Unprofessional Conduct: MD Accountability for the Actions of a Physician Assistant

Collaborative arrangements are not a new concept in the healthcare delivery system. Physicians work with nurse practitioners or physician assistants. In the office or clinic setting patients often see the nurse practitioners or physician assistants for routine care and common health complaints. When considered necessary or appropriate, the collaborating physician also sees the patient.

Nurse practitioners and physician assistants working in collaborative arrangements also complete rounds in skilled nursing facilities, nursing facilities and hospitals. Medical staff bylaws that recognize collaborative arrangements usually include a framework for privilege delineation for the nurse practitioners and physician assistants. However, when the collaborating physician is no longer a credentialed member of the medical staff, nurse practitioners and physician assistants in such arrangements must find another physician with whom to participate – a physician who is a credentialed member of the medical staff.

Many state laws and regulations include a framework for collaborative arrangements.¹ Such laws aside, judicial decisions focused on the collaborative arrangement reflect the longstanding agency concept of respondeat superior. That is, the physician is held legally responsible for the errors and omissions of the collaborating nurse practitioner or physician assistant arising during and in the course of the agreement.

A Supreme Court of Vermont ruling² examined yet another aspect of the collaborative arrangement. The question before the court was whether the state board of medicine should subject a physician in a collaborative agreement to disciplinary action for the actions of a physician assistant? In other words, should the physician be vicariously liable for unprofessional conduct?
Although the Vermont decision is very much dependent on state law, it does shed light on an important aspect of the collaborative relationship. The lessons learned may help others going forward reduce the risk of professional disciplinary action in collaborative arrangements.

**The Vermont Case.**

From 1996 through 2009, Dr. J.P. was the supervising physician for a P.A.

Dr. J.P. was also the director of a university center for health and wellbeing. In 2009, a group of nursing students were conducting a study of drug diversion at the university medical school.³

In the course of a student interview, a comment was made that Dr. J.P.’s physician assistant was the source of controlled substances. When he learned of this comment, Dr. J.P. launched an investigation, utilizing electronic medical records.⁴

Dr. J.P. found that the physician assistant was an “outlier” in terms of the amount of opiates and other controlled substances prescribed compared to other PAs. Dr. J.P. decided that the physician assistant had been pursuing improper prescribing practices and he filed a formal complaint with the state Board of Medical Practice.⁵

The Board of Medical Practice launched an investigation in August 2009. The physician assistant acknowledged that he had improperly prescribed opiates and he stipulated that his activities involved both professional negligence and unprofessional conduct. The state Board of Medical Practice then took disciplinary action against the physician assistant.⁶

That was not the end of the matter. In December 2010, the State filed several charges against Dr. J.P. As recounted by the state high court, the State asserted in the first count of a complaint that Dr. J.P. was

“legally liable [as a matter of professional discipline] for the inappropriate and non-compliant prescribing activities of [the PA], who acted as Respondent's agent. Attributing the PA's actions to the doctor, the State alleged that the doctor had vicariously engaged in unprofessional conduct, and was therefore subject to disciplinary action.”⁷
In fact, there was a four-part complaint against Dr. J.P.:

- Count II alleged that in supervising the PA, the doctor failed to meet the “essential standards of acceptable and prevailing practice and constituted unprofessional conduct.”
- Count III alleged that by failing to properly monitor the PA, in accordance with a Board rule, the physician was "liable for the actions of [the PA] by law."
- Count IV alleged that the physician had not developed a policy to “provide meaningful review of the PA’s practice under Board Rule 7.1(c).”
- Count V alleged that the physician had failed to complete regular “retrospective review[s] of the PA’s charts under Board Rule 7.5.”

In asserting that counts I and III should be dismissed, the doctor pointed out that applicable state law made the supervising physician “legally liable” to an injured third party for the “tortious conduct” of the PA. However, the relevant state law did not encompass holding the supervising physician vicariously “guilty in professional disciplinary proceedings of unprofessional acts committed by a PA on a theory of "strict liability.”

The Board denied the motion and a three-person committee held a hearing in September 2011. The committee recommended to the Board that it find that Dr. J.P. did commit unprofessional conduct as set forth in count I. However, the three-person committee did not recommend that the Board sanction Dr. J.P. The rationale expressed by the three-person committee was that since state law created an agency relationship between the doctor and the PA, once the latter was found guilty of unprofessional conduct in prescribing controlled substances, the doctor was guilty “[s]ince the acts of the agent are the acts of his principal.”

As to counts II, IV, and V, the three-person committee recommended to the Board that these assertions be dismissed because it said that the physician had properly supervised the PA. Indeed, the committee indicated that the doctor had “met or exceeded applicable standards of acceptable and prevailing practice. Further, since the three-person committee had recommended finding the physician “legally liable” for the same behavior in Count I as was alleged in Count III, it suggested that Count III should be dismissed.

Both sides objected to the proposed recommendation of the three-person hearing committee. In January 2012, the Board declined to accept the three-person committee’s recommendation on Count I. The Board indicated that it was not the
doctor who was involved in improperly prescribed scheduled drugs. Moreover, he did not know about the PA’s improper behavior “and could not reasonably be expected to be aware of it.” The Board said that the law did not require a finding of unprofessional conduct against the doctor for the actions of the PA.\textsuperscript{17}

As to Counts II through V, the Board accepted the three-person committee’s findings. It dismissed all the charges against Dr. J.P.\textsuperscript{18}

On appeal, the Supreme Court of Vermont pointed out that it would defer to the Board’s “interpretation of statutory provisions that are within its particular areas of expertise.”\textsuperscript{19} On the Board determining the meaning of the term “legal liability” the court said that the administrative body had taken action beyond the scope of its legislative authority.\textsuperscript{20}

Saying that the role of the Court in interpreting the meaning of a statute was to give effect to legislative intent, the court looked at the “plain meaning” of the term “legal liability” and said that it did not include accountability for what it termed “violations of professional obligations.”\textsuperscript{21} On this point the Court added:

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“Being legally obligated or accountable denotes some obligation that is grounded in law, such as a statutory, common-law, or regulatory provision that enforces another party's rights or imposes a legal penalty. That concept is distinct from being accountable from the standpoint of professional discipline under the laws enacted by the Legislature. Such obligations derive from standards and rules that govern a specific profession and provide a structure for regulating conduct within that profession.”\textsuperscript{22}
\end{quote}

Having explained the meaning of the term “legal liability,” the Court said that

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“while the doctor may have legal liability for his agents' acts of professional negligence, the State's argument that one may be "legally liable" for his or her agents' unprofessional conduct is unavailing. The language consistently used by the Legislature does not square with such an interpretation.”\textsuperscript{23}
\end{quote}

The Vermont Supreme Court then went on to agree with the Board’s determination that under applicable state legislation it was not required to find Dr. J.P. guilty of unprofessional conduct purely on the basis that the PA he supervised improperly prescribed drugs. However, it did so based on different reasoning. The court emphasized that the Board did not possess any legal
authority to discipline Dr. J.P. under state legislation just on the basis of the PA’s unprofessional conduct.24

As the court noted, applicable state legislation set forth 39 grounds upon which a physician may be held professionally accountable:

“The list does not include misconduct of a PA, but focuses instead on a physician's acts, namely actions that bear on a physician's fitness and ability to practice in the state. The regulatory scheme does, however, provide standards to ensure adequate supervision and discipline for doctors who fall short.”25

The Court recognized that any unprofessional behavior in this situation involved only the actions of the PA. State legislation did not include any grounds for taking disciplinary action against a physician for the acts of a PA. The Board lacked the authority to take action against Dr. J.P in this circumstance. The Board’s determination was affirmed.26

**Observations on the Vermont Case.**

The Vermont case highlights some important points involving the legal relationship between supervising physician and PAs. It also reflects the importance of applying statutory requirements in an accurate manner. As the Vermont Supreme Court pointed out, the state legislature had drawn a distinction

“between the principles of legal liability and professional responsibility because the two concepts are discrete. One is used in the context of liability, while the other is used in the context of professional disciplinary schemes.”27

Beyond the legal theories discussed in the case, there are some practical risk management considerations. Here, the first evidence of possible improper prescribing behavior was identified by nursing students conducting a study on drug diversion. Thereafter the supervising physician, Dr. J.P., did a review of electronic medical records that led to his filing a formal complaint against the PA with the Board.
Here the supervising physician was director of the university Center for Health and Wellbeing. Such an entity should have in place tools for monitoring prescribing patterns, particularly with respect to controlled substances. The task should be routine especially where the health care center used electronic medical records. Yet, but for the fact that the nursing study identified the issue, the improper practice could have continued for some time.

Dr. J.P. took the right action once he learned of the potential that the PA was an outlier in prescribing opiates and other controlled drugs. Notwithstanding the final disposition in the case, it points to the need for continuous monitoring of controlled substance prescribing practices. Prompt action is warranted when data substantiates improper conduct that could lead to potential disciplinary action against a supervising care provider.

**Risk Management Strategies for Reducing Vicarious Unprofessional Conduct for Supervising Physician.**

Supervising physicians have many responsibilities. Aside from clinical care, the supervising physician often has administrative tasks and oversight responsibility for the midlevel provider. Achieving a balanced approach is important to lessen risk exposure. There are several risk management strategies that could help lessen vicarious accountability for unprofessional conduct, including the following:

1. **Set Clear Expectations for Supervising Physicians.**
   Establish unambiguous requirements for physicians supervising midlevel providers such as physician assistants. Delineate what must be done in terms of supervision. Make clear if such supervision includes regular electronic medical record reviews, evaluating prescribing practices, follow-up with specialists and patients, and “closing the loop” on laboratory and diagnostic imaging tests.

2. **Make Certain Collaborative Agreements Address Supervision and Prescribing Pattern Surveillance.**
   Incorporate in collaborative practice agreements what steps must be accomplished for purposes of a physician supervising a physician assistant or nurse practitioner. Be specific about such tasks as electronic medical record reviews and evaluating controlled substance prescribing practices on the part of physician assistants and nurse practitioners.
Make certain that the midlevel providers understand the terms and conditions under which their work will be monitored and evaluated.

3. **Work with IT to Develop a Prescribing Pattern Surveillance Program.**
   Develop a practical ongoing prescribing pattern surveillance protocol to identify outlier in terms of higher than expected prescriptions for opiates and other controlled drugs. Consider taking a similar approach for other prescription drugs that make indicate concerns about diagnosis or treatment plans. Implement the surveillance program once it has been piloted. Make certain that the surveillance program captures monthly as well as trended data.

4. **Evaluate Promptly Outlier Prescribing Patterns.**
   Complete a thorough assessment of identified outlier prescribing patterns generated by the surveillance protocol. Make certain that the data is reliable. Conduct the evaluation as quickly as possible after outlier information is evaluable.

5. **Take Appropriate Action Under Internal Office or Clinic Policies and Procedures.**
   Follow established policies and procedures for responding to identified outlier prescribing patterns. Recognize that for cases involving patient safety issues counseling, training, or outside review may be indicated for identified physician assistants, nurse practitioners and physicians. Take appropriate action internally with respect to improper prescribing practices involving opiates and controlled drugs. Note that this may mean a suspension, job termination, and reporting to state licensing agencies and, in some instances law enforcement.

6. **Seek Legal Advice for Handling Improper Controlled Drug Prescribing Practices.**
   Work with legal counsel to manage the employment practices and reporting requirements with regard to identified improper opiate and controlled drug prescribing by physician assistants and other providers.

7. **Document Evaluation and Notification Measures.**
   Complete requisite documentation of identified outlier situations, the evaluation, and steps taken to stop inappropriate prescribing practices. Follow guidance from legal counsel with respect to documenting internal assessments and also notifications to state licensing boards and law enforcement. Document when insurance carriers are placed on notice.
regarding possible potential compensatory events linked to identified inappropriate prescribing practices.

Conclusion.

The electronic medical record can be a valuable tool in providing timely, accurate, and effective patient care. The electronic medical record can generate data regarding treatment outcomes, missed appointments, delays in care, and prescribing practices.

The same electronic system can be mined for prescribing practices that could lead to poor clinical outcomes and inappropriate activity on the part of a provider. Knowing that the data is available and should be evaluated on a regular basis, there is little room to excuse the failure to do so.

Software programs can facilitate appropriate data assessment and help identify aberrant practices. Rather than wait until a serious problem develops that may cast doubt upon a supervising physician, the data should be evaluated regularly and acted on when a threshold or “trigger” is met in the surveillance process. When such action is prompt and effective it can lessen the risk of what transpired in the Vermont case, and thereby reduce the risk that the doctor will become the subject of accountability proceedings by a state licensing board.

If would like risk management assistance with collaborative arrangements, please contact us at:

www.therozovskycroup.com
or
(860) 242-1302

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2 In re J.P., 70 A.3d 915 (VT. 2012).

3 Id. at 917.
Id.

Id.

Id.

Id.

Id.

Id.

Id.

Id.

Id.

Id.

Id. Referencing 26 Vt. Statutes Annotated, §1739.

Id. at 318, referencing 26 V.S.A. §1739(a) (agency relationship); and 26 V.S.A. §1354(b)(2) a “failure to conform to the essential standards of acceptable and prevailing practice” on the part of the PA.

In re J.P., 70 A.3d 915 (VT. 2012) supra note 3 at 318.

Id.

Id.

Id.


In re J.P., 70 A.3d 915 (VT. 2012) supra note 3 at 319.

Id.


In re J.P., 70 A.3d 915 (VT. 2012) supra note 3 at 319.

Id. at 920 referencing 26 V.S.A. § 1354.

Id. at 921, referencing 26 V.S.A. § 1354(b)(2).

Id. at 922.

Id. at 920.