American Academy of PAs

Medical Liability Implications of Modernized PA Practice

In May 2017, the PA profession adopted policy that would expand access to care and position the profession to meet healthcare needs. Updating PA practice laws and regulations using AAPA policy as a guide will happen over time, on a state-by-state basis, as political realities evolve.

The policy, reflected in AAPA's Guidelines for State Regulation of PAs:

- Eliminates the legal requirement that each PA have a specific relationship with a physician, putting decisions about the degree of collaboration at the practice level where patient care takes place.
- Specifies that nothing in the law should require or imply that a physician is responsible or liable for care provided by a PA, unless the PA is acting on the specific instructions of the physician.
- Maintains the current requirements to become a PA: graduation from an accredited PA program, passage of a national certifying exam, and securing a state license.
- Retains current elements that determine PA scope of practice: education, training and experience, state laws, policies of employers and facilities, and the needs of patients.

PAs AND MEDICAL LIABILITY CLAIMS

Data from the National Practitioner Data Bank reveals that PAs have a remarkably low rate of malpractice claims paid against them, far lower than physicians. From 2005-2014, the rate of reported liability payments for physicians ranged from a high of 19.0 paid claims per 1,000 physicians (in 2005) to a low of
11.2 claims paid per 1,000 physicians (in 2014). For PAs, the rate of liability payments ranged from a high of 2.4 claims paid per 1,000 PAs (in 2011) to a low of 1.4 claims paid per 1,000 PAs (in 2007).[1]
One study of data from the Colorado Physicians Insurance Company (COPIC)[2] found:

- Physicians were sued more often than PAs.
- Specialty was the single greatest determinant of a physician's liability risk.
- PAs were involved in litigation for generally the same reasons as physicians.
- Physician supervision did not appear to protect against PA malpractice litigation risk.
- PA-physician teams had lower rates of malpractice litigation than physicians alone.

DISRUPTION AFFECTS PHYSICIAN INCENTIVES

When the PA profession was created in the 1960s and high percentages of physicians owned their own practices, physicians signed supervisory documents committing to taking on legal liability for care provided by a PA they employed in order to reap the financial and practice benefits. The physician-owners' day-to-day workload of patient care and coverage were reduced, and their practices could care for more patients at lower cost than if a physician were added.

The healthcare marketplace has changed dramatically since then. Today, physicians are more likely to be employees than owners.[3] State practice laws have not caught up with this trend. In most states, PAs are still required to have a specific relationship with a physician or a group of physicians in order to practice. A regulatory authority may require evidence of this relationship or tether through a formal agreement or other documentation that must be agreed to by the PAs and physicians involved. A non-owner physician employee who enters into a specific relationship with a PA incurs the potential liability that accompanies that arrangement without fully reaping the benefits.

Rather than practice alone, physicians are more likely to practice in large groups or institutions.[4] Documenting specific relationships among all the physicians and PAs who work together in large groups can be difficult, creating a risk of disciplinary action for administrative infractions unrelated to patient care or outcomes. Physicians are increasingly unwilling to enter into such arrangements.

Updated PA practice laws should authorize a PA to practice without a legal requirement for a specific relationship with a physician or any other healthcare provider — enabling practice-level decisions about collaboration. This would expand access to care, reduce administrative burdens, and eliminate physician liability for care provided solely by a PA. Physicians would only share liability for consults or for patient care on which they specifically collaborated.

CONCERNS ABOUT INSURANCE AVAILABILITY

Concerns have been expressed that removing the legal tether between a PA and a physician will make it difficult for PAs to obtain liability insurance. This is unlikely. Most PAs who are employees of practices and institutions have employer-provided liability coverage or may be able to obtain coverage on their own. This is likely to continue to be the norm. Furthermore, in the more than 20 states and the District of Columbia where nurse practitioners (NPs) are not required by law to have a practice relationship with physicians, there is no evidence they are having difficulty securing coverage.

PA SCOPE OF PRACTICE AND MODERNIZED LAWS

The boundaries of a PA's scope of practice would likely not change if practice laws were updated as PA policy envisions. Currently, the boundaries of each PA's scope of practice are determined by five parameters: state law, education, training and experience, policies of employers and facilities, and the needs of patients. Under updated laws, these will remain the parameters that define PA scope of practice. Study after study confirms that PAs provide high-quality care.[5-9] Updated laws would authorize PAs to practice without a specific relationship with a physician, enabling practice-level decisions about collaboration.

COMMITTED TO TEAM PRACTICE

The PA profession remains committed to team practice with physicians and other healthcare providers. Modernizing PA practice laws allows decisions about collaboration to be determined at the practice level based on the team's structure and patient care needs. This is consistent with what PAs have long held true: The best medicine is practiced in teams. Team practice allows for optimal use of the skills of each member of the team, including physicians and PAs.[10]

March 2021

REFERENCES

1 Brock DM, Nicholson JG, Hooker RS. Physician assistant and nurse practitioner malpractice trends. *Med Care Res Rev.* 2017;74(5):613-24.

2 Victoroff M, Ledges M, Ginde AA. Physician assistants and your risk of malpractice. *Med Econ*. 2011;88(19):34-42.

3 Kane CK. Updated Data on Physician Practice Arrangements: For the First Time, Fewer Physicians are Owners Than Employees. American Medical Association. 2019. https://www.ama-assn.org/system/files/2019-07/prp-fewer-owners- benchmark-survey-2018.pdf Accessed March 9, 2021.

4 Muhlestein DB, Smith NJ. Physician consolidation: Rapid movement from small to large group practices 2013-15. *Health Affairs*. 2016;35(9):1638-42.

5 Kurtzman ET, Barnow BS. A comparison of nurse practitioners, physician assistants, and primary care physicians' patterns of practice and quality of care in health centers. *Medical Care.* 2017; 55(1):615-22.

6 Yang Y, Qi Long Qi, Jackson SL, et al. Nurse Practitioners, Physician Assistants, and Physicians Are Comparable in Managing the First Five Years of Diabetes. *Am J Med*. 2018;131(3):276-83.e2.

7 Liu H, Robbins M, Mehrotra A, et al. The impact of using mid-level providers in face-to-face primary care on health care utilization. *Medical Care.* 2017;55(1):12-18.

8 Kleinpell RM, Grabenkort WR, Kapu AN, Constantine R, Sicoutris C. Nurse practitioners and physician assistants in acute and critical care: A concise review of the literature and data 2008-2018. *Crit Care Med*. 2019;47(10):1442-9.

9 U.S. Congress, Office of Technology Assessment. Nurse practitioners, physician assistants, and certified nurse midwives: a policy analysis. Health Technology Case Study 37. Washington, DC, 1986.

10 Salsberg ES. Is the physician shortage real? Implications for the recommendations of the Institute of Medicine Committee on the governance and financing of graduate medical education. *Academic Medicine*. 2015;90(9):1210-14.