

STATE OF VERMONT  
BOARD OF MEDICAL PRACTICE

In Re: Jon Porter, M. D.

Docket No. MPS 122-1109  
MPS 137-1209

Proposed Decision and Order (Draft)

Procedural History

On February 24, 2010, the State of Vermont filed a seven-count Amended Specification of Charges against Dr. Jon R. Porter (Dr. Porter), Director of the University of Vermont Center for Health and Wellbeing (CHWB) with the Vermont Board of Medical Practice (Board), alleging that Dr. Porter had engaged in unprofessional conduct. The State alleged the Board had jurisdiction under 26 V.S.A. §§1353, 1354, 1733, 1734(b), 1735, 1739 and Board Rules, 5, 6 and 7.

On March 18, 2011, Dr. Porter filed a Motion to Dismiss (Counts I and III) and Motion for Summary Judgment. Both motions were denied in Orders dated May 9, 2011. The State filed a Motion to Exclude Expert Testimony on April 22, 2011 and a Motion to Add an Expert Witness on July 1, 2011. These motions were denied in Orders dated May 10, 2011 and July 8, 2011, respectively.

Hearing

A Hearing Committee, composed of Dr. Russell Davignon, Sister Janice Ryan and Ellen Thompson, heard testimony in this matter on September 26-28, 2011 in Burlington, Vermont. Atty. Crocker Bennett represented Dr. Porter. Assistant Attorney General Terry Lovelace represented the State of Vermont. Atty. Robert V. Simpson, Jr. served as Presiding Officer.

The State called three witnesses (Board Investigator Paula Nenninger, Board Certification Specialist Tracy Hayes and Physician Assistant Peter Nobes) in an effort to prove each of its charges by a preponderance of the evidence<sup>1</sup>. Dr. Porter testified in his own behalf. Dr. Thomas Peterson, Chair of the University of Vermont (UVM) Department of Family Medicine, testified as an expert witness for Dr. Porter.

The Committee deliberated on September 29 and November 18, 2011 in Burlington, Vermont.

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<sup>1</sup> 26 VSA § 1354 (c)

## Summary of State's Allegations and Dr. Porter's Response

The State's seven charges of unprofessional conduct against Dr. Porter are based on his alleged legal responsibility for supervision of two physician assistants.

### Counts I-V focus on PA Peter Nobes

Dr. Porter was Nobes' primary supervising physician<sup>2</sup> (supervising physician) during period from January 9, 2008 through February 25, 2009. (Exhibit 18)<sup>3</sup> During that period, Nobes engaged in "improper prescribing practice" in violation of essential standards of practice and board policy in prescribing drugs such as Oxycodone and Percocet to twelve UVM student-patients. (Exhibit 15)

The State contends in Counts I and III that because Nobes was acting as Dr. Porter's "agent" in prescribing these and other "schedule drugs," Dr. Porter is legally liable for Nobes' *improper conduct*. More specifically, it argues that the law treats the acts of the agent (Nobes) as the acts of the "principal" (Dr. Porter) who delegated his authority to prescribe drugs to Nobes. Under the law, according to the State, it is as though Dr. Porter, himself, actually did the improper prescribing and this improper prescribing, in turn, constitutes unprofessional conduct by Dr. Porter. The State relies on 26 VSA § 1739 (a) and Board Rule 5.1 in support of its position on Counts I and III<sup>4</sup>.

Counts II, IV and V allege that Dr. Porter is directly liable for his own conduct in improperly supervising Nobes. Count II alleges that Dr. Porter failed to conform to the "essential standards of acceptable and prevailing practice" in violation of 26 V.S.A. § 1354 (b) (2) by failing to "adequately follow the progress of patients treated by" Nobes. Counts IV and V charge Dr. Porter with violation of Board Rules 7.1 (c) and 7.5 (b)<sup>5</sup> in his supervision of Nobes.

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<sup>2</sup> PAs may not practice without a supervising physician. 26V.S.A. §§ 1732 (5) and 1735

<sup>3</sup> The State's exhibits are numbered. Dr. Porter's exhibits are letters.

4. Title 26 V.S.A. §1739 (a) says:

"(a)The supervising physician delegating activities to a physician's assistant shall be legally liable for such activities of the physician's assistant, and the physician's assistant shall in this relationship be the physician's agent."

Board Rule 5.1 says in pertinent part:

"Physician assistants shall be considered agents of their supervising physicians in the performance of all practice-related activities, including but not limited to, the ordering of diagnostic, therapeutic and other medical services."

<sup>5</sup> Rule 7.1 (c) says:

"The supervising physician shall outline in detail how he or she will be available for consultation and review for consultation and review of work performed by the physician assistant."

Rule 7.5 (b) says that "supervision shall include":

"(b) Regular, retrospective review of selected PA-generated charts by the supervising physician, with documentation of such review."

## Counts VI and VII Focus on PA-K<sup>6</sup>

Counts VI and VII allege that PA-K was employed as PA at the CHWB during a period from October 20, 2009 to October 27, 2009. These counts allege further that during this period: (1) PA-K treated patients while she was not certified by the State in violation of 26 V.S.A. §1735 and (2) Dr. Porter was her supervising physician. The State's theory of liability for unprofessional conduct is similar to its theory in Counts I and III. That is, PA-K was acting as Dr. Porter's agent when she was treating patients without being certified. As a consequence, according to the State, PA-K's unlawful conduct is attributable to Dr. Porter and constitutes unprofessional conduct on his part.

### Summary of Dr. Porter's Response to the State's Allegations

Counts I, III, VI and VII are based on the State's theory that the acts of his alleged agents (Nobes and PA-K) count as Dr. Porter's own acts for purposes of establishing whether Dr. Porter engaged in *unprofessional conduct*. Dr. Porter says there is no legal basis for this theory.

Dr. Porter argues that while the Legislature *did intend* to make him "legally liable" for medical malpractice for the acts of his PA -"agent" if these acts resulted in harm to a patient; the Legislature *did not intend* to give the Board the authority to sanction him for his PA's conduct. In other words, while a PA's actions may leave the physician "strictly liable" for monetary damages, the Legislature did not intend to put a physician's license to practice medicine at risk based solely on actions of his/her PA agent that were not known to the supervising physician.

As for counts II, IV and V, Dr. Porter says that his supervision of PA Nobes met the standard of care required of supervising physicians and that the State's evidence fell far short of proving otherwise.

### Recommended Findings of Fact and Conclusions of Law

After considering all evidence admitted at the hearing, the Committee recommends that the Board adopt the following Findings of Fact, Conclusions of Law and Order.

#### Findings of Fact

1. Dr. Porter holds Vermont Medical License #042- 0008579 issued by the Board on July 29, 1992.
2. Dr. Porter has served as Director of the CHWB from the late summer of 2007 to present. Transcript, 9/27 (T2) p. 56

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<sup>6</sup> PA-K is identified only by her last initial because, although it investigated her case, the Board did not enter a finding of "unprofessional conduct" against her.

### CHWB

3. The CHWB has a staff of approximately 65 people. That includes three PAs, two nurse practitioners, 12 counselors and 4 to 5 physicians. T2 pp. 23, 25
4. The CHWB is comprised of several units, including a medical, women's health, counseling and psychiatry, athletic medicine and health education. T2 p. 23
5. The CHWB, which has 7 sites on the UVM campus, has 20,000 "visits" per year – 13,000 are medically related and 7,000 are related to counseling and psychiatry. Id.
6. CHWB had approximately 12,000 active medical charts at any given time. T2 p. 61

### PA Peter Nobes

7. In 2008, PA Nobes had been a PA for approximately 35 years and he had been working in college health for 21 years after joining CHWB in 1988. T, p. 161
8. PA Nobes was a fellow of the American College Health Association (ACHA) and a reviewer for the ACHA peer-reviewed journal. T 2, pp. 53-54
9. PA Nobes was past president of the New England College Health Association (NECHA). T, pp. 166-67
10. PA Nobes was a trusted employee at the CHWB. In a performance review of PA Nobes, dated August 25, 2008, Dr. Porter reported: "Peter continued to carry out his clinical work effectively and with genuine concern for the students under his care in the 2007-08 academic year; this strong clinical work has characterized his work at the University . . ." Exhibit 10, p. 3

### Supervision of PA Nobes

11. Dr. Porter noted one-on-one meetings with Nobes in his calendar and he would "often" make a note on the record, itself, when he reviewed these records. T2, p. 118
12. Dr. Porter held hour-long weekly staff meetings which PA Nobes attended. The first half of the meeting was devoted to discussing clinical issues of interest. The second half typically dealt with "systems issues." T2, p. 36-37
13. Dr. Porter encouraged PA Nobes and other PAs to bring questions to him at any time. T2, p.38
14. Dr. Porter encouraged, and enabled, PAs to continue to learn on the job, either through the services at the Dana Medical Library, CMEs or summer education projects. T2, pp. 47-48

15. Dr. Porter was supervising physician for up to 4 PAs during the period that Nobes was employed at CHWB. Transcript, September 26 (T) pp. 206 -207
16. When he became director of the CHWB, Dr. Porter began to devote more time to administrative duties. The breakdown was 20% clinical work and 80% administrative work. T2, p. 109-10

#### Retrospective Review

17. Dr. Porter met with PA-Nobes in 38 one-on- one meetings from 2007-2009. PA Nobes was expected to bring charts to these meetings and bring up issues that Nobes had questions about. T2, 35
18. Dr. Porter reviewed PA charts with individual PAs when there were “adverse outcomes”: a patient complaint, a hospitalization or student death. T2, pp. 44-45
19. Dr. Porter designed a process for peer review that involved at least two sessions per semester. One session per semester was devoted to retrospective review. Dr. Porter assigned PA Nobes the responsibility for selecting 8 charts for each of the 5 to 7 clinicians. Dr. Porter was usually present as the charts were reviewed during these two to three hour sessions during which clinicians would critique each other’s work. T2, pp.37-41
- 20 PA Nobes saw between 1,600 and 2,000 patients per year - between 16-18 patients per day. T2, p. 154
- 21 Dr. Porter and Nobes’s peers reviewed a total of 16 of Nobes’s charts per year in these peer review sessions.
- 22 At the Duke University Health Center the policy is that supervising physicians must review “every fifth chart” of PA for review. T, 203
- 23 At the Charlotte Family Health Center “every chart” was pulled for review. Id
- 24 Dr. Porter did not pull charts. “The fact that I did not go out and pull charts” meant that he was more interested in engaging Nobes and other clinicians in “meaningful conversations.” T2, p. 127
- 25 Dr. Porter rejects the idea that a supervisor is a policeman. He does not see the role of supervising physician as being one of enforcement. He feels it is “not a good use” of his time. Dr. Porter testified that a collaborative approach to supervision is the “usual standard” in medicine. T2, p. 122
- 26 Dr. Peterson, Chair of the Family Medicine Department at UVM, testified as an expert for Dr. Porter. He agreed with Dr. Porter’s collaborative approach to supervision.

## Prescription Drug Abuse

28. In 2008, PA Nobes attended a presentation at an NECHA conference entitled "Prescription Drug Misuse on Campus" presented by Dr. P. Davis Smith of Wesleyan University. T2 187
29. PA Nobes was told that prescription drug abuse is the "most common form of illicit drug use after marijuana." T p. 189
30. PA Nobes was told that prescription drugs that are used improperly are often obtained from "physicians who don't recognize the potential for diversion." T p. 191
31. In April, 2009, nursing students conducted a study of drug diversion at UVM. T2, pp. 61-62
32. Dr. Porter was not surprised that UVM students were engaged in drug diversion. "We know nationally that about 15 per cent in this age group report taking medications that are not their own, so it's not a surprise that this phenomenon existed . . ." T2, p. 62
33. Dr. Porter was surprised that one of the students interviewed by the nursing students reported that one practitioner at CHWB was the source of controlled substances. T2, pp. 62-63
34. Once he learned of the comment to the nursing student, Dr. Porter conducted an "audit" of CHWB using "electronic medical records." He learned through the audit of these electronic records that PA Nobes was the CHWB "outlier" in prescribing opiates and other controlled substances. T2, pp. 62-63
35. Dr. Porter reviewed the records of 12 students that he had identified through the audit may have been prescribed drugs inappropriately. He discovered that Nobes had engaged in a prescribing practice that failed to recognize that substance abuse was one of the "primary risks" to students ("It's how we lose students"). T2, p. 64
36. At the time Dr. Porter first audited PA Nobes prescribing records, these electronic records had been available for audit at CWHB for 15 months (February, 2008 through April, 2009). T2, p. 63, Exhibit B, p2
37. Dr. Porter was PA Nobes' supervising physician for fourteen years (1996- March, 10, 2009). He was Nobes' supervising PA for all but the last two months of the period of

Nobes' improper prescribing covered in the Dr. Porter's audit. T 2, pp, 63, 150-51, Porter Proposed Finding (Porter Finding) #24

38. According to Dr. Porter, it is "quite easy" to audit electronic records to look for, and find, improper prescribing. Transcript September 28 (T3) T3, p. 104
39. PA Nobes had been prescribing controlled drugs without taking a thorough patient history, without a clear diagnosis or a treatment plan. T2, pp.65-66
40. Dr. Porter was "stunned" by Nobes' conduct. For example, Dr. Porter had been treating one student-patient for opiate addiction for nine months and had prescribed suboxone. When the student returned from summer vacation, the student had stopped taking suboxone despite Dr. Porter's encouragement. The student "came in to see Mr. Nobes for a seemingly minor issue and left the office with a prescription for opiates." T2, pp.66-67
41. On, or about June 22, 2009, Dr. Porter sent the records of the twelve student-patients that he had reviewed to Dr. Gilbert Fanciullo, an expert in "pain management." Exhibit A, T2, p.64
42. In a letter dated July 15, 2009, Dr. Fanciullo reported to Dr. Porter that he had considered the records of the twelve student-patients after reviewing the "Vermont Board of Medical Practice Policy for the Use of Controlled Substances for the Treatment of Pain (Approved December 7, 2005)." Exhibit A, p. 1
43. Dr. Fanciullo explained that the Board "expects that physicians will incorporate safeguards into their practice to minimize the potential for abuse and diversion of controlled substances." He said that the Board "has adopted criteria to be used when evaluating the physician's use of controlled substances. These criteria include but are not limited to the documentation of a history and physical examination, discussion of risks and benefits of the use of controlled substances, documentation of methods used for obtaining prescriptions, risk surveillance, periodic review, obtaining consultations for patients with a history of substance abuse or comorbid psychiatric conditions and requirements for medical record contents." Id
44. Dr. Fanciullo concluded that PA Nobes had: (1) failed to comply with most of the Board's recommendations in treating *all* the student-patients "for whom he prescribed opioids"; (2) failed to meet the standard of care for use of opioids and (3) failed to comply with the Board's policy for use of controlled substances for the treatment of pain. Exhibit A, p.2

45. Although Dr. Porter had expected that the Board's policy recommendations for using controlled substances for the treatment of pain had been incorporated into CHWB practice prior to the discovery of Nobes' improper prescribing, Dr. Porter had the policy "formalized internally" at CHWB after learning of Nobes' improper prescribing. T2, p.86
46. PA Nobes filed a formal stipulation with the Board in which he admitted that he had failed to comply with the Board policy for use of controlled substances for the treatment of pain and that he was negligent in prescribing opiates for some patients. More specifically, he admitted: prescribing opiate medications for student-patients without documenting that a physical examination had taken place; prescribing opiate medication for student-patients without an appropriate in-person visit and on more than one occasion "providing refills of opiate medication to patients who claimed that their medication had been lost or stolen." Exhibit 15
47. A spreadsheet analysis of Nobes' prescribing practice shows that the vast majority of incidents involving improper prescribing for the twelve student-patients took place during the period Dr. Porter was PA Nobes' primary supervising physician. Exhibit B, T2, p.76
48. Prescription drug abuse and diversion was never a topic at the two-three hour long sessions that were scheduled at least once a semester to discuss important current issues in college health. T, p.209

PA-K

- 49 PA-K treated up to 15 patients at CHWB without being properly certified as required under 26 VSA § 1735 during a period between October 20 and October 27, 2009. Her license was no longer in effect and she had no supervising physician. T2, p. 129, Exhibit 9
50. Neither PA-K, nor the administrative worker who checked her credentials, were aware that PA-K's license was terminated as a matter of law when she left her previous employer. T2, p. 98
51. Dr. Porter did not know that PA-K was working at CHWB during the period she was working without being properly certified. T2, p. 94
52. Dr. Porter had expected that Dr. Mariani would serve as PA-K's supervising physician. T2, p. 95
53. Dr. Porter had no intent to serve as PA-K's supervising physician at the time she was treating patients without being properly certified. Id.

## Counts I and III –Unprofessional Conduct Based on Conduct of PA Nobes

The State met its burden on Count I. Count III is dismissed.

PA Nobes was acting as Dr. Porter's agent when he (PA Nobes) prescribed controlled substances for the twelve student-patients identified in Dr. Porter's audit. Since the acts of the agent (PA Nobes) are the acts of his principal (Dr. Porter), then under the law Dr. Porter prescribed controlled substances such as Oxycodone and Percocet to the twelve patients. The Committee finds that this conduct constitutes "failure to conform to the essential standards of acceptable and prevailing practice" in violation of 26 VSA 1354 (b) (2).

The period of "improper prescribing" that Dr. Porter discovered in his audit of electronic medical records covered fifteen months - February, 2008 through April, 2009. During that period PA Nobes prescribed controlled substances in a manner that violated Board policy and the standard of care for using controlled substances in the treatment of pain for twelve student-patients.

Dr. Porter was PA Nobes' primary supervising physician for fourteen years - including all but the last two months of the fifteen-month audit period. Dr. Porter knew<sup>7</sup> throughout that fourteen-year period that because he had delegated his authority to engage in specified "medical activity," including his authority to prescribe controlled substances to PA Nobes, that he (Dr. Porter) was "responsible" for Nobes' conduct in exercising that delegated authority. More specifically, Dr. Porter knew that he was "legally liable" for Nobes' conduct in prescribing controlled substances because under the law, PA Nobes was acting as Dr. Porter's "agent" in carrying out these delegated activities. 26 VSA § 1739 (a)

Under the law, Dr. Porter is PA Nobes' "principal." Dr. Porter "is the person who gives his authority to his agent (PA Nobes) to act for him." Black's Law Dictionary, 4<sup>th</sup> Edition (1968) pp. 1355-56 "Under the general principles of agency, the acts of an agent are the acts of the principal." *U.S. v. Wedemann & Godnecht, Inc.*, 515 F.2d 1145, 1148 (Fed. Cir. 1975) In other words, when PA Nobes is prescribing controlled substances, the law imputes Nobes' conduct to his "principal" – Dr. Porter. In the plainest terms, the law holds that Dr. Porter is legally liable<sup>8</sup>

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<sup>7</sup> When a prospective supervising physician files his/her application to be a supervising physician, the prospective supervising physician certifies on the application that s/he has read Vermont statutes and Board rules dealing with physician assistants and that s/he is "responsible" for the PA's actions in exercising that delegated authority.

<sup>8</sup> This is not "strict liability" ("liability without fault") as Dr. Porter contends. Dr. Porter is "vicariously liable" for PA Nobes' "fault" – PA Nobes' negligence. Dr. Porter agreed to be "legally responsible" for PA Nobes' "fault" when he delegated his prescribing authority to Nobes and made him his agent. The Federal Ninth Circuit Court of Appeals explained the difference between "vicarious liability" and "strict liability" in *Kohler v. Inter-Tel Tech.*, 244 F.3d 1167 (9th Cir. 2001)

"Liability of employers to third parties for acts of its employees is commonly referred to as "vicarious liability." See Black's Law Dictionary 927 (7th ed. 1999) (defining "vicarious liability" as "liability that a supervisory party (such as an employer) bears for the actionable conduct of a subordinate or associate (such as an employee) because of the relationship between the two parties.") The term "strict liability" is ordinarily applied to ultra hazardous activities or products-liability cases. It is also referred to as "liability without fault." *Id.* at 926 Under this theory, a plaintiff may prevail without presenting any evidence that the

because it is Dr. Porter who is violating the standard of care. It is Dr. Porter who is prescribing controlled substances in violation of Board policy.

The application of the principle of vicarious liability to Counts I and III is straightforward: PA Nobes was acting as Dr. Porter's agent when he (PA Nobes) prescribed controlled substances for the twelve student- patients identified in Dr. Porter's audit. Since the acts of the agent (PA Nobes) are the acts of his principal (Dr. Porter), then under the law *Dr. Porter prescribed* controlled substances such as Oxycodone and Percocet to the twelve patients. Since all agree that this conduct violated the standard of care and the Board's policy for use of controlled substances for the treatment of pain, there is no question that Dr. Porter is guilty of unprofessional conduct.

Although the State does not cite a specific statutory provision in its Proposed Findings & Conclusion, the Committee finds that this conduct constitutes "failure to conform to the essential standards of acceptable and prevailing practice" in violation of 26 VSA §1354(b) (2).

#### Dr. Porter's Response

Dr. Porter agrees that PA Nobes' conduct violated Board policy and the standard of care for prescribing controlled substances. He also agrees that he (Dr. Porter) is "legally liable" for this conduct because he had delegated his prescribing authority to PA Nobes and PA Nobes was acting as his agent when Nobes committed these violations. But, he insists that his "legal liability" for his agent's conduct *does not extend* to liability for unprofessional conduct. His basic argument is: the Legislature intended the "legal liability" language of 26 § 1739 (a) to apply solely to civil actions (torts) for medical practice in Vermont Superior Court; it did not intend to give the Vermont Board of Medical Practice the authority to place any limitations on his, or any other supervising physician's license for the properly delegated, but improper, conduct of the supervising physician's PA/agent. Dr. Porter's, Proposed Findings & Conclusions (Porter), p. 19

According to Dr. Porter, "the plain language of 1739(a) indicates that the Legislature intended the term 'legally liable' to refer to tort liability by which a patient can hold a physician liable in money damages for harm arising from the actions of a supervised PA." Id. He does not cite this "plain language." In fact, the phrase "tort liability, does not appear in the PA statutes. If, as Dr. Porter claims, the Legislature merely intended to reaffirm the long- established principle that physicians may be held liable "in tort" for the actions of their agents when the agents are acting within the scope of their delegated authority, it would have made more sense to insert the provisions of § 1739 (a) in Title 12, the volume which contains statutes dealing with litigation of medical malpractice cases in our trial courts.

The Legislature had some purpose behind its decision to, instead, embed the provisions of § 1739 (a) in Title 26 – a volume which is devoted almost exclusively to a series of statutes

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owner of land where the ultra hazardous activities are conducted, or the manufacturer of the defective product, acted negligently or intended to do harm. . ."

244 F3d 1177

authorizing administrative agencies to regulate professionals by revoking, suspending or otherwise limiting their professional licenses. It is reasonable to believe the Legislature included the language making a supervising physician “legally liable” for the acts of his PA/agent in this code of professional regulation to give *added protection for the public* – protection that the civil and criminal courts could not provide. The Legislature has made it plain that the single, overriding reason for creating Boards of Medical Practice, Pharmacy Boards etc. was protection of the public:

“It is the policy of the state of Vermont that regulation be imposed upon a profession or occupation *solely for the purpose of protecting the public.*” 26 VSA § 3101 (emphasis added)

The Legislature was evidently not convinced that the Vermont Courts provided Vermonters with sufficient protection from the misconduct of professionals, including PAs and physicians. Otherwise it would not have adopted the statutory framework in Title 26 which establishes a process for regulating nearly all the professions. It is important to point out that the provisions of Title 26 enable administrative bodies such as the Board to step in to limit, or suspend a physician’s license and order remedial action *before unprofessional conduct results in injury* to the patient. To pick one of many possible examples, under 26 VSA § 1354 (a) (22), a physician may be found liable for unprofessional conduct if the physician fails “to use and exercise on repeated occasions, that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, *whether or not actual injury to a patient has occurred.*” (emphasis added) The courts do not provide this protection.

Yet, Dr. Porter argues that the Legislature intended to limit the scope of a supervising physician’s liability for the acts of his PA agent to situations where the PA’s “tortious conduct” caused an *injury* to the patient. Under his reading of the statute, even if the Board was aware that a supervising physician’s PA/agent was engaged in potentially harmful conduct, it would have no authority to find the supervising physician vicariously liable for that conduct *until an injury occurs*. In fact, under Dr. Porter’s reading of his “legal liability” under 26 VSA § 1739 (a), the Board would have no authority to sanction him even if one of the twelve student-patients had died of a drug overdose as a result of his agent’s negligence. It would all be left to the courts.

The Legislature plainly included language making the supervising physicians legally liable for the properly delegated conduct of his PA/ agent in Title 26, which is in effect, Vermont’s Code of Professional Regulation, in an effort to protect patients from unprofessional conduct before they suffer harm. This provision encourages supervising physicians to engage in consistent, meaningful supervision of the PAs they supervise by giving them notice that to do otherwise may result in loss of the supervising physician’s professional license.

#### Four Points

Dr. Porter raises four basic points in support of his claim that his “legal liability” under 26 § 1739 does not extend beyond liability in medical practice actions in superior court : (1) *no statute* gives the Board statutory authority to discipline him for PA Nobes’ conduct; (2) *no case*

law in Vermont or anywhere else in the country, supports the proposition that the Board, or any other regulatory board similar to it, has the authority to discipline a supervising physician for the acts of his PA; (3) it would be *bad policy* to interpret 26 § 1739 (a) to allow the Board to discipline supervising physicians for the acts of their PAs and (4) the Legislature limited the Board's authority to sanction physicians for conduct involving PAs to situations where the physician's actions constitute "use" of a PA "in a manner that is inconsistent with" statutes regulating the conduct of PAs.<sup>9</sup>

#### (1) Statutory Authority

Dr. Porter points out that various statutes in Title 26 list approximately 40 specific "grounds" that can serve as a basis for concluding that a physician has engaged in "unprofessional conduct" and not one of them authorizes the Board to sanction a supervising physician for the actions of the PA he is supervising. This means, he says, that the language of 26 § 1739 (a) which says a supervising physician is "legally liable" for the acts of his PA/agent cannot serve as a basis for finding that he has engaged in unprofessional conduct. Porter pp. 17-18

This analysis ignores the principles of "agency" which, as discussed above, hold that the properly delegated acts of the "agent are the acts of the principal." Therefore, again as noted above, under the law of agency it was Dr. Porter who violated the standard of care by prescribing controlled substances for the twelve student-patients in a manner that was contrary to Board policy. The conduct imputed to Dr. Porter not only can serve as a basis for finding him liable for malpractice; but, it can also serve as a basis for finding that he has engaged in unprofessional conduct by failing "to conform to the essential standards of acceptable and prevailing practice" in violation of 26 VSA §1354(b) (2), or, that he has engaged in unprofessional conduct by failing "to use and exercise on repeated occasions, that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred" in violation of 26 VSA § 1354 (a) (22).

#### (2) Case Law

Dr. Porter points out there are numerous cases in Vermont and other jurisdiction which use the term "legal liability" in the context of tort, or contract cases; but, there are no cases that hold that a supervising physician can be held "legally liable" for the acts of the PA he supervises. He contends that this means that the Board is precluded from interpreting the "legally liable" language in 26 § 1739 (a) to mean that he may be found to have engaged in unprofessional conduct based on the acts of his PA/agent.

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<sup>9</sup> 26 VSA 1739 a says: "Use of the services of a physician's assistant or a physician's assistant trainee by a physician in a manner which is inconsistent with the provisions of this chapter constitutes unprofessional conduct by the physician and such physician shall be subject to disciplinary action by the board in accordance with the provisions of chapters 23 or 33 of this title, as appropriate."

The fact that *neither party* has found a case that addresses the issue does not mean that the Board is bound to conclude that it cannot find that Dr. Porter has engaged in unprofessional conduct based on PA Nobes' actions. It means only that apparently no court has addressed the issue so far. There is no logic that precludes the Board from concluding that it is finding a physician "legally liable" when it finds he has engaged in unprofessional conduct. The proceedings which lead to a finding are conducted pursuant to the law - Title 3, Chapter 25, the Administrative Procedures Act- and the determination that a physician has engaged in unprofessional conduct is a finding of "legal liability" that can be enforced by Vermont courts and is appealable to the Vermont Supreme Court.

In fact, *there is Vermont precedent* for the general proposition that a professional can be held vicariously liable for the unprofessional conduct of his agent in an administrative proceeding that regulates the conduct of professionals. *In Re Desautels Real Estate, Inc.*, 142 Vt. 326, 337, 457 A.2d 1361 (Vt. 1982), the Vermont Supreme Court upheld the statutory authority of the Vermont Real Estate Commission, an administrative body charged with regulating the professional conduct of real estate brokers and agents, to hold a supervising broker vicariously liable for violations of the law, (including commission rules) committed by his agent/ salesperson. It upheld a 30-day license suspension for the managing broker who had been found vicariously liable for a "scam" committed by agents/ salespersons working for the corporation the broker managed.

The Court pointed out that it made no difference whether the relationship between the broker and the agent/ salesperson working for him is "labeled that of master and servant or principal and agent," the broker can be held "vicariously liable" for the conduct of a salesperson.

A real estate salesperson can only be licensed when he or she is employed by some licensed real estate broker. (Citation omitted). Moreover, his or her license terminates when this employment relationship ceases. (Citation omitted). Therefore, it is axiomatic that the legislature intended to impose a relationship of vicarious liability upon the employers of these salespersons for any violation of the prescribed conduct set forth in 26 V.S.A. ch. 41 or in the regulations of the Commission.

*Id.* at 337-338.

The Court held that the Commission was acting within its statutory authority when it imposed vicarious liability upon the managing broker (who evidently had no actual knowledge of the scam) "for the acts of malfeasance or misfeasance" on the part of the broker/ officer manager as well as on the part of the salespersons. *Id.*

The legal relationship between the real estate broker and the real estate sales person/agent is similar to the relationship between the PA and his supervising physician in that, like the real estate sales agent, the PA may not practice unless he has a licensed supervisor and, again like the real estate sales agent, the PA's legal right to practice ends when his employment with the licensed supervisor ends. 26 VSA§ 1732 (4) and § 1735 (a).

### Desautels

Dr. Porter argues that *Desautels* is distinguishable from the case here. He points out the real estate brokers and their sales agents who cannot practice unless they are working under the license of broker/ principal are all fueled by the profit motive. As a consequence, he argues, real estate brokers and their agents “require a greater degree of oversight” than supervising physicians and PAs who are bound by the same principal/agent relationship:

Both the broker and salesperson are paid through commissions from sales, and therefore, the more sales, the more personal gain for the broker. This creates a profit motive to look the other way when confronted with unprofessional conduct, and hence requires a greater degree of oversight and accountability of the broker. Porter, p. 23

First, it is reasonable to believe that the Legislature considers that money (i.e. saving it) is an important component of the supervising physician- PA relationship. The Legislature determined that the ability of PAs to provide quality medical services at a relatively low cost was a primary purpose for enacting the statutes that license and regulate PAs:

“The general assembly recognizes the need to provide means by which physicians in this state may increase the scope and efficiency of their practice in order to ensure that quality medical services are available to all Vermonters *at reasonable cost*. (Emphasis added)

Second, there is every reason to believe that, if anything, the Legislature felt that the supervising physician/ PA relationship warranted an even greater level of “oversight and accountability” than real estate broker / real estate sale agent relationship. This case is a good example. The Committee heard testimony that prescription drug diversion and abuse is particularly dangerous.<sup>10</sup> The Legislature made it clear in 26 VSA § 3101 that the State imposes regulation on professions “solely for the purpose of protecting the public.” It is reasonable to believe, as noted earlier, that the Legislature approved the licensing of PAs with the understanding that requiring a principal/agency relationship between supervising physician and the PA would encourage the supervising physician to take his role seriously and provide consistent, meaningful oversight of his PA/agent or face professional reprimand or suspension of his professional license.

### (3) Policy - “Chilling Effect”

Both Dr. Porter, and his expert, Dr. Peterson, predict that if the Board finds Dr. Porter vicariously liable for the acts of PA Nobes’ it will have an immediate “chilling effect” on decisions to hire PAs in Vermont. Porter, p. 25 That may be. It is up to Legislature, not the Board, to decide policy. If the Legislature finds that the statute, as written, has produced a result that is, on balance, not in the interest of the public, then the Legislature must change the law.

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<sup>10</sup> Dr. Porter suggested that “it’s how we lose students.” Finding 35 (above)

(4) Board Policy - 26 VSA § 1739 a

Finally, Dr. Porter points out that while 26 §1739 (a), the statute making supervising physicians “legally liable” for acts of their PA/agents, *does not* specifically authorize the Board to sanction supervising physicians; the statutory provision that follows, 26 §1739 a, *does* specifically authorize the Board to sanction any physician who “uses” a PA in a “manner that is “inconsistent with” the provisions of the PA statutes:

“Use of the services of a physician's assistant or a physician's assistant trainee by a physician in a manner which is inconsistent with the provisions of this chapter constitutes unprofessional conduct by the physician and such physician shall be subject to disciplinary action by the board in accordance with the provisions of chapter 23 or 33 of this title, as appropriate. 26 §1739 a

Dr. Porter contends that this is plain evidence that the Legislature did not to give the Board the authority to sanction him for PA Nobes’ acts in improperly prescribing controlled substances. Porter, 27 That is, the Legislature clearly gave the Board the authority in 26 §1739 a to sanction physicians who actively “use” a PA in a manner that is inconsistent with the PA statutes; but, by failing to include the authority to sanction in 26 §1739 (a) it just as clearly demonstrated that it did not intend to give the Board the authority to find a supervising physician had engaged in unprofessional conduct based solely on the acts of his PA/agent.

First, this argument, once again, ignores the principles of “agency” which hold that the properly delegated acts of the “agent are the acts of the principal.” Under the law of agency, it was Dr. Porter who prescribed controlled substances in violation of the standard of care. The Board already had the authority to sanction Dr. Porter under provisions such as 26 §1354 (b) (2) for failing “failure to conform to the essential standards of acceptable and prevailing practice.” There was no need for the Legislature to give the Board additional authority.

Second, the argument fails to recognize the fact that the Legislature gave the Board the responsibility to regulate PA practice. The Board is responsible for the certification of PAs. It is also responsible developing rules regulating the “training, practice and qualification” of PAs. 26 §1733 The Board regulates the number of PAs a supervising physician may supervise. 26 §1735 It is also responsible for disciplining PAs and physicians for unprofessional conduct. 26 §1736, 26 §1354

The supervising physician is central to the process that the Board is responsible for regulating. Sections 1732 -1735, provide that the PA cannot practice without a supervising physician, that the PA cannot engage in medical activity unless the supervising physician has delegated his/her authority to conduct that activity to the PA and that at “no time shall the practice of the physician's assistant exceed the normal scope of the supervising physician's practice .” The supervising physician must certify that he/she will “be responsible for all medical activities” of the PA.

Dr. Porter argues that when the Legislature provided in § 1739 (a) that the supervising physician was “legally liable” for the properly delegated acts of the PA he/she was supervising, the Legislature was not talking about the Board’s authority to impose legal liability for the failure of a relationship that is central to the process the Board is responsible for regulating. Instead, according to Dr. Porter, the Legislature was only talking about tort liability which is handled in superior court.

This is simply not a reasonable interpretation of the statutory framework. To accept this interpretation, one would have to believe the Legislature gave the Board responsibility for insuring that PAs were supervised and then, when the Legislature was delegating authority through § 1739 (a), to impose legal liability for failure of that supervision, it ignored the Board and turned to the courts.

**Counts II, IV and V- Alleged Unprofessional Conduct of Dr. Porter Based on His Supervision of PA Nobes**

Count II

The State did not meet its burden on Count II

The State alleges Dr. Porter “failed to adequately follow the progress of patients treated by PA Nobes” and that in doing so, he failed to conform to the essential standards of acceptable prevailing practice” in violated of 26 VSA § 1354 (b) (2).

Upon reviewing the transcript, the Committee found that the State introduced little, if any evidence on this issue. It is true that PA Nobes’ improper prescribing for 12 student-patients had been going on for at least 15 months (the CHWB did not get electronic records until February or March, 2008) before it was discovered. But PA Nobes saw 2,000 patients per year. The State introduced no evidence that Dr. Porter failed to adequately follow the progress of the overwhelming majority of Nobes’ patients.

Count III

Count III is dismissed

The State alleged that Dr. Porter was vicariously liable for the improper prescribing of PA Nobes under Board Rule 5.1. The Committee has already found that Dr. Porter is legally liable for unprofessional conduct for the same conduct under the same theory of liability in Count I. There is no basis for finding him liable twice for the same conduct.

#### Count IV

##### The State did not meet its burden on Count IV

The State alleges Dr. Porter violated Board Rule 7.1 (c) which says: "The supervising physician shall outline in detail how he or she will be available for consultation and review of work performed by the physician assistant."

Once again, the State introduced little evidence on this issue. Dr. Porter did. The record shows that Dr. Porter had one-on-one meetings with PA Nobes every three weeks. He held weekly staff meetings at which clinical issues were discussed. Dr. Porter also developed a process for peer review sessions that reviewed patient's charts at least once every semester. Beyond that, he testified always encouraged PAs to come to him any time they had a question about their work.

We find that Dr. Porter's process for review exceeded the review process specified in the scope of practice that had been approved by the Board.

#### Count V

##### The State did not meet its burden on Count V

The State alleges Dr. Porter violated Board Rule 7.5 which says: "Supervision shall include the regular, retrospective review of selected PA-generated charts by the supervising physician, with documentation of such review."

The record shows that Dr. Porter conducted regular retrospective review through: (1) review of PA Nobes' charts during at two to three hour peer review process at least once per semester; (2) review of PA Nobes' charts during one-on-one meetings with PA Nobes once every three weeks; (3) review of PA charts following the death of a student-patient; (4) reviewing PA charts following a complaint from a student-patient and (5) following hospitalization of a student-patient. In addition, Dr. Porter was available to review PA-generated charts any time a PA had a question.

Dr. Peterson testified as an expert on the standard of care for a PA's supervising physicians in the State of Vermont. In his opinion, the process implemented by Dr. Porter more than met the standard of care required of supervising physicians in our state. We agree.

Dr. Porter met both the requirements of Board Rule 7.5 and of the scope of practice that he and PA Nobes agreed upon and the Board approved.

Dr. Porter noted on more than one occasion in this testimony that the Board gave little guidance on what constituted "regular retrospective review" and little guidance on what was expected of a PA's supervising physician in general. We agree. If the Board feels that more is

needed, it should amend its rules to say so. In the mean time, it can address any perceived shortcomings, individually, when it reviews the scope of practice proposed by the PA and his/her supervising physician.

**Counts VI and VII – Unprofessional Conduct of Dr. Porter Based on Conduct of PA-K**

The State did not meet its burden on Counts VI and VII.

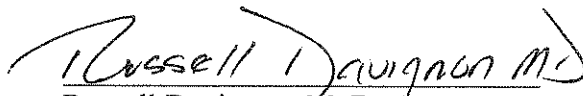
PA-K treated up to 15 patients at CHWB without a valid license over “three clinical days” during a period between October 20-27, 2009. The State alleges Dr. Porter is vicariously liable for PA-K’s conduct (in treating patients without a license) under 26 VSA 1739 (a) and under Board Rule 5.1. But, the State produced no evidence that Dr. Porter was PA-K’s supervising physician on the days she was treating patients. He had not delegated his authority to engage in medical activity to her on those days because he was not even aware she had begun working at CHWB at that time. The fact that he signed an application to serve as her supervising physician On October 28, 2009 which stated that she had been working at CHWB does not alter the fact that PA-K could not have been Dr. Porter’s agent when she was treating patients. Therefore, he is not vicariously liable for her conduct under either §1739(a) or Board Rule 5.1.

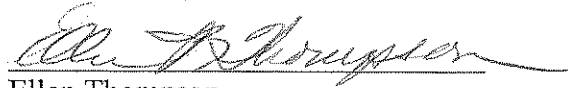
Recommended Order

Dr. Porter is liable under the law for the improper prescribing of PA Nobes. Once he learned of PA Nobes conduct, he responded promptly and effectively to ensure that students were protected from further harm by PA Nobes and that there could be no recurrence. His response included notification to the Board that PA Nobes had engaged in improper prescribing.

- (1) We recommend that the Board not sanction Dr. Porter in any way.
- (2) We recommend further that the Board include the following in its standard "Primary Supervising Physician Application:"

"I understand that the physician assistant is my agent. When the physician assistant engages in medical activity that I have delegated to the physician assistant that is within the scope of practice we have agreed upon, the physician assistant's acts become my acts. If those acts would constitute unprofessional conduct by a physician, I, as the supervising physician, can be found to have engaged in unprofessional conduct by the Vermont Board of Medical Practice. The Board can then impose restrictions on my license to practice medicine up to, and including, revocation."

  
Russell Davignon, M. D.

  
Ellen Thompson

  
Sister Janice Ryan

Sister Janice Ryan (concurring and dissenting), I agree with the Recommended Order and with all of the Proposed Findings and Conclusions except the Conclusion on Count V. I believe the State did meet its burden on Count V for the reasons set out below.

The State alleges Dr. Porter violated Board Rule 7.5 which says: "Supervision shall include the regular, retrospective review of selected PA-generated charts by the supervising physician, with documentation of such review."

The record shows that Dr. Porter conducted little retrospective review of PA-generated charts and when he did review charts, they were charts that were selected by PA Nobes.

First, the record shows that Nobes saw as many as 2,000 patients per year. Dr. Porter and PA Nobes' peers reviewed no more than 16 of Nobes charts per year at their peer review sessions. There are no figures covering charts reviewed in the one-on-one meetings but even if

we assume that two charts were reviewed at each meeting that only means an additional 40 charts. Fifty-six charts out of 2,000 is only a little under three per cent of the charts.

PA Nobes testified that 1 out of every 5 PA charts is reviewed at the Duke University college health center. He also testified that his former supervising physician in Charlotte reviewed every one of this charts.

There is little case law; but, the judge in *Macdonald v. US*, 853 F. Supp. 1430 (M.D. Ga. 1994), which is apparently the only reported case on the issue, ruled that even random review of ten per cent of the PA files did not meet the standard of care:

Two years of study as a physician's assistant does not operate as a sufficient substitute for the extensive study and training required to become a doctor. It is because doctors have undergone this extensive study and training that they have the responsibility to perform adequate oversight over physician's assistants in their charge. In this case, the oversight required by the standard of care was missing. A random review of approximately ten percent of all patients treated in the clinic is not sufficient. Such a review allows the physician's assistant to substitute his judgment for that of a doctor's. Accordingly, the court finds that the supervising physicians at Moody AFB breached the standard of care by failing to adequately supervise the physician's assistants under their control.  
853 F. Supp. 1430 (M.D. Ga. 1994)

Moreover, there is little evidence that Dr. Porter selected any of the relatively few charts that he did review. It is hard to see how Dr. Porter's practice of rejecting random review and allowing PAs to select the charts provides adequate protection for patients. This practice fails to protect patients from PAs who divert or deliberately over-prescribe drugs such as Oxycodone to make extra money. More importantly, it fails to protect patients from PAs who are negligent - PAs who should know what they are doing is wrong, but don't. Allowing PAs to select the charts Dr. Porter reviews may lead to an important learning experience for the PA, but it ignores the very real possibility that the PA overlooks a chart that might reveal that he is engaging in a dangerous practice. The PA overlooks the chart, not because he wants to cover up; but, because, he does not realize what he is doing is dangerous.

Dr. Porter made it clear that he does not believe acting like a "police man" is a productive use of his time. Yet, this aversion to "looking for bad things" might have endangered the safety of his student-patients. CHWB had electronic records for nearly 15 months before Nobes' improper prescribing was discovered. Dr. Porter could have done the electronic "audit" - a process he now describes as "easy" - much earlier. If he had, he would have quickly learned that Nobes had been prescribing opiates for a student who Dr. Porter had been treating for opiate addiction.