CASE

Collaborative practice agreements

Duty of care owed to a nurse practitioner's patient by a collaborative practice partner comes into question.

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Ms. B, a 36-year-old nurse practitioner (NP), had known Dr. C, a 45-year-old family practice physician, for several years before she asked him to enter into a collaborative practice agreement with her. The two clinicians had once worked together and were friends.

Ms. B knew that the physician, in addition to having his own busy practice, had collaborative practice agreements with several other NPs. Ms. B wanted to start her own practice but needed a physician to sign a collaborative practice agreement to do so. Dr. C quickly agreed to Ms. B's request, telling her that he was already in collaborative practice agreements with 8 other NPs. The clinicians signed the agreement, and Ms. B opened her practice and began treating and writing prescriptions for her patients.

According to the law of the state in which they practiced, as part of the collaborative practice agreement, Dr. C was required to review at least 5% of Ms. B's charts each week to evaluate her prescriptive practices. Although both clinicians were aware of this, neither was particularly concerned about the requirement, and Dr. C did not review any of the charts of Ms. B's patients, although he did occasionally review her notes. At one point after reviewing Ms. B's notes, the physician expressed some concern about Ms. B's prescribing practices and suggested that she attend a narcotic-prescribing seminar. However, he never followed up, and Ms. B never took the suggestion.

An NP enters into a collaborative practice agreement with a family physician, but the clinicians do not adhere to all of the requirements.

One of Ms. B's patients was high-risk, with a history of pain, depression, suicide attempts, and polysubstance abuse. During the 3-month period, from January to March, in which Ms. B was treating the patient, she prescribed multiple medications, including hydrocodone/acetaminophen, methadone, bupropion, lithium, and alprazolam. In late March, the patient died, and an autopsy revealed the cause of death to be acute bronchopneumonia complicated by a mixed-drug interaction.

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Cases presented are based on actual occurrences. Names of participants and details have been changed. Cases are informational only; no specific legal advice is intended. Persons pictured are not the actual individuals mentioned in the article.

The patient's widow consulted with a plaintiff's attorney. After a discussion with the attorney and examination of the patient's records by an expert, the widow decided to sue. Although Dr. C never examined the patient or looked at his file, both he and Ms. B were named in the lawsuit.

The lawsuit caused terrible tension between the two clinicians. Their working relationship swiftly turned hostile and fell apart. Dr. C was angry and resentful at being drawn into a lawsuit that he felt was none of his business. He hired a defense attorney and filed a motion to dismiss the case, based on his assertion that he owed no duty of care, which is a required element for a medical malpractice case, because he never saw or treated the patient.

The trial court ruled that Dr. C did indeed owe a duty of care to the patient. Dr. C appealed to the state's Court of Appeals. During the appeal, Dr. C argued that he had never even seen the patient's file, that the patient was not his patient, and that the only one who owed a duty of care to the patient was Ms. B. The Court of Appeals disagreed and held that Dr. C did have a duty to the patient.

Legal background

Dr. C's main argument was that since he had no doctor-patient relationship with the patient, then he owed no duty to the patient. However, healthcare practitioners can still sometimes owe a duty to a third party to whom they have not provided care. In analyzing whether a duty existed, the Court of Appeals looked at 3 factors: 1) the relationship of the parties; 2) the reasonable foreseeability of harm to the person who was injured; and 3) public policy concerns.

> This case shows how important it is to comply with all requirements of a collaborative practice agreement.

While there was no direct relationship between Dr. C and the patient, the court held that when a physician voluntarily enters into a contract with a nurse practitioner pursuant to which he agrees to provide oversight of her prescriptive practices, the purpose is for the protection of the NP's patients. The court found this to weigh in favor of a duty.

When looking at the second factor—foreseeable harm—the court noted that Dr. C admitted that his failure to adequately supervise and review Ms. B's charts, as required by their collaborative practice agreement, could result in harm to her patients. This also pointed toward a duty by the physician, because he knew his action or inaction could affect Ms. B's patients.

Finally, the court looked at public policy and noted that the legislature had created a detailed list of requirements that a collaborative practice agreement must fulfill. The reason, the court noted, is to protect and ensure the safety of the public.

Based on this, the court rejected Dr. C's argument that he did not owe a duty to the patients of Ms. B with whom he had a collaborative practice agreement, and it ruled that the case could proceed against him.

The lawsuit is not over, however. The case has been sent back to trial court where a jury will decide the remaining issues: whether the clinicians breached their duty to the patient, and whether the breach was the cause of the patient's death.

Protecting yourself

Collaborative practice agreements vary widely from state to state. In some states, nurse practitioners need a written agreement with a physician to diagnose, treat, and prescribe. In other states, physician collaboration is only needed for NPs to prescribe. Some states do not require collaborative practice agreements at all.

If you have a collaborative practice agreement with a physician, be sure you understand and follow the requirements, for the benefit of yourself, your patients, and your collaborative practice partner. Both Ms. B and Dr. C were aware that the agreement into which they entered required the physician to review a random 5% of Ms. B's patient charts each week. Yet neither clinician took this seriously.

Had Ms. B pushed the physician to look at the charts, he might have spotted a dangerous prescribing behavior that could have better protected Ms. B's patient and thus, protected Ms. B from a lawsuit. In the case of Dr. C, it is even clearer why he should have complied. The Court of Appeals held that, had he fulfilled his legal obligation to review the required number of charts and found nothing wrong, he would not be liable for malpractice committed by Ms. B in the care of a patient whose chart was not reviewed.

Although malpractice in this case has not yet been established, nor may it ever be established, this case is an example of how necessary it is for both parties to comply with all requirements of a collaborative practice agreement. ■

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