

# Physician Shortage Malpractice Impact and Risk Solutions

Explore 2025

Graham Billingham, MD, FACEP, FAAEM



MedPro Group

a Redden Healthcare company

## Speaker bio

**Graham Billingham, MD, FACEP, FAAEM, Chief Medical Officer, MedPro Group**  
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Dr. Billingham has 40 years of experience as an emergency medicine physician. He speaks nationally and internationally and has lectured in more than 400 continuing medical education courses on risk management, operations, patient safety, documentation, information technology, coding and billing, and malpractice prevention.

As MedPro's Chief Medical Officer, he is responsible for leading the company's Risk Solutions department and working with other leaders to support clinical risk, claims, underwriting, and sales efforts. His team focuses on improving patient safety and outcomes, decreasing risk and preventing claims before they happen.

Prior to joining MedPro, Dr. Billingham served as president and CEO for EPIC RRG. He also served on the physician advisory boards of several technology companies and the American College of Emergency Physicians' Medical Legal Committee and Coding and Nomenclature Committee. He is emeritus chairman of the Emergency Medicine Patient Safety Foundation and has served on the Emergency Department Practice Management Association's Board of Directors.

Dr. Billingham also founded and served as medical director for the Center for Emergency Medical Education and was a co-founder of the National Emergency Medicine Board Review Course.



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## Disclosure

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When there are relevant financial relationships mitigation steps are taken. Additionally, the individual(s) will be listed by name, along with the name of the commercial interest with which the person has a relationship and the nature of the relationship.

Today's faculty, as well as CE planners, content developers, reviewers, editors, and Risk Solutions staff at MedPro Group, have reported that they have no relevant financial relationships with any commercial interests.



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## Agenda

Overview of healthcare staffing challenges

Factors contributing to staffing challenges

Litigation in healthcare staffing

Strategies to mitigate staffing challenges

Future outlook and recommendations



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## Healthcare Staffing Challenges

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## Healthcare delivery changes



**Corporatization of medicine**  
Including private equity investments



**CV19 impact on population health**  
Deferred care, missed care, etc.



**Healthcare consolidation**  
Larger, more complex healthcare systems



**Healthcare staffing**  
Contract staffing, provider burnout, turnover, violence



**Physician employment**  
Less private practice, more corporate/hospital



**Scope of practice**  
Expanding for PAs, NPs, CRNAs, etc.



**Shifting environment of care**  
More outpatient, home health, telehealth, etc.



**Technology innovations**  
Artificial intelligence (AI), genomics, etc.



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### The problem: Physician supply vs demand

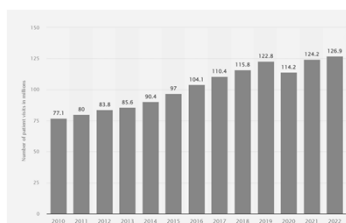


Projected supply of and demand for physicians, 2026, 2031, and 2036

	2026	2031	2036
Supply	919,370	938,510	969,740
Demand	1,027,220	1,073,150	1,109,680
Surplus / (Shortage)	(107,850)	(134,640)	(139,940)
Percent Adequacy	90%	87%	87%

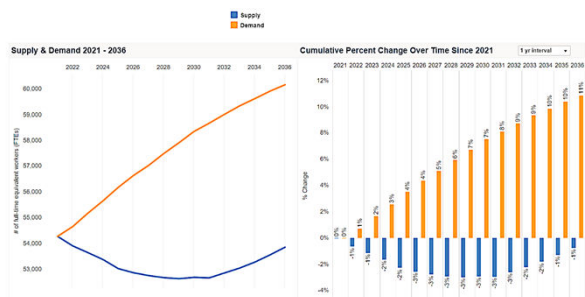
Source: Department of Health and Human Services, Health Resources and Services Administration, Health Workforce Projections. Available at <https://www.hrsa.gov/data-research/review-health-workforce-research>

### Total number of US health center patient visits



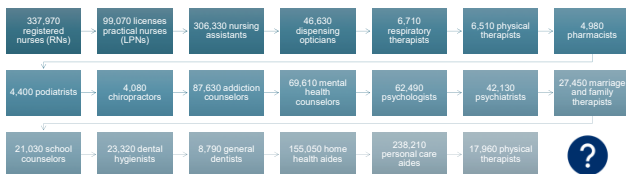
Retrieved from: <https://www.statista.com/statistics/752327/health-center-patient-visits-in-us/>

### All healthcare workforce



## It's not just the docs

Over the next 15 years (through 2036), NCHWA projects shortages in many key allied health occupations, including:



Retrieved from <https://data.bna.gov/data-research/projecting-health-workforce-supply-demand>

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## We are creating healthcare deserts

Number of healthcare deserts



Healthcare Deserts,  
County by County

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## Consumer sentiment: digital technology



45% of consumers own a wearable health device or use a smartphone to track wellness

More than 1 million smart rings were sold in 2022

More than 7 million continuous glucose sensors were sold in 2023

Bloomberg estimates the wearables market will grow to \$76 billion by 2028

Bloomberg estimates the wearables market will grow to \$76 billion by 2028

57% believe the data is useful and want their doctors to collect it

74% of millennials prefer teleconsultations to in-person appointments

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### Contributing factors

#### Workforce issues

- Insufficient staffing
- Burnout: High-stress workload can cause healthcare workers to leave the profession
- Training bottlenecks: Limited capacity in medical and nursing schools can restrict the number of new graduates entering the workforce

#### Economic factors

- Insufficient funding for healthcare systems can limit resources available for hiring and retaining staff workforce

#### Demographic disparities

- An aging patient population often requires more healthcare services, straining existing resources
- Chronic conditions can increase the demand on healthcare services

#### Policy and regulation

- Complex licensing processes can delay the entry of qualified professionals into the workforce



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### Contributing factors

#### Geographic disparities

- Rural areas experience more shortages of healthcare providers
- Healthcare deserts

#### Technological changes

- Introducing new technologies may outpace the training and adaptation of healthcare personnel

#### Insurance and access issues

- Insurance limitations: Changes in insurance coverage can affect the number of patients seeking care and the types of services available

#### Social determinants of health

- Inequities: Socioeconomic factors can affect access to care and the ability to respond to community needs



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**MPL Impact**

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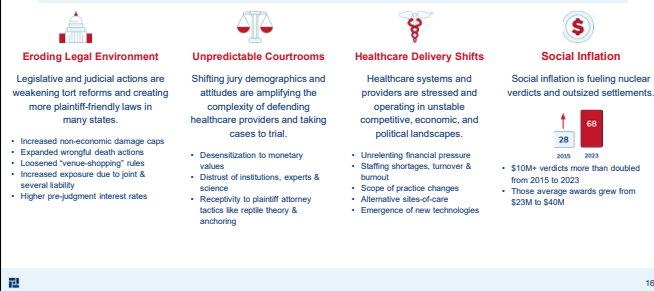
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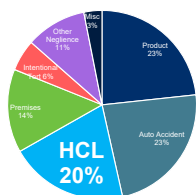
## Biggest Known Risk: step-change in severity

Headwinds driving a step-change in severity for US HCL insurers



## Social inflation

Many factors drive social inflation across many US industries ... HCL is ~20% of nuclear verdicts (economic inflation less a factor now back to historic norms)



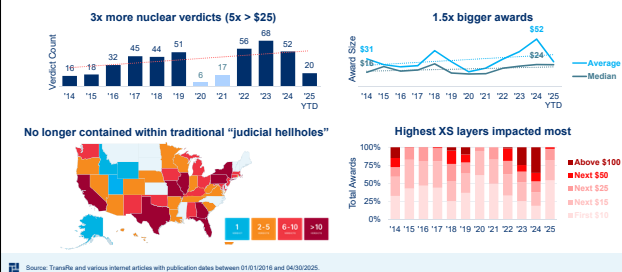
INCREASED CLASS ACTION LITIGATION  
SOPHISTICATION & ORGANIZATION OF PLAINTIFF BAR  
POLITICIZATION OF HEALTHCARE  
VIEWS OF SOCIAL RESPONSIBILITY & RIGHTING WRONGS  
USING SOCIAL MEDIA, NEWS & ADVERTISING BY PLAINTIFF BAR  
HEALTHCARE CONSUMER EXPERIENCE  
DESENSITIZATION TO LARGE VERDICTS & SETTLEMENTS  
THIRD-PARTY LITIGATION FUNDING  
TREATMENT & INTERPRETATION OF CLAIMS  
PSYCHOLOGICAL TACTICS USED BY PLAINTIFF BAR  
DISTRUST OF CORPORATIONS & INSTITUTIONS  
DIMINISHED VALUE OF MONEY  
JURY DEMOGRAPHICS

U.S. Chamber for Commerce Institute for Legal Reform – May 2024

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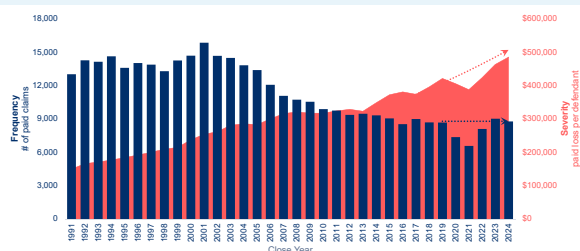
## The micro result: US HCL nuclear verdicts continue to increase

Nuclear verdict frequency and severity have risen over the past decade ... increasing settlement values, and less discounting from verdicts-to-settlements. Is lower '24 frequency driven by fear of going to trial (also leading to higher settlement values)?



### The macro result: increasing loss trends due to severity ...

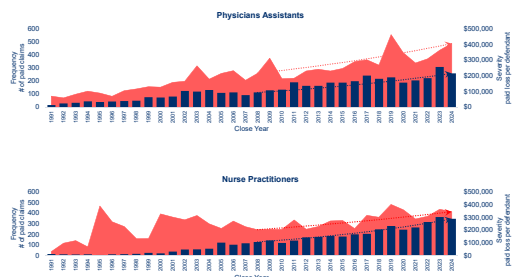
Industry trends: frequency flat & severity up (excl. impact of CV19).  
Will general economic inflation impact these trends?



Source: National Practitioner Data Bank Public Use Data File, December 2024, Physicians, Surgeons, Nurse Anesthetists, Nurse Practitioners, Physician Assistants, and Nurse-Midwives Countrywide

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### Severity & social inflation: loss trends for Advanced Practitioners



Source: National Practitioner Data Bank Public Use Data File, December 2024, Nurse Anesthetists, Nurse Practitioners, Physician Assistants, and Nurse-Midwives Countrywide

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### Malpractice litigation staffing impact



- Transactional nature of medicine
- Bridge Physicians
- Increased scope of practice
- Work-arounds are dangerous
- Locum tenens and staffing agencies
- Regulatory Compliance with Staffing ratios
- Boarding patients
- Transfers
- Private Equity
- Technology has limitations
- Loss of historical and institutional knowledge
- Does an AI solutions require informed consent?

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## Challenges

Rural recruiting – school debt relief

Private equity models – mixed blessing – patient vs. profit?

Sub specialization – reimbursement model

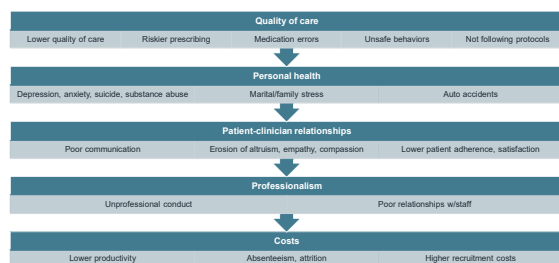
How decisions are traditionally made – BOGSATLGW

Physician unions on the rise

Locums tenums



## Burnout



## Litigation causes

### Malpractice issues

• Malpractice claims arise when healthcare providers fail to meet the standard of care, leading to patient harm. Understanding these claims is crucial in mitigating risk.

### Staffing shortages

• Staffing shortages can increase stress and errors among healthcare providers, resulting in potential litigation. Addressing these shortages is vital for care quality.

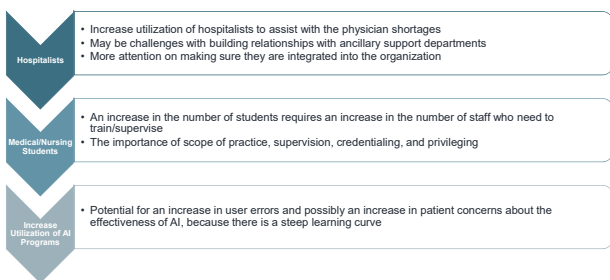
### Regulatory compliance failures

• Failure to comply with healthcare regulations can result in penalties and litigation. Organizations must prioritize understanding and adhering to these regulations.





### Agency staff – litigation pressure



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### Oklahoma Legislation

- **Oklahoma:** Neither the Oklahoma Workers' Compensation Act nor case law directly addresses the exclusive remedy rule in connection with employee leasing situations. The Oklahoma Court of Appeals, however, has held that a worker assigned by a temporary agency to a client company is considered a loan servant, and that both employers are responsible for the provision of workers' compensation, and therefore cannot be sued in a third-party action. *Zant v. People Electric Cooperative*, 900 P.2d 1008 (Okla. App. 1995).

• [Van Zant v. Peoples Elec. Co-op. :: 1995 :: Oklahoma Court of Civil Appeals Decisions :: Oklahoma Case Law :: Oklahoma Law :: U.S. Law :: Justia](#)



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### Oklahoma Scope of Practice

- **HB2298 (Hilbert/Paxton)** – Grants independent prescriptive authority to Advanced Practicing Nurses who meet certain requirements. Passed House; Amended and Passed Senate HHS (SPEAKER/PRO TEM BILL)
- **HB2584 (Hilbert/Paxton)** – Establishes standards related to physician assistants, establishing a pathway to independent practice for PAs meeting certain requirements and setting oversight authority. Passed House; Amended and Passed Senate HHS (SPEAKER/PRO TEM BILL)
- **SB741 (Gollihare)** – Allows pharmacist to test, screen, and initiate drug therapy for nonchronic health conditions. Passed Senate HHS Committee – Title Stricken\*; Laid Over on the Senate Floor (OPPOSE) (DORMANT\*)
- **HB1173 (Stark)** – Establishes standards for licensed psychologists to prescribe certain psychotropic medication under limited circumstances and with the supervision of a physician. Passed House Public Health; not heard in Oversight Committee (OPPOSE) (DORMANT\*)

\*DORMANT means the bill did not advance in 2025 but can be reconsidered in 2026



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## Indemnification clause

To reimburse (another) for a loss suffered because of a third party's or one's own act or default

Subcontractor shall be solely responsible for compliance with the obligations of this clause with respect to any Protected Health Information it retains and shall indemnify, defend, and hold harmless Client and its employees, directors, officers, representatives, and agents from and against any and all claims, obligations, actions, suits, debts, judgments, losses, fines, penalties, damages, costs, expenses (including reasonable attorney's fees), and other liabilities they may incur from Subcontractor's violation of such obligations.



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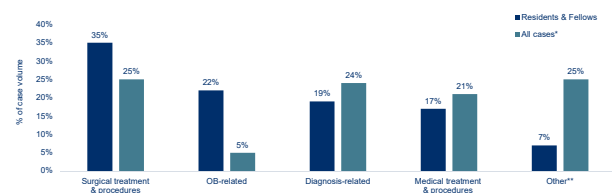
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## Most Common Major Allegations

INTRODUCTION | KEY POINTS | GENERAL DATA ANALYSIS | CONTRIBUTION FACTORS | FOCUSED DATA ANALYSIS | RISK MITIGATION

Each case reflects one major allegation category. Categories are designed to enable the grouping and analysis of similar cases and to drive focused risk mitigation efforts. The coding taxonomy includes detailed allegation sub-categories; insight into these is noted later in this report. With the exception of OB cases, the distribution of allegations stemming from cases involving residents and fellows is relatively similar to all other cases.



\*All Group + M&MC cases opened 2014-2023. Residents & Fellows in a primary responsible service site (2014-2023). \*\*All cases with any site identified (2014-2023). \*\*\*Other includes allegations for which no significant findings were identified.

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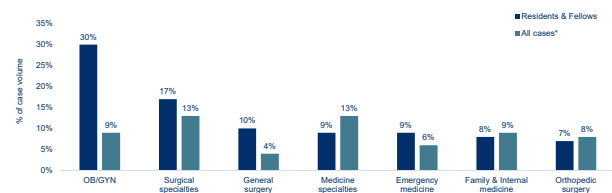
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## Most Common Primary Responsible Services

INTRODUCTION | KEY POINTS | GENERAL DATA ANALYSIS | CONTRIBUTION FACTORS | FOCUSED DATA ANALYSIS | RISK MITIGATION

A malpractice case can have more than one responsible service, but the "primary responsible service" is the specialty that is deemed to be most responsible for the resulting patient outcome. With the exception of OB/GYN cases, and to a lesser extent general surgery, the distribution of primary responsible services stemming from cases involving residents and fellows is relatively similar to all other cases.



\*All Group + M&MC cases opened 2014-2023. Residents & Fellows in a primary responsible service site (2014-2023). \*\*All cases with any site identified (2014-2023).

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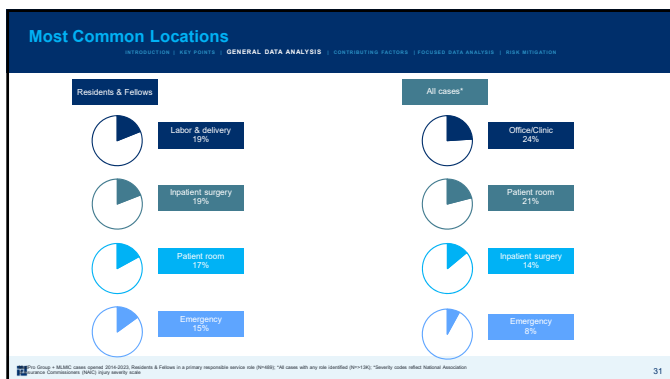
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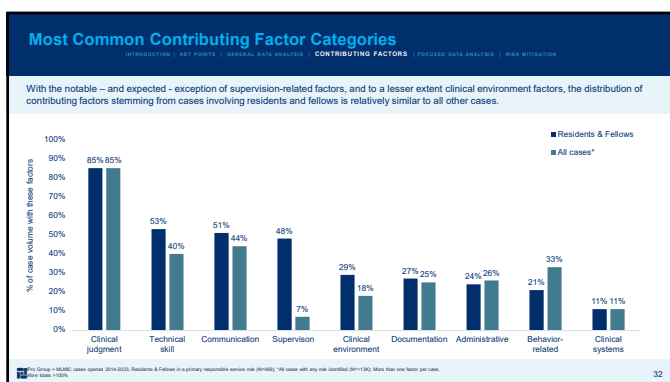
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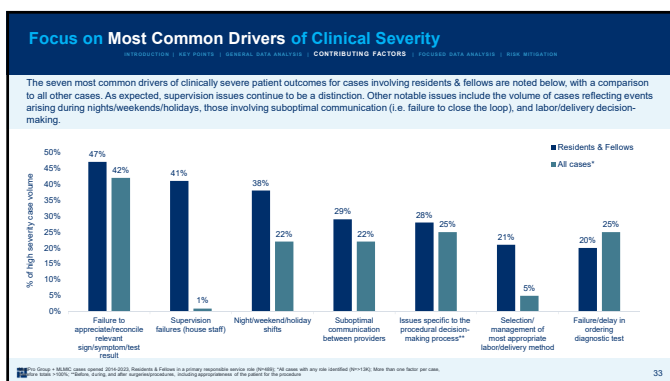
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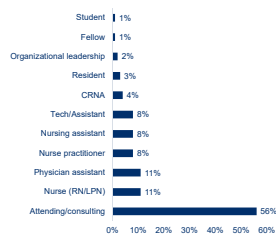
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## APPs with a primary role in claim



Credentialing

Privileging

Supervision

Increasing scope of practice

More patient volume

More complex patients

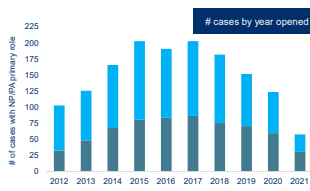
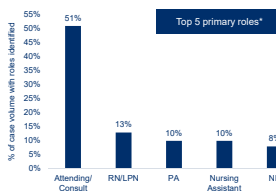
No longer get a free pass

Compliance with staffing ratios

MedPro Group • MLMC cases opened 2012-2021 (N=22,626)

## Overall Case Volume

INTRODUCTION | KEY POINTS | GENERAL DATA ANALYSIS | CONTRIBUTING FACTORS | FOCUSED DATA ANALYSIS | CASE EXAMPLES | RISK MITIGATION



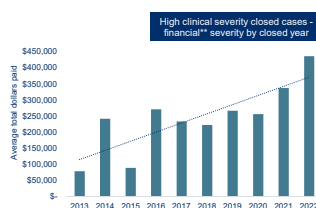
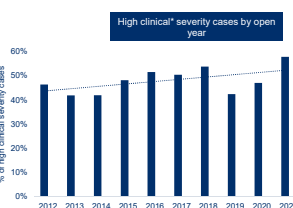
While the attending/consult physician role is most prevalent, **NPs and PAs combined are noted in 18% of all cases**.  
As the involvement of NPs and PAs in healthcare has continued to climb, it is not surprising to see cases noting  
NPs and PAs in the primary role steadily increasing over many of the past 10 years. The unexpected more  
recent decline in this data set is likely related to the fact that not all cases opened in 2020 and 2021 have yet matured  
for coding.

MedPro Group • MLMC cases opened 2012-2021; NP or PA as primary responsible service role (N=1466; NP=646; PA=820); more than one role possible per case; "0" cases in which a primary role is identified (potential code error due to too few cases to generate)

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## Clinical\* & Financial Severity

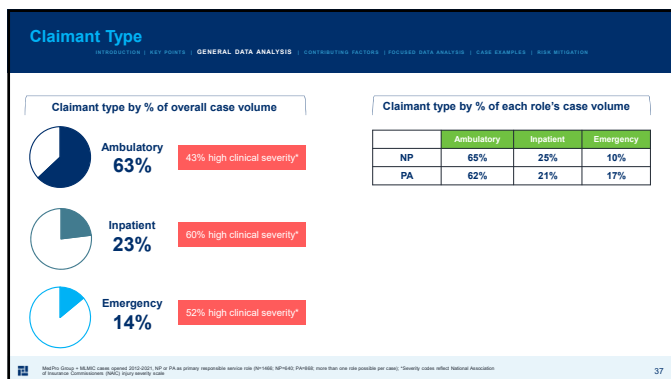
INTRODUCTION | KEY POINTS | GENERAL DATA ANALYSIS | CONTRIBUTING FACTORS | FOCUSED DATA ANALYSIS | CASE EXAMPLES | RISK MITIGATION



Across the years, the percentage of cases opened each year noting a high clinical severity outcome is steadily rising. Likewise, the average cost to resolve high clinical severity cases is rapidly increasing.

MedPro Group • MLMC cases opened 2012-2021; NP or PA as primary responsible service role (N=1466; NP=646; PA=820); more than one role possible per case; \*Severity codes reflect National Association of Insurance Commissioners (NAIC) injury severity code (high severity 8-10); \*\*Total dollar paid = reported + indemnity high severity closed case (N=105)

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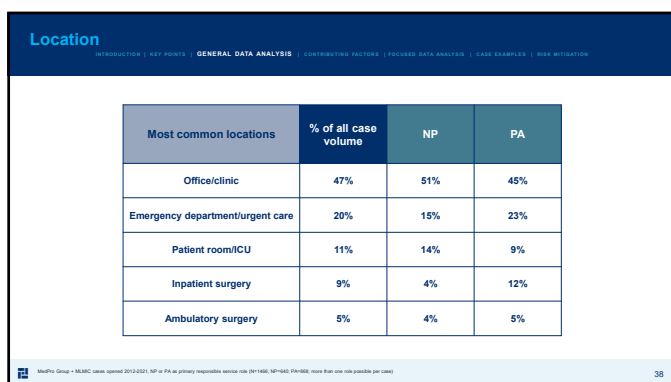
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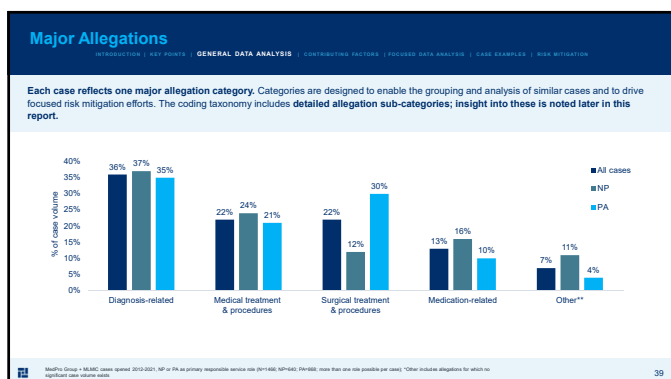
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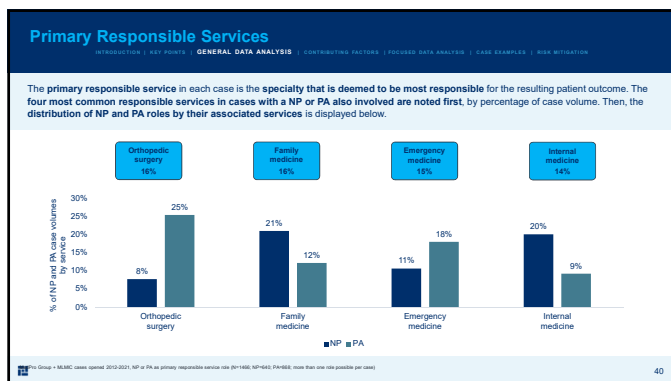
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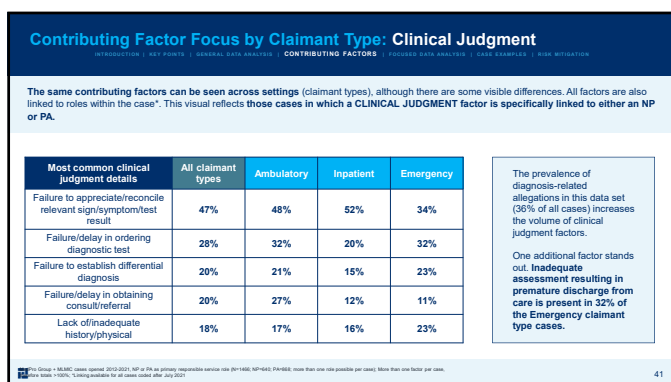
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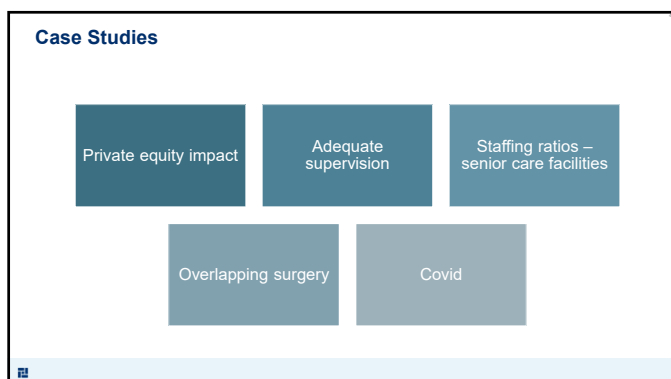
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Introductory Case Examples

INTRODUCTION | SET POINTS | JOURNAL DATA ANALYSIS | CONTRIBUTING FACTORS | FOCUSSED DATA ANALYSIS | CASE EXAMPLES | RISK MITIGATION

SETTLED

\$4.3M

RESPONSIBLE SERVICE

Internal medicine (supervising specialty)

PRIMARY ROLE

Nurse practitioner

FAILURE TO DIAGNOSE STROKE

Patient's **anticoagulation regimen** was being regularly monitored every six months by his internal medicine physician; INR levels remained stable and in the therapeutic range.

On a **Sunday**, the patient presented to an urgent care clinic for a headache and neck pain (8/10 reported pain level). The physician assistant (PA) prescribed Vicodin and discharged the patient to home.

Two days later, the patient returned to the same clinic with increased head and neck pain (now 10/10). The nurse practitioner (NP) examined him, and prescribed a muscle relaxant. The NP's chart documentation was very poorly written; it contained no detail regarding whether a neurological exam was completed, only that the patient had "no focal deficits." No head CT was ordered, despite readily available chart reference to the patient's chronic anticoagulant use, and repeat visits for head and neck pain.

The next day, the patient was taken to the Emergency Department with a vertebral dissection and hemorrhagic stroke.

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Introductory Case Examples

INTRODUCTION | SET POINTS | JOURNAL DATA ANALYSIS | CONTRIBUTING FACTORS | FOCUSSED DATA ANALYSIS | CASE EXAMPLES | RISK MITIGATION

SETTLED

\$600K

RESPONSIBLE SERVICE

General surgery (supervising specialty)

PRIMARY ROLE

Physician assistant

IMPROPER PERFORMANCE OF SURGERY AND IMPROPER MANAGEMENT OF A SURGICAL PATIENT

A general surgeon performed a laparoscopic reduction and repair of a complex para-esophageal hiatal hernia. On post-operative day one, the patient complained of left shoulder pain. Some lab results were concerning, but **no new differential diagnoses were considered**.

Discharge was planned, but the patient stated he didn't feel ready; he told the surgical physician assistant (PA) that he was unable to eat or drink (even clear liquids didn't go down smoothly).

Despite a low grade fever, belching, nausea, and newly elevated blood pressures, the patient was discharged to home three days post-operatively on pureed diet. He died one day later.

Autopsy revealed gastric necrosis and perforation. Experts were critical, opining there was a deviation by both the general surgeon and the surgical PA in prematurely discharging this patient; both failed to order imaging studies and timely intervene with placement of a nasogastric tube for decompression or surgery that would have avoided his death.

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Case Examples

INTRODUCTION | SET POINTS | JOURNAL DATA ANALYSIS | CONTRIBUTING FACTORS | FOCUSSED DATA ANALYSIS | CASE EXAMPLES | RISK MITIGATION

SETTLED

\$750,000

CONTRIBUTING FACTORS

Clinical oversight - nights/weekends

Clinical judgment

Patient assessment - narrow diagnostic focus

Failure to appreciate and recognize relevant signs/symptoms/initial result

Misinterpretation of diagnostic studies

Choice of practice setting (failure to refer to the ED)

Documentation

Lack of documentation - review of participation in care

FAILURE TO DIAGNOSIS ISCHEMIC HEART DISEASE RESULTING IN PERMANENT HEART DAMAGE

A female in her early 70's with history significant for coronary artery disease, hypertension, diverticulosis, and smoking, presented to an urgent care facility on a weekend with complaints of mild (1/10) chest pain, pressure, and a burning sensation in the right anterior chest and upper back for the past 24 hours. She was seen by a physician's assistant (PA). The patient stated she typically consumed "a lot of tomato juice" and that eating exacerbated her pain. She stated that antacids helped to alleviate her symptoms.

The PA's physical examination of the patient noted that she was in no acute distress, with stable vital signs. A 12-lead echocardiogram (ECG) was interpreted as sinus rhythm with a left bundle branch h block. The patient reported her last cardiology visit was over a year ago and her last stress test was over five years ago. She was advised to schedule a follow up with her cardiologist and to return to the urgent care facility the next day for a follow-up on the abnormal ECG. (Of note, the facility's supervising family medicine physician did not see the patient nor sign-off on the PA's treatment until three days later.)

That same evening, the patient's pain returned. She called 911 and then collapsed at home. When EMS arrived, they did CPR, revived the patient, and took her to the Emergency Department (ED). It was determined that she had suffered an ST-elevation myocardial infarction (STEMI). The patient underwent surgery, and had two stents and a defibrillator device placed, but suffered permanent, significant heart damage.

The patient claimed the permanent damage to the heart was from failing to properly read the ECG and diagnose ischemic heart disease. Experts who reviewed the ECG noted that the PA failed to recognize concerning ST elevations on the ECG which were concerning for myocardial ischemia. Experts also opined the PA failed to refer the patient to the ED immediately for further cardiac evaluation.

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## Risk Solutions

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Increase retention – transition to retirement

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<https://pubmed.ncbi.nlm.nih.gov/35611401/>

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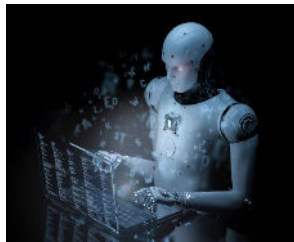
## Artificial intelligence scribes

### Pros:

- Increases efficiency
- Improved accuracy
- Cost effective
- 24/7 availability
- Scalability

### Cons:

- Initial learning curve
- Informed Consent?
- Limited understanding of context
- Dependence on technology
- Privacy concerns
- Potential for bias
- Forensic audits and metadata
- AI self-life-requires human accuracy checks
- Ripcord strategy



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## The cost of technology



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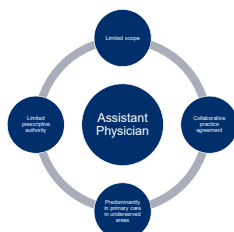
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## Think outside the box: Assistant physician

Medical school graduate, passed USMLE Step 1 and 2, but not residency



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## Expand the scope of non-physician practitioners



Safety

State by state variation

How much is to much?



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## Solutions that target retention

### Increase in training and education

- Expanding training programs for healthcare professionals to include the utilization of AI

### Address Burnout and Retention

- improve working conditions
- improve compensation
- peer support
- work life balance
- self scheduling
- employee engagement programs
- employee recognition programs
- increase in technology-virtual admission/discharge systems



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## Conclusion

Change is inevitable.



First, do no harm.



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## Resources

[Full Report: The Complexities of Physician Supply and Demand: Projections from 2021 to 2036](#)

[Summary Report: The Complexities of Physician Supply and Demand: Projections From 2021 to 2036](#)

[U.S Physician Workforce Data Dashboard](#)

[AMMC Report on Residents](#)

[Addressing the Physician Workforce Shortage](#)



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## Access more information, tools, and education



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[MedPro Publications](#)



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[MedPro Education](#)



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