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Healthcare Liability Law Relating to Mid-Level Practitioners and Their Collaborating Physicians

by

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Mid-level practitioners have assumed an increasingly important role in the delivery of healthcare services to the senior citizen population in West Virginia. The number of physician assistants and nurse practitioners is primed to grow at a rate of over 35% in the coming decade. Their growth is expected to exceed that of physicians.[2] The scope of their practice has expanded and become mostly autonomous. The Legislature has authorized these professionals to examine, diagnose, treat, and prescribe because, in many West Virginia communities, both rural and urban, they are the primary healthcare providers. The increased assumption of primary care responsibilities by these mid-level professionals will inevitably result in a greater number of malpractice actions.[3]

Knowledge of the laws and principles governing these mid-levels is and will be important to both plaintiff's lawyers and defense counsel when applying the Medical Professional Liability Act ("MPLA") in the representation of the mid-level provider and their collaborating physicians. This article will identify, review, and discuss the application of the MPLA, common law vicarious liability, and common litigation themes in the practice of mid-levels.

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[2] Physicians and surgeons are projected to grow 13% and add 91,400 jobs from 2016-26; https://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm#tab-6.

[3] Physician Assistants are projected to grow 37% and add 39,600 jobs from 2016-26; https://www.bls.gov/ooh/healthcare/physician-assistants.htm. Nurse Practitioners are projected to grow 36% and add 56,100 jobs from 2016-26; https://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm#tab-6.

Historical Background

The term "mid-level" is often used as a colloquial term when referring to a physician assistant and/or a nurse practitioner and has become ubiquitous in healthcare. Mid-levels are healthcare professionals with formal training, accreditation, and certification with the ability to treat patients autonomously, but are subject to a more restricted scope of practice than a physician.

Despite the seemingly informal nature of the term "mid-level" over the more formal physician assistant or nurse practitioner, and apparently much to the chagrin of some of these professionals,[4] the Federal Government has also used the term mid-level to describe physician assistants and nurse practitioners in the Code of Federal Regulations ("CFR").[5] The West Virginia Legislature defines a mid-level provider in the West Virginia Code as including, but not limited to "advanced nurse practitioners, nurse-midwives and physician assistants," and acknowledges that primary care is generally rendered by physicians and mid-level providers.[6]

Mid-level practice came to prominence out of necessity in response to the shortage of primary care physicians that the United States began experiencing in the 1960s. The scope of practice and medical training of mid-levels has continued to evolve due to the rapidly changing and advancing healthcare industry since that time.[7] Additionally, cutbacks in Medicare and Medicaid programs and economic pressure from insurers to reduce costs have continued to lead to the growth in the number of mid-levels, which many see as a cost-effective solution to provide

[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4093350/
[5] 21 CFR § 1300.01
[6] W. Va. Code § 18B-16-3(e)
[7] W. Va. Code § 30-7-18. *See also* https://www.aapa.org/about/history/.

competent, professional healthcare in a range of settings and contexts that physicians would otherwise be required to cover.[8]

Because both Physician Assistants ("PAs") and Nurse Practitioners ("NPs") share statutory healthcare authority to provide similar services within complimentary scopes of practice, it is not surprising they fall together under the broad umbrella of the term "mid-level." However, despite such similarities, these are two distinct professions that have separate statutory authority and levels of physician oversight.

Physician Assistants Practice Act

The rules governing the practice of PAs are codified in W.Va. Code §§ 30-3E-1, *et seq*., otherwise known as the Physician Assistants Practice Act (PA Act). This Act sets forth a PA's requirements for licensing, scope of practice, and collaborating physician oversight. The Act also delegates regulatory authority to the West Virginia Board of Medicine and the West Virginia Board of Osteopathic Medicine ("Boards").[9] These Boards provide identical regulations pertaining to PAs and are found under Titles 11 and 24 in the West Virginia Code of State Rules.[10]

PAs receive their license to practice through the West Virginia Board of Medicine or the West Virginia Board of Osteopathic Medicine, depending on the licensure of the PA's collaborating physician.[11] A PA must obtain either a bachelor's or master's degree from an accredited physician assistant program, pass the PA National Certifying Examination, obtain certification from the National Commission on Certification of Physician Assistants, and be of

[8] *Id.*
[9] W. Va. Code § 30-3e-2.
[10] W. Va. Code St. R. §§ 11-1A-1, *et seq*. and §§ 24-1-1, *et seq*.
[11] W. Va. Code § 30-3e-4.

good moral character in order to receive his or her license.[12] A PA is subject to continuing education requirements and must renew licensure every other year.[13]

A collaborating physician is a licensed physician who "collaborates with the physician assistant by overseeing the activities of, and accepting responsibility for, the medical services rendered by the physician assistant."[14] A PA may not practice independent of a collaborating physician. The PA Act clarifies that "collaboration" does not mean constant physical presence, nor that the physician even has to be personally present at the location where the PA renders medical services. Rather, the collaborating physician and PA must be able to immediately contact each other in person or by available communication modalities including telecommunication.[15]

The Boards explain that appropriate collaboration consists of active and continuing overview of the PA's activities to determine that the collaborating physician's directions are being implemented.[16] Such overview should be accomplished through personal and regular review of selected patient records and periodic educational and review sessions discussing specific conditions, protocols, procedures, and patients. The patient records are chosen on the basis of written criteria established by the collaborating physician and the PA, and must be performed at least quarterly to assure adequate review of the PA's scope of practice. Notably, there is a special supervisory rule for PAs who are in their first year of practice and in their first six months of an authorized practice agreement in that such periodic in person meetings between

[12] *Id.*
[13] *Id.*
[14] *Id.*
[15] W. Va. Code § 30-3e-11.
[16] W. Va. Code St. R. §§ 11-1B-10 and 24-2-10.

the PA and collaborating physician must occur monthly.[17] The collaborating physician and PA must retain written documentation of these meetings.[18]

In the absence of the PA's regular collaborating physician, it is the collaborating physician's responsibility to ensure that collaboration in maintained.[19] Accordingly, a collaborating physician may designate an alternate collaborating physician under which a PA may practice. An "alternate collaborating physician" is a physician who provides collaboration with the PA in accordance with a written practice agreement during periods when the collaborating physician is unavailable.[20] An alternate collaborating physician, jointly with the collaborating physician, is legally responsible for the acts of a PA that occur during periods where the alternate collaborating physician is collaborating with the PA.[21] An alternate collaborating physician may not accept collaborative responsibility of the PA for an interval exceeding forty-five consecutive days. Additionally, credentialed medical facility staff and attending physicians of a hospital who provide direction to or utilize PAs are considered alternate collaborating physicians, even if such credentialed staff and attending physicians are not named in the written practice agreement.[22]

A collaborating physician may enter into practice agreements with up to five PAs at any one time but is prohibited from serving as a collaborating physician or alternate collaborating physician for greater than five PAs at any one time.[23] However, a physician practicing medicine in an emergency department of a hospital or a physician who collaborates with a PA who is employed by or on behalf of a hospital may collaborate with up to five PAs per shift if the

[17] *Id.*
[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] *Id.*
[22] *Id.*
[23] *Id.*

physician has an authorized practice agreement in place with the PA or the physician has been properly authorized as an alternate collaborating physician for each PA. Alternatively, a PA may simultaneously maintain practice agreements with more than one collaborating physician.[24]

A "practice agreement" is a key component of a PA's practice and the collaborating physician's oversight. After a PA is licensed, but before he or she may practice or a physician may delegate medical acts, the PA and collaborating physician must file a written practice agreement with the appropriate licensing board and receive written authorization from the same pursuant to such agreement.[25] A practice agreement is a written document executed between a PA and collaborating physician that is required to include a description of the: (1) qualifications of the collaborating physician, alternate collaborating physicians, and PA; (2) settings in which the PA will practice; (3) continuous physician collaborating mechanisms and experience and training of the PA; (4) medical acts to be delegated; (5) medical care the PA will provide in an emergency and the definition of an emergency; (6) and the PA's limitation of prescriptive ability, as set forth in § 30-3E-3(7).[26]

The limitation of prescriptive ability, at a minimum, forbids PAs from prescribing Schedule I and II drugs, and they may only prescribe Schedule III drugs to a thirty-day supply without refill.[27] The PA must enter each prescription and subsequent refills on the patient's chart.[28] A PA may also administer local anesthesia to patients.[29]

The collaborating physician may only delegate authority to provide medical services that are described in the practice agreement and that are within the scope of practice of the

[24] W. Va. Code St. R. §§ 11-1B-11 and 24-2-11.
[25] W. Va. Code § 30-3e-10.
[26] *Id.*
[27] W. Va. Code § 30-3e-3(7).
[28] W. Va. Code St. R. §§ 11-1-12 and 24-2-12.
[29] *Id.*

collaborating physician and PA. The collaborating physician must provide an attestation to the licensing board to this effect with the practice agreement.[30] The licensing board has the discretion to decline to authorize a PA to practice with written notice if it determines that the practice agreement is inadequate or that the PA is incapable of performing delegated duties safely.[31] A PA must provide written notification to the licensing board within ten days of the termination of a practice agreement; failure to provide timely notice constitutes unprofessional conduct and may subject the PA to disciplinary proceedings.[32]

The PA Act sets forth vicarious liability for the collaborating physician and also the alternate collaborating physician if the latter assumes the role of collaborating physician during the care and treatment in question. The PA Act also establishes vicarious liability for a health care facility employing a PA.[33] The Act states:

> A collaborating physician is responsible at all times for the PA with whom he or she is collaborating, including: (1) The legal responsibility of the physician assistant; (2) Observing, directing and evaluating the physician assistant's work records and practices; and (3) Collaborating with the physician assistant in the care and treatment of a patient in a health care facility . . . [and] [a] health care facility is only legally responsible for the actions or omissions of a physician assistant when the physician assistant is employed by or on behalf of the facility. Credentialed medical facility staff and attending physicians of a hospital who provide direction to or utilize physician assistants employed by or on behalf of the hospital are considered alternate collaborating physicians.[34]

A PA's statutorily imposed scope of practice allows the PA to perform medical acts delegated as part of an authorized practice agreement, customary to the practice of the collaborating physician, and commensurate with the PA's education, training, and experience.[35]

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[30] W. Va. Code § 30-3e-10.
[31] *Id.*
[32] *Id.*
[33] W. Va. Code § 30-3e-11.
[34] *Id.*
[35] W. Va. Code § 30-3e-12.

A PA is restricted from performing "any specific function or duty [of] . . . chiropractors, dentists, dental hygienists, optometrists or pharmacists, or certified nurse anesthetists."[36]

The Boards provide a far more detailed description of a PA's scope of practice. They mandate that PA, at a minimum, must have the knowledge and competency to perform "core duties" with appropriate physician collaboration.[37] A PA's core duties, as set forth by the Boards, include: screening, taking, and reviewing patient history and identifying abnormal findings therefrom; physical examinations; recording pertinent patient data and summaries; appropriate management and treatment of patients; requesting lab studies; collecting specimens for analyses and cultures; evaluating and managing emergency situations; counseling and instruction regarding patient problems and/or questions; and performing clinical procedures such as venipuncture, EKG, suturing, casting and splinting, application of dressings and bandages, removal of superficial foreign bodies, CPR, audiometry screening, visual screening, and aseptic and isolation techniques.[38] A PA is also expected to assist in surgery, prepare patient discharge summaries, and assist the collaborating physician in a manner by which to learn and become proficient in new procedures. A PA may sign orders within the scope of his or her practice, including admission and/or discharge orders for patients he or she has been involved in treating. However, PAs may not independently delegate a task assigned by the collaborating physician to another individual. A PA's core duties and scope of practice may be expanded by education, training, and/or experience.[39]

[36] *Id.*
[37] W. Va. Code St. R. §§ 11-1B-9 and 24-2-9.
[38] *Id.*
[39] *Id.*

Registered Professional Nurses Act

The Registered Professional Nurses Act ("RPNA") governs NPs and is wholly distinct from the PA Act, primarily and most importantly in the definition and role of a "collaborating physician."[40] The RPNA permits NPs to practice independently of a physician and also delegates regulatory authority to the West Virginia Board of Examiners for Registered Professional Nurses ("RPN Board") under Title 19 of the West Virginia Code of State Rules. Nurse practitioners, along with nurse-midwives, registered nurse anesthetists, and clinical specialists, fall under the definition of "advanced practice registered nurse" within the provisions of W.Va. Code §§ 30-7-1, *et seq.*[41] As this article only attends to nurse practitioners, only the provisions relevant to NPs will be covered, although most of the following discussion generally applies to the other categories of advanced practice registered nurses listed above.

In order to practice as an NP, a practitioner must be licensed by the West Virginia Board of Examiners for Registered Professional Nurses.[42] To obtain such license, an applicant must be in good standing with the RPN Board as a registered professional nurse, complete an accredited graduate level nurse practitioner program, and be certified as a nurse practitioner by a national certification organization.[43] The nurse practitioner program must include instruction preparing the enrollee to fulfill a licensed nurse practitioner's scope of practice, which at a minimum encompasses pharmacology, advanced physical assessment, advanced pathophysiology, and clinical management of disease and differential diagnosis.[44]

Upon application and authorization by the RPN Board, an NP may prescribe medications, with the exception of Schedule I and II drugs, and is limited to prescribing Schedule III drugs to

[40] W. Va. Code §§ 30-7-1, *et seq.*
[41] W. Va. Code § 30-7-1.
[42] W. Va. Code § 30-7-2.
[43] *Id.*
[44] W. Va. Code St. R. § 19-7-9.

a thirty-day supply without refill.[45] An NP may also administer local anesthetics to a patient.[46] The RPN Board authorizes the NP prescriptive authority pursuant to a collaborative agreement with a collaborating physician, which must be in writing and include: (1) mutually agreed upon written guidelines for prescriptive authority; (2) statements describing the individual and shared responsibilities of the NP and collaborating physician; (3) periodic and joint evaluation of prescriptive authority; and (4) periodic joint review and updating of the written guidelines for prescriptive authority. Each prescription and subsequent refills given by an NP must be entered into the patient's medical record.[47] Further, at the time of the initial prescription, an NP must record the plan for continued evaluation of the effectiveness of the controlled substances prescribed.[48]

A collaborating physician in the context of an NP is much different than a collaborating physician in the context of a PA. An NP's collaborating physician only collaborates with an NP to develop a collaborative prescriptive agreement; otherwise, an NP's collaborating physician does not oversee or become legally responsible for the NP's care. This is in contrast to a PA's collaborating physician who does oversee and becomes legally responsible for the PA's care.

After an NP has practiced for three years under a collaborative agreement, and upon application to the Board, an NP may be issued prescriptive authority without the requirement of a collaborating physician and agreement.[49] An NP's prescriptive authority must be renewed every other year in addition to continuing education requirements in pharmacology.[50]

[45] W. Va. Code § 30-7-15a.
[46] W. Va. Code St. R. § 19-8-5.
[47] W. Va. Code St. R. § 19-8-5.
[48] *Id.*
[49] W. Va. Code § 30-7-15b.
[50] W. Va. Code § 30-7-15c.

The MPLA As It Relates to Mid-Levels

As with any professional, mid-level providers present a variety of liability concerns in relation to their practice and the services they render. The West Virginia Medical Professional Liability Act ("MPLA") applies to PAs and NPs, both of which are specifically listed as a "health care provider" in its definitions section.[51] The standard of care for PAs and NPs is statutorily prescribed under the MPLA, and is "that degree of care, skill and learning required or expected of a reasonable, prudent health care provider in the profession or class to which the health care provider belongs acting in the same or similar circumstances."[52] As such, PAs and NPs have distinct standards of care from one another and from any other healthcare provider, including physicians. The standard of care for PAs is that of a reasonable, prudent PA in the same or similar circumstances, and for NPs is a reasonable, prudent NP in the same or similar circumstances. This codified standard of care is consistent with the national consensus, which was explored in the seminal case of *Cox v. M.A. Primary and Urgent Care Clinic*, 313 S.W.3d 240 (2010).

In *Cox*, the Tennessee Supreme Court examined liability issues surrounding PAs, which also may generally relate to NPs. There, a patient brought a medical malpractice action against a clinic and physician for injuries she allegedly suffered as a result of the PA's failure to diagnose her cardiomyopathy.[53] The Tennessee Supreme Court ruled that PAs are not held to the same standard of care as physicians.[54] The court reasoned it was "logically inconsistent" to impose significant limitations on PAs and yet simultaneously hold them to the same standard of care of

[51] W. Va. Code § 55-7b-2.
[52] W. Va. Code § 55-7b-3.
[53] *Id.* at 243.
[54] *Id.*

their supervisors, physicians.[55] *See also, Paris v. Kreitz*, 75 N.C. App. 365, 331 S.E.2d 234, 247 (1985) (PAs are not subject to the same standard of practice as a medical doctor); *Johnson v. Westfield Mem'l Hosp., Inc*., 184 Misc.2d 792, 710 N.Y.S.2d 862, 863 (N.Y.Sup.Ct.2000) (a PA's standard of care is different than an ophthalmologist's). *But see Andrews v. United States*, 548 F.Supp. 603, 611 (D.S.C.1982) (applying physician's standard of care to PA under South Carolina law).

Under the MPLA, the standard of care relating to PAs and NPs must be established by an expert witness who possesses professional knowledge and expertise, along with knowledge of the applicable standard of care.[56] The expert must be engaged or qualified in a medical field and must have experience and/or training in diagnosing and treating injuries or conditions similar to those of the patient.[57] As such, physicians that practice in a particular mid-level's related field and have experience with the mid-level's standard of care, may testify as to the mid-level's standard of care. *See generally Philipp v. McCreedy*, 298 S.W.3d 682, 687-89 (Tex.Ct.App.2009) (medical doctor familiar with the standard of care for physician assistants may testify as to a PA's standard of care).

The necessary qualifications of a competent expert to establish a PA's standard of care was another issue explored in *Cox*. In that context, the court ruled that the plaintiff failed to present expert testimony from a competent witness establishing the PA's standard of care, which was required to support her malpractice action.[58] This evidentiary insufficiency occurred because plaintiff's proffered expert, a cardiologist, testified during deposition that he had never worked with PAs, did not know the responsibility of a supervising physician with respect to his duties

[55] *Id.* at 257.
[56] W. Va. Code § 55-7b-7.
[57] *Id.*
[58] *Cox* at 259-260.

toward a PA, and was not in a position to testify about the standard of acceptable professional practice of a PA.[59] *See also Wilson v. James*, 2010 WL 1107787 (Del.Super. Feb. 19, 2010) (unpublished opinion from Superior Court of Delaware finding board-certified pediatrician was not qualified to testify as an expert regarding the standard of care required by a PA due to pediatrician's admission of lack of familiarity of "what the 'scope of practice of physician's assistants' was under Delaware law"); *see also Mikheil v. Nashville General Hospital at Meharry*, 2016 WL 373726 (2016) (court holding that plaintiff's expert was not competent to testify concerning relevant standard of care for nurse practitioners because during deposition expert stated that he is not an expert on the standard of care as it applies to nurse practitioners).

In some cases, plaintiffs have asserted that policies and guidelines contained in agreements between a health care facility and a mid-level establish the standard of care. One such case regarding an NP was addressed in the Court of Appeals of Ohio case of *Moreland v. Oak Creek OB/GYN, Inc.*, 970 N.E.2d 455 (2005). In *Moreland*, the plaintiffs argued that the trial court erred in failing to instruct the jury that the NP was negligent per se, based on evidence that she violated certain statutory and contractual provisions.[60] The plaintiffs claimed that these statutory and contractual provisions defined the scope of the standard of care for the NP.[61] Despite plaintiffs' argument, the court held that the NP's liability must be assessed by determining whether she violated the applicable nurse practitioner standard of care.[62] The court reasoned that "[w]hile her alleged failure to comply with the terms of [the statute] and the agreement may be relevant to whether [the NP] satisfied or breached the standard of care . . . the

[59] *Id.* at 261.
[60] *Id.* at 461.
[61] *Id.*
[62] *Id.* at 462.

issue whether a nurse has satisfied or breached her duty of care owed to a patient is determined by the applicable standard of conduct, which is proven by expert testimony."[63]

Moreland is relevant in light of the MPLA's relation to NPs. As discussed *supra*, the MPLA requires that an NP's standard of care must be established by expert testimony, and *Moreland* supports the notion that experts have the original and final word on establishing the standard of care.

Relatedly, neither a PA nor an NP may sign a certificate of merit for a medical malpractice claim against a physician, and by implication, is unqualified to testify and establish a physician's standard of care.[64] *See generally*, *Bradford v. Alexander*, 886 S.W.2d 394, 397 (Tex.Ct.App.1994) (physician assistant could not testify as to the standard of care for physician); *see also*, *Shook v. Herman*, 759 S.W.2d 743, 747 (Tex.Ct.App.1988) (doctor required to testify about the standard of care and defendant's breach of it).

Vicarious Liability for Collaborating Physicians

There is a risk of vicarious liability for physicians who collaborate with PAs and NPs due to the nature of professional oversight these physicians provide or should have provided. Although the vicarious liability for collaborating physicians, alternate collaborating physicians, and health care facilities is clearly established in the Physician Assistants Act, vicarious liability as it relates to NPs is more nuanced. Because NPs have the ability to practice independently, save for their prescriptive authority, vicarious liability is not a given; however, the potential exists in relation to their statutorily mandated collaborative prescriptive agreements. Despite such vicarious liability issues that are present in the practice of PAs and NPs, any liability for a

[63] *Id.*
[64] W. Va. Code §§ 30-3e-12, 30-7-15d.

collaborating physician due to a mid-level's medical negligence can and should be tempered by the several liability provision contained in the MPLA.[65]

The important, real world consequences of failing to account for the distinction in legal liability between NPs and physicians were evidenced in *Moreland*. There, the appellate court found reversible error where the verdict form submitted to the jury by the trial court did not allow the jury to make a separate finding of negligence for an NP and for the physician with whom the NP treated the plaintiff-patient.[66] The plaintiffs sued two separate defendants, Oak Creek, which was the NP's employer, and Dr. Little, a physician who worked together with the NP in treating the patient.[67] Oak Creek was sued on the theory of respondeat superior for the NP's alleged negligence and effectively stood in the place of the NP as to her alleged negligence and liability.[68] At trial, the jury was presented with a verdict form structured so that the jury might find that either both Oak Creek and Dr. Little were liable or that neither were liable.[69] This form did not offer the jury the option of finding the NP individually negligent, or not negligent, without finding the same result for Dr. Little.[70] The court ruled that a reasonable jury may have credited the plaintiffs' allegations regarding the NP, concluding that she was negligent, with the result that Oak Creek would be liable under the doctrine of respondeat superior. And, that the same jury may have declined to credit plaintiffs' allegations concerning Dr. Little, concluding that he was not negligent.[71]

However, because the physician was not liable for the negligence of the NP and their negligence was not distinguished on the verdict form, the court held that the failure to distinguish

[65] W. Va. Code § 55-7b-9.
[66] *Moreland* at 457.
[67] *Id.* at 458.
[68] *Id.* at 457.
[69] *Id.* at 459.
[70] *Id.*
[71] *Id.*

the two was reversible error.[72] The *Moreland* court noted that "when competing theories of liability are advanced against separate defendants, separate verdict forms should be used."[73] As such, NPs and the physicians with whom they work must be treated as separate defendants without vicarious liability automatically attaching for the physician and verdict forms must reflect as much.

Regarding liability concerns that an NP's collaborating physician may face from a collaborative prescriptive agreement, the Supreme Court of Utah has provided guiding principles in assessing such a case. In *Jeffs v. Rodier*, 342 P.3d 803 (2015), the court held that the collaborative prescription provision of Utah's Nurse Practice Act, which is congruent with West Virginia's Registered Professional Nurses Act, did not establish a duty by the collaborating physician to consult on an individual, prescription-by-prescription basis with the prescribing NP.[74]

In *Jeffs*, the plaintiffs alleged that the NP negligently prescribed medication, and framed their claim as an "omission" in that the collaborating prescriptive physician had a duty to consult directly with the NP as a precondition to any individual prescription.[75] Plaintiffs claimed that Utah Code § 58-31b-102(5), which allowed NPs to prescribe medication pursuant to a written consultation and referral plan with a collaborative physician, required that the collaborative physician affirmatively reach out and discuss the NP's treatment plan prescriptions regarding each patient.[76]

The court ruled that Utah's Nurse Practice Act did not establish a duty on behalf of the collaborating physician to consult on an individual, prescription-by-prescription basis because

[72] *Id.* at 460.
[73] *Id.*
[74] *Jeffs* at 806.
[75] *Id.* at 805.
[76] *Id.*

the Act was aimed at regulating the conduct of nurse practitioners, not physicians.[77] Additionally, the Act did not address the specific duty that the plaintiff alleged, which is that a collaborating physician has a duty to consult with the NP on a prescription-by-prescription basis, but merely in accordance with the written consultation and referral plan.[78] The court reasoned that if "individual consultation is required as to each prescription or administration, no further 'plan' is needed," because this would cause the NP to fall under the direct supervision of a physician, which is contrary to the Act's purpose.[79]

Although *Jeffs* was decided by the Supreme Court of Utah, its decision was rooted in the court's interpretation of a statute nearly identical in form and function to West Virginia's Professional Nurses Act.[80] Utah's Nurse Practice Act sets forth the qualifications for licensure of NPs, their scope of practice, and that their prescriptive authority is limited by a written "consultation and referral" plan that is jointly developed with a "consulting physician."[81] Such arrangements are also provided for in the Professional Nurses Act, which makes the Supreme Court of Utah's holding persuasive in its reasoning.[82]

Common Litigation Themes in the Practice of Mid-Levels

The collaboration that occurs between mid-levels and collaborating physicians demands clear and open lines of communication. Sufficient communication may require in person meetings, precise medical recordation, and the immediate availability of the collaborating physician. Expectations for communication should be delineated in collaborative and practice agreements. A review of medical malpractice actions involving PAs and NPs reveals that

[77] *Id.* at 806.
[78] *Id.*
[79] *Id.* at 807.
[80] Utah Code §§ 58-31b-101, *et seq*.
[81] *Id.*
[82] *Cf.* Utah Code §§ 58-31b-1-1, *et seq*. with W. Va. Code §§ 30-7-1, *et seq*.

problems arise when these professionals fail to sufficiently chart their findings, fail to refer the patient to a specialist, and/or fail to communicate their concerns with collaborating physicians. These failures have repeatedly led to malpractice actions wherein the plaintiff alleges that consultation with a collaborating physician should have occurred and/or that a mid-level was practicing outside of his or her scope, resulting in a failure to diagnose. *See generally, Reeves v. Healy,* 192 Ohio App.3d 769 (2011) (plaintiff alleged physicians, physician assistant, and hospital failed to diagnose and treat stroke during emergency room visit); *MacDonald v. U.S.* 853 F.Supp. 1430 (1994) (plaintiff alleged physicians and PAs negligently failed to diagnose heart attack and physicians negligently supervised PAs); *Adams v. Anderson,* 84 A.D.3d 1522 (2011) (plaintiff alleged medical group, PA, and orthopedic surgeon failed to timely diagnose and treat complex regional pain syndrome); *Polone v. Shearer,* 287 S.W.3d 229 (2009) (plaintiff alleged that physician and PA were negligent in failing to closely follow up after mammogram showed mass); *see also, Siegel v. Husak,* 943 So.2d 209 (2006) (plaintiff alleged decreased arm use resulting from failure of physician and NP to properly diagnose ruptured tendons); *Fein v. Permanente Medical Group,* 38 Cal.3d 137 (1985) (plaintiff alleged that he was injured by failure of medical group, including NP, to promptly diagnose impending heart attack); *Mikheil v. Nashville General Hospital at Meharry*, 2016 WL 373726 (2016) (plaintiff alleged NP and neurologist failed to properly diagnose and treat patient's severe cervical stenosis with myelopathy); *Brock v. Gatz,* 237 Fed.Appx. 321 (2007) (plaintiff alleged physician and NP failed to diagnose skin cancer).

Actions alleging that a PA should have consulted the collaborating physician have at times resulted in infighting between the PA and physician as to the degree of consultation that occurred. As such, counsel for these professionals should always find all sources of

communication at the outset of any case. In *Gaspari v. Sadeh*, 61 A.D.3d 405 (2009), the plaintiff claimed that the PA breached the standard of care in failing to consult with her collaborating physician and such failure was a proximate cause of her injuries as it delayed the diagnosis of her disease process.[83] The PA testified that it was beyond her expertise to diagnose the plaintiff's condition and that she asked the physician to examine the patient on the day in question but that the physician refused.[84] The physician alleged that the PA did not follow up with him after her examination of the patient, wrote illegible notes documenting her medical findings, and it was unlikely he was even in the office on the day in question as he would have made a notation had the PA approached him.[85] As such, the physician argued that he was not liable for the PA's alleged negligence. The court ruled that despite the physician's argument, he was vicariously liable for all of the PA's alleged acts and omissions, pursuant to state law.[86]

Despite the communication required between PAs and collaborating physicians, a collaborating physician is not required to look over the PA's shoulder when rendering care. The case of *Cleveland ex rel. Cleveland v. U.S.*, 457 F.3d 397 (2006) provides an example of a factual situation wherein the PA acted independently by evaluating, diagnosing, and prescribing without his collaborating physician's consultation and approval. The trial court found that the PA met the standard of care and the appellate court affirmed this finding as Louisiana law, similar to West Virginia law, permitted a PA to act independently pursuant to previously delegated authority by the collaborating physician.

[83] *Id.*
[84] *Id.* at 406.
[85] *Id.*
[86] *Id.*

In *Cleveland*, the plaintiff alleged that a PA failed to diagnose her decedent-husband's congestive heart failure, leading to his death.[87] The evidence revealed that upon examination, the PA diagnosed the decedent with an upper respiratory infection, bronchitis, and sinusitis, and prescribed him an antibiotic and decongestants.[88] At the time of his alleged failure to diagnose, the PA did not consult with his collaborating physician nor did he receive physician approval for prescribing such medications.[89] The plaintiff alleged that the PA's failure to consult and receive approval from the collaborating physician breached the standard of care.[90] However, the trial court found that no such breach occurred and that the PA met the standard of care.[91] The appellate court affirmed the trial court's findings because "Louisiana law permits a physician assistant to act independently of a supervising physician when the authority to act had been previously delegated . . . [and the PA] was authorized to 'diagnose and treat minor illnesses' without a physician being present."[92] Additionally, the PA was authorized to prescribe the class of medications ordered in treating the decedent under Louisiana law.[93]

Courts have also found PAs not liable in circumstances where the PA did not consult the collaborating physician, yet there was no evidence that the collaborating physician would have been able to diagnose or the treat the patient any differently than the diagnosis and care rendered by the PA. In the case of *Montgomery v. South Philadelphia Medical Group, Inc.*, 441 Pa.Super. 146 (1995), the plaintiff presented to a PA and complained of pain in her left breast.[94] The PA noted the complaint and ordered a baseline mammogram that revealed no abnormality.[95] Some

[87] *Id.* at 400.
[88] *Id.*
[89] *Id.*
[90] *Id.*
[91] *Id.* at 402.
[92] *Id.* at 409.
[93] *Id.*
[94] *Id.* at 150.
[95] *Id.*

thirteen months later, the plaintiff was diagnosed with Stage II cancer and underwent a modified radical mastectomy of the left breast, followed by chemotherapy.[96] The plaintiff filed a civil action and alleged that the PA failed to diagnose her cancer and negligently failed to refer her to a physician after she complained of breast pain.[97] At trial, the plaintiff introduced the testimony of a board certified internist, Dr. Karp.[98] Upon the completion of plaintiff's case at trial, the trial court entered a compulsory non-suit, finding that the plaintiff failed to make out a prima facie case of medical malpractice as she failed to establish the element of causation.[99] The appellate court affirmed the trial court's ruling, holding that the plaintiff's evidence of causation was insufficient to require submission to a jury.[100] The appellate court explained that despite there being evidence that plaintiff had complained of pain in her left breast and she had not been referred to a physician, there was no evidence of the presence of any lump or mass and the mammogram showed no abnormality.[101] "Thus, there was no evidence that an examination by a physician would have disclosed anything more than was discovered by the physician assistant."[102]

Further, plaintiff did not present evidence as to the time when the tumor could first have appeared. And, although Dr. Karp testified that the PA's failure to refer the plaintiff to a physician breached the standard of care, he did not testify that the risk of harm had been increased thereby. Dr. Karp merely testified that it was "'very possible' that the failure to refer

[96] *Id.* at 151.
[97] *Id.*
[98] *Id.*
[99] *Id.* at 152.
[100] *Id.* at 161.
[101] *Id.* at 160.
[102] *Id.*

the plaintiff to a physician 'may have increased her chance'" of injury.[103] The appellate court held that Dr. Karp's testimony was insufficient to establish causation.[104]

As to NPs, a plaintiff is required to specifically establish the reason an NP's failure to consult a physician or specialist breached the standard of care. Courts have rejected conclusory allegations that an NP's failure to consult with or refer a patient to a physician was medical negligence. *Rivers v. Birnbaum*, 102 A.D.3d 26 (2012) involved this type of conclusory assertion, wherein the plaintiff alleged that an NP failed to consult with a physician and failed to diagnose and advise of conditions that led to development of plaintiff's disease.[105] The NP moved for summary judgment dismissing the complaint and submitted affirmations from her experts.[106] Plaintiffs opposed the motion and submitted their own expert affirmations.[107] The trial court determined that the plaintiffs' expert's affirmation in opposition raised a triable issue of fact as to whether the NP departed from the standard of care due to the failure to consult and denied the NP's motion.[108] The *Rivers* court sided with the NP and overturned the trial court's decision to deny the motion.[109] It reasoned that plaintiffs' expert's affirmation, which opined that the NP should have consulted with a physician, failed to raise a triable issue of fact as to whether the NP breached the standard of care because it was conclusory and speculative.[110] The *Rivers* court reasoned that plaintiffs' expert "merely concluded that [the NP's] failure to follow up with a physician in light of the alleged red flag was an 'obvious departure from the standard of care.'"[111]

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[103] *Id.*
[104] *Id.*
[105] *Id.* at 31.
[106] *Id.* at 46.
[107] *Id.* at 47.
[108] *Id.*
[109] *Id.*
[110] *Id.*
[111] *Id.*

As is evident from the foregoing cases and factual situations, collaborating physicians and health care facilities should foster a culture where communication is expected and encouraged. Additionally, clear documentation of any communication that occurs regarding a patient, by both mid-levels and collaborating physicians, may help to preclude infighting during litigation.

Conclusion

With the challenges that are sure to come with providing affordable, accessible healthcare to an underserved and aging population, mid-levels are primed to grow in number and importance as pieces in the healthcare industry. Accordingly, the practice of mid-levels and their collaboration with physicians will continue to be tested and interpreted. As mid-level practice continues to evolve and increase in importance, with oversight from and the help of collaborating physicians, the foregoing framework will be vital in the legal representation of these healthcare professionals.