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THE ROLE OF THE PHYSICIAN ASSISTANT

Reducing the Risks of Potential Liability Exposure

Richard E. Murphy, PA-C, MBA
Assistant Professor of Surgery, Public Health & Community Medicine
Director, Physician Assistant Program
Tufts University School of Medicine

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DISCLOSURES

- I am neither an attorney nor a physician
- I have no relevant financial relationships to disclose
- I have served for 12 years on the Massachusetts Board of Registration of Physician Assistants, 3 years as its chair
- I have practiced for over 40 years as a PA in cardiac surgery, critical care, emergency medicine, and primary care
- I have served as a paid expert witness in over 140 cases involving PA practice in the United States
- I have never been sued for medical malpractice (at least, not yet)

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HUMAN FRAILTIES

- We make mistakes everyday
- Most smart systems are built by humans
- Patients may assume you are someone/something else

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BACKGROUND

- PAs practice medicine in almost every medical discipline
- Dependent practitioners working under supervision of licensed physicians (MDs and DOs)
- **Who is legally responsible for a PA's clinical practice?** Chapter 112, s. 9E states that "If a physician assistant is employed by a physician or group of physicians, the assistant shall be supervised by and shall be the legal responsibility of the employing physician or physicians." And "If a physician assistant is employed by a health care facility, the legal responsibility for his acts and omissions shall be that of the employing facility."
- A fair amount of practice autonomy exists within these relationships

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LEGAL REQUIREMENTS FOR PA PRACTICE IN MASSACHUSETTS

- Bachelor's degree
- Graduate of ARC accredited PA program
- NCCPA certified
- Licensed by DPH
- Physician supervision documented
- Prescriptive guidelines (263 CMR 5.07)
- Practice guidelines if performing major invasive procedures (263 CMR 5.04 (4))
- Maintenance of CME credits
- If prescribing: CSR and DEA certificates

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PHYSICIAN SUPERVISION OF PAs

- Massachusetts General Laws, Chapter 112, section 9E authorizes PAs to perform medical services when a supervising physician is not present. ["…supervision shall be continuous but shall not require the personal presence of a supervising physician or physicians."]
- Effective November 4, 2012, M.G.L. c. 112, § 9E was amended to eliminate the limitation on the number of physician assistants who could be supervised by a supervising physician. Board regulation 263 CMR 5.05(2) containing the same limitation was deleted by emergency regulation effective May 29, 2013. Physician assistants must continue compliance with 263 CMR 5.05, *Scope of Supervision Required,* and supervising physicians must continue compliance with 243 CMR 2.08, *Physician Assistants.*

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PA SUPERVISION

- Supervising physician is liable:
  - For his or her own negligent acts (direct liability)
  - For the negligent acts of a subordinate PA (vicarious liability)
- PA acts with authority if the supervising physician approves his/her conduct
- If the PA breaches his/her duty to the patient, the physician may be held directly liable
- The physician may be held directly liable if he/she is negligent in selecting, supervising, or otherwise controlling the PA

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TEMPORARY SUPERVISION

- The **name** of the temporary supervising physician who serves as the PA supervisor when the supervisor of record is not available, and who is the MD/DO that day, is listed on the official ER schedule (that hospitals usually keep on file).
- A memo should also be kept on file that states the MD/DO of the day will serve as the de facto PA supervisor when the supervisor of record is not available and explains their **scope of responsibility**
- In private practices a covering physician agreement should include supervision of the PA as well

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PA PRESCRIPTIVE PRACTICE

- Must be memorialized in writing (and signed by PA & supervisor annually) describing how, what and to whom the PA will be prescribing controlled substances
- PAs in Massachusetts and most other states may prescribe for all schedules (including narcotics) with their own DEA and CSR numbers

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SCOPE OF PA PRACTICE

- The PA's practice must be the same as that of his/her physician supervisors
- Pursuant to M.G.L. Chapter 112, §9E a physician assistant may perform medical services when such services are rendered under the supervision of a registered physician, that such supervision shall be continuous but shall not require the personal presence of the supervising physician.
- PAs may first assist in major surgical procedures, perform minor procedures independently, pronounce death, serve as primary care providers, staff clinics, practices, hospitals

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WHY DO PAs GET SUED

- Negligence
- Delay in diagnosis or misdiagnosis
- Lack of, or poor communication with patient and/or physician
- Misrepresentation (patient thought he/she was a doctor)
- Violation of the standard of care
- Breach of their responsibilities (agreements with physician/practice)
- Failure to refer to physician or consultant
- Bad luck
- Their name was in the chart

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PA RISK FACTORS

- Similar to physicians
- Work schedules
- Volumes of patients
- Increasing responsibilities
- PAs are frequently in positions of caring for high risk patients
  - Intensive Care Units
  - Emergency Departments (walk-ins, acute and non-acute centers)
- Levels of physician supervision vary

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PA EDUCATION

- Average 26 months in length after undergraduate college
- Intense, broadly based education
- Rigid accreditation process for all programs
- Master's level education
- No mandatory residency training afterwards (but a few exist)
- Formal national certification and renewal process
- Annual CME requirements

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PA PRACTICE

- Almost 100,000 graduates of PA programs
- 190 accredited PA programs in the country (90 more in development)
- About 2,500 PAs are practicing in Massachusetts
- US Department of Labor projects 39% growth in PA jobs by 2020
- Primary care jobs (ACA)
- Supplement to residency positions (hours restrictions)
- Hospitalist and nocturnist positions growing
- Underserved areas

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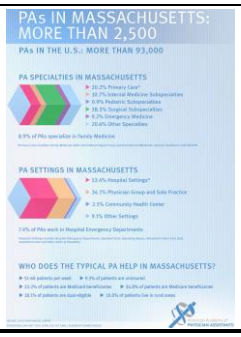

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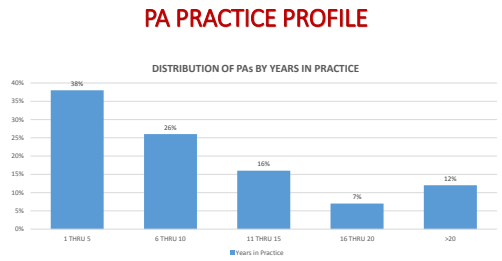

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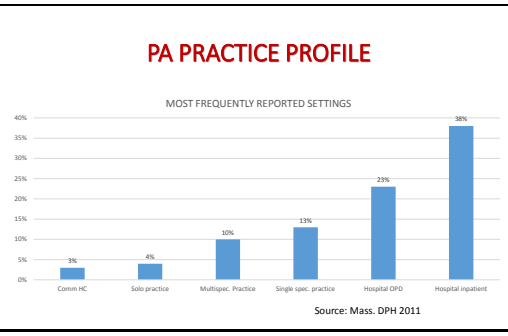

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CASE STUDY 1

- 54 y/o female, mother of 3 children under 21 presents to ED, seen by both PA & MD for abdominal pain & fever
- White count elevated, abnormal smear (toxic granulations)
- Equivocal CT scan of abdomen (? uterine fibroids)
- Telephone consult with GYN resident (details never fully documented)
- Multiple doses of IV and PO pain meds w/o improvement
- Fever worse despite Tylenol
- End of shift issue (clear the board)
- Pt discharged on PO pain meds, F/U with GYN next day (Sunday)

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CASE STUDY 1

- Patient unable to be awakened the next am
- Brought to another hospital by ambulance in septic shock
- Multiple vasopressors for several days
- Lost hands and feet but survived
- Grew *Streptococcus* from blood (Toxic Shock Syndrome)
- Responded to antibiotics
- Jury trial, awarded $25 million to plaintiff

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CASE STUDY 1
Issues

- Both PA & MD missed red flags
- End of shift syndrome
- Failed identify cause of fever & pain
- Failed to follow standard of care (i.e., culture, observe or admit, ID consult)
- Failed to fully document consultation (resident never saw patient)
- Delay in diagnosis
- Both were negligent
- Both failed to meet the standard of care

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CASE STUDY 2

- PA sees 32 y/o male patient with chest pain in ED urgent care
- ECG normal (PA's read, cardiology read later as normal)
- No enzymes drawn
- PA diagnosis is "musculoskeletal strain"
- Patient discharged with CP instructions, Motrin, F/U with PCP
- MD never sees patient (per protocol) but signs off on chart
- Patient dies in bed that night, presumed MI
- No autopsy
- Family sues

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CASE STUDY 2
Issues

- Who is at fault here?
- PA, MD, hospital?
- Family thought the provider was a doctor
- PA clearly identified himself as a PA (nametag & verbally)

- ED policies
- Level of supervision
- Would a physician have cared for this patient differently?

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RISK AVERSION TACTICS

- Clearly state role of provider
  - Post sign in waiting room
  - Require clear nametags, avoid misrepresentation
  - Have policy reviewed by all (MDs, PAs, RNs)
- Clearly define supervision
  - Types of patients to be seen independently by PA
  - Define triggers for referral to physician or main ED
  - Chart review in a timely fashion
  - M&M, near misses, root cause analyses
- Documentation policies

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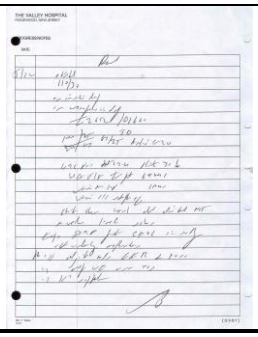

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ERRORS

- Negligence
  - Failure to hire and/or supervise properly
- Systems errors
  - Hospital or practice systems are flawed
  - Lab results not tracked, reviewed, followed up in a timely fashion
  - Flawed EMRs
  - Paper problems (legibility, patient instructions, busy schedules, etc.)
- Communication errors
- Handoff issues
- Exceeding scope off practice

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RESPONDEAT SUPERIOR

"Let the superior respond"

- If the "physician extender" commits a negligent act and it is shown that the physician was in a position to control the PE's activity, the physician could be liable
- Criteria for "master and servant relationship"*
  - Selection and engagement
  - Payment of wages
  - Power to discharge
  - Power to control the servant's conduct
  - Whether the work is a part of the regular business of the employer

*Keitz v National Paving 1957 MD Court of Appeals

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SYSTEM *vs* CLINICAL ERRORS

- System or practice errors may not be the domain of the PA/NP
- Bad systems play havoc with our ability to practice efficiently and safely
- EMR, paper records, filing systems, poorly trained support staff
- Silos of care versus collaboration
- Chart & patient review

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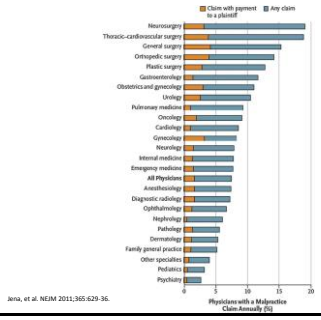

Jena, et al. NEJM 2011;365:629-36.

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PHYSICIAN ASSISTANTS
Malpractice Premiums
ANNUAL OCCURRENCE RATE TABLES
LOUISIANA

CLASS P3 LIMIT	FULL TIME OCCURRENCE
$100,000/$300,000	$ 3,975
$200,000/$600,000	$ 5,366
$250,000/$750,000	$ 5,764
$500,000/$1,000,000	$ 6,777
$1,000,000/$3,000,000	$ 8,014
$1,000,000/$6,000,000	$ 8,348

Class P3: A physician assistant who is involved in any of the following:
1. Assisting an orthopedic surgeon, neurosurgeon, OB/GYN surgeon, cardiovascular surgeon and/or plastic surgeon in surgery in an operating room other than for observation;
2. Practicing or any exposure (more than 10 hours a week) in trauma/emergency room procedures or responsibilities;
3. Contact or exposure with Obstetrics including delivery room responsibilities;
4. Contact or exposure with cardiac catheterization labs; and
5. Assisting in Cosmetic/Aesthetic procedures.

Source:
2011 CM&F Group, Inc.
CM&F Group, Inc.
99 Hudson Street, 12th Floor
New York, New York 10013

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PHYSICIAN ASSISTANT CLAIMS

- Little data on numbers and payments
- Becoming more frequent targets as the profession grows in numbers & plaintiff attorneys learn of our existence
- High acuity employment venues
  - ICUs -Procedures
  - ORs -Assistant in surgery
  - Postoperative management
  - Emergency department
  - Cardiac cath labs
  - NICUs and pediatric units

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MALPRACTICE PAYMENTS

	AVERAGE	MEDIAN
PHYSICIAN	$301,150	$150,821
ADVANCED PRACTICE NURSE*	$350,540	$190,898
PHYSICIAN ASSISTANT	$173,128	$80,003

**Includes nurse anesthetists & nurse midwives*

Source: National Practitioner Database

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INCIDENCE OF PAYMENTS

- 1 malpractice payment for every 32.5 PAs
- 1 malpractice payment for every 2.7 physicians
- Of the $74 billion in malpractice payments for PAs, APNs, and physicians for 1991-2007, only $245 million was for PAs (3.3%)

Source: National Practitioner Database

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Are PAs more likely to make a mistake?
Conflicting Theories

- Inferior/shorter training than a physician "Shorter education translates to more errors of cognition and judgment and, therefore, more litigation risk"
- Two heads are better than one
  - Pilot/Co-pilot model based on the thought that although both are human and capable of making mistakes, it is unlikely that they will make the same mistake
  - Team approach is safer
  - PAs practice as part of a team

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

Characteristics	Provider-years	Claims/suits per 1,000 provider-years	P value
Provider type			<0.001
Physician assistants	5,204	5.8	
Physicians	21,393	38.2	
Provider type - year			
Physician assistants			0.006
2002-2004	2,176	9.2	
2005-2007	3,028	3.3	
Physicians			0.68
2002-2004	10,991	37.7	
2005-2007	10,402	38.8	
Provider type - gender			
Physician assistants			0.12
Male	1,889	7.9	
Female	3,315	4.5	
Physicians			<0.001
Male	15,730	41.1	
Female	5,663	30.2	

Victoroff & Ledges 2011

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NATURE OF PA SUITS

- Frequent face-to-face interaction
- Bedside procedures
- Discharge instructions
- Telephone triage
- Postoperative care
- Delay or failure to diagnose complications
- Failure to communicate

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RISK AVERSION *vs* GOOD PRACTICE

- What is your standard of practice?
- Do you meet national standards?
- Do you cut corners or take short cuts?
- Are you a life-long learner?
- Are you a good communicator with your patients and professional colleagues?
- Do you follow the policies of your practice/institution?

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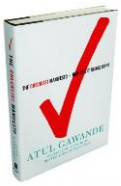
TACTICS TO REDUCE RISK

- Empowerment of PAs and other staff to question situations & superiors
  - "Time out"
  - Preoperative "huddles"
  - Open and non-threatening dialogue with attendings
- Communication & policies
- Check lists and standard orders
- PA participation at the highest level possible



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COMMUNICATION & SIGN-OUTS

Lessons from the military

Lessons from the airlines

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HANDOFFS

- ED to ICU
- OR to PACU
- Shift to shift
- Hospital to Hospital

- Reduced shift hours for residents means more handoffs per day
- PAs may supplement or replace housestaff
- Improved efficiency, less mistakes?

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ERROR MANAGMENT

- Military experience & airline industry
- US Forest Service ⟹ Disaster management programs
- Team development
- Leadership training
- Birth of checklists

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INCIDENTAL FINDINGS

Where are the cracks in your system?

- "Chest X-ray reveals a 6.5 mm lesion in LUL. Recommend follow up CT scan for further evaluation." *[Radiology report during hospitalization for spinal surgery]*
- I work in neurosurgery; this is not my problem to follow up on. His PCP can deal with it."
- What if his PCP doesn't get the report? What if he does but doesn't read it or act on it?
  - Forward copy of report to PCP; include details in discharge summary; give written instructions to patient to have PCP order CT scan…document!



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PITFALLS

- DVT & PE
- Telephone triage
- Bowel complications
- Iatrogenesis
- Wrong-side surgery
- Informed consent
- Wound infections
- Bed sores
- UTIs
- Strokes
- Falls
- MIs

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HOSPITAL CREDENTIALING

- Standardized approach to PAs
- Clearly defines scope of practice & level of supervision required
- Standardized prescriptive & practice guidelines
- Put more responsibility on the institution
- Provides more protection for all concerned
- Leave some wiggle room

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STANDARD OF CARE

- Should a PA be held to the same standard as that of a physician?
- In the matter of *Cox v M.A. Primary and Urgent Care Clinic* (TN Supreme Court, 2010): The standard of care applicable to PAs was distinct from that applicable to physicians; specifically "a physician assistant must be held to the recognized standard of acceptable professional practice in the profession of physician assistants and any specialty thereof."
- However, if a physician delegates a procedure to a PA, would this be considered an "inferior" procedure?

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CONTINUING EDUCATION

- Mandate
- Provide resources and/or funding
- Simulation (credentialing and continuing education)
- On-going training as a team should be part of the culture of the institution
- Evolution of EMRs and smart systems (CPOE)
- M&Ms and Root Cause Analyses

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SUMMARY

- PAs are here and growing in numbers and importance to our health care system
- They are at-risk for claims, similar to MDs, DOs, RNs but there is insufficient data to suggest they are more likely to commit errors
- By virtue of their "dependent" or team member status, they should be less likely to make independent mistakes of omission or commission
- The newness of the PA profession represents an opportunity to build a better "mousetrap" through early education, continuing education, oversight, and evaluation