LAW OFFICE OF CAROLYN BUPPERT, P.C.
TELEPHONE: 410-570-0058
WEBSITE: WWW.BUPPERT.COM
E-MAIL: BUPPERTCAROLYN@GMAIL.COM

LAW OFFICE ADDRESS:
7972 OLD GEORGETOWN RD.
BETHESDA, MD 20814

CURRENT MAILING ADDRESS:
(AWAITING ADMISSION TO CO BAR)
851 7TH ST.
BOULDER, CO 80302

January 22, 2013

Kathy Hoebelheinrich, APRN
Chair, 407 Credentialing Review
Secretary, Nebraska Nurse Practitioners

Re: Collaborative physician liability for nurse practitioner malpractice

Dear Ms. Hoebelheinrich,

On behalf of Nebraska Nurse Practitioners, you asked me to address issues regarding physician liability in malpractice cases against nurse practitioners, when the physician is the named collaborative physician for the nurse practitioner. Nebraska law requires that a nurse practitioner have a physician collaborator under an integrated practice agreement. As I understand the situation, there is interest in Nebraska in deleting the physician collaboration requirement and questions are arising about physician liability when there is a collaborative relationship.

The issues are:

- Whether there is case law history regarding who is liable in lawsuits brought against nurse practitioners who have supervisory/collaborative relationships with physicians
- Whether, in cases where an NP was named with a physician, the physician was the employer or simply the supervisor/collaborator required in statute
- Whether the physician was determined to be liable and why
- Whether a physician is more or less likely to be found liable in an employment relationship in those states with independent NP practice.

Research

To prevail in a malpractice action, the plaintiff must prove 4 elements:
1) That the clinician had a duty of care to the patient
2) That the clinician breached the standard of care
3) That the patient was injured and

4) That the breach of the standard of care was the proximal cause of the patient's injury.
Source: Prosser and Keeton on the Law of Torts (5th edition 1984) §30, page 164-165

When finding a collaborating physician liable, a court must first find that the physician owed the patient a duty of care. The threshold issue is whether collaboration, as mandated by state law, inherently assigns a duty of care to the collaborating physician.

How the research was conducted

I performed a search in the Westlaw data base for all states and the federal case law data base. The cases in the state law data base are at the appeals court level. No cases at the federal level were on point to these issues. There is no data base of cases at the state trial court level where one can search by issue. However, there is a newsletter -- *Malpractice Verdicts, Settlements and Experts* -- in which attorneys summarize their cases at the trial level. I have subscribed to that newsletter for many years and, every month, review the publication for cases against nurse practitioners. I have a compiled a data base of cases against nurse practitioners, from that newsletter and other sources. I searched my file for cases in which the physician collaborator or employer was mentioned. So, the cases analyzed here are from state trial courts and from state appeals courts.

Research results

I found no cases from Nebraska.

I found 11 cases where I could determine that a nurse practitioner and his or her collaborating physician was sued for malpractice. (There are many cases where a nurse practitioner was sued, but no discussion of collaborator liability.) I looked for any discussion by the court about who was liable. (I should note that the appeals cases were not specifically about the issue of who was liable, but often were appeals of summary judgments; that is, the trial court dismissed a party and the plaintiff appealed the decision. The appeals court therefore discussed possible liability. If the appeals court disagreed with the trial court, they would remand to the trial court for a reconsideration of liability.)

Of the 11 cases where the court discussed liability of the collaborating physician, the physician was found liable in 5. These cases are summarized in Table 1. In 6 cases, the physician was found not liable and dismissed from the case. Those cases are summarized in Table 2.

Looking closely at the facts of the 5 cases where the physician collaborator was found liable, we find:
Case 1 (Texas): The nurse practitioners and physicians were a team in a neonatal intensive care unit, all rounding on the patient, all equally responsible, and all involved in the subsequent settlement.
Case 2 (Alabama): The nurse practitioner had not consulted with the physician about the patient's issue (monitoring -- or lack thereof -- of INRs while on Coumadin) but the physician had

initiated the Coumadin therapy. The appeals court felt the physician should have remained involved in the patient's care, once he initiated the treatment.
Cases 3 and 4 (Maryland and New York): The nurse practitioner had consulted the physician about the case.
Case 5 (Massachusetts): The nurse practitioner had not consulted the physician about the case.

In the 6 cases where the physician was found not liable, the nurse practitioner had not consulted the physician, so the physician had no opportunity to become involved. In those cases, the fact that the physician was the named collaborator did not persuade the judges that the physician had a duty to the patient and should share liability. In the Massachusetts case where the collaborating physician was held liable but where the nurse practitioner had not consulted the physician, the jury apparently responded positively to an expert witness' opinion that the collaborating physician did not adequately supervise the nurse practitioner. The defendant physician had contended that a random review of patient files constituted adequate supervision and that he had no independent duty to review individual charts and sign off on a regular basis.

In 10 of the 11 cases reviewed, the nurse practitioner's employer was sued. (In the 11th case, the nurse practitioner owned the clinic.) The employer was the physician collaborator in 4 of the cases. In one of those cases the physician employer was sued but found not liable.

It is instructive to read the appeals court judges' view of the requirements of a mandated collaborative relationship. Here is the Maryland court's reasoning about why the collaborator had a duty to the patient:

> "At the first hearing, the trial court agreed that whether Nurse Schemm [the nurse practitioner] ever discussed Ms. Miller's medical care with Dr. Desmangles was the central issue. [Reference omitted.] At the second hearing, however, the trial court found that Nurse Schemm consulted with Dr. Desmangles, but characterized it as "in passing" and "not for the purpose of having Dr. Desmangles participate in the care." [Reference omitted.] Such a characterization did not construe the pertinent evidence and testimony in the light most favorable to the Appellant. Moreover, given the fact that Nurse Schemm had contradicted Dr. Desmangles' sworn disavowal of involvement in Ms. Miller's care, it is respectfully submitted that the evidence of Dr. Desmangles' Affidavit deserved absolutely no weight or consideration whatsoever.
>
> The question of the existence of a legal duty in a medical malpractice case depends upon the specific facts of each case, and a duty may be implied by the facts and circumstances. *Sterling v. Johns Hopkins Hosp.*, 145 Md. App. 161, 171, 802 A.2d 440, 446 (2002) ("It is beyond cavil that a physician-patient relationship may be created through an implied contract"). In the case at bar, it is submitted that a duty is implied both by law and by the factual circumstances.
>
> Because Dr. Desmangles was Nurse Schemm's "collaborating physician," he was required by Maryland law to provide "continuing medical management" of any medical care provided by the nurse practitioner to patients participating in a health maintenance organization. Md. Health-Gen. Code Ann. § 19-705.l(b)(5), (c)(1). That statute (entitled

"Standard of care") manifests the clear intention of the Legislature that, although a nurse practitioner may act as a patient's primary care provider, a collaborating physician must be involved in the care to ensure that the nurse practitioner is appropriately managing the patient's medical care. In the case at bar, therefore, the degree to which Dr. Desmangles managed Ms. Miller's medical care is immaterial to the existence of his legal obligation to do so.

By analogy, a collaborating physician is "on call" to the nurse practitioner, and available to provide medical consultation and advice. In that regard, this Court's holding in *Sterling v. Johns Hopkins Hosp.* is instructive. The plaintiff in *Sterling* contended that an "on call" obstetrician at Johns Hopkins Hospital owed a duty of care to her, arising when her own attending obstetrician consulted with the "on call" physician. The court acknowledged that a duty of care could arise under those circumstances:

> In the final analysis, we take it as well-settled that a physician-patient relationship may arise by implication where the doctor takes affirmative action to participate in the care and treatment of a patient. An "on-call" physician may be in the position to direct the care of a patient whom he has never seen, so that his or her instructions are followed, the results of which are manifest in the ensuing course of the patient's treatment. But "[w]here... the treating physician exercises his or her own independent judgment in determining whether to accept or reject [a consultant's] advice,the consultative physician should not be regarded as a joint provider of medical services with respect to the patient." *Gilinsky v. Indelicato,* 894 F.Supp. 86, 92 (E.D.N.Y. 1995). ***We recognize as well that in some circumstances a consultant may undertake by contract to take this "affirmative" action, and by that accord be deemed to participate in the care and treatment of patients.*** *Sterling*, 145 Md. App. at 187-88, 802 A.2d at 455 (emphasis added). Because the plaintiffs' attending physician "was free to accept or reject the directions" from the "on call" physician, the court held that no implied physician-patient relationship existed. *Sterling*. 145 Md. App. at 191-92, 802 A.2d at 457-58. In contrast, the Court in *Sterling* observed that when an "on call" physician is consulted by nurses, the "physician's directives were not merely hortatory, they were conclusive." *Sterling*,145 Md. App. at 192, 802 A.2d at 58 (*citing Wheeler v. Yettie Kersting Mem. Hosp.,* 866 S.W.2d 32 (Tex. App. - Houston [1st Dist.] 1993)). The *Sterling* court approved the holding in *Wheeler,* in which an implied physician-patient relationship was held to arise when nurses consulted an "on call" physician concerning a patient.

In the case at bar, Dr. Desmangles made a series of affirmative actions that generated a duty of care owed to Ms. Miller. First, he signed the Collaboration Agreement, pursuant to which he agreed to certain duties and responsibilities with respect to the patients seen primarily by the nurse practitioner:

- The physician will asses *[sic]* and evaluate the CRNP's practice through observation, questioning, chart review and discussion.
- The physician will serve as the admitting physician for any client, under the care of the CRNP, who is hospitalized.

- The physician will assist the CRNP through a collaborative relationship.

Pursuant to the Collaborative Agreement, Nurse Schemm was permitted to establish the diagnosis only "of common short term problems" that, by definition, do not include lung cancer. As the physician who has agreed to assist a nurse practitioner "through a collaborative relationship," Dr. Desmangles had at least an implied duty to observe, question, review and discuss the matter of investigating and diagnosing Ms. Miller's suspicious lung mass, after he became aware of the existence of that mass following the October 3, 2003, CT scan. Dr. Desmangles took no action of any kind, however, by his own admission. [Reference omitted.] In that regard, there can be no dispute that Nurse Schemm consulted with Dr. Desmangles regarding the investigation of Ms. Miller's suspicious lung mass as early as October of 2003, when she discussed with him the prospect of ordering a PET scan. It is plain from Nurse Schemm's deposition testimony that she did not question the recommendations made by physicians -- she unquestioningly followed the recommendations of Dr. Desmangles and also felt
that it was her obligation to obey the radiologists who recommended further radiographic testing.

Under these circumstances, as this Court held in Sterling, the "on call" physician who has made an affirmative action towards the patient owes a duty of care to that patient by virtue of the implied physician-patient relationship. For all of these reasons, it is respectfully submitted that the evidence and testimony generate a triable issue of fact concerning the existence of an implied physician-patient relationship in this case. As such, the Appellee's motion for summary judgment should have been denied." *Jiminez v. Desmangles*, 2007 WL 4449671 (Md.App. 2007), page 12 and following.

In one of the New York cases, where a patient presented to an emergency department having injured his arm on a ladder, the nurse practitioner examined the patient, and the collaborating physician signed the nurse practitioner's note and prescribed a medication, but did not examine the patient. That court also cited the *Sterling* case, saying: "An implied physician-patient relationship can arise when a physician gives advice to a patient, even if the advice is communicated through another health care provider." *Hytko v. Hennessey*.

In the Alabama case, the court said "If [the nurse practitioner] acted negligently, their negligence does not relieve [the physician] of responsibility for [the patient's] death, if a jury were to find that he acted negligently in treating [the patient] and that negligence caused her to have a dangerously elevated INR in the first place. His negligence began the chain of events that resulted in the death." *Frazier v. Gillis*. In that case the physician initiated Coumadin therapy and then turned the care of the patient over to the nurse practitioner.

With regard to the issue of whether a physician is more or less likely to be found liable in an employment relationship in those states with independent nurse practitioner practice, we need to agree upon the states to which the adjective "independent" applies. According to the National Council of State Legislators (NCSL), "Nurse practitioners in Alaska, Arizona, Idaho, Iowa, Maine, Montana, New Hampshire, New Mexico, Oregon, Washington and the District of Columbia can practice independently, although Maine requires they be supervised by a physician

in the first two years of practice."

Source: http://www.ncsl.org/issues-research/health/a-primary-problem.aspx#n.

I would add Colorado and Utah to that list, but will use the NCSL's list so as to avoid controversy.

It is beyond the scope of this project to compare the data on employer liability in independent nurse practitioner states and collaborative/supervisory states by researching all malpractice cases in each state. (As previously stated, there is no searchable trial court data base. One would need to go to the state and physically search all malpractice cases.)

What we can access are National Practitioner Data Bank statistics which report state-by-state adverse actions taken against physicians and licensed or certified nursing professionals, including medical malpractice payments, state licensure actions, Medicaid/Medicare exclusions, Drug Enforcement Administration actions.

For state-by-state ratios of NPDB reports compared with number of practitioners in the state, see Table 3. I tallied the NPDB reports of actions against nurse practitioners in the 11 states where they are independent and the 39 states where they are not, and calculated averages. I also calculated the averages for physicians in the 11 states where nurse practitioners are independent and the 39 states where they are not, and found the following:

NPDB reports on NPs in independent states averaged 1:104 (one report for every 104 nurse practitioners).
NPDB reports on NPs in collaborative/supervisory states averaged 1:124.
NPDB reports on MDs in independent NP states averaged 1:3.5.
NPDB reports on MDs in collaborative/supervisory states averaged 1:3.5.

Analysis

When courts assign liability to a collaborating physician, it appears that they look for some "affirmative action" of the collaborating physician, in addition to being named as the collaborating physician and/or signing a collaborative agreement. In the Maryland case, the court said the collaboration agreement assigns some duty of care to the physician, but in that case, the physician had made more "affirmative actions" which imposed a duty of care. In the Alabama case, the physician had taken the affirmative action of initiating the patient's Coumadin, thereby beginning the chain of events which led to the patient's injury. In the New York case, the physician signed the nurse practitioner's note and prescribed a medication for the patient.
It is only the Massachusetts case where the physician did nothing more than employ the nurse practitioner and sign the collaborative agreement. That case is at the trial court level and was reported by one of the attorneys involved. We have no more information than what the attorney reported -- that the physician did not think he needed to review every case, but the plaintiff's expert thought he did.

I cannot determine from this research (and know of no way to research) the frequency with which nurse practitioners are sued but the nurse practitioner's collaborating physician is not sued. So we can't calculate the likelihood that a collaborating physician will be sued. The picture that

emerges from my review of cases where the collaborating physician was sued is that a collaborating physician may or may not be held liable. It appears that it is to a collaborating physician's advantage to stay clear of nurse practitioners' cases. That is, the collaborating physician is more likely to be found liable if he or she becomes involved, so it is in the interest of the physician to remain uninvolved. An alternative way of viewing the case holdings is that a collaborating physician should either remain "hands off" or examine and make a medical decision on every patient the nurse practitioner sees. The "hands off" approach to collaborating is counterproductive to the goal and intent of mandated collaboration. If the collaborating physician has to evaluate and manage every patient, that is counterproductive to the premise that nurse practitioners increase access and make hospitals and medical practices more efficient.

To address the four issues directly:

- Whether there is case law history regarding who is liable in lawsuits brought against nurse practitioners who have supervisory/collaborative relationships with physicians.

  Yes

- Whether, in cases where an NP was named with a physician, the physician was the employer or simply the supervisor/collaborator required in statute

  When a nurse practitioner is sued, an employer and/or collaborating physician is likely to be sued. Whether the physician is found liable depends, for the most part, on whether he or she had some involvement with the patient other than simply being named as the collaborating physician. I cannot make generalizations about the frequency of employers being dismissed from cases, but I can say that some are.

  Every employer knows or should know that if his or her employee is sued, the company will be sued, under the legal theory of respondeat superior. However, not all employers are held liable. A physician who is not the employer but is the collaborator should know that he or she is likely to be sued, if the nurse practitioner is sued, but the chances that the physician will be held liable depends on whether he or she made some affirmative action toward treating the patient.

- Whether the physician was determined to be liable and why

  Physician collaborators sometimes are found liable and sometimes not. When they are found liable, it is usually because they were involved (took some affirmative action) in the care of the patient. In some cases, the courts have said being a collaborating physician does not mean the collaborator is inherently liable.

- Whether a physician is more or less likely to be found liable in an employment relationship in those states with independent NP practice.

  I cannot find data to support conclusions on this issue. However, the NPDB data sheds some light. In states where nurse practitioners are independent, it appears that physicians

are no more or less likely to have NPDB actions filed than in states where collaboration or supervision is required. And, it appears that nurse practitioners in independent states are more likely to have NPDB actions filed. We should note that the NPDB actions against nurse practitioners are a fraction of the NPDB actions against physicians.

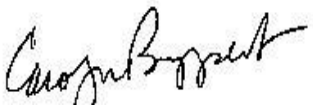
Conclusions

Based on this review of cases and NPDB data, the implications for states considering abolishing collaborative requirements are as follows:

- The collaborative requirement is meant to assure patient safety. However, the cases show that it is advantageous for collaborating physicians to avoid being involved in the care of patients being evaluated and managed by nurse practitioners. Therefore mandates for collaboration may be accomplishing nothing, or accomplishing something other than what legislators intended.
- Collaboration/consultation does not appear to shield nurse practitioners from litigation or from being found liable. They can be held liable whether or not they consulted with the collaborating physician.
- If there is no mandate for collaboration, then I suggest that nurse practitioners may be more likely to refer patients to physicians in a formal way, in the manner of primary care provider to specialist, rather than getting an "on the fly" consultation from the collaborating physician. The formal referral process probably is safest for all concerned, because physicians know that a formal referral means they have a duty to care for the patient by personally and thoroughly assessing the patient and making their own medical decisions. I believe the responsibility of each party would be far clearer without the mandated collaboration requirement.
- I hesitate to make too much of the NPDB data; however, that data suggests that it is unlikely to affect physician liability if the collaborative requirements in state law are deleted.

Thank you for the opportunity to assist you with this project. If you have any further questions, please give me a call.

Sincerely,



Carolyn Buppert

Table 1: Cases where physician was found liable

Case	MD sued?	MD liable?	MD employed NP?	NP liable?	NP consulted MD?
Alabama	yes	Yes	yes	yes	no (but MD initiated the treatment at issue)
New York	yes	Yes	no	yes	Yes
Maryland	yes	Yes	yes	yes	Yes
Texas	yes	Yes	no	yes	Yes
Massachusetts	yes	Yes	yes	yes	No

Table 2: Cases where physician was found not liable

Case	MD sued?	MD liable?	MD employed NP?	NP liable?	NP consulted MD?
Michigan	yes	No	no	no	no
Ohio	yes	no	yes	To be determined	no
New York	yes	no	no	yes	no
Missouri	yes	no	no	yes	no
Virginia	yes	no	no	yes	no
Louisiana	yes	no	no	yes	no

Table 3:

NPDB & HIPDB State Ratios

STATE LISTINGS OF NPDB & HIPDB RATIOS COMPARING RATES OF NPS, DOS & MDS

	NP State Ratio for NPDB Occurrence	DO State Ratio for NPDB Occurrence	MD State Ratio for NPDB Occurrence	NP State Ratio for HIPDB Occurrence	DO State Ratio fo Occurrenc
ALABAMA	1:642	1:10	1:8	1:10	1:10
ALASKA	1:123	1:8	14	1:39	1:5
ARIZONA	1:74	1:3	1:3	1:521	1:6
ARKANSAS	1:300	1:5	1:4	1:193	1:10
CALIFORNIA	1:196	1:8	1:3	1:1135	1:24
COLORADO	1:91	1:5	1:4	1:3184	1:5
CONNECTICUT	1:685	1:22	1:6	1:95	1:33
DELAWARE	1:240	1:4	1:4	0	1:13
DC	1:146	1:5	1:5	0	0
FLORIDA	1:65	1:3	1:2	1:259	1:15
GEORGIA	1:221	1:5	1:4	1:811	1:10
HAWAII	1:456	1:7	1:5	1:456	1:13
IDAHO	1:73	1:8	1:4	1:82	1:16
ILLINOIS	1:227	1:6	1:3	1:454	1:93
INDIANA	1:285	1:3	1:3	1:3135	1:17
IOWA	1:148	1:3	1:3	0	1:6
KANSAS	1:220	1:3	1:2	1:550	1:12
KENTUCKY	1:165	1:6	1:3	1:165	1:9
LOUISIANA	1:98	1:3	1:2	1:91	1:48
MAINE	1:155	1:7	1:4	1:544	1:7

MARYLAND	1:134	1:14	1:4	0	1:33
MASSACHUSETTS	1:105	1:11	1:5	1:296	1:13
MICHIGAN	1:247	1:2	1:2	1:210	1:10
MINNESOTA	1:364	1:11	1:7	1:2913	1:15
MISSISSIPPI	1:118	1:5	1:2	1:247	1:7
MISSOURI	1:225	1:3	1:3	0	1:5
MONTANA	1:69	1:4	1:2	0	1:11
NEBRASKA	1:339	1:7	1:3	1:508	1:15
NEVADA	1:72	1:5	1:3	1:239	1:16
NEW HAMPSHIRE	1:139	1:15	1:3	1:764	1:15
NEW JERSEY	1:161	1:3	1:2	1:2,740	1:12
NEW MEXICO	1:51	1:2	1:2	1:584	1:261
NEW YORK	1:165	1:6	1:2	1:433	1:19
NORTH CAROLINA	1:166	1:11	1:5	1:142	1:22
NORTH DAKOTA	1:238	1:6	1:3	1:475	1:3
OHIO	1:777	1:3	1:3	1:604	1:5
OKLAHOMA	1:91	1:4	1:3	1:13	1:8
OREGON	1:82	1:7	1:5	1:106	1:8
PENNSYLVANIA	1:216	1:2	1:2	1:171	1:13
RHODE ISLAND	1:77	1:2	1:3	1:345	1:15
SOUTH CAROLINA	1:263	1:7	1:3	1:230	1:17
SOUTH DAKOTA	1:115	1:6	1:3	1:76	1:8
TENNESSEE	1:133	1:4	1:4	1:85	1:16

TEXAS	1:114	1:3	1:3	1:1943	1:11
UTAH	1:131	1:9	1:3	1:131	1:10
VERMONT	0	1:12	1:4	1:250	1:7
VIRGINIA	1:243	1:12	1:5	1:104	1:12
WASHINGTON	1:91	1:5	1:4	1:36	1:8
WEST VIRGINIA	1:151	1:4	1:1	0	1:8
WISCONSIN	1:908	1:8	1:7	1:1816	1:22
WYOMING	1:85	1:2	1:2	0	1:5

http://www.pearsonreport.com (accessed January 23, 2013)

Cases cited:

Beard v. Hatch, et al. Case no 2004-01801, Essex (Massachusetts) Superior Court, May 21, 2010

Frazier v. Gillis, 85 So.3d 443 (Alabama 2011)

Fineis v. Sienko, WL 520262 (Michigan App.2011)

Hytko v. Hennessey, 62 A.D.3d 1081, 879 N.Y.S.2d 595 (New York 2009)

Jiminez v. Desmangles, WL 4449671 (Maryland App. 2007)

Monahan v. Obici Medical Management Services, WL 1773370 (Virginia Cir. Ct. 2002)

Oliver v. Magnolia Clinic, 71 So.3d 1170, (Lousiana App. 3rd Cir. 2011)

Quirk v. Zimmerman, 196 Misc.2d 496, 765 N.Y.S.2d 440 (New York 2003)

State ex rel Howenstein v. Roper, 155 S.W.3d 747 (Missouri 2005)

Striff v. Luke Medical Practitioners, WL 5296941 (Ohio App. 3 Dist. 2010)

Unnamed Texas case summarized by Texas Medical Liability Trust at insurer's web site http://www.tmlt.org/newscenter/closedclaims/ophthalmology.html?x=3.