What Is the Medical and Legal Risk of Physicians Supervising Advanced Practice Providers?

Always check with your state's licensing board.

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Editor's Note: *Not every state allows podiatrists to supervise PAs and NPs. Check with your state licensing board.*

In medical practice, when physicians supervise physician assistants (PAs), nurse practitioners (NPs), and other advance practice providers (APPs) they assume the legal role of respondeat superior, a legal doctrine that states a supervising party (physician) is responsible for the acts of their agents (APPs). In medical practice, the physician working with an APP is the responsible party, and the APP is an agent of the physician. This relationship is bound by the rules of agency law.

Liability exposure in a healthcare negligence or liability claim rarely is a cut-and-dried matter. Office-based physicians often are taken aback when confronted with the fact that they, their medical group, or their professional association may be responsible for the conduct of another in their office or practice. This confusion often arises from the failure to appreciate and understand the concept of indirect or vicarious liability embodied in the legal theory of respondeat superior. The potential legal responsibility for the acts of others does not stop there, though. This article discusses the basic theories and circumstances under which a healthcare professional may be responsible for the acts of those employed by that entity or the individual physician.

Respondeat superior embodies the general rule that a physician is responsible for the negligent acts or omissions of its APPs. Under respondeat superior, a physician is liable for the negligent act or omission of any APP acting within the course and scope of their employment. This is dependent purely on the vicarious liability theory of liability, meaning the physician does not base a finding of liability on any improper individual action. The fact that the physician may have acted reasonably in hiring, training, super-

Continued on page 78

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Supervising (from page 77)

vising, and retaining the APP is irrelevant and does not provide a basis on which the physician can avoid liability for the acts of APPs. The underlying premise of respondeat superior is that the cost of torts (i.e., negligent acts or omissions) committed in the daily practice of a medical business enterprise should be borne by that physician as a cost of doing business.

Whether or not a master–servant relationship exists depends primarily on whether the physician has the "right of control" over the APP. The legal issue is the right to control the details and manner of the work performed by the APP. In an evaluation of the control issue, the inquiry focuses on whether the physician has the right to control the APP in performing the task at issue. For example, in healthcare claims, the focus is on whether the physician has the ability to control the APP's provision of evaluation, diagnosis, or treatment services to patients.

Vicarious Liability: Responsibility for the Acts of Others

The relationship between supervising physicians and APPs sets the stage for physicians to be vicariously liable for the acts or omissions of APPs. The three elements that must be met for vicarious liability are as follows:

- The wrongful act must have been committed by an APP;
- The APP must have been acting within the scope of their employment; and
- The physician must have had the ability to control the acts or omissions of the APP.

This vicarious liability concept that puts physicians in a position of being responsible for the acts of others should make physicians step back and better understand the risks associated with the supervision of APPs when an agency relationship exists. An agency relationship is created when the physician consents to an APP acting on their behalf, subject to the physician's control, and the APP agrees to do so. Let's review a case study to highlight the complexity in this agency relationship.

This case example highlights the complex physician–APP relationships that may exist in today's medical practice. It also highlights the need for physicians to understand the present-day and evolving law that impacts these agency relationships, because there is the potential for liability risk. This complexity of the agency relationship is further exacerbated by the recent relaxation of laws pertaining to PA supervision and delegation. Expansion of the roles that non-physician providers may play in healthcare delivery has long been hotly debated within state legislatures. In the past year, however, multiple states adopted or revised legislation to permit PAs to work more independently to deliver healthcare services.

This includes several states that transitioned from "supervision" models to "collaboration" models, states that eliminated or reduced requirements for chart review and supervision agreements, and several states that eliminated the need for a supervising physician to be physically co-located with the PA. These legislative changes signal a trend in which providers wishing to collaborate with PAs to deliver healthcare services—including through tele-

Continued on page 79

A Real and Shocking Case Study

After 10 years working as a PA with a large primary care practice, a PA left to open a solo primary care clinic. The PA arranged for a physician she met at a professional meeting to serve as her off-site supervising physician. The PA was a trusted provider in her previous practice, and many established patients elected to follow her to the new clinic. After one year in successful solo practice, the PA decided to expand the scope of services she offered to include cosmetic procedures, primarily Botox and dermal fillers that the PA learned to inject at a two-day workshop. The PA marketed the new services with a print advertising campaign, sending direct mail postcards, and even renting a billboard in her town.

Several months after the PA launched the cosmetic services, the medical board opened an investigation based on an anonymous complaint that the PA was practicing without physician supervision. In her written response, the PA stated that she did have a supervising physician who worked at a different practice location and speculated that the complainant must mistakenly believe that PAs are required to have on-site supervision. The PA provided the medical board with the name and contact information of her supervising physician.

On further investigation, the medical board discovered that, upon opening her own practice, the PA had not met monthly with her supervising physician for the first six months, as is required for PAs in a new supervisory relationship. When asked about this, the PA indicated that she did not think this rule applied to her because she had a decade of experience, not realizing that the rule applies to new supervisory relationships and not to new PAs.

In addition, the PA's scope of practice and prescribing documents were cursory, and the PA was only able to produce documentation for one quality improvement meeting with her supervisor during their entire 13-month relationship. When asked to explain the lack of contact, the PA stated that she was able to handle all patient care independently and did not need to consult with her supervising physician. After interviewing the supervising physician, who confirmed that contact with PA had been minimal, the medical board learned that he was not trained to perform Botox and dermal filler injections and, in fact, had never treated a single patient with the treatments he was "supervising." PM

Supervising (from page 78)

medicine—may now consider doing so in states that were formerly too restrictive to consider that path.

States That Have Recently Relaxed Physician Assistant Supervision and Delegation Laws

Several states have recently relaxed their laws applying to physician supervision of and delegation to PAs.

- *Illinois:* Before January of 2020, Illinois limited physicians to supervising no more than two PAs and required the supervising physician to be within a "reasonable travel distance" of the PA at all times. Recent revisions to those laws now permit physicians to supervise up to seven PAs and no longer impose any physical geographic proximity requirement on the supervising physician. Instead, supervising physicians must now be available at all times through telecommunications or other electronic communications.
- *California:* California SB 697, which became effective January 1, 2020, served to revise California PA supervision and delegation laws to eliminate several previous require. Critically, the law eliminated the requirement that the physician be physically available to the PA for consultation and replaced it with a provision stipulating that availability by telephone or other electronic communication is sufficient. The law also eliminated requirements that the supervising physician review and countersign a significant portion of patient medical records.
- *Rhode Island:* Rhode Island HB 5572/SO 443, which became effective in July of 2019, served to revise state laws in several important ways. It first eliminated all prescriptive physician supervision requirements and shifted the nature of the relationship between physicians and PAs to collaborative rather than supervisorial. Although a physician must be "accessible at all times for consultation" by the PA, supervision and collaboration standards may be established by the physician as dictated by the skill, education, experience, and nature of the clinical practice of the PA. The law also eliminated requirements that hospitals and healthcare practices have written supervision agreements with each PA on file.
- *Missouri:* Missouri SB 514 became effective in August of 2019. In addition to transitioning from a supervision-based model to a collaboration-based model, the bill also eliminated the requirement that a supervising physician practice at the same facility as the PA for 4 of every 14 days. The new law also eliminated language that required a PA to practice at a location where the physician routinely sees patients.

Physicians must still evaluate requirements on a state-by-state basis and ensure that PA engagement is compliant with other state laws (such as state telemedicine laws and standards).

Implications of State Law Changes

The state regulatory landscape appears to be transitioning to permit more remote supervision of PAs and to reduce administrative burdens for the oversight of PA clinical practice. As this happens, healthcare providers—including healthcare providers wishing to provide telemedicine services—may find that engaging PAs to help deliver clinical services is becoming a more viable prospect.

Physicians must pause and reflect before jumping to conclusions regarding the agency relationship between physicians and APPs. Physicians must still evaluate requirements on a state-by-state basis and ensure that PA engagement is compliant with other state laws (such as state telemedicine laws and standards). However, physicians are being encouraged to consider how PAs might be used to expand clinical care access to low-access patients and locations in states that have relaxed their previously restrictive laws and regulations.

Succinct Overview of Recent Legislative Action

States have historically required close supervision of APPs, including chart review requirements, supervising physician practicing at same site location where medical care is delivered, and limiting APPs' scope of practice.

Several states cited earlier have taken legislative action to reduce the supervision and delegation encumbrance upon physicians practicing with APPs.

The Respondeat Superior Doctrine and Vicarious Liability

Medical informed consent is essential to the physician's ability to diagnose and treat patients as well as the patient's right to accept or reject clinical evaluation, treatment, or both. Medical informed consent should be an exchange of ideas that buttresses the patient–physician relationship. The consent process should be the foundation of the fiduciary relationship between a patient and a physician. Physicians must recognize that informed medical choice is an educational process and has the potential to affect the patient–physician alliance to their mutual benefit. Physicians must give patients equality in

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Continued on page 80

Supervising *(from page 79)*

the covenant by educating them to make informed choices.

When physicians and patients take medical informed consent seriously, the patient–physician relationship becomes a true partnership with shared decision-making authority and responsibility for outcomes. Physicians need to understand informed medical consent from an ethical foundation, as codified by statutory law in many states, and from a generalized common-law perspective requiring medical practice consistent with the standard of care. It is fundamental to the patient–physician relationship that each partner understands and accepts the degree of autonomy the patient desires in the decision-making process.

This understanding of medical informed consent should cause physicians to pause when considering the implications of a supervisory role over APPs. Respondeat superior teaches us the physician is legally responsible for all acts or omissions that occur during the treatment of a patient. The law of agency that governs the relationship between a physician and an APP mandates that the prudent physician will control the decisions that are made and adhere to the historically required close supervision of APPs, including chart review requirements, same-site location where medical care is delivered, and limiting APPs' scope of practice. The physician would be prudent to personally take a detailed history, and perform a detailed physical examination of the patient.

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The patient–physician relationship must become a true partnership. The APP can help buttress that fiduciary relationship between a physician and a patient, but cannot replace it. **PM**

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