The New Jersey Legislature authorized the licensing of Physician Assistants (PAs) in 1991. These mid-level practitioners have been useful as “physician extenders” in both office and hospital settings. In primary care and surgical specialties, PAs can undertake diagnostic evaluations, manage inpatient care and function as a hospitalist, assist in surgery or invasive procedures and can perform some noninvasive procedures. PAs can also write prescriptions, including controlled substances. While PAs can add value, New Jersey court decisions make it clear that physicians employing PAs must observe the inherent practice constraints for these limited license practitioners.
LEGAL RESPONSIBILITIES FOR MALPRACTICE

The rate of frequency for PA malpractice payments has been low. In Annual Reports for 2005 and 2006, the National Practitioner Data Bank specifically noted that PAs were responsible for “less than one percent of Medical Malpractice Payment Reports,” with about half involving diagnosis issues.¹ This breakdown is not in recent Annual Reports, but for comparison, the number of payments on behalf of nurses in various capacities (registered nurse, nurse anesthetist, nurse midwife, nurse practitioner and advanced practice nurse) has been approximately five times higher. (Data concerning other allied health professionals like physical therapists are not broken out in the Annual Reports.) Nonetheless, a 1985–2004 closed claims review indicated that while the frequency of payments for PAs was lower, the average payment amount for a PA defendant was somewhat higher than that for physicians.² These statistics, along with recent New Jersey Supreme Court decisions, underscore the need for awareness of and attention to the regulatory limits on PA scope of practice and the relationship of those limits to potential malpractice liability. Although a PA faces potential tort liability for his or her own actions or inactions resulting in patient injury, the physician with whom the PA works, as well as any entity employing the PA, can also incur liability.

Direct Liability: A physician’s legal responsibility for a PA can result from the physician’s own actions. This is referred to as direct liability. Such occurrences can involve the negligent selection or hiring of a PA candidate. Direct liability can also result from treatment decisions made by the physician with only tangential or incidental involvement by the PA.

Vicarious Liability: The more expansive is referred to as vicarious liability. This is an indirect legal responsibility that arises in several circumstances. The most straightforward instance is an employer-employee relationship. This relationship triggers the doctrine of respondeat superior, which is the principle that the employer as the master or superior must answer and be responsible for the acts and omissions of employees performed within his or her employment. This doctrine is grounded in concepts of principal and agent law.

Vicarious liability can also be imposed in situations with no formal principal-agent relationship agreed to, but the physician exercises or has the right to exercise control over the PA or otherwise has a supervisory responsibility. Vicarious liability can also result from a “holding out” of someone so that he or she has the appearance of acting as and being an agent of the supposed principal.

LIMITATIONS ON THE SCOPE OF PA PRACTICE

The Physician Assistant Licensing Act (PALA) limits the scope of PA practice and mandates a supervisory relationship with a physician licensed by the State Board of Medical Examiners (BME).³ A PA holds only a limited license and can practice only in a supervisory relationship with a plenary license holder. One limit is the settings in which a PA provides medical care. The general rule is that a PA may “practice in all medical care settings, including a physician’s office, a health care facility, an institution, a veterans’ home or a private home.”⁴ However, such practice is subject to the following requirements:

1) The PA is under the direct supervision of a physician pursuant to section -27.18 of the PALA  
2) The practice of the PA is limited to those procedures authorized under section -27.16 of the PALA  
3) An appropriate notice of employment has been filed with the BME pursuant to section -27.14(b) of the PALA  
4) The supervising physician or PA advises the patient at the time that services are rendered that they are to be performed by the PA  
5) The PA conspicuously wears an identification tag using the term “physician assistant” whenever acting in that capacity  
6) Any entry by a PA in a clinical record is appropriately signed and followed by the designation “PA-C”⁴

Certain liability implications flow from these statutory physician supervision requirements. The PALA defines “physician” as “a person licensed to practice medicine and surgery.”⁵ A physician is permitted by the Act to “delegate to a [PA] under his supervision only those procedures identified in section [-27.16] of this act.”⁶ An important limitation regarding delegable procedures is the distinction between those procedures and tests that
are invasive and those that are noninvasive. Direct physician supervision is required at all times when a PA is working in an official capacity. By regulation, the BME has authorized a supervising physician to assign a PA to a “physician designee” who then is responsible for the PA during the assignment and who can discharge the direct supervision requirement.

The PALA describes differing categories of direct supervision in inpatient and outpatient settings.

Direct Supervision in Inpatient Setting: The PALA defines inpatient direct supervision by a physician as:
1) Continuing or intermittent presence with constant availability through electronic communications
2) Regularly scheduled review of the practice of the PA
3) Personal review by a physician of all charts and records of patients and countersignature by a physician of all medical orders, including prescribing and administering medication, within 24 hours of their entry by the PA

Direct Supervision in Outpatient Setting: Outpatient direct supervision by a physician consists of:
1) Constant availability through electronic communications
2) Regularly scheduled review of the practice of the PA
3) Personal review by a physician of the charts and records of patients and countersignature by a physician of all medical orders, within seven days of their entry by the PA, except that in the case of any medical order prescribing or administering medication, a physician shall review and countersign the order within 48 hours of its entry by the PA

The BME by regulation has limited supervisory ratios to no more than two PAs to one supervising physician in a private practice that is not hospital based or institutionally affiliated and four PAs to one supervising physician in all other settings. Importantly, the principal-agent relationship between a PA and supervising physician is explicit in the licensing statute. The PALA declares that “[i]n the performance of a medical procedure, a [PA] is conclusively presumed to be the agent of the physician under whose supervision the [PA] is performing.” (The Act uses the term “procedure” to describe the various functions that a PA may perform.) The PAs status in the supervising physician principal-agent relationship is discussed in one set of published New Jersey court decisions; however, these cases were not in a liability context but rather concerned regulatory scope of practice issues.

CASE LAW
Although no New Jersey case directly analyzed the principal-agency relationship of supervising physician and PA for malpractice claims, a Tennessee case is particularly instructive. In Cox v. M.A. Primary and Urgent Care Clinic, the court ruled that a supervising physician had an agency relationship with a PA and thus could be found vicariously liable for the PAs negligence, if the negligence were proven. As in New Jersey, PAs are recognized medical providers in Tennessee and by statute are limited in the procedures they are authorized to perform, must perform those procedures under the supervision of a physician and function under the control and responsibility of a physician. In reviewing the statutory provisions and local rules, the Tennessee Supreme Court held that “as a general matter a [PA] stands in an agency relationship with his or her supervising physician when the [PA] is providing authorized medical services.” Accordingly, where a “medical doctor delegates certain responsibilities to her [PA], she remains responsible for the assistant carrying out those responsibilities in an appropriate manner,” and under such circumstances, “the [PA] occupies the role of agent and the supervising doctor occupies the role of principal.” Accordingly, in Cox, the PA was an agent of the supervising physician, and the supervising physician was subject to vicarious liability. The Court determined, however, that the standard of care applicable to PAs was distinct from that applicable to physicians; specifically “a physician assistant must be held to the recognized standard of acceptable professional practice in the profession of physician assistants and any specialty thereof.”

There is no New Jersey court opinion addressing the applicable standard of care, that is, whether it is that of the average PA or rather that which would be applicable to the physician under whose supervision the PA is practicing. This may be resolved in some future decision. The somewhat related topic of the New Jersey Affidavit of Merit Statute has also not been directly addressed. However, because “Physician Assistant” is not in the listing
of “licensed persons” for whom this threshold requirement must be met (and in light of an appellate ruling finding that the absence of “midwife” from the then-existing statutory list was a basis for not requiring such a preliminary affidavit), it is likely that an Affidavit of Merit as to the PA would not be required.21 The additional procedural element in the 2004 Medical Care Access and Responsibility and Patients First Act22 that in a medical malpractice action any person providing an Affidavit of Merit or testifying as an expert must be from “the same specialty” as the defendant was determined by a federal court to be inapplicable. This was because PAs are not included among the list of specialty boards in that statutory provision.23

The PALA and its regulations delineate the scope of practice of a PA. Significantly, “any [PA] who practices in violation of any of the conditions specified [in the Act] shall be deemed to have engaged in professional misconduct.”24 Similarly, a physician permitting a PA to practice contrary to the PALA is deemed to have engaged in “professional misconduct” and subject to discipline including license suspension or revocation.25

In Bedford v. Riello,26 the New Jersey Supreme Court considered a malpractice case in which a chiropractor had manipulated a patient’s knee. The Court viewed the principal issue as whether adjustment of a knee fell within the scope of chiropractic practice under New Jersey law, which permitted manipulation of articulation of the spine and related structures. While concluding that what constituted a “related structure” had to be made on a case-by-case basis, the Court stated that a jury was to be instructed that if it concluded that the treatment intervention was outside the scope of chiropractic practice, as defined in the New Jersey statutes and regulations, “such violation may be considered evidence that defendants were negligent.”27

The Bedford ruling, approving use of regulatory scope of practice as a basis for finding professional negligence, has predictive importance for a medical practice utilizing PAs when confronted with a malpractice lawsuit. Although not dealing with professional liability, the scope of practice, as it applies to a PA, was assessed in Selective Insurance Co. v. Rothman.28 A neurologist sought payment of No-Fault Act benefits from a patient’s insurer for a needle electromyography (EMG) done by a PA in the physician’s office. The insurer denied coverage on the grounds that the physician had not personally performed the procedure and that, in doing so, the PA had performed a procedure outside the scope of the PAs legally authorized practice. The insurer’s position was based on the following statutory language:

“A person shall not perform needle electromyography unless that person is licensed to practice medicine and surgery in this State pursuant to chapter 9 of Title 45 of the Revised Statutes.”29

A No-Fault Act dispute resolution professional determined the PA’s work was authorized by the statute because the physician reviewed and countersigned for the work. In addition to seeking confirmation of the arbitration award that the claim should have been paid, the physician initiated a separate action seeking a declaratory judgment that PAs were legally authorized to perform EMGs; the physician hoped to lay the foundation for other claims that had been denied by the insurer. A trial judge reviewed and upheld the arbitration determination and also ruled in the neurologist’s favor on the declaratory judgment action. The matter moved on for further review by the appellate division and eventually the New Jersey Supreme Court. The intermediate appellate court agreed with the insurer and reversed the lower court, holding that the PA was not authorized to perform the procedure at issue.30 The Supreme Court affirmed the appellate division’s judgment against the neurologist.31

The Court emphasized the limited nature of a PA’s license. First, the Court looked to the “plain language of the governing statute[,] noting it] limits the performance of [the procedure at issue] to those who are licensed to practice medicine and surgery in this State pursuant to chapter 9 of Title 45 of the Revised Statutes.”32 The Court reasoned that PAs “do not qualify for, nor do they receive, a plenary license to practice medicine.”33 It further noted the statute “generally authorizing [the] performance of [the procedure at issue] refers only to healthcare professionals other than PAs, [and] neither the wording of the statute nor its legislative history suggests that
the Legislature intended to include PAs when it did not do so explicitly.”

In addition to the statutory text and legislative history authorizing the particular procedure at issue, the Court looked at the PALA, which allows PAs to “assist” a physician with regard to the performance of “invasive” studies. The Court concluded that the word “‘assist’” is not equivalent to “‘perform in the place of’” as this would be “contrary to the clear word that the Legislature chose [and] would expand the authority given to PAs well beyond the boundaries that the statute established.” It also rejected the argument that the BME had authorized PAs to perform the procedure at issue through the BME’s power to adopt regulations increasing the procedures that a PA is authorized to perform. The Court found that, although the BME may have approved minutes of its PA Advisory Committee referring to performance of the EMG procedure, that was not enough to effect adoption of a regulation or “overcome the statutory limitations on the procedures that a PA is authorized to perform.”

In determining whether a PA acted within the scope of regulatory authority, the Supreme Court considered the language and legislative intent of the law authorizing the procedure at issue and the law defining the scope of PA practice. The clear implication under Selective Insurance Co. in combination with Bedford is that a physician who allows a PA under his or her supervision to perform contrary to the PALA or other law may be held responsible for that PA’s deviation.

**STATUTORY AND REGULATORY SPECIFICS REGARDING SCOPE OF PRACTICE**

In light of the case law, awareness of and attention to even the most tedious details of statutory and regulatory standards are important. Additionally, potential problems can arise when a PA performs and submits insurance reimbursement claims for procedures that are not among those authorized. Not only might this circumstance trigger disciplinary action against the physician, but it might also provide the basis for an action based on the New Jersey Insurance Fraud Protection Act (IFPA) by either an affected insurance company or by the Commissioner of the Department of Banking and Insurance. Beyond an award of attorneys’ fees and costs, together with administrative civil penalties, the amount of damages awarded in an IFPA action can be tripled.

Section -27.14(b) of the PALA requires that “a physician, health care facility, institution or veteran’s home which employs a [PA shall file with the [BME] a notice of employment” ; it also details the time and form requirements. This notice requires identification of a supervising physician. The supervising physician is authorized to assign supervision to a “physician designee” who is responsible for the practice of the PA in the absence of the original supervising physician during the assignment. This assignment is allowed, provided that the physician designee is a plenary licensee and the scope of that physician’s practices encompasses the duties assigned to the PA.

**Procedures Approved for PAs:** As emphasized in the Selective Insurance decision, the PALA limits the procedures a PA is authorized to perform. The following procedures may be performed by a PA:

1) Approaching a patient to elicit a detailed and accurate history, perform an appropriate physical examination, identify problems, record information and interpret and present information to the supervising physician
2) Suturing and caring for wounds including removing sutures and clips and changing dressings, except for facial wounds, traumatic wounds requiring suturing in layers and infected wounds
3) Providing patient counseling services and patient education consistent with directions of the supervising physician
4) Assisting a physician in an inpatient setting by conducting inpatient rounds, recording patient progress notes, determining and implementing therapeutic plans jointly with the supervising physician and compiling and recording pertinent narrative summaries
5) Assisting a physician in delivering services to patients requiring continuing care in a private home, nursing home, extended care facility or other setting, including reviewing and monitoring treatment and therapy plans
6) Facilitating the referral of patients to, and promoting the awareness of, healthcare facilities and other appropriate agencies and resources in the community
7) Such other procedures suitable for discretionary and routine performance by PAs as designated by the BME pursuant to section -27.24 of the PALA.
Procedures That Are Discretionary and Routine: The PALA authorizes the BME to adopt regulations “designating additional procedures which may be performed on a discretionary and routine basis by licensed [PAs].” The regulation adopted by the BME supplements the statute by permitting a PA to perform the following additional procedures on a “discretionary and routine basis”:

1) Collecting fluids for diagnostic purposes, including .... blood, urine, sputum and exudates
2) Placing and utilizing access catheters and tubes for diagnostic, therapeutic or interventional purposes, including ... intravenous, arterial, nasogastric and urinary
3) Performing minor surgical procedures such as simple excisions, incision and drainage, debridement and packing of wounds
4) Applying and removing medical and surgical appliances and devices such as splints, casts, immobilizers, traction, monitors and medication delivery systems
5) Managing emergency and life-threatening conditions
6) Performing low-risk obstetrical deliveries
7) Subject to review by the BME, such other written procedures established by the employer, provided the procedures are within the training and experience of both the supervising physician and the PA

Procedures Ordered by Supervising Physician: The PALA sets forth procedures a PA may perform only when “directed, ordered or prescribed by the supervising physician.” Such procedures include the following:

1) Performing noninvasive laboratory procedures and related studies or assisting duly licensed personnel in performing invasive laboratory procedures and related studies
2) Giving injections, administering medications and requesting diagnostic studies
3) Suturing and caring for facial wounds, traumatic wounds requiring suturing in layers and infected wounds
4) Writing prescriptions or ordering medications in an inpatient setting in accordance with section -27.19 of the PALA

5) Such other procedures as may be specified in accordance with section -27.24(b)

Additionally, the regulation also permits a PA to perform the following procedures only when directed by the supervising physician or specified in a written protocol approved by the BME:

1) In the operating room, assisting a supervising surgeon as a first assistant or second assistant
2) Performing other procedures for diagnostic, therapeutic or interventional purposes such as ... introduction of contrast material for radiologic studies, use of endoscopic instruments and aspiration of fluid from joints and body cavities, collection of cerebrospinal fluid, biopsy of tissues, placement of central venous catheters or chest tubes and endotracheal intubation
3) Subject to review by the BME, such other written procedures established by the employer, provided the procedures are within the training and experience of both the supervising physician and the PA

The PALA and implementing regulation permit the ordering of medications in both inpatient and outpatient settings as long as it is done in accordance with either an established protocol or the specific direction of a physician. There are, however, special requirements for controlled dangerous substances. These include a requirement that a supervising physician has authorized the PA to order or prescribe a Schedule II, III, IV or V controlled substance in order to do the following:

1) Continue or reissue an order or prescription issued by a supervising physician
2) Adjust the dosage for a controlled substance originally ordered or prescribed by a supervising physician provided there is prior consultation with the supervising physician
3) Initiate an order or prescription for a controlled substance provided there is prior consultation with the supervising physician and the substance is not being used as part of a treatment plan for a terminally ill patient
4) Initiate an order or prescription as part of the treat-
ment plan for a patient with a terminal illness where the supervising physician has determined that the patient’s life expectancy is 12 months or less.\textsuperscript{44} The PA is required to have authorization and be registered with federal and state agencies to order or prescribe controlled substances.\textsuperscript{44} For any medication, whether or not a controlled substance is involved, the regulation also sets out with great specificity the information to be detailed on the prescription blanks issued by PAs, including whether it is pursuant to protocol or specific physician direction.

**RISK MANAGEMENT**

Risks of liability confront the PA, the physician and any practice entity—whether a professional corporation, limited liability company or otherwise—that employs the PA. The existence of a practice entity does not insulate a physician from liability resulting from the conduct of persons for whom there is a supervisory responsibility. This is explicitly set forth in the pertinent statutes and BME regulations.\textsuperscript{45}

There are steps that can be taken to minimize and control liability risks when using a PA in a medical practice. These start with careful and rigorous attention to checking credentials at the time of the initial hiring. Thereafter, awareness of and adherence to scope of practice, including use of written protocols, when appropriate, should follow. Equally important is the clear delineation of and expectation of compliance with the scope of practice in employment documentation signed by the PA.

Ongoing monitoring of PAs to prevent exceeding either skill and competence or legal authority is necessary. The difference in medical education between a PA and the physician should not be forgotten, as well as the need for experience over time—commonly three to five years after graduation—for a PA to achieve proficiency. Accordingly, there should be an environment in which consultation with supervising physicians is not only expected but encouraged. Failure of a PA to contact the physician can result from a failure to recognize the significance of findings on history or physical examination. Given the increased malpractice loss experience in the area of diagnostic error, physician involvement in consultation and communication is especially important during patient assessment.

Record-keeping should be maintained in a manner that reflects the involvement in patient care of both practitioners in a meaningful way. Sign-off by the supervising physician implies an understanding and acceptance of the plan of care, which may commit the physician to more than is prudent.

Last, pertinent professional liability coverage for both physician and the PA should be confirmed. A particular policy might not apply or have limitations that impact on the potentially divergent interests of the practice group, a supervising physician and the PA. Certainly, PAs can obtain individual coverage that will not depend on the continuity of employment in a particular practice setting. Such individual coverage can resolve questions concerning “tail coverage” exposure arising from an employer’s claim-made policies for an incident that only becomes a lawsuit after changing employment and insurance. Advantages and disadvantages involving cost, control and comfort emotionally need to be weighed on an individual basis.

The benefits of Physician Assistants are many and include greater patient satisfaction through improved communication, empathy and follow-up. However, the liability risks connected with the use of PAs as outlined in this article must be weighed against the benefits to determine the value of PAs in a physician’s practice.

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5 N.J.S.A. 45:9-27.11.


7 N.J.S.A. 45:9-27.18(a); See also, N.J.A.C. 13:35-2B.10(a).


9 N.J.S.A. 45:9-27-18(b); See also, N.J.A.C. 13:35-2B.10(b)(1).
 [Note: Physician availability is for “consultation or recall.”]


11 N.J.A.C. 13:35-2B.10(b)(5). [Note: On application, the BME can alter the ratio.]

12 N.J.S.A. 45:9-27.17(c).


15 Cox v. M. A. Primary and Urgent Care Clinic, 313 S.W.3d 240 (Tenn. 2010).


17 Id. at 249, 254. (Citing to Tenn. Code Ann. § 63-19-106(a), (b).)

18 Id. at 254.

19 Id. at 258.


23 Lomando v. United States, 667 F.3d 363, 387 (3rd Cir. 2011).

24 Id. at § -27.15(b).

25 Id. at §§ 45:1-21 and :9-27.17(b).