SPECIAL ARTICLE

Evaluating liability in the supervising physician, PA, and employer relationship

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ABSTRACT

Emerging case law demonstrates that physicians who collaborate with physician assistants (PAs), as well as the entity that employs the physician and PA, are facing allegations of liability. The allegations of liability arise from the actions of the PA, inaction of the physician, and failure to meet the regulatory requirements for the oversight of PA practice. In some instances, the physician and employer struggle to meet the complex state regulatory requirements that govern the relationship(s) between the PA and the physician. A review of case law demonstrated that courts generally assign liability for the actions of the PA to the PA, but liability to the physician and employer for failure to meet the statutory requirements for oversight of the PA. All stakeholders must use the lessons learned from case law to mitigate physician and employer liability.

Keywords: physician assistant, PA, supervising physician, liability, malpractice, healthcare compliance

Organizations and physicians incorporating physician assistants (PAs) into their teams, and modernization of PA practice acts have left physicians and employers discussing the liability for the actions of the PA due to the concept of agency. The requirements of supervision have led courts to evaluate if the employer and/or supervising physician employing and overseeing the PA is liable for the PA's professional actions. The perceived liability, additional supervision requirements, and potential decrease in work relative value units (wRVU) production in some instances have led physicians to request compensation for PA oversight, increasing an employer's expenditure.[1,2]

Historically, the practice of medicine has broadly been defined as "all endeavors related to human illness or health."[3] Despite this broad definition, which appears to be practitioner-neutral, the practice of medicine traditionally has been strictly limited to physicians. Most states, through laws and regulations authorized by a respective board, authorize PAs to practice medicine or the "healing arts" under the supervision of physicians. State law and regulations further define what functions a PA may perform under the oversight of the physician and how the physician will demonstrate oversight. On the federal level, the Department of Health and Human Services (HHS) has regulatory responsibility for delivering medical services in the United States. In response to a directive by the executive branch, the Centers for Medicare and Medicaid Services (CMS) published a rule deferring to the states to define the physician-PA relationship and any oversight requirements for that relationship.[4,5]

Most states, through statutory or common law, recognize the physician-PA relationship as an agency.[6] An agent (the PA) is one who acts on behalf of the principal (the physician), in which the principal can control the actions of the agent. PAs, therefore, work as an agent of the physician. The common law of agency is a fiduciary relationship produced by the assent of both parties, in which the agent will represent the principal, subject to the principal's control.[7] Common law agency requires three elements to be met to establish a relationship:

- A consensual relationship between the parties in which the principal acknowledges that the agent acts on behalf of the principal and the agent accepts.
- The principal must have the ability to control the agent throughout the duration of the relationship.
- The agent must have the power to represent on behalf of the principal.[6,7]

Under the theory of agency, principals can face direct liability for their direct actions and indirectly for the actions of agents under theories of vicarious liability (**Table 1**). The physician's direct liability can arise from:

- Negligent hiring and credentialing of the PA
- The physician not adhering to state oversight law and regulations
- The physician's own medical decision-making, in which the PA may or may not participate.

For employers of PAs, vicarious liability arises from the doctrine of *respondeat superior*, also known as a master-servant relationship. When it is demonstrated that the agent was under the principal's control, the principal

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Key points

- The physician and PA legal relationship is generally viewed as an agency relationship.
- Supervising physicians meeting legal requisite supervision can mitigate physician liability for the PA's actions.
- Employers of PAs should implement compliance strategies including education on the laws and regulations of physician supervision requirements of PAs.

can be found liable for the agent's tortious (that is, wrongful) act that results in a third party being harmed.[8]

UNDERSTANDING AGENCY

Agents can exercise professional judgment on behalf of the principal while legally maintaining their own identities. When the principal is not aware of or cannot exercise control over the professional judgment, the courts have generally not found the principal liable for the agent's actions, as demonstrated in *Blatchley v. Cunningham*, US District Court for the District of Colorado.[9] In *Blatchley*, the plaintiff argued that because of the agency relationship between the defendants (two physicians and two PAs), the physicians were liable for the PAs' negligence in a timely diagnosis of the medical condition.[9] The PAs asserted their own medical decision-making without the physician being aware. The physicians were not the physicians consulted on the patient's care and were unaware of the PAs' actions. As the PAs' actions occurred outside the control and presence of the physicians, the physicians did not have the ability to exercise control. Without the ability to control, a master-servant relationship did not exist, and the physicians were not held vicariously liable for the PAs' actions.[9]

Another case holding from the US District Court for the District of Colorado, *Freeman v. Costa*, supported the premise that an active agency relationship is required for the physician to be held liable for negligent supervision or negligence per se.[10] In *Freeman*, the plaintiff argued that the PA's alleged acts led to wrongful death, and the physician was vicariously liable and negligently supervised the PA.[10] At the time of the alleged incident, the physician had terminated the relationship with the PA for unknown reasons, and another physician began acting as the supervising physician, as reflected in the employer's executive committee minutes.[10] The termination of the agency relationship occurred before the alleged events. The state medical board did not yet reflect the state registration at the time of the PA's alleged negligence, but it is unknown if the registration was not filed or the state had not yet processed the registration.

The foundation of an agency relationship rests within the relationship being consensual. The physician, new supervising physician, and PA admitted that the parties agreed to terminate the relationship, and the PA was not acting under the direction of the physician at the time of the alleged injury. The physician did not have the ability to control the actions of the PA at the time of the alleged events. Thus, the physician could not be held liable for the PA's actions, or for violating requisite supervision. Further, the court opined that generally "administrative rules—unlike legislative enactments—neither create private causes of action for their violations nor relieve litigants of their evidentiary burdens in private litigation."[10] The court's rationale also was cited in the *Freeman* opinion. The court dismissed the physician from the complaint under summary judgment, leaving the PA and employer as defendants to the case.[10]

In *Buman v. Alycia D. Gibson, PA*, before the Court of Appeals of Tennessee, the patient alleged that the physician negligently supervised the PA, resulting in the amputation of the plaintiff's leg.[11] At the time of the alleged malpractice, Tennessee regulation required the physician to review 20% of the PA's charts every 30 days.[11] Certain circumstances also induced this duty of care from the physician, which would require the PA to alert the physician of the need for review. The PA exercised professional judgment and did not believe the circumstance existed to notify the physician to review the case; therefore, the physician could not intervene on the PA's actions. The defendant demonstrated compliance with the state's oversight regulations, provided meaningful continuous oversight, and therefore was not liable for the PA's professional judgment.[11]

Physicians, PAs, and NPs have recently been indicted and often convicted for their direct roles in providing inappropriate prescriptions for opioids. The states continue to look

TABLE 1. Selected legal terms[20,21]

- Dismissed with prejudice—The court's decision is final, and the claim cannot be brought against the individual for the same accusation.
- Negligence per se—The negligent act was a violation of a statute, regulation, or law intended to protect the public. It must be demonstrated that the violation was the proximate cause of injury to successfully uphold a claim.
- Negligent credentialing—A legal theory that holds the employer liable of an employee's negligence. It must be demonstrated the employee was incompetent to perform the procedure or act, the employer failed to properly evaluate the employee's credentials and skills to demonstrate competence, and the negligence must have occurred at the place of employment.
- *Respondeat superior*—Latin for *let the master answer*. This doctrine is used in tort law arising out of the law of agency. The doctrine holds the principal responsible for the actions of their agent.
- Vicarious liability—Arises from the doctrine of *respondeat superior*, making the principal liable for the agent's tortious act that results in the third party being harmed.

for ways to reduce the opioid crisis through regulations and ensure that negligent parties are held liable. Physicians and employers may restrict PAs' ability to prescribe controlled substances due to concerns about increasing their liability. In Vermont, a PA improperly prescribed opioids, causing the physician to report the actions to the Vermont Board of Medical Practice.[12] The State of Vermont alleged the physician was vicariously engaged in the PA's unprofessional conduct and recommended professional discipline. The petitioner in *In re Porter* argued in the Supreme Court of Vermont that the state statute held the physician legally liable, "as a matter of professional discipline" for the actions of the PA and failure to conform to requisite supervision.[12]

The court reasoned that the law of agency demonstrates actions when the principal would be held liable for the agent's tortious acts but did not extend to encompass professional discipline.[12] The physician demonstrated he met the state supervision requirements of the PA and reported the actions to the Vermont Board of Medical Practice, thus fulfilling the required professional obligations. The court affirmed the Vermont Board of Medical Practice's decision that the board was not required to find the physician guilty of unprofessional conduct for the PA's unprofessional actions.[12]

In an active case, the Superior Court of New Jersey Appellate Division affirmed that violations of New Jersey statute and regulation do not create criminal liability for the physician for a PA's professional misconduct.[13] The PA had allegedly been inappropriately providing controlled dangerous substance prescriptions to individuals, among other charges. The physician, designated as the supervisor, also was charged. The state argued, among other charges, that the physician did not appropriately supervise the PA.[13] The court reasoned that professional violations are to be resolved by the appropriate board via civil penalties based on their interpretation of the legislative intent.[13] As a result of the reasoning, the court dismissed all charges against the physician with prejudice. The PA still has pending criminal charges.[13]

In *Cox v. M.A. Primary and Urgent Care Clinic*, the Supreme Court of Tennessee heard on appeal whether the PA's alleged misdiagnosis of the plaintiff's condition and physician's oversight met the medical and professional standard of care.[14] The plaintiff failed to demonstrate either, and the court reasoned that the state statute did not hold the PA and physician to the same professional standard of care. "It is logically inconsistent to impose significant limitations on physician assistants and yet simultaneously hold them to the same stand or care improved by their supervisors."[14] Without demonstrated negligence by the PA, neither the employer nor physician could be vicariously liable for the PA's actions. The plaintiff's case failed on both counts, supporting that physicians maintaining requisite oversight supports meeting the standard of care.

LACK OF UNDERSTANDING AND LIABILITY

Physicians and employers who are unaware of or fail to meet oversight requirements put themselves at risk for physician and employer liability. The US District Court of Western Pennsylvania in *Brogdon v. Correct Care Solutions* evaluated whether the physician met the supervision requirements of the Commonwealth of Pennsylvania.[15] The physician, by admission, could not evaluate the quality of patient care delivered by the PA, as the physician failed to understand and meet the requirements of PA supervision enacted to protect the citizens. The physician stated that "he understood Mr. Telega's (PA) independent medical judgment with regard to patient diagnosis and treatment to be unrestricted as part of his job duties. When asked, 'Did you in any way monitor Mr. Telega's compliance with any of his written supervision agreements,' defendant testified, 'I really don't know.'"[15] The court determined pretrial that there was evidence that the physician and employer could be negligent per se for failing to comply with the oversight requirements. However, it was not decided that the negligence was the proximate cause of the injury. The case proceeded to a jury trial and the defendants were found not guilty of all charges.[15]

In *Ford-Sholebo v. US*, US District Court for the Northern District of Illinois, Eastern Division, $920,500 was granted for the wrongful death to the deceased's estate, assigning partial liability to the PA and physician's employer.[16] The deceased had refused medications. Metropolitan Correctional Center policy was to document refusal and to notify the physician so the physician could discuss with the inmates the risks of not adhering to said medical therapy.[16] The forms were not used and the physician was unaware of the medication refusals because the physician did not regularly attend the meetings designed to discuss inmate medical treatment concerns.[16] The employer, Metropolitan Correctional Center, failed to monitor and enforce policies to ensure physicians were aware of prisoners' medication refusal and the policies surrounding appropriate supervision of PAs.[16] As the proximate cause of the inmate's death was in part, the correctional center's failure to ensure these policies, the center was found liable.[16]

RESTRICTIVE LANGUAGE IN STATE REQUIREMENTS

In 2017, the Supreme Court of Pennsylvania, in *Shinal v. Toms*, evaluated whether the qualified staff of a physician (Steven A. Toms, MD) was authorized as a matter of commonwealth law to provide information as part of the informed consent process for surgical intervention.[17] The plaintiff alleged that a PA provided information under the supervision of the defendant physician outside of the initial consult performed by the defendant. The plaintiff asserted that the information provided by the PA was a component in their decision to proceed with surgery. The court held that the physician could not

delegate the duty to provide sufficient information, as part of the informed consent process as required by the Medical Care Availability and Reduction of Error Act (MCARE Act).[17,18] The court remanded the case back for jury trial. The court decision was not unanimous and reflected in the dissenting opinion in which Chief Justice Max Baer opinioned, "Courts should not impose such unnecessary burdens upon an already strained and overwhelmed occupation when the law does not clearly warrant this judicial interference."[17]

The case went to arbitration in lieu of another jury trial. The arbitrator found that Dr. Toms provided a description of the procedure, including the risks and alternatives, in a fashion that a reasonably prudent person would need to make an informed decision. Thus, the arbitrator found in favor of Dr. Toms. (Personal communication with Steven A. Toms, MD, regarding *Megan & Robert Shinal vs. Steven A. Toms, MD*).

Despite the arbitration decision, the supreme court holding remains a Pennsylvania precedent. The holding left Pennsylvania healthcare organizations evaluating their informed consent policies and procedures for compliance with the Pennsylvania MCARE requirements, and questioning whether PAs and NPs could obtain informed consent and in what circumstances. The Pennsylvania Legislature earlier this year amended the MCARE Act to extend the process of informed consent to all qualified members of the healthcare team.

RECOMMENDATIONS

The HHS Office of the Inspector General (OIG) has given guidance for implementing effective compliance programs and strategies, stressing education, and monitoring policies and procedures.[19] The OIG guidance should be used by employers to strategize with their legal, compliance, credentialing, and privileging colleagues to implement policies and procedures to audit and monitor to ensure:

- PAs have and state requirements to practice and maintain licensure.
- Physicians supervising or collaborating with PAs have been educated on their responsibilities as defined by the state and have filed requisite paperwork as applicable.
- Agreements between the physician and PA (when required by state law) align with the PA's granted privileges and the state's authorized scope of practice.
- Agreements and PA medical practice are reviewed in a frequency prescribed by the state law/regulation and employer policies.
- The organization ensures that the physician-PA team practice is in compliance with policies and procedures that meet the CMS Conditions of Participation, organizational accreditation standards, state public health code, and CMS Conditions of Payment.

Employers must provide education on the physician-PA relationship at the time of hire and ad hoc to physicians, PAs, and those overseeing said employees. Continuing education promotes the opportunity to address changes in employer policies and procedures, state and federal laws and regulations, and deficiencies identified from audits. Education cannot stand on its own, and continuous auditing and monitoring must validate that education and implementation are effective and maintained.

The employer's code of conduct must instill a culture of compliance. The employer, physician, and PA must foster a culture of transparency and open communication to improve care delivery and uphold the code of conduct. Through effective and nonjudgmental communication, a unified physician-PA relationship can develop. The dynamic lets PAs to approach physicians or employers without fear of judgment or retaliation when requesting guidance on patient care delivery. PAs must take the same responsibility and be receptive to feedback. Physicians and employers must play an integral part of PAs' clinical continuing education as a tool of ongoing assessment and development of PAs' clinical journey.

The electronic health record (EHR) must be a tool to effectively document PA oversight and not just to meet state oversight requirements. The EHR also should not hinder the PA's ability to practice within the state's scope of practice. Physicians should review PA documentation as outlined by state requirements, in lieu of simple electronic co-signatures and attestations. The EHR also should assist in auditing and monitoring of physician-PA compliance.

Employers must incorporate PA administrators to assist in the strategies to ensure compliance with all elements of PA practice. As PA leaders emerge, a self-reflection must occur to evaluate knowledge and skill deficiencies, with plans to resolve said deficiencies and lead in an ever-changing atmosphere appropriately. PA leaders must know how to evaluate laws and regulations, where to find information, and how to effectively communicate concerns to an employer's general counsel and compliance office.

CONCLUSION

Case law has demonstrated that employers and physicians will face liability when failing to meet the requisite supervision of PAs. Case law has demonstrated maintaining oversight requirements allows PAs to exercise their professional judgment while mitigating potential liability to the PA's principal. The court in *Ford-Sholebo* urged the employer to "carefully study this opinion to ensure that these breakdowns do not reoccur [sic] in the future."[16] Employers, physicians, and PAs must monitor case law and changes in legislation and regulations of PA practice to develop policies and procedures for PA and physician collaboration to avoid noncompliance and potential risk of liability. As modernization of PA practice evolves, further studies will be needed to evaluate PA, employer, and physician liability along with PA malpractice trends. **JAAPA**

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