

Physician assistants and your risk of malpractice

Case study examines your litigation risks — and the findings may surprise you

October 10, 2011

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Claims and suits against physician assistants (PAs) and their supervising physicians are rare, and the outcomes usually are favorable for the defense. Some risks remain, however, and understanding agency law, liability, and the elements necessary for malpractice claims may give you a better vantage point in preventing lawsuits or winning them.

The PA profession has grown tremendously since its birth in the 1960s. Today, PAs are licensed in all 50 states and practice in most specialties and settings. The profession's popularity also is evident in an increasing number of PA schools, numerous independent rankings and growth projections, and recent global expansion.^{1,2,3}

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Yet controversy remains regarding how PAs' malpractice litigation risk compares with that of physicians and to what extent doctors' risk of malpractice litigation is affected by supervising PAs. The dependent practice model remains at the core of the PA profession. It also fuels much of this debate, however.

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LEGAL FRAMEWORK

The nature of a dependent practice unites PAs and physicians not only in individual patient care but also in any litigation that may develop as a result. The legal principle of agency is the basis of the PA-doctor relationship and underlies most states' statutes governing PA practice. Generally, agency law holds a supervising physician liable: 1) for his or her own negligent acts (direct liability); or 2) for the negligent acts of a subordinate PA (vicarious liability).⁴

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Negligence claims are generally required to have four basic elements:

- The provider owed a duty to care.
- The provider breached that duty.
- The breach proximately caused an injury.
- The injury resulted in compensable legal damages.

In practice, both direct and vicarious liability may be alleged in a single case.

DIRECT LIABILITY

A PA acts with authority if the supervising doctor approves his or her conduct. In such cases, if the PA breaches his or her duty to the patient, the physician may be held directly liable. The doctor also may be held directly liable if he or she is negligent in selecting, supervising, or otherwise controlling the PA.

Negligent selection is a type of direct liability claim in which the physician can be liable for hiring a PA if the doctor knew or should have known the PA had some dangerous propensity. Here, the plaintiff must prove that the act of hiring the PA proximately caused injury and that the physician would have discovered the PA's propensities with reasonable diligence.

Negligent supervision is another type of direct liability claim; the acts of the doctor (and not necessarily those of the PA) are at issue. State statutes codify supervision requirements and, by extension, what constitutes negligent supervision. Statutes vary by state, but most address issues related to physician presence, acceptable PA-doctor ratios, and chart review obligations.⁵

Dynamic elements of PA practice such as clinical setting, level of experience, and employment duration may affect these requirements. Additionally, some states differentiate between primary and secondary supervisory relationships, adding to the complexity of what constitutes diligent supervision.

VICARIOUS LIABILITY

Agency law provides that a physician also may be held vicariously liable for negligent acts by a PA. *Respondeat superior*, Latin for "let the master answer," is the primary vehicle used to assert this type of liability. This principle provides that an employer is subject to liability for torts—civil wrongs—committed by employees acting within the scope of their employment.

The PA's status as employee or independent contractor is irrelevant as long as the patient reasonably believes the PA has authority to act on the doctor's behalf. *Respondeat superior* claims differ from negligent selection and negligent supervision claims in that the physician may be held solely liable for the negligent acts of the PA. In fact, under this principle, the supervising doctor may not have been present or even aware of the patient encounter.

These legal principles fuel competing theories comparing PAs and physicians. Some suggest that because PA school is shorter in duration than medical school and residency, PAs inherently have more litigation risk. This theory seems to rest on an assumption that shorter formal education translates to more errors of cognition and judgment and, therefore, more litigation risk.

In contrast, some suggest that PAs carry less litigation risk than their doctor counterparts, for two primary reasons. First, PAs commonly treat patients with less acute conditions and leave more complicated cases to physicians. This argument assumes that patients with lower acuity complaints are less likely to suffer harm and are less litigious.

The second argument is that two heads are better than one. The success of the pilot/co-pilot model is based on the fact that although two people both may make mistakes, it is unlikely they will each make the same mistake. The odds that the doctor and PA will make identical mistakes at the same time should be lower for the same reason. This argument contends that a culture of collaboration reduces injury—a critical tenet of risk management.

So which theory is correct? Are PAs involved in more or less malpractice litigation than physicians? Does intensity of doctor supervision affect the outcome of claims and suits?

As with the practice of medicine itself, the devil is in the details. Complexities of individual cases, heterogeneity of claims analyses, varying state statutes, and malpractice environments have limited discussion in the literature to case reports. Although such reports illustrate legal concepts or offer cautionary tales, they do not provide the necessary context to accurately gauge PA malpractice litigation risk.

PHYSICIANS SUED MORE OFTEN

We conducted the largest case series of PA claims to date, to analyze PA and physician malpractice litigation risk. Our primary aim was to determine the rate of claims and suits brought against PAs versus doctors. Our secondary aims were to evaluate how intensity of supervision may factor into the outcome of the case, and to determine whether any other factors were more associated with cases that resulted in a settlement versus cases that were dismissed or otherwise not pursued.

To quantify PA and physician malpractice litigation risk, we performed a structured chart review of all claims and suits brought against Colorado-licensed PAs from January 1, 2002, to December 31, 2009. We limited our data collection to PAs and doctors who were insured by COPIC.

COPIC insures about three-fourths of physicians and two-thirds of PAs in the Colorado private market, making it the largest private professional liability carrier in the state. We used COPIC's definition of a claim: "Any demand for damages, arising from professional activity or circumstances, brought by a patient or patient representative, indicating the possibility of legal action."

With approval from the Colorado Multiple Institutional Review Board (COMIRB), we reviewed claim summaries, medical records, depositions, and other legal documents. We recorded data using a standardized data collection form. We identified a total of 34 claims and suits against Colorado-licensed PAs over an 8-year period, 32 of which were no longer active at the time of our analysis. Because Colorado statutes require that claims and suits be brought within 2 years from the time harm was first recognized, we limited our risk calculations and analysis of temporal trends to the first 6 years of our 8-year study to account for much of this reporting lag.

Overall, PAs experienced 5.8 claims and suits per 1,000 provider years, whereas the doctors' rate was nearly seven times higher at 38.2 (see Table 1). Between 2002 and 2007, the rate of claims and suits against PAs dropped by nearly two-thirds, whereas the rate against physicians increased marginally.

Gender appeared to play a significant role in the rate of claims and suits against both PAs and doctors. Female providers experienced a considerably lower rate of claims and suits compared to their male counterparts.

Table 2 summarizes the clinical characteristics of the 34 claims and suits brought against PAs. A majority of cases involved primary care and emergency medicine/urgent care, each accounting for 14 cases (41%). Over one-half of the cases occurred in an outpatient setting.

Seven of the 34 cases began as claims but did not progress to lawsuits, whereas the remaining 27 did. Twenty cases (59%) were dismissed or otherwise not pursued, 11 (32%) settled, and two remained open (6%). Only one case went to trial and was successfully defended.

The most common presenting complaints involved the musculoskeletal, gastrointestinal, and neurologic systems, corresponding to 44%, 21%, and 15% of the cases, respectively. The most common patient outcomes were either a complication or worsening of the problem (41%), development of a new problem (32%), and death (21%). We found no injury alleged in two of the 34 cases.

The three categories of supervision were spread nearly equally: both the PA and physician examined the patient in 12 cases (35%), the doctor discussed the patient with the PA but did not examine the patient in nine cases (26%), and the PA did not consult with the supervising physician in the remaining 13 cases (38%). Of the 27 cases (79%) where both the PA and the supervising doctor were named in a claim or suit, the physician had examined the patient nearly 50% of the time.

Although being named as a defendant has important psychological and practical ramifications, the outcome of the case has a greater effect on a provider's future practice. Therefore, we performed a subgroup analysis based on the final disposition of the case (see Table 2).

A greater proportion of cases that were not pursued involved musculoskeletal complaints compared with cases that settled. No patient or provider characteristics, however, including intensity of supervision, were significantly associated with patient outcome or the final disposition of the case.

Of the 11 cases that settled, the median settlement for PAs was \$100,000 compared with \$200,000 for doctors. Although claims and suits against PAs usually settled for half what claims and suits against physicians did, their interquartile range of payments was substantially greater: \$12,500 to \$925,000 and \$159,000 to \$390,000, respectively.

The median cost to defend a claim or suit varied considerably depending on the final disposition. If the case was dismissed or otherwise not pursued, the median defense cost for doctors was \$28,000. If the case was settled or went to trial, the median cost was \$79,000. Defense expenses for PAs were considerably less, at \$16,000 and \$41,000, respectively.

ROLE OF DIRECT SUPERVISION

Despite having a much lower rate of malpractice litigation, we found that the distribution of claim and suit outcomes involving Colorado PAs closely approximates that of a recent nationwide study of claim and suit outcomes against physicians.⁶

Supervising doctors evaluated the patient or were consulted by the PA in two-thirds of all cases that ended in a monetary settlement or that went to trial. This high rate of direct supervision in cases the plaintiff pursued to litigation suggests that:

- PAs are involved in litigation for generally the same reasons as physicians.
- Direct supervision does not appear to protect against malpractice litigation risk.

A study of sufficient size comparing PAs who have been involved in litigation with a cohort of those who have not, based on level of supervision, may better address this issue.

Although harm is a basic component of malpractice claims, severity of harm did not correlate with case outcome. In fact, of the seven cases involving death, only two ended in a monetary settlement. The rest were dismissed or otherwise not pursued. Musculoskeletal complaints were the most common presenting problem and represented the greatest number of settlements. It is unclear whether this finding reflects the PAs' patient population or the high volume of musculoskeletal complaints that providers face.

Provider gender was the only other factor that appeared to be associated with increased litigation risk. Gender differences in liability risk among doctors, however, have been shown to disappear after adjusting for factors such as specialty and patient volume.⁷ Because we were unable to account for these factors in our study, we were unable to evaluate this hypothesis regarding PAs.

Finally, errors and outcomes are rarely related. Serious errors may occur without causing adverse events. Regrettable outcomes may occur despite the highest standard of care. In malpractice litigation, the quality of care delivered may not be the dominant factor that determines whether a claim prevails.

Table 1: Rates of claims and suits against Colorado physician assistants compared with physicians, by year and gender

Table 2: Characteristics of claims and suits brought against Colorado physician assistants, 2002 to 2009

GREATEST DETERMINANT FOR RISK

For physicians, specialty is the single greatest determinant for liability risk.⁷ Because our database did not categorize all PAs by specialty, we were unable to account for this factor in our risk calculations. We were also unable to account for additional factors including patient acuity and practice volume.

Another limitation of our study was a small number of PA claims and suits, despite a relatively large number of provider-years. Although the rate of claims and suits achieves statistical significance, the subgroup analysis lacked statistical power. Additionally, our data did not attempt to address any possible difference in a practice's claims experience before and after employing a PA.

Further, our study was limited to providers insured by COPIC in Colorado. Although COPIC is the dominant professional liability insurer in the state, academic institutions were not represented in this study. Although PAs and doctors have similar policy limits, some PAs may have been subsumed under a professional corporation and may not have been identified in the study population.

Finally, the malpractice environment in a given state is largely dictated by statutes governing the practice of medicine. In this respect, Colorado has a somewhat more favorable environment for medical practice than some other states. It is unclear how our data would generalize to states with different legal environments.

MITIGATING LITIGATION RISK

The overarching goals of healthcare risk management are to identify and reduce the risk of harm to patients and providers. Once risk is identified, a thorough evaluation must take place to develop risk reduction strategies. Identifying avoidable error is a key component of this approach.

Although PAs have a much lower rate of claims and suits than physicians, they are not immune to malpractice allegations. To protect both patients and practices, employers should be diligent in hiring and credentialing. Reducing direct doctor liability for the acts of PAs begins with the selection process. Verify education and licensure, and check for board actions in every state where the PA has practiced. Query the National Practitioner Data Bank. Perform a criminal background check and contact all references. It is also appropriate to contact past supervising physicians and coworkers, even if they are not listed on a resume.

To reduce your risk of negligent supervision, it is critical to establish protocols and practice policies. These protocols and policies should outline problems, treatments, procedures, and other matters that the PA is expected to manage independently (allowing for retrospective quality review) and those for which real-time consultation is expected. Keep records of periodic evaluations and chart reviews. Many state statutes require such supervisory steps, but it is good practice to consider them minimum standards even where they are not mandated.

A culture of collaboration is essential for effective PA/doctor partnerships and quality care. If you are a supervising physician, be available and approachable whenever PAs ask for help. Simply waiting for PAs to ask for help, though, may not always be sufficient. Invite consultation with questions such as, "Have you seen any interesting cases lately?"

Document all consultations. A simple note referencing discussion or examination by the supervising doctor is sufficient. When a PA consults a physician from outside his or her practice, the consultant's specific recommendations should be documented. Many times, consultants will not include a note in the chart unless they evaluate the patient. And because these brief interactions may be considered a form of supervision, it is essential that PAs document these consultations.

To reduce your risk of vicarious liability, PAs must keep their knowledge and skills current. Providing a continuing education allowance is a good start. Include PAs in continuing education activities alongside other practice providers. It's a good habit to schedule regular provider meetings to discuss policies and best practices.

Finally, it is essential that liability insurance for doctors and PAs address both joint and separate liability, because litigation aimed at PAs routinely involves their supervising physicians.

MORE SIMILARITIES THAN DIFFERENCES

Based on this large, structured chart review, we have found that PAs and their supervising doctors experience a low rate of malpractice litigation compared with physicians overall. Direct supervision does not appear to protect against litigation. Although we were not able to adjust for provider specialty or patient acuity, case outcomes involving PAs and doctors closely parallel outcomes involving only physicians. This finding suggests that more similarities than differences may exist between the malpractice risk of doctors and PAs.

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