grew only mixed skin flora. Blood cultures revealed no growth after five days. The patient was discharged home on June 28, 2017, with oral antibiotics.

**JULY
3**

On July 3, 2017, the patient underwent tendon repair surgery with the plastic surgeon, who saw no further signs of infection. The patient was advised to continue oral antibiotics. His wound culture from surgery was positive for 1+ polys and 1+ gram-positive cocci in clusters.

**JULY
20**

On July 20, 2017, the plastic surgeon performed right hand debridement, noting significantly decreased swelling and cellulitis but continued purulent drainage and tendon repair dehiscence. Cultures from this surgery were negative and an MRI was ordered. On August 10, 2017, MRI of the right hand was concerning for osteomyelitis at the third metacarpal and a possible abscess collection within the bone.

**AUGUST
13**

On August 13, 2017, a new hand surgeon took over the patient's care to address the osteomyelitis and ultimately performed right MCP joint incision and drainage as well as craterization of the bone. He noted extensive infection and necrotic tissue, overall consistent with chronic active osteomyelitis. Wound and tissue cultures identified 1+ alpha-hemolytic streptococcus. Infectious disease reviewed current and previous cultures and felt oral flora was the likely infection etiology due to the mechanism of injury. He initiated treatment with IV vancomycin and ertapenem, which would continue until October 3, 2017.

While the patient's infection eventually resolved, over time he became unable to extend his right middle finger and ultimately underwent a right middle finger MCP joint replacement arthroplasty and extensor tendon reconstruction and graft on January 6, 2018. He reported continued joint pain, popping, and numbness as of October 1, 2018, and was offered revision surgery versus pain management but did not pursue either option.



DISCUSSION

The plaintiff's experts who reviewed this case were not supportive of the UCC physician's management of the patient. The emergency medicine expert opined that the plaintiff had a classic clenched-fist fight bite injury and that skin disruption allowed a portal for infection. He stated that both the UCC nurse and physician failed to elicit the mechanism of injury; clean and irrigate the wound; start oral antibiotics; and later refer the plaintiff to the ED for admission, IV antibiotics, hand surgery consult, exploration, and debridement. He felt that these failures significantly contributed to the plaintiff's complications.

The plaintiff's orthopedic surgery expert stated that the extensor tendon laceration, deep infection, surgeries, and joint arthritis were caused by the negligent treatment of the plaintiff's injuries at the UCC. Further, he opined that joint replacement and tendon reconstruction were due to the severity of the infection and that the injury would require future care as well as potential surgical intervention and pain management.

The plaintiff's infectious disease expert believed that the bite injury inoculated aggressive bacteria and organisms deep into the wound and rapidly caused significant tissue destruction, and that prompt wound management and antibiotics were critical to help mitigate the clinical course. It was his opinion that the plaintiff's chronic osteomyelitis and multiple procedures stemmed from the lack of proper wound management and antibiotics at the UCC. A bite wound, the expert said, required antibiotics. Further, he stated that the UCC physician failed to obtain a complete history of the injury to determine the appropriate treatment.

The plaintiff's infectious disease expert believed that the bite injury inoculated aggressive bacteria and organisms deep into the wound and rapidly caused significant tissue destruction, and that prompt wound management and antibiotics were critical to help mitigate the clinical course.

Experts for the defense were somewhat supportive of the UCC physician's care. The internal medicine expert opined that the care was appropriate for management of a nondisplaced digit fracture and that clinical history supported his diagnosis. The expert noted that no one at the UCC documented a history of a fight and that a UCC physician is not required to get a complete history from a reluctant patient. Moreover she felt it unlikely that the plaintiff's wound was not cleaned on June 23, 2017, that a healing abrasion does not require antibiotics, and that this injury did not require an emergency referral to orthopedics. The orthopedic hand surgery expert believed the plaintiff's age and swollen hand required the UCC physician to ask whether he had been in a fight and to be concerned about infection. However, the expert also believed the initial impact injury caused the tendon laceration, not the infection. He believed the UCC treatment was appropriate and that the patient's injuries were related to his delay in treatment between June 23 and June 25, 2017, and to the nature of a fight bite—not to negligence.

The case was complicated by the FM and patient's conflicting recollection of events during testimony. The FM testified that the patient said that he'd struck his hand on "something," but without explanation as to what he struck. The patient testified that he told the FM he had been in a fight and that the physician remarked that the mouth was the dirtiest place to hit someone. The FM also testified that the patient was told to see an orthopedist that day, and this would have been possible given his relationship with the provider who commonly accepted same-day referrals. The patient testified he was advised to see an orthopedist only if his pain persisted. Lack of documentation outlining these specifics would have complicated defense at trial. Because of the limited support for the UCC physician's actions, failure to elicit the mechanism of injury, and lack of documentation, the case was settled for a reasonable amount per the wishes of the insureds.



PREVENTING DIAGNOSTIC ERROR: RISK REDUCTION STRATEGIES

According to the Institute of Medicine (IOM), diagnostic error refers to the inability to provide a precise and timely diagnosis of the patient's health condition or to effectively communicate the diagnosis to the patient.³ Measuring and reducing diagnostic error has been identified as a patient safety priority by both the World Health Organization and IOM in the United States. Diagnosis is a complex process that can be influenced by various factors including systems, cognitive abilities, teamwork, and social factors.⁴ A variety of strategies is necessary to reduce diagnostic errors. The last case highlights the importance of eliciting a thorough history in order to make a precise and timely diagnosis of the patient's condition. It also highlights how documentation may become the most important piece of evidence in the successful defense of a medical professional liability claim. Consider the following risk reduction strategies:

- Identify interventions and resources to improve decision-making and reduce cognitive errors. The Society to Improve Diagnosis in Medicine (SIDM) offers resources in collaboration with Health Research & Educational Trust, such as the [Improving Diagnosis in Medicine Change Package](#),⁵ for clinical team members to improve cognitive skills and work within their health systems to improve the diagnostic process.
- Gain insight into cognitive and affective influences that have resulted in delayed or missed diagnoses. SIDM also offers a [Clinical Reasoning Toolkit](#)⁶ clinical team members can explore to learn more about the causes of errors in clinical reasoning and the key factors in making more mindful decisions.
- Improve diagnostic accuracy by utilizing tools such as checklists, algorithms, cognitive aids (e.g., mnemonics), clinical practice guidelines, and handheld computers.
- Follow up on patient outcomes after initiating referral to specialists, or transfer to a higher level of care to gain feedback on your diagnostic performance. Use lessons learned as staff education and training opportunities.
- Ensure your documentation includes all relevant information about the patient's history, physical exam, diagnosis, treatment plan, and any follow-up care that is needed. Incorporate patient education efforts and patient acknowledgment of the care plan, including risk of noncompliance should they choose to delay or forgo a referral to a specialist or higher level of care. Use clear and precise language and be sure to avoid making assumptions or leaving out important details.



Urgent Care Center Emergencies:

Learning from Diagnostic Errors to Prevent and Mitigate Claims

CONCLUSION

In urgent care settings, these issues can prompt allegations of negligence: diagnostic error, failure to be reasonably prepared to handle emergencies or conditions that require care beyond the UCC's capabilities, failure to transfer a patient to a higher and more appropriate care setting in a timely manner, and failure to provide appropriate follow-up care. Healthcare professionals can help ensure the best possible outcomes for their patients by being aware of these risks and taking steps to avoid them. Appropriate documentation in the medical record is also essential and can aid in the defensibility of a claim when a resultant patient injury occurs.

See page 13 for details on how to earn continuing medical education credit for completing this course.

ENDNOTES

The documents referenced in this article, along with many other risk management resource documents and past editions of *Claims Rx*, are available by calling Risk Management at 844-223-9648 or by email at RiskAdvisor@ProAssurance.com.

1. "What Is Urgent Care Medicine?" American Academy of Urgent Care Medicine, accessed April 25, 2023, <https://aaucm.org/what-is-urgent-care-medicine/?ftag=MSFd61514f>.
2. Kelly E. Wong et al., "Emergency Department and Urgent Care Medical Malpractice Claims 2001–15," *Western Journal of Emergency Medicine* 22, no. 2 (2021): 333–338, <https://doi.org/10.5811/westjem.2020.9.48845>.
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4. Hardeep Singh, Denise M. Connor, and Gurpreet Dhaliwal, "Five Strategies for Clinicians To Advance Diagnostic Excellence," *BMJ* (February 2022): 376:e068044, <https://doi.org/10.1136/bmj-2021-068044>.
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6. "Clinical Reasoning Toolkit," Society to Improve Diagnosis in Medicine, accessed May 3, 2023, <https://www.improvediagnosis.org/clinical-reasoning-toolkit-how-we-make-decisions/>.

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