

Who's really in charge?

LINDA MILLER ATKINSON

Physician assistants and nurse practitioners are common in health care facilities.

But how much responsibility do they have? If a patient is injured, you need to find out who—the midlevel provider, the supervising doctor, the facility, or all of them—is responsible.

Once upon a time, a person seeking medical care walked into a doctor's office, hospital, or clinic expecting to see a doctor who would perform the examination. Not anymore. Most patients seeking primary care today will leave the office, clinic, or hospital without ever being seen by a doctor. They will be examined, possibly get some tests and even a prescription or two, and be discharged with instructions from a midlevel provider.

The role of physician assistants and nurse practitioners—collectively called midlevel providers—in health care is growing. Once they gained statutory recognition and licensing, their ranks expanded to meet patient needs for health care—particularly in primary care, where physicians have become scarce. Health care facilities save money by employing midlevel providers to see patients in place of doctors, because the physician can bill for supervisory functions and still see and treat other patients.¹

Not to be confused with medical assistants, who perform routine clinical and clerical tasks, physician assistants (PAs) are formally trained to provide diagnostic, therapeutic, and preventive health care services, as delegated by a physician. Working as members of a health care team, they take medical histories, examine and treat patients, order and interpret laboratory tests and X-rays, and make diagnoses. They also treat minor injuries by suturing, splinting, and casting. PAs record progress notes, instruct and counsel patients, and order and carry out therapy. In 48 states and the District of Columbia, PAs may prescribe medications.

Nurse practitioners (NPs) are independent advanced-practice nurses who provide ambulatory, diagnostic, clinical, and primary care. NPs have graduate education and clinical training be-

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yond their preparation as registered nurses. They are licensed to practice in all states and in the District of Columbia under statutes that define their scope of practice.²

Clinically practicing physician assistants and nurse practitioners are always supervised by physicians, and the number of PAs or NPs one physician can legally supervise is limited by statute.³

Formal training of midlevel providers dates back to 1965, when the University of Colorado offered the first nurse practitioner courses and

than 325 colleges and universities educate nurse practitioners, and more than 115,000 NPs practice across the country.⁴

Now, in the 21st century, midlevel providers' domain has expanded beyond primary care to every aspect of health care delivery in the United States. PAs and NPs practice not only in primary care specialties, such as general internal medicine, pediatrics, and family medicine, but also in areas such as emergency medicine, obstetrics, and geriatrics. PAs specializing in surgery provide preoperative and postoperative

etary pressures—to order testing or transport to a hospital, and whose supervision consists of having a physician review the charts weekly at most.

■ Specialists depend on midlevel providers for monitoring and follow-up even in complicated medical cases, expecting them to alert the specialists to drug reactions, drug toxicities, and other complications that often exceed the midlevel provider's expertise.

In such instances, increased reliance on midlevel providers may result in patients receiving substandard care. For example, if a patient sees a midlevel provider without ever seeing the supervising doctor, the PA or NP may fail to recognize a significant sign—such as a drug toxicity or disease process—that results in injury. Reluctant to “overuse” imaging or diagnostic tests, a midlevel provider may choose not to order an essential chest X-ray, CT scan, or even a complete blood count test, thus overlooking the tools to diagnose pneumonia, embolism, tubal pregnancy, or stroke. In a lawsuit alleging injury due to a midlevel provider's negligence, defendants may include the hospital or facility, supervising doctors, and the PAs and NPs themselves.

Midlevel providers practice in primary care specialties, such as general internal medicine, pediatrics, and family medicine, as well as emergency medicine, obstetrics, and geriatrics.

Duke University Medical Center offered the first physician assistant class. All states require NPs and PAs to complete accredited, formal education programs and pass national exams to obtain licenses.

Full-time PA programs last at least two years. Most programs are in schools of allied health, academic health centers, medical schools, and four-year colleges; a few are in community colleges, the military, and hospitals.

All states and the District of Columbia have legislation governing the qualifications or practice of physician assistants. All jurisdictions require PAs to pass the Physician Assistant National Certifying Examination, administered by the National Commission on Certification of Physician Assistants and open only to graduates of accredited PA education programs.

In 2005, more than 135 education programs for PAs were accredited or provisionally accredited by the American Academy of Physician Assistants (AAPA). More than 90 of these programs offered the option of a master's degree, and the rest offered either a bachelor's or an associate degree. Most applicants to PA educational programs already have a bachelor's degree. More

care and may work as first or second surgical assistants.⁵

The problem

While the increased use of midlevel practitioners has had many salutary effects, extending access to health care and ostensibly relieving physicians of ordinary primary responsibilities with patient care, it has also had dangerous and sometimes deadly results.

For example:

■ Hospital emergency departments often delegate walk-ins to midlevel providers who are not supervised directly or consistently.

■ Private family clinics use “sign-in logs” to separate patients who need or want to see a doctor from those who can see midlevel providers, leaving this clinical decision to the patient—the person least capable of making it.

■ Surgeons use midlevel practitioners as assistants and then delegate follow-up responsibilities—including ordering medications and determining when to discontinue them—to them. In some cases, surgeons effectively abandon their patients.

■ In large measure, health care in prisons is provided almost entirely by PAs who are hesitant—because of budg-

Standard of care

Midlevel practitioners' professional associations have developed as sources of knowledge, continuing education, philosophy, and advocacy. For example, the American Academy of Nurse Practitioners (AANP) has formulated standards of practice and publishes an online journal.⁶

While associations of specialized PAs exist, the American Academy of Physician Assistants (AAPA) is the only national professional society that represents the interests of PAs in every area of medicine. Like the AANP, the AAPA has developed written standards and ethics.

Trial lawyers can use these organizations' standards to establish the standard of care for midlevel providers. For example, the first tenet of the AAPA's Statement of Values is: “Physician assistants hold as their primary responsibility the health, safety, welfare,

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and dignity of all human beings." This tenet provides the basis for the question fundamental to liability: "Do you agree with the PA principle that any risk of serious injury or death is always unreasonable and always unacceptable if reasonable PA measures would either minimize or eliminate that risk?" This is the question upon which liability turns in every case. The standard of care rests on the availability of reasonable prevention measures.

Proof of liability

Each state has enacted enabling statutes that define and regulate the permissible activities of midlevel providers. These statutes prescribe the foundation and dimensions for establishing the liability of PAs and NPs, and doctors' duties of supervision. Typically, states regulate PAs and NPs by defining their scope of practice, requiring supervision by a licensed physician, requiring some level of written direction, and controlling the level of education required for licensure.⁸

Scope of practice. What a physician assistant or nurse practitioner is required to do depends considerably on the enabling statutes found in state law. Indiana's Physician Assistant Act, for example, explicitly makes a PA the agent of the supervising physician.⁹ Midlevel providers are held to the standard of care applicable to the doctor. Thus, liability in any given case requires proof of the standard of care in the supervising physician's field. As a practical matter, this means not only including the supervising physician as a defendant, but also presenting expert testimony by a physician in that field, as well as a midlevel provider.

In general, a physician assistant will see many of the same types of patients as the physician does. The cases physicians handle generally are more complicated or require care that is not routinely part of the PA's scope of work. For unusual or hard-to-manage cases, the PA may refer the patient to the physician or work in close consultation with the patient and the physician. Physician assistants are trained to know their limits and refer patients to

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physicians appropriately.

The Georgia Supreme Court's holding in *Central Anesthesia Associates v. Worthy* illustrates the extent to which the statutory definition circumscribes PAs' practice.¹⁰

During a tubal ligation, Brenda Worthy suffered cardiac arrest and became comatose under anesthesia administered by Bonnie Castro, an RN who was employed by Central Anesthesia Associates (CAA), a corporation of eight anesthesiologists, and enrolled as a senior student nurse anesthetist in the anesthesia school CAA operated at the hospital. Castro had written the anesthesia plan and conducted the preoperative consult, on which she placed the name of a CAA anesthesiologist who later denied having seen or signed it. On the anesthesia record, she wrote the name of another CAA anesthesiologist, who also denied any involvement.

In administering anesthesia by mask to Worthy, a deviation from acceptable care, Castro was supervised by David Krencik, a physician assistant also employed by CAA who had left the operating room for 10 minutes when the patient suffered cardiac arrest. The appeals court held that the nurse "had a duty not to practice medicine beyond what the law allowed" and that the PA "had a duty not to undertake and supervise her performance, as he was not authorized under the statute to do so."¹¹ The supreme court affirmed.

Where patient injury occurs in clinical instances such as that in *Worthy*, plaintiff lawyers can use the statute's limitations, AAPA guidelines, and the patient chart to show that the midlevel provider acted beyond the permissible scope of practice. This liability picture often involves clinic or hospital protocols specifying when the PA should refer the patient to the physician.

Statutes and protocols are not the only determinants of PAs' and NPs' scope of practice. The patient's consent or lack of it can determine whether midlevel providers practiced beyond their limits. The plaintiff lawyer should always examine whether the patient consented to being treated by a midlevel provider instead of a

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physician. In *Worthy*, the court pointed out that the hospital's consent form, which the patient had signed, clearly specified that the anesthesia would be supervised by an anesthesiologist.

Another case that demonstrates this concept is *Sanborn v. Zollman*.¹² In this case, the patient planning liposuction surgery clearly crossed out provisions allowing assistants at surgery and specified that she wanted the surgeon to perform the surgery. The Sixth Circuit Court of Appeals held that she had stated a claim for battery when the clinic proceeded with the surgery using assistants.

Supervision. Although physician assistants and nurse practitioners work under a physician's supervision, a PA or NP may be the principal care provider in a rural, inner-city, or prison clinic, and a physician may be available only one or two days each week. However, some states require that the supervising physician or designee review the patient encounters within 24 hours.¹³ In such cases, the midlevel provider confers with the supervising physician as needed.

For example, in a remote clinic with an elderly patient complaining of intense abdominal pain accompanied by decreasing blood pressure, the midlevel provider who suspects an aortic aneurysm may immediately transport the patient to a hospital. The severity of the patient's condition may require the midlevel provider to summon the physician, confer with the physician by phone, or even transport the patient to a regional facility. PAs also may make house calls or go to hospitals and nursing care facilities to check on patients, as long as they report to the physician afterward.

In a case involving a midlevel provider, the trial lawyer should identify the supervising and sponsoring physicians and the specific employer. For example, a typical interrogatory directed to any putative defendant—including the clinic, hospital, physician, and midlevel provider—would ask the following about a defendant PA:

- What was the physician assistant's date of hire?
- What is the name of the PA's su-

pervising physician?

- How many other PAs were supervised by the same physician, and what are their names?

- How many patients were assigned to each PA?

- After patients were examined by the PA, were they also seen by the supervising physician before leaving the clinic?

- Did the supervising physician require that the PA confer with him or her as to each patient before the patient left the clinic?

The PA is the physician's representative, treating the patient in the style and manner developed and directed by the supervising physician. This can help prove liability and causation for both.

- Was the PA required to retain each patient in the clinic until the supervising physician had signed the patient's chart?

The health care team concept can be an important theme in cases where the patient's care is shared by the physician and the PA. It can be central to proving liability and causation. According to the AAPA's Statement of Values, "Physician assistants work with other members of the health care team to provide compassionate and effective care for patients." The AAPA's guidelines also address the PA's role and responsibility: "[T]he care that a PA provides is an extension of the care of the supervising physician. . . . Physician assistants have an ethical obligation to see that each of their patients receives appropriate care."¹⁴

Any medical negligence scenario involving a PA or NP requires investigating both the midlevel provider and the supervising, employing, and sponsoring physician. The PA is the physician's representative, treating the patient in the style and manner developed and directed by the supervising physician. This construct can help prove liability and causation for both the midlevel provider and the physician.

The AANP, the AAPA, and the American Medical Association (AMA) endorse the idea of the health care team. In 1995, the AMA developed suggested guidelines for how physicians and PAs should work together to deliver medical care. The guidelines state, for example, that the physician is ultimately responsible for coordinating and managing patient care and ensuring the quality of health care provided to patients; the physician must be available for consultation with the PA at all times, either in person or through telecom-

munication systems or other means; and patients should be made clearly aware at all times whether they are being cared for by a physician or a PA.¹⁵

Rockefeller v. Kaiser Foundation Health Plan of Georgia illustrates the importance of the supervising physician.¹⁶ In that case, a PA failed to order a chest X-ray in the presence of indications of pneumonia, and ordered medications—all while supervised by physicians who had not been approved to supervise him. The Georgia Court of Appeals upheld the trial court's grant of a directed verdict for the plaintiff on questions of whether the defendants committed negligence per se as a result of the PA's treatment of the plaintiff in the absence of a board-approved physician.

Written direction. Statutes permitting midlevel practice require explicit written direction, though the form may be a job description, guideline, protocol, or collaborative agreement. South Carolina's statutory provision is remarkable for its brevity: "Physician assistants may perform: (1) medical acts, tasks, or functions with written scope of practice guidelines under physician supervision."¹⁷

Georgia's statutory scheme is more

detailed.¹⁸ The physician seeking to employ a midlevel provider files an application with the Composite State Board of Medical Examiners listing the supervising physician(s) for that PA and including the PA's job description. That written description, which must be filed with the board authorizing the use and delegation of the physician assistant, controls the general scope of permissible activity.

However, the job description still must be interpreted in the particular circumstances of a case. For example,

even be present in the facility. The job description for the PA often provides a catchall delegation in these circumstances, such as: "Should a life-threatening emergency situation arise in the absence or unavailability of the supervising physician, the PA is authorized to initiate appropriate evaluation and treatment."

Again, the terms of the job description require evidence and interpretation in the specific case to help a jury determine whether the PA's training justified this delegation and whether

- written collaborative agreement(s) specifying the defendant PA's duties

- written position description specifying the defendant PA's job duties and responsibilities.

In addition to seeking answers to written interrogatories, discovery should include requests that the defendant facility, supervising physician, and midlevel provider produce

- any employment contracts or contracts for services between the defendant PA and the hospital, defendant surgeon, or defendant clinic

- each document, standard, guideline, protocol, collaborative agreement, policy, procedure, or other direction identified in answers to interrogatories

- each policy, protocol, or procedure manual; checklist; algorithm; or other handbook issued by the defendant's employer to the defendant PA directing physician assistant practices

- the defendant PA's job description in effect at the time of the incident.

The written protocol or job description required by statute is essential to defining the scope, responsibility, and potential liability of midlevel providers.²⁰ The Georgia Physician Assistant Act is a typical example in defining the job description.²¹

The midlevel provider's contract of employment with the clinic, office, or hospital is important because it can incorporate statutes and standards of practice by reference, making them part of the defendant's actual or constructive knowledge of his or her own standard of care. Curricula, training programs, manuals, and handbooks frequently use written algorithms—flow charts showing graphic representations of complex processes, such as a differential diagnosis of chest pain—for diagnosis and treatment.

Once established as reliable and authoritative, algorithms make excellent exhibits that graphically show the binary path of the correct decisions to be made at each point, based on diagnostic information such as chest X-ray, cardiac enzymes, and vital signs. The algorithms also show outcomes of decision pathways such as "administer oxygen," "monitor," and "admit"—making them

Discovery can allow you to develop evidence showing what is routine, what is within the PA's training, and what the physician's normal scope of practice is. Often, these areas require expert testimony.

the job description often contains broad statements authorizing the PA to "perform those routine medical treatments and diagnostic procedures for which he/she is qualified by training and which fall within the normal scope of practice of the supervising physician as delegated by the supervising physician." It may authorize the PA to "gather data on all new patients or established patients with new problems, to include a complete medical history and physical examination, medical record review, [and] appropriate initial diagnostic studies" and note that he or she "will be responsible for transmitting that information to the supervising physician(s) for review."

This language obviously requires further discovery to develop evidence showing, for example, what is routine, what is within the PA's training, and what the physician's normal scope of practice is. Frequently, these areas require expert testimony.

Cases raising the questions of whether the PA acted beyond his or her permitted scope of practice and whether the supervising physician failed to supervise the PA often concern sudden or unanticipated conditions where the physician may not

supervision was appropriate under the circumstances.

The statutory requirements for PA and NP practice indicate directions for pretrial discovery. The trial lawyer should identify the level of education the PA or NP attained and obtain all the written contracts, job descriptions,¹⁹ collaborative agreements, and specific protocols that were in force at the time of the alleged negligence. A typical interrogatory follows.

Identify each of the following that the defendant physician assistant was provided and/or was expected to use in managing the defendant's patients before January 20, 2003, and identify by whom each was provided or enforced:

- protocols used for examining the patient

- guidelines/protocols for assessing the patient's risk factors

- a checklist of necessary preoperative laboratory tests

- guidelines/protocols for charting

- circumstances requiring the PA to notify the physician of abnormal test results

- specifications requiring the PA to consult the physician immediately

- algorithm(s) for examining, assessing the risks of, evaluating, testing, clearing, and scheduling the specific type of patient

useful not only for standard of care but also for causation.

Incentives. Many clinics, hospitals, and physician practices specify economic incentives for the PA or NP in their contracts. One common type of incentive is a bonus for exceeding a threshold number of patients processed monthly or quarterly. The trial lawyer should discover the process by which midlevel providers' performance is evaluated, especially the incentive system that encourages speed and volume without monitoring quality of patient care.

Another important aspect of mid-level practice concerns continuing professional training and keeping up with new diagnostic and treatment methods. Midlevel providers are required to earn continuing education credits each year for licensing. Exploring these subjects and the depth and breadth of the "classes" can be revealing. Sometimes the class is nothing more than an infomercial for a device or product, conducted by the seller. The defendant's actual or constructive knowledge about complications, signs requiring testing, significance of abnormal test results, and other tools for diagnosis—in the form of seminars, journals, and professional literature—provides important proof of liability.

A typical *duces tecum* notice of deposition of the midlevel provider should ask for

- the most current curriculum vitae, showing his or her background, training, employment history, and education

- all documents, reports, statements, records, literature, and tangible items that the witness reviewed in preparation for the deposition

- all documents, records, and tangible items evidencing the defendant's care for the patient in office and clinic

- the original of all medical records and personal notes pertaining to the patient that are in the defendant's possession, custody, or control

- the contract, job description, and collaborative agreement employing the defendant

- a list of CME classes and any other training, workshops, or seminars at-

tended by the defendant

- a list of all CME classes and any other training, workshops, or seminars specifically regarding the procedure and diagnosis at issue

- all professional articles in the field of physician assistant practice authored by the defendant

- all literature, research, or online searches concerning any issues in the case that the defendant reviewed for examination and treatment of the patient

- all literature, research, or online search materials that the defendant re-

viewed for the deposition

- each performance evaluation of the defendant's job performance by his or her supervising physician, clinic director, and any other person performing evaluation of the defendant's work for five calendar years before the incident at issue.

Trial lawyers concerned with preventing health care errors and encouraging safer patient care need to recognize and pursue midlevel providers' negligence. We must enforce the duties of the employing hospitals and the supervising and sponsoring physicians as more than rubber stamps. In doing so, we can develop the law of nondelegable duty of the hospital, clinic, and physician. We must enforce the requirement for written protocols and collaborative agreements—and hold midlevel practitioners to their own professional standards. ■

Notes

1. Charles L. Hudson, *Expansion of Medical Professional Services with Nonprofessional Personnel*, 176 JAMA 839-41 (1961).

2. See the American Academy of Nurse Practitioners Web site at www.aanp.org.

3. See e.g. Mich. Comp. Laws Ann. §333.17548 (West 2006). The number of PAs one physician can supervise varies among the states.

Georgia, for example, allows one physician to supervise four PAs (Ga. Code Ann. §43-34-103 (b)(2)(A) (West 2006)); South Carolina limits one physician to supervising two PAs (S.C. Code Ann. §40-47-955 (D) (2006)).

4. U.S. Bureau of Lab. Statistics, *Occupational Outlook Handbook*, 2006-07 Edition, www.bls.gov/oco.

5. Ruth Ballweg et al., *Physician Assistant: A Guide to Clinical Practice* 1-22 (3d ed., W.B. Saunders Co. 2003).

6. See J. Am. Acad. Nurse Pract., <http://aanp.org/Publications/JAANP/JAANP.asp>; see also *The Nurse Practitioner*, www.tnpj.com.

7. Am. Acad. Phys. Assts., *Guidelines for Ethical Conduct for the Physician Assistant Profes-*

sion, www.aapa.org/policy/23-EthicalConduct.pdf, at 3.

8. See e.g. Mich. Comp. Laws Ann. §§333.17062, 333.17076, 333.17001 (West 2006).

9. Ind. Code §25-27.5-5-3 (2001).

10. 333 S.E.2d 829 (Ga. 1985).

11. 325 S.E.2d 819, 824 (Ga. App. 1984).

12. 40 Fed. Appx. 916 (6th Cir. 2002).

13. See e.g. Ind. Code §25-27.5-6-1 (2006).

14. Am. Acad. Phys. Assts., *supra* n. 7, at 4.

15. Am. Acad. Phys. Assts., *Information about PAs and the PA Profession*, www.aapa.org/geninfo1.html.

16. 554 S.E.2d 623 (Ga. App. 2001).

17. S.C. Code Ann. §40-47-935, art. 7 (2006).

18. Ga. Code Ann. §43-34-100-108 (West 2006).

19. See e.g. Ga. Code Ann. §43-34-102(5) (West 2006).

20. See e.g. Ga. Code Ann. §43-34-26.1 (West 2006).

21. Ga. Code Ann. §43-34-103(5) (West 2006).

Letters welcome

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