Advanced practice providers, among them physician assistants, are ubiquitous in the delivery of healthcare across specialties and locations. Overall, claims brought against advanced practice providers are generally similar to that of the specialty area within which they are practicing. However, it should be noted that the level of care provided by individual advanced practice providers can vary amongst locations and within specialty areas, and will therefore have an impact on the claims data. In this analysis, we review physician assistant claims arising in the emergency department. These represent 15% of MedPro Group’s claims involving physician assistants, and we will contrast to claims against emergency physicians.

In a MedPro Group analysis of emergency physician claims data, diagnostic allegations are most common, representing nearly 70% of claims and nearly 80% of all dollars paid. Therefore, when analyzing patient events arising in the emergency department (ED), we generally focus our attention on diagnostic issues. The most common diagnoses common include myocardial infarctions (MI), strokes (CVA), fractures, intracranial (IC) bleeds, appendicitis and infections.

**Focus on Diagnostic Allegations**

How do physician assistant (PA) emergency claims compare? The distribution of allegations is very similar to the emergency physicians (EP) (Figure 1), with diagnostic allegations representing over 70% of the total PA claim volume.
When we look at the diagnoses involved in these claims, we see some key differences (Figure 2). Missed fractures are noted most often in the PA claims; spinal fractures account for 55% of those. Interestingly, and related to the spine, is the relatively high frequency of cauda equina syndrome. Third most frequent are wounds in which tendon involvement went undiagnosed, followed by meningitis, cancer, and CVA.
Are there conclusions we can draw? How does the level of care provided by physician assistants affect these diagnoses? If PAs are limited to managing “fast-track” emergency patients, then those with presenting symptoms of possible MI, CVA, pulmonary embolus or other significant disease symptoms, might not receive care from PAs. Or is it that physician assistants have been more careful with potentially catastrophic diagnoses, and have involved their supervising emergency physician, or sought other specialty consultations? However, the claims data still reveals missed strokes, meningitis and cauda equina. Did these patients present with more innocuous symptoms that mimicked simple back pain or viral illness? Regardless of the answers, you should be aware of and incorporate the data into your risk management and patient safety efforts.

**Clinical Severity**

Reflective of the diagnoses involved in these ED claims is the level of patient injury severity (Figure 3); high-severity injuries include death or serious permanent injury. While more than 50% of the PA-related claims involve high severity patient outcomes, overall the physician assistant claim severities are lower than those of the EP claims, as would be expected by the comparative diagnoses noted in Figure 2.

**Figure 3. Clinical Severity of Patient Injuries**

![Graph showing clinical severity of patient injuries]
**Risk Factors**

Risk factors are those breakdowns that contributed to poor patient outcomes, and ultimately to the claim or suit. Multiple factors are generally applied to each claim, and all factors split into multiple sub-factors. The factors for physician assistants follow closely those of the emergency physicians (Figure 4). A notable exception however, is supervision, specifically inadequate supervision of the PA by the EP. In these claims, supervision is not necessarily the direct oversight of care, although it can be. Rather, supervision refers to the physician’s responsibility for adequate oversight of the PA’s competencies, record review and observation. The EP should be able to validate that the general care provided by the PA is within clinical protocols and reflects appropriate knowledge and experience levels.

**Figure 4. Risk Factors: Diagnostic Allegations in the ED**

In emergency-based diagnostic claims involving physician assistants, there is no single outstanding breakdown in care, although patient assessment errors (clinical judgment), specifically the failure to obtain consults, are noted most often (Figure 4a).

Communication factors arise less often in the physician assistant claims; these factors refer to inadequate communication with patients and amongst other providers. In earlier PA claim studies, this comparative differential was greater than what it is now. PA-related
documentation issues were generally less frequent as well in earlier studies, supporting the belief that physician assistants had/took more time to document and communicate. That advantage has eroded somewhat, and could reflect on the adoption of electronic health record systems, or changing roles/scope of practice.

**Figure 4a. Focus on Clinical Judgment and Communication Details**

Inadequate patient assessment skills, specifically those related to appreciating all relevant signs/symptoms and timely obtaining diagnostic tests or consults (which could include the supervising physician) are more frequently noted in claims involving physician assistants. A note regarding assessment skills: there is some commonality across all allegation types involving wound care, particularly those involving tendon and/or nerve involvement and retained foreign bodies; both of these scenarios present in a higher percentage of PA claims than in EP claims.

**The Intersection of Events**

Adverse ED patient outcomes involving diagnostic issues rarely arise from a single cause; clinical decision-making and ineffective communication between members of the care team all contribute to the end result.
Case Study Example #1: Failure to Diagnose Cauda Equina

The patient called his primary care physician (PCP) regarding back pain and difficulty with urination for almost two days. The PCP referred the patient to the ED where the patient was examined by the PA. The patient complained of back pain with numbness in his buttocks and perineal region. The exam demonstrated no neurologic deficits. A lumbar spine x-ray was read as showing degenerative changes. The patient was able to ambulate without difficulty, and showed no leg weakness. The physician assistant consulted with the PCP. The emergency physician did not see patient. The PA received instruction from PCP to catheterize the patient, resulting in one liter of urine. The patient was instructed to follow up with his PCP the next morning, to get an MRI the next day (this was scheduled by the PA prior to the patient’s discharge from the ED).

Based on the next day’s MRI results, the PCP consulted with a neurosurgeon who admitted the patient emergently for spinal surgery to address cauda equina syndrome. Post-operative improvement was noted in the patient’s condition, but bladder and bowel deficits remain. The patient alleged that if a surgical consult had been requested by the PA at the time of the ED visit, his outcome would have resulted in less severe injuries.

Case Study Example #2: Failure to Diagnose Nerve & Tendon Damage

In the ED, the physician assistant evaluated the patient’s left index finger for a laceration and determined that the wound was superficial. The PA did not document her assessment of the patient’s range of motion nor the presence/absence of any paresthesia. The wound was cleaned and sutured. Discharge instructions provided to the patient included keeping the wound clean, applying antibiotic ointment daily, and to follow-up with his PCP for suture removal in 10 days. The PA did not request a consult/evaluation by either her supervising emergency physician or a hand/orthopedic surgeon.

Three days later the patient was evaluated by an orthopedic hand surgeon at the patient’s request. The surgeon determined that there was an injury to the nerve and the tendon in the patient’s finger and recommended immediate surgery. The patient obtained a second opinion two days later which confirmed the diagnosis and the immediate need for surgery. During surgery, it was discovered that two tendons and a
nerve had been severed as a result of the original injury. Following physical therapy, the patient claimed a permanent limited range of motion, residual pain and sensory loss.

Key Points

- Ensure that physician assistants have a scope of practice that reflects their individual skills/competencies. Not all PAs will have the same level of experience at time of hire. Define in that scope of practice any patient conditions which require the PA to include the supervising emergency physician in final decision making.

- Ensure that the PA understands the differential diagnoses to consider in all cases, particularly those appearing in the claims data - cauda equina, meningitis and strokes.

- Create a working environment in which all PAs feel at ease asking the EP for consultation. They cannot be made to feel that asking questions diminishes their value/contributions to the care team.

- Supervision involves more than the EP co-signing medical records and being available for consults. Schedule regular performance meetings with each PA. Seek input from other physicians who work with the PA. These performance meetings can help to ensure a good working relationship and understanding of capabilities, work flow and responsibilities.

- Review medical records of patients who are seen by the PA, but not by the EP, to ensure quality of care. Discuss these record reviews with the PA.

- When both the physician assistant and the emergency physician see a patient in the ED, ensure that all documentation in the medical record is consistent, or that any differences in patient assessment documentation are acknowledged and explained.

- Ensure that nursing staff also understand the role of the PA, including the PA’s scope of practice (what they can and cannot do).

Resources

- Clinical Judgment in Diagnostic Errors: Let’s Think About Thinking
- Reducing Diagnostic Errors in Emergency Medicine
Data Source
MedPro Group closed claims data, 2008-2017