
MEDICAL MALPRACTICE LITIGATION

Who Saw the Patient

Nurse Practitioners, Physician Assistants, and Supervision in Malpractice Cases

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Nurse practitioners and physician assistants deliver a huge share of American healthcare, often excellent care, in emergency departments, urgent care, primary care, hospitals, and nursing homes. In a lot of rural areas they're the main source of care. None of what follows is about whether they're good clinicians. It's about the fact that the legal and clinical framework around their practice differs from physicians', varies widely by state, and matters when something goes wrong.

That framework keeps moving. As of 2026, 29 states plus the District of Columbia give nurse practitioners full practice authority, meaning they can evaluate, diagnose, treat, and prescribe without a formal physician agreement. Other states require some form of collaboration or supervision. More than a dozen states have expanded NP authority since 2021, and more bills are pending. PA laws are changing too, with several states replacing supervision with collaboration and some adopting the title "physician associate."

WHAT STANDARD APPLIES?

Is a nurse practitioner held to the standard of a reasonable NP, or of a reasonable physician doing the same task? States answer that differently, and it affects who can testify as an expert. That's counsel's call. Clinically, the core questions are the same either way. Did the clinician take the history and do the exam the complaint called for? Recognize the red flags? Order what was indicated? And, most important, recognize when the problem exceeded their training or role, and escalate?

A FICTIONAL CASE

A 38-year-old woman walks into an urgent care on a Saturday with a sudden, severe headache that started while she was exercising. She calls it the worst headache of her life. A physician assistant is working alone that day with a supervising physician available by phone. Her blood pressure is mildly high; her neuro exam is charted as normal. She's diagnosed with a tension headache, given medication, and sent home. Two days later she collapses with bleeding in the brain from a ruptured aneurysm.

READING THE ENCOUNTER

A sudden, severe, “worst ever” headache, especially one that starts with exertion, is a textbook red flag for subarachnoid hemorrhage. The usual expectation is urgent evaluation, typically a CT in an emergency department and sometimes further testing.

Did the note capture the sudden onset, the “worst headache” description, the exertional start? Many templates have headache red-flag checkboxes; were they checked, and accurately? Urgent care usually can't do CT. Was she sent to an ED? If not, why? Was the supervising physician called, and is there a record of the call?

SUPERVISION AND COLLABORATION

Where PAs practice under supervision or collaboration, there's usually a written agreement covering how the physician is available, which cases require consultation, and how charts are reviewed. Some states require a set percentage of chart review or regular meetings. Compare the agreement to reality. Was the physician reachable that day? Did practice policy require consultation for severe headache or chest pain? Was it followed? In full-practice NP states there may be no supervising physician at all, and the focus shifts to the practice's own protocols and the NP's training and experience.

CERTIFICATION AND SETTING

NPs are certified by population: family, adult-gerontology primary care or acute care, pediatrics, psychiatric-mental health, and others. A family NP running an ICU overnight, or a primary care-certified NP managing critically ill inpatients, may be working outside what their certification was built for. Some states and hospitals address that in rules and credentialing; some don't. Find out the clinician's certification and experience in that setting, and whether credentialing considered it.

CO-SIGNATURES AND WHO REALLY SAW THE PATIENT

A physician co-signature can mean the physician saw the patient, carefully reviewed the note, or clicked “sign” on a batch days later. Billing can help tell which. Medicare has specific rules for billing an APP's work under a physician's name, including “incident to” billing in offices and

split or shared visits in hospitals. How the visit was billed can shed light on who actually evaluated the patient, and a mismatch can raise separate questions.

HOSPITALS AT NIGHT

Many hospitals staff overnight coverage with NPs or PAs, with a physician on the phone or covering several units. The key questions are about escalation. When the patient got worse, did the APP call the physician? How fast? Did the physician come in? What did policy require? Paging logs and secure messages are often the best evidence.

THE ORGANIZATION'S ROLE

Hospitals grant privileges through the medical staff process, which is supposed to match what a clinician may do to their training and competence. Urgent care and retail clinic companies set staffing models, protocols, and productivity targets. Was it reasonable to staff a PA alone on a weekend? What training on red-flag symptoms did the company provide? Did protocols require ED referral for certain complaints? How many patients an hour was the clinician expected to see? High volume and no on-site physician can create the conditions for missed red flags, and those choices can be part of the case.

DID SHE KNOW WHO WAS TREATING HER?

Many states require clinicians to identify their credentials. Badges, introductions, and how the visit summary lists the provider all matter. A patient who thought she'd seen a physician, and says she'd have gone to the hospital had she known otherwise, raises a different question. Whether it's legally significant depends on the state, but document it.

WHAT SUPPORTS THE CLINICIAN

If the PA documented the red flags, recommended the ED, and the patient declined, the case changes completely. If the supervising physician was called and agreed with the plan, the focus shifts to that physician. Read the record for all of it.

CAUSATION

Would a CT on Saturday probably have shown a bleed or a warning leak? Would treating the aneurysm before the major rupture probably have changed the outcome? That's for a neurosurgeon or neuroradiologist, and it depends on the first bleed and her course in between.

RECORDS WORTH REQUESTING

- The complete visit record, including intake forms and the template used
- The clinician's license, certification, and credentialing file or privileges

- The supervision or collaboration agreement
- Practice protocols for the presenting complaint
- Consultation call records, paging logs, and secure messages
- Billing records for the encounter
- Staffing schedules and patient volume data for that day
- State practice rules in effect at the time

SOURCES

- NursePractitionerOnline.com, “Full Practice Authority States for NPs in 2026”; CM&F Group, “NP Full Practice Authority in 2026”
- 42 C.F.R. § 482.22 (hospital medical staff and privileges); CMS Medicare Claims Processing Manual guidance on “incident to” and split/shared visits

This newsletter is for education only and isn't medical or legal advice. The case is fictional. Scope-of-practice and standard-of-care rules vary by state.

ABOUT LEXCURA CLINICAL INTELLIGENCE

Lexcura Clinical Intelligence provides integrated clinical and regulatory analysis for attorneys handling healthcare litigation. If you have a case where an NP or PA saw the patient and you need the encounter, the supervision, and the organization's choices examined together, we'd welcome the conversation.

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