Medical Malpractice: Comparing Physician Assistants, Nurse Practitioners, Physicians in America

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PURPOSE

The physician assistant and nurse practitioner movement began half a century and yet their ability to deliver care safely and effectively remains an issue. We examined the malpractice incidence and disciplinary actions of PAs and NPs. The purpose was to determine if PAs and NPs are more liable than physicians.

METHODOLOGY

The National Practitioner Data Bank was probed. As of 2014 the NPDB data consisted of more than 414,404 events resulting in a malpractice payment or disciplinary action. Each record had up to 54 variables including descriptive characteristics of practitioners (e.g., age group, state, field of license) with medical malpractice payments and adverse actions. Adverse actions included license actions, clinical privileges actions, professional society membership actions, Drug Enforcement Administration actions, and Medicaid/Medicare program sanctions. The presumption is that documentation and archiving criteria in the NPDB affects all providers equally.

Excluded were nurse midwives and nurse anesthetists because few PAs work in these areas. The Bureau of Labor Statistics provided annual clinically active numbers. To adjust for inflation, the net present value of all awards was calculated to 2014.

RESULTS

Spanning 10 years (2005 through 2014) the NPDB recorded 105,289 unique providers involved in medical malpractice or disciplinary actions. Physicians totaled 99,877 (94.9%), PAs 3,061 (2.1%), and NPs 2,258 (2.0%). In the aggregate 61.7% were malpractice reports and 38.3% were adverse action reports. Physicians had significantly more malpractice events than adverse actions (62.9% versus 37.1%), but reversed for PAs who had significantly fewer malpractice events than adverse actions (28.1% versus 71.9%). NPs were equally distributed between adverse actions and malpractice.

Physician median malpractice total payments were significantly greater than those of PAs and NPs for each year but decreased across the 10-year period. Conversely, PA and NP payments fluctuated by year, but no trend emerged. Across the 10-year period the range of malpractice for physicians was 9.9-16.6 per 1000. For PAs the rate was 1.4 to 2.4 and for NPs the range was 1.1 to 1.4. The population adjusted malpractice risk ratios for physician to PA, physician to NP, and PA to NP rates revealed little differences between PAs and NPs.

The top three reasons delineated by the NPDB for a malpractice award were the same for PAs and NPs: errors in diagnosis, treatment, and medication. The top three reasons for a malpractice award for physicians were errors in diagnosis, surgery, and treatment.

CONCLUSION

This study affirms that PA and NP utilization in American society is beneficial in liability exposure when compared to physicians. Their employment may be a cost savings for the healthcare industry when the safety of patients is considered. This most recent ten year examination of the NPDB suggests that the quality and safety of PA and NP care is at least that of physicians if not better. Healthcare outcomes may be influenced positively by the employment of more PAs and NPs in the clinical workplace. One limitation is that the NPDB does not provide practice specialty.