DEFENDING ADVANCED PRACTITIONERS IN THE AGE OF TELEMEDICINE AND EXPANDING AUTONOMY

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I didn't think that we were involved in great change . . . but then change became the name of the game.

– Loretta Ford, co-founder of the country's first pediatric nurse practitioner training program

Appropriate access to healthcare has always included patients' access to the right healthcare providers for their needs. But the perception of who constitutes "the right healthcare provider" for a given patient's needs has changed more than once. For example, "[f]or centuries past, only women attended women during childbirth, and only women were midwives."[1] Then Peter Chamberlen, a barber-surgeon, invented the obstetric forceps in 1588. Over the following centuries, the field of obstetrics grew into its own physician specialty with obstetricians eventually taking the place of midwives as the primary medical attendants at childbirth.[2] Nevertheless, the pendulum, however gradually, swings both ways. Since 2005, that particular trend is gradually reversing in Virginia following the adoption of statutes defining, licensing, and regulating the practice of midwifery.[3]

Pressure for additional healthcare providers in underserved areas eventually gave rise to new, defined scope of practice levels between a registered nurse and a physician—new types of "the right healthcare provider." In 1965, two new training programs opened in the United States: Duke University's physician assistant training program[4] and Loretta Ford and Henry Silver's pediatric nurse

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1 Phyllis L. Brodsky, *Where Have All the Midwifes Gone?*, 17:4 J. PERINAT EDUC. 48, 48 (2008).

2 *Id.* at 49–50.

3 See VA. CODE ANN. §§ 54.1-2957.7 through -2957.13 (2005 amendments).

4 John A. Braun, *et al.*, *The Physician's Associate—A Task Analysis*, 63:12 AM. J. PUBLIC HEALTH 1024, 1024 (1973) (hereinafter Braun, *The Physician's Associate*).

practitioner training program at the University of Colorado.[5] By the 1980s, many more programs offered masters-level training in multiple medical disciplines.[6]

The nomenclature for this new class of healthcare provider also developed over time. One person's physician assistant may be another person's physician associate,[7] (collectively, "PAs" and nurse practitioners "NPs"). Both classes are sometimes tagged as a group with terms like "mid-level providers," "physician extenders," or "non-physician practitioners."[8] Virginia, however, defines the term *nurse practitioner* as "an *advanced practice* registered nurse who is jointly licensed by the Boards of Medicine and Nursing."[9] Accordingly, in this article PAs and NPs are referred to collectively as "advanced practitioners."

The use of advanced practitioners in Virginia, particularly in more rural areas, has expanded over the past few decades as demand for healthcare increased. But the COVID pandemic brought both patient-access difficulties and the potential for improved access through advanced practitioners into sharp focus. While the use and supervision of these providers remain subject to debate, COVID left little doubt that the Commonwealth needs more, not fewer, healthcare resources. Advanced practitioners appear poised to increase their role in modern healthcare as it transitions from the traditional brick-and-mortar services to a mixture of in-office, virtual, and in-home healthcare.

Expansion of both the role of advanced practitioners and the virtual delivery of healthcare—both due to and independent from COVID—can present jurisdictional challenges when the advanced practitioner and patient are located in different states during a healthcare interaction. This article explores some of the potential personal jurisdiction defenses that may arise when Virginia attorneys are tasked with defending out-of-state advanced practitioners sued in the Commonwealth. This article also considers aspects of defending advanced practitioners in medical negligence actions that are unique to these providers. Finally, the article discusses the potential future of these disciplines as more and more care is provided in-home or via telemedicine.

I. VIRGINIA'S ADVANCED PRACTITIONERS

Long before COVID darkened Virginia's doorstep, the scarcity of qualified healthcare workers both created the cadre of advanced practitioners and pressed them toward independence.[10] From 2014 to 2019, the number of li-

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[5] Barbara L. Brush, *et al.*, *Revisiting "A Nurse for All Settings": The Nurse Practitioner Movement, 1965–1995*, 8:1 J. AM. ACAD. NURSE PRACTITIONERS 5, 5 (1996).

[6] *Id.* at 6.

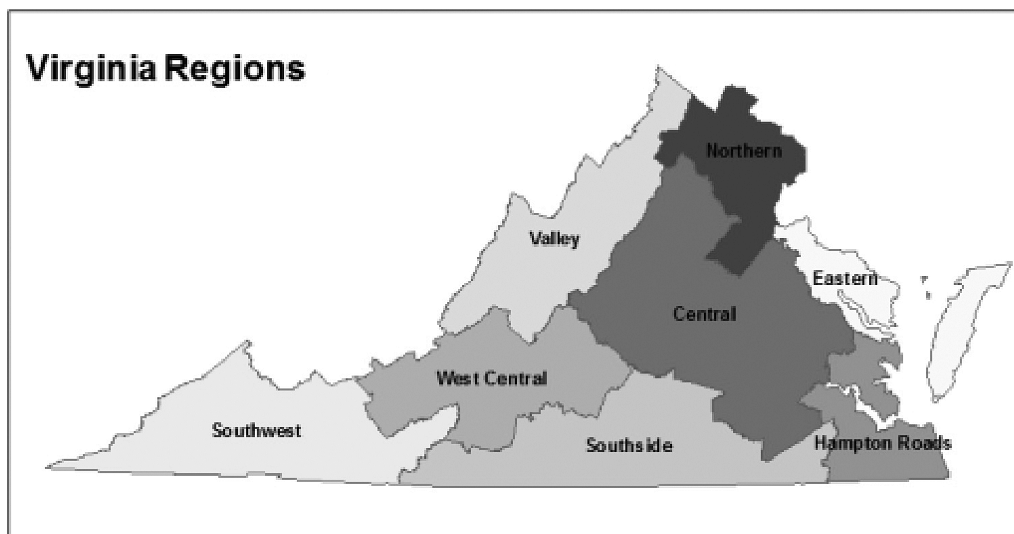
[7] Braun, *The Physician's Associate, supra* note 4, at 1024.

[8] Catherine S. Bishop, *Advanced Practitioners Are Not Mid-Level Providers*, 3:5 J. ADV. PRACT. ONCOL. 287, 287 (2012).

[9] VA. CODE ANN. § 54.1-2900 (emphasis added).

[10] *See* WORLD HEALTH ORGANIZATION, MID-LEVEL HEALTH PROVIDERS A PROMISING RESOURCE TO ACHIEVE THE HEALTH MILLENNIUM DEVELOPMENT GOALS at 5 (2010); Ge Lin, *et al.*, *The Geographic Distri-*

censed NPs in Virginia grew by 52%,[11] and the number of licensed PAs grew by 30%.[12] In 2019 alone, Virginia's Health Care & Social Assistance workforce increased by 16,800 healthcare providers.[13] Yet only about 0.25 full-time PAs per 1000 residents practiced in the rural Southwest and Southside Regions of the Commonwealth, and less than 1.5 full-time NPs per 1000 residents practiced in these regions.[14] A 2018 survey of Virginia physicians found that only 16% reported participating in a collaborative practice agreement with a nurse practitioner and only 10% reported participating in a collaborative practice agreement with a physician assistant.[15]



By 2020, however, 21% of physicians reported working with NPs under a collaborative practice agreement, and 14% reported working with PAs under a collaborative practice agreement.[16] PAs were not re-surveyed after 2019, but a 2021 survey of Virginia NPs found that between 2018 and 2021 their ratios in the Southwest and Southside Regions increased to about 5 NPs per 1000 residents

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bution of Nurse Practitioners in the United States, 1:4 APPLIED GEOGRAPHICAL STUDIES 287, 288 (1997); Roderick S. Hooker, *et al.*, *Physician Assistants/Associates at 6 Decades*, 27:11 AM. J. MANAG. CARE. 498, 498 (2021).

11 HEALTHCARE WORKFORCE DATA CENTER, VIRGINIA DEPARTMENT OF HEALTH PROFESSIONALS, VIRGINIA'S LICENSED NURSE PRACTITIONER WORKFORCE: 2019 (2020).

12 HEALTHCARE WORKFORCE DATA CENTER, VIRGINIA DEPARTMENT OF HEALTH PROFESSIONALS, VIRGINIA'S PHYSICIAN ASSISTANT WORKFORCE: 2019 (2020).

13 HEALTHCARE WORKFORCE DATA CENTER, VIRGINIA DEPARTMENT OF HEALTH PROFESSIONALS, VIRGINIA HEALTHCARE WORKFORCE BRIEFS INDICATORS FROM THE BUREAU OF LABOR STATISTICS' CURRENT EMPLOYMENT STATISTICS SURVEY SERIES 2: REGIONAL & SECTORAL EMPLOYMENT (JAN. 2020).

14 *See supra* notes 11 & 12.

15 HEALTHCARE WORKFORCE DATA CENTER, VIRGINIA DEPARTMENT OF HEALTH PROFESSIONALS, VIRGINIA'S PHYSICIAN WORKFORCE: 2018 (2019).

16 HEALTHCARE WORKFORCE DATA CENTER, VIRGINIA DEPARTMENT OF HEALTH PROFESSIONALS, VIRGINIA'S PHYSICIAN WORKFORCE: 2020 (2021).

despite Virginia's population of NPs as a whole decreasing by 6% since 2016.[17] The significant increase in NPs practicing in rural areas is reflective of Virginia's trend toward independence for advanced practitioners to address patients' needs. This move toward greater independence is further illustrated by the General Assembly's pre-COVID creation of an autonomous practice certificate for qualifying nurse practitioners and its substitution of the term *collaboration* in place of *supervision* in the statutes regulating the practice of medicine by physician assistants.

A. REGULATIONS GOVERNING PHYSICIAN ASSISTANTS IN VIRGINIA

The General Assembly adopted regulations requiring licensure of physician assistants in 1988.[18] The 1988 changes directed the Virginia Board of Medicine to develop education and training standards for PAs and gave licensed PAs the ability to prescribe medications consistent with DEA regulations.[19] Ten years later, the General Assembly added a definition of *physician assistant* to the Code and added "requirements for licensure as a physician assistant."[20] These licensure requirements included obliging PAs to provide the Board of Medicine with (1) a list of their supervising physicians and (2) "[a] description of the practice and the way in which the physician assistant will be utilized"—that is, the practice agreement.[21] Individual practice agreements govern a PA's scope of practice, and providing healthcare outside the terms of that agreement is grounds for suspension or revocation of the PA's license.[22]

In 2019, Governor Northam signed into law changes that eliminated the term *supervision* from the statutes governing PAs.[23] Physician assistants now practice "in collaboration and consultation" as part of a "patient care team" that includes a physician or physicians.[24] The revised statute mandates that physician assistants have an "electronic practice agreement with one or more patient care team physicians," and each practice agreement must include "provisions for appropriate physician input in complex clinical cases, in patient emergencies, and for referrals."[25] "No physician assistant" may "perform any acts beyond those set forth in the practice agreement or authorized as part of the patient care team."[26] However it is important to note that the statutory definitions of *collab-*

[17] HEALTHCARE WORKFORCE DATA CENTER, VIRGINIA DEPARTMENT OF HEALTH PROFESSIONALS, VIRGINIA'S LICENSED NURSE PRACTITIONER WORKFORCE: 2021 (2021).

[18] VA. CODE ANN. § 54.1-2949 (1988, c. 765).

[19] VA. CODE ANN. §§ 54.1-2950, -2952.1, -3303.

[20] VA. CODE ANN. §§ 54.1-2900, -2951.1.

[21] VA. CODE ANN. § 54.1-2951.1 (1998).

[22] VA. CODE ANN. § 54.1-2953(3).

[23] LEGISLATIVE INFORMATION SYSTEM (LIS), HB 1952, *Patient care team; podiatrists and physician assistants,* as enacted on Feb. 22, 2019, *available at* https://lis.virginia.gov/cgi-bin/legp604.exe?191+ful+CHAP0137.

[24] *Id.*

[25] VA. CODE ANN. § 54.1-2951.1(C).

[26] VA. CODE ANN. § 54.1-2952(E) (2016).

oration and *consultation* do not mandate in-person or even voice-to-voice communication.[27] It is also important to note that, while these changes give PAs additional independence in their practices, unlike nurse practitioners no autonomous practice pathway exists for physician assistants in Virginia.

B. REGULATIONS GOVERNING NURSE PRACTITIONERS IN VIRGINIA

Virginia began allowing nurse practitioners to provide patient care under a physician's supervision in 1973.[28] By 2019, similar to physician assistants, nurse practitioners with less than five years of full-time clinical experience were required to "maintain appropriate collaboration and consultation, as evidenced in a written or electronic practice agreement, with at least one patient care team physician."[29] But unlike PAs, by 2019 Virginia NPs had three carve-outs that enabled them to provide patient care independent of a practice agreement. First, if the NP's patient care team physician died, became disabled, retired, or had his or her license suspended or revoked, the NP could apply to the Department of Health Professionals for leave to treat patients without an agreement for sixty days.[30] Second, if the NP was previously licensed in a state that did not require a practice agreement and had "the equivalent of at least five years of full-time clinical experience," then the NP could apply for an autonomous practice designation in Virginia (*i.e.*, a license designation allowing the NP to practice independently without a practice agreement) "in accordance with the laws of the state in which the nurse practitioner was licensed."[31]

Finally, in 2018 the General Assembly created an autonomous practice designation for NPs who had "completed the equivalent of at least five years of full-time clinical experience as a licensed nurse practitioner."[32] If endorsed by a patient care team physician who was "a party to [the NP's] practice agreement," or upon other evidence if such endorsement is unavailable, NPs in this category may "practice in the practice category in which [they are] certified and licensed *without a written or electronic practice agreement*."[33] NPs whose licenses contain an autonomous practice designation must still "consult and collaborate with

27 VA. CODE ANN. § 54.1-2900; 18 VA. ADMIN. CODE § 85-50-10(A).

28 *General Assembly Easing Path to Independent Practice for Nurse Practitioners*, VIRGINIA TELEHEALTH NETWORK (Mar. 26, 2021) https://www.ehealthvirginia.org/general-assembly-easing-path-to-independent-practice-for-nurse-practitioners/. Virginia treats certified registered nurse anesthetists (CRNAs), certified nurse midwives, and clinical nurse specialists differently from nurse practitioners specializing in any other category. This article does not address nurse practitioners in these three specialties. Accordingly, the term *nurse practitioner*, as used in this article, generally does not include CRNAs, nurse midwives, or clinical nurse specialists. VA. CODE ANN. § 54.1-2957(G) (2019).

29 VA. CODE ANN. § 54.1-2957(C) (2019).

30 VA. CODE ANN. § 54.1-2957(G) (2019).

31 VA. CODE ANN. § 54.1-2957(E) (2019).

32 VA. CODE ANN. § 54.1-2957(I) (enacted Apr. 4, 2018). "'[C]linical experience' means the postgraduate delivery of health care directly to patients pursuant to a practice agreement with a patient care team physician." VA. CODE ANN. § 54.1-2957(A).

33 *Id.* (emphasis added).

other health care providers based on the clinical conditions of the patient to whom health care is provided" and "establish a plan for referral of complex medical cases and emergencies to physicians or other appropriate health care providers."[34] But, very broadly, these directives are generally applicable to any Virginia physician—that is, a duty to consult, pursuant to their professional judgment, with other physicians (including specialists) and refer cases when appropriate.

C. LIMITED CHANGES TO NP AUTONOMOUS PRACTICE DURING COVID

Due to the COVID pandemic, Virginia temporarily lowered the minimum clinical experience requirement for NPs to apply for an autonomous practice designation from five years to two years. Governor Ralph Northam created the temporary two-year experience threshold by executing Executive Order 57 on April 17, 2020. Then on November 18, 2020, Governor Northam signed Virginia's budget bill into law. Item 309(B) of that budget bill moved the two-year threshold from an Executive Order to an Act of the General Assembly and extended it "until the termination of a declared state of emergency due to the COVID-19 pandemic." On February 25, 2021, the General Assembly approved a temporary amendment to Virginia Code section 54.1-2957(I) changing the clinical experience requirement for NPs to obtain an autonomous practice designation from five years to two years, but that change expires on July 1, 2022.[35] Without further extension, on July 1, 2022 the temporary amendment will sunset, and Virginia will revert to the pre-COVID version of Virginia Code section 54.1-2957(I) requiring NPs to have five years of clinical experience before they can apply for an autonomous practice designation.[36]

On January 20, 2022, Delegate Dawn M. Adams of House District 68, a nurse practitioner, introduced HB 1245. This bill was intended to repeal the sunset provision of Virginia Code section 54.1-2957(I), thus making permanent the two-year clinical experience requirement for nurse practitioners to apply for an autonomous practice designation.[37] The bill passed the House of Delegates but was amended in the Senate Committee on Education and Health. The Senate amendment would have allowed the two-year clinical experience requirement to sunset on July 1, 2022, but would have also allowed any nurse practitioner who gained an autonomous practice designation before that date to keep that designation going forward.[38] At a February 25, 2022, hearing of the Health Profes-

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[34] *Id.*

[35] *See* LIS, HB 1737, *Nurse practitioners; practice without a practice agreement*, as enacted on Feb. 25, 2021, *available at* https://lis.virginia.gov/cgi-bin/legp604.exe?212+ful+CHAP0001.

[36] *Id*.

[37] LIS, HB 1245 (relative to nurse practitioners; practice without a practice agreement, repeals sunset provision), as presented to the House on Jan. 20, 2022, *available at* https://lis.virginia.gov/cgi-bin/legp604.exe?221+ful+HB1245.

[38] LIS, HB 1245, as proposed by the Senate Committee on Education and Health on Mar. 3, 2022, *available at* https://lis.virginia.gov/cgi-bin/legp604.exe?221+ful+HB1245S1.

sions Subcommittee of the Senate's Education and Health Committee, Virginia Department of Health Professionals' Director David E. Brown, DC, stated that even without action by the General Assembly the DHP would likely allow NPs with an autonomous practice designation to continue practicing without a practice agreement after July 1, 2022, regardless of their years of clinical experience.[39] The House rejected the Senate amendment, and HB 1245 was continued to the General Assembly's 2022 Special Session I.[40] The 2022 Special Session I convened on April 4, 2022, and HB 1245 was listed as pending as of May 26, 2022.

While this article leaves the appropriate regulation of advanced practitioners to the General Assembly and the Department of Health Professionals, as advised by medical professionals, it appears that their healthcare autonomy will continue to expand as they collaborate with more Virginia physicians and become a more familiar option for Virginia patients. And, of course, the more care advanced practitioners provide, the more they will be exposed to and involved in medical negligence claims related to that care. Given the changes in healthcare delivery over the past few years, the defense of advanced practitioners will require familiarity with jurisdictional issues surrounding telemedicine.

II. The Increasing Use of Telemedicine and Jurisdictional Challenges

Even before Covid forced healthcare providers to deliver more services remotely and in-home, pilot programs studied the efficacy of advanced practitioners providing telephonic follow-up in lieu of in-office visits. For example, in one study, advanced practitioners conducted post-operative visits following hernia repairs with patients via telephone.[41] Patients received a telephone call from a dedicated physician assistant two to three weeks after surgery and answered a predetermined questionnaire. A face-to-face clinic visit was scheduled based on the results of the call or at the patient's request. The authors of this retrospective study concluded that "[t]elephone follow-up by a midlevel provider after laparoscopic inguinal hernia repair [was] feasible and effective and [was] well received by patients."[42] Other studies have similarly concluded that telemedicine can be used as a substitute for the standard postoperative clinic

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[39] The video of the subcommittee's discussion of HB 1245 is available at http://virginia-senate.granicus.com/ViewPublisher.php?view_id=3. Delegate Adams's comments begin at 8:55 in the video, and Director Brown's comments begin at 26:14. Brown stated that "[t]he [DHP's] consensus has always been to not take away a privilege once it has been granted." Based on that statement, he told the subcommittee that in the absence of direction otherwise from either the General Assembly or the attorney general the DHP would treat autonomous practice designations gained before July 1, 2022, in the same manner. The subcommittee's discussion of HB 1245 with Del. Adams concludes at 42:44.

[40] LIS, HB 1245, Bill Tracking, *available at* https://lis.virginia.gov/cgi-bin/legp604.exe?221§um+HB1245.

[41] Dan Eisenberg, *et al.*, *Telephone Follow-Up by a Midlevel Provider after Laparoscopic Inguinal Hernia Repair Instead of Face-to-Face Clinic Visit*, 19:1 J. Society of Laparoscopic & Robotic Surgeons 1, 1 (2015).

[42] *Id.* at 3.

visit for patients who underwent laparoscopic cholecystectomy both safely and with a high degree of patient satisfaction.[43]

COVID accelerated the use of remote health care for healthcare providers, including advanced practitioners, all over the world. For example, in the United Kingdom some post-partum visits were converted to video or other remote means to reduce the need to expose mother and child to the risk of an additional office visit. Medical professionals used telemedicine to provide on-line birth preparedness classes, antenatal and postnatal care by video/phone, and on-line psychosocial counseling. A recent study in the *British Medical Journal* concluded that these programs were "a double-edged sword."[44] Challenges included lack of infrastructure and technological literacy, limited monitoring, financial and language barriers, lack of nonverbal feedback and bonding, and distrust by patients. Nevertheless, that study determined that overall, telemedicine—while far from perfect—is an important alternative to in-person consultations.[45]

The demand for telemedicine and in-home medical care is unlikely to subside in the near future. Telemedicine enables patients to receive the care they need from the comfort of their homes, thereby avoiding the time and cost of traveling to their healthcare providers. COVID forced healthcare providers to implement and refine their ability to deliver healthcare remotely. As a consequence, healthcare providers can now reliably deliver healthcare to patients anywhere accessible by phone and Internet.

Like many other healthcare providers, Virginia's advanced practitioners are practicing remotely more and more often. "With the exception of prescribing controlled substances, the Virginia General Assembly has not established statutory parameters regarding the provision and delivery of telemedicine services. Therefore, practitioners must apply existing laws and regulations to the provision of telemedicine services."[46] From a defense attorney's standpoint, remote delivery of healthcare amplifies the importance of both (1) the various parties' locations during these remote interactions and (2) the logistics of the interactions themselves.

But what happens when an out-of-state advanced practitioner answers a patient's inquiry—either via a message through the patient portal, via email, by phone, or by videoconference—while the patient is in Virginia? How is the col-

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43 *See*, *e.g.*, Kimberly Hwa, *et al.*, *Telehealth Follow-Up in Lieu of Postoperative Clinic Visit for Ambulatory Surgery: Results of a Pilot Program*, 148:9 JAMA SURG. 823 (2013).

44 Anna Galle, *et al.*, *A Double-Edged Sword—Telemedicine for Maternal Care during Covid-19: Findings from a Global Mixed-methods Study of Healthcare Providers*, BMJ GLOBAL HEALTH (2021), *available at* https://gh.bmj.com/content/bmjgh/6/2/e004575.full.pdf.

45 *Id.*

46 VIRGINIA BOARD OF MEDICINE, TELEMEDICINE, at 1 (2021), *available at* https://www.dhp.virginia.gov/media/dhpweb/docs/med/guidance/85-12.pdf. Additionally, please note that as of April 8, 2022, out-of-state healthcare providers who provide "behavioral health services" to patients located in Virginia are not required to have a Virginia medical license under certain conditions. VA. CODE ANN. §§ 8.01-2901(A)(33), 54.1-3501(7), 54.1-3601(11), 54.1-3701(6).

laborating physician consulted when healthcare is delivered remotely? Does it matter whether the advanced practitioner knows the patient is located in another state during the interaction? Does the answer to that question depend on the type of interaction?

The Commonwealth's definition of "'[t]elemedicine services' does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire."[47] This may insulate an out-of-state advanced practitioner against a claim of practicing without a license in those situations. But plaintiffs may still point to these contacts, either alone or in combination with others, to justify a lawsuit in Virginia, especially as healthcare providers increasingly encourage these types of electronic interactions. Indeed, most healthcare entities have web sites with a "contact us" tab that enables patients to create a message for a healthcare provider. And once a patient is established, most electronic medical records systems automatically generate an invitation to the patient asking them to sign up for patient portal access. The patient portal not only gives patients access to their own medical charts but also typically enables patients to send questions and information electronically to their healthcare providers. And in many practices, patient portal requests are directed to and answered by an advanced practitioner, with physicians consulting only when needed.

Thus, a Virginia healthcare provider may never leave Virginia, but depending on the patient's location at the time of remote healthcare, that provider may be exposed to a lawsuit in another state. Conversely, an out-of-state advanced practitioner working with a Virginia patient may inadvertently be subjected to a lawsuit in the Commonwealth. These claims are likely to be very fact specific but may very well justify a personal jurisdiction challenge and perhaps limited discovery under the provisions of Virginia Code section 8.01-277.1. Once personal jurisdiction has been challenged, the plaintiff has the burden of proving by a preponderance of the evidence that the Virginia court has personal jurisdiction over the defendant.[48]

Virginia's long-arm statute—Code section 8.01-328.1—extends personal jurisdiction to the extent permitted by the Due Process Clause. "[T]he statutory inquiry necessarily merges with the constitutional inquiry, and the two inquiries essentially become one."[49] If a Virginia circuit court makes "either . . . a proper finding [of] specific jurisdiction based on conduct connected to the suit or . . . [a proper] finding [of] general jurisdiction," the court "may assume power over an out of-state defendant."[50] General jurisdiction, of course, refers to a court's au-

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47 VA. CODE ANN. § 38.2-3418.16; VIRGINIA BOARD OF MEDICINE, TELEMEDICINE, at 5 (2021), *available at* https://www.dhp.virginia.gov/media/dhpweb/docs/med/guidance/85-12.pdf.

48 Azzure Denim, L.L.C. v. E & J Lawrence Corp., 69 Va. Cir. 485, 486 (Norfolk 2006) ("When a court's personal jurisdiction is properly challenged the jurisdictional question thus raised is one for the judge, with the burden on the plaintiff ultimately to prove the existence of a ground for jurisdiction by a preponderance of the evidence." (quoting Combs v. Bakker, 886 F.2d 673, 676 (4th Cir. 1989))).

49 Young v. New Haven Advocate, 315 F.3d 256, 261 (4th Cir. 2002) (internal citations omitted).

50 *Id.*

thority to hear any case arising within its geographic area, and specific jurisdiction refers to a court's authority over a specific defendant due to the defendant's contacts with the forum.

A. GENERAL JURISDICTION REFRESHER AND POTENTIAL DEFENSES

In Virginia, general jurisdiction over individual healthcare providers is limited to their state of residence. General jurisdiction for corporations—including healthcare entities employing advanced practitioners—"is limited to cases where 'their affiliations with the State are so continuous and systematic as to render them essentially at home in the forum State.'"[51] For example, jurisdiction may be appropriate in the place "in which the corporation is fairly regarded as at home."[52] A corporation is considered at home in a state "where it is incorporated and where it has its principal place of business."[53] Courts have "declined to stretch general jurisdiction beyond [these limits]," and it "has come to occupy a less dominant place in the contemporary scheme."[54] The Supreme Court of the United States has squarely "rejected the . . . assertion that general jurisdiction could be exercised 'in every State in which a corporation engages in a substantial, continuous, and systematic course of business,' describing the assertion as 'unacceptably grasping.'"[55] When analyzing general jurisdiction, "the existence of continuous and systematic contacts with the forum" is "not sufficient to support the exercise of general jurisdiction."[56]

Accordingly, where the individual advanced practitioner does not live in Virginia and the employing entity is not incorporated in Virginia and does not maintain its principal places of business in Virginia, general jurisdiction is not appropriate. This is true even if the advanced practitioner or the employer maintained a substantial, continuous, and systemic course of business in Virginia.

For example, if a healthcare entity domiciled in Maryland was also registered to transact business in Virginia, that is likely an insufficient basis for general jurisdiction. In Virginia, "a company does not consent to jurisdiction by registering with the state and appointing an agent for service of process."[57] "A finding of general personal jurisdiction on the basis of registration and appointment of an agent alone is extremely conducive to forum shopping because many companies have registered to do business and appointed an agent for service of process

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51 Fidrych v. Marriott Int'l, Inc., 952 F.3d 124, 132 (4th Cir. 2020) (quoting Goodyear Dunlop Tires Operations, S.A. v. Brown, 564 U.S. 915 (2011)).

52 Daimler AG v. Bauman, 571 U.S. 117, 137 (2014) (internal citations omitted).

53 *Fidrych*, 952 F.3d at 132.

54 *Daimler,* 571 U.S. at 132–33.

55 *Fidrych*, 952 F.3d at 133 (citing *Daimler*, 571 U.S. at 138).

56 *Id.*

57 Reynolds & Reynolds Holdings, Inc. v. Data Supplies, Inc., 301 F. Supp. 2d 545, 551 (E.D. Va. 2004).

in numerous states."[58] If general jurisdiction does not exist, the analysis must move on to specific jurisdiction.

B. SPECIFIC JURISDICTION REFRESHER AND POTENTIAL DEFENSES

Specific jurisdiction claims are based upon Virginia's long-arm statute:[59]

> [a] court may exercise personal jurisdiction over a person, who acts directly or by an agent, as to a cause of action arising from the person's . . . [c]ausing tortious injury in this Commonwealth by an act or omission outside this Commonwealth if he regularly does or solicits business, or engages in any other persistent course of conduct, or derives substantial revenue from goods used or consumed or services rendered, in this Commonwealth.

In Virginia state courts, "[p]ersonal jurisdiction analysis is a two-step process."[60] First, "each alleged cause of action must be measured for a fit against each alleged part of the Long Arm Statute, Va. Code § 8.01-328.1."[61] If—and only if—the court determines that "a fit" exists, it must then determine whether the exercise of jurisdiction comports with federal due process.[62] Only the exercise of jurisdiction that does "not offend 'traditional notions of fair play and substantial justice'" can satisfy the Due Process Clause of the Fourteenth Amendment.[63]

Analyzing these "traditional notions" has been synthesized into a three-part test requiring courts to consider: "(1) the extent to which the defendant purposefully availed itself of the privilege of conducting activities in the State; (2) whether the plaintiffs' claims arise out of those activities directed at the State; and (3) whether the exercise of personal jurisdiction would be constitutionally reasonable."[64] "[T]he first prong articulates the minimum contacts requirement of constitutional due process that the defendant purposefully avail himself of the privilege of conducting business under the laws of the forum state."[65] Minimum contacts might include maintaining an office in Virginia, owning property in Virginia, soliciting business in Virginia, or engaging in long-term business in Virginia.[66]

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58 *Id.*; *see also Fidrych*, 952 F.3d at 135 (holding that Marriott was not subject to personal jurisdiction in South Carolina despite maintaining a certificate to transact business in the state).

59 VA. CODE ANN. § 8.01-328.1(A)(4).

60 Bergaust v. Flaherty, 57 Va. App. 423, 436, 703 S.E.2d 248, 254 (Va. Ct. App. 2011).

61 *Id.*

62 *Id.*

63 Witt v. Reynolds Metals Co., 240 Va. 452, 454, 397 S.E.2d 873, 875 (1990).

64 Consulting Eng'rs Corp. v. Geometric Ltd., 561 F.3d 273, 278 (4th Cir. 2009).

65 *Id.*

66 *Id.*

If, and only if, the first prong is met, the court should consider the next two prongs.[67] Skipping the second prong for the moment,[68] the third prong requires courts to address whether jurisdiction is reasonable under the circumstances and "permits a court to consider additional factors to ensure the appropriateness of the forum once it has determined that a defendant has purposefully availed itself of the privilege of doing business there."[69] In making this decision, the court should consider factors including: "(1) the burden on the defendant of litigating in the forum; (2) the interest of the forum state in adjudicating the dispute; (3) the plaintiff's interest in obtaining convenient and effective relief; (4) the shared interest of the states in obtaining efficient resolution of disputes; and (5) the interests of the states in furthering substantive social policies."[70]

The second prong, whether the "plaintiff's claims arise out of the activities directed at the forum . . . requires that the defendant's contacts with the forum state form the basis of the suit."[71] In 2017, the Supreme Court of the United States provided in-depth guidance to courts analyzing whether a cause of action arose from the defendant's contacts with the forum state in *Bristol-Myers Squibb Co. v. Superior Court*.[72] The plaintiffs in that case alleged that Plavix, a drug made by the Bristol-Myers Squibb Company (BMS), headquartered in New York and incorporated in Delaware, had damaged their health.[73] The plaintiffs filed suit in California and argued that jurisdiction was appropriate there because BMS maintained five research and laboratory facilities in California, had hundreds of employees in California, and maintained a state-government advocacy office in California.[74] The plaintiffs were not California residents and had not purchased Plavix in California. And none of BMS's California facilities "manufacture[d], label[ed], [or] package[d]" Plavix.[75] Nevertheless, the Supreme Court of California determined that jurisdiction was appropriate because BMS "engage[d] in extensive activities in California" and said, "the more wide ranging the defendant's forum contacts, the more readily is shown a connection between the forum contacts and the claim."[76]

The Supreme Court of the United States reversed, stating that specific jurisdiction requires "an affiliation between the forum and the underlying controversy, principally, [an] activity or an occurrence that takes place in the forum

67 *Id.*

68 Because the second prong requires the most analysis, the authors exercise their artistic license by addressing the second and third prongs out of order.

69 *Consulting Eng'rs Corp.*, 561 F.3d at 279.

70 *Id.*

71 *Id.* at 278–79.

72 137 S. Ct. 1773, 1777 (2017).

73 *Id.* at 1778.

74 *Id.* at 1777–78.

75 *Id.* at 1778.

76 *Id.*

State."[77] "When there is no such connection, specific jurisdiction is lacking regardless of the extent of a defendant's unconnected activities in the State."[78] The Court went so far as to say that "unconnected activities in the State" are not "relevant" when analyzing whether specific jurisdiction is appropriate for an out-of-state defendant.[79] Instead, "[w]hat is needed—and what is missing here—is a connection between the forum and the specific claims at issue."[80]

It is noteworthy that the *Bristol-Myers Squibb* decision was not based on the relationship of the plaintiffs to California. Instead, it concentrated on the link, or nexus, between California and the alleged tortious act. In doing so, the United States Supreme Court cited approvingly to its 2014 holding in *Walden v. Fiore* that "Nevada courts lacked specific jurisdiction even though the plaintiffs were Nevada residents and 'suffered foreseeable harm in Nevada.' Because the 'relevant conduct occurred entirely in Georgi[a] . . . the mere fact that [this] conduct affected plaintiffs with connections to the forum State d[id] not suffice to authorize jurisdiction.'"[81] Even before *Bristol-Myers Squibb*, the Supreme Court of Virginia recognized the necessity of a "'nexus' between the in-state conduct of a defendant and the cause of action" to establish specific jurisdiction.[82]

Only a few months after *Bristol-Myers Squibb*, the Supreme Court of the United States vacated and remanded a case from the Court of Appeals of Arkansas "for further consideration in light of *Bristol-Myers Squibb*."[83] And the Court explicitly rejected the Arkansas Court of Appeals' conclusion that its decision comported with the U.S. Supreme Court's analysis when it vacated the lower court's decision. On remand, the Arkansas Court of Appeals overturned its prior holding and found that jurisdiction did not exist.[84] The Arkansas Court of Appeals found that "*Bristol-Myers* prevents a court from exercising specific jurisdiction when there is no connection between the cause of action and the forum" even when other factors might favor granting jurisdiction.[85]

Another example occurred in 2019 when the U.S. District Court for the Southern District of Indiana analyzed whether a treating doctor from Utah could be hailed into Indiana court because the patient was a citizen of Indiana.[86] In that case, the defendant doctor treated the patient in Utah. He was not licensed in Indiana, and he did not advertise his services in Indiana. In fact, the

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77 *Id.* at 1781 (citing Goodyear Dunlop Tires Operations, S.A. v. Brown, 564 U.S. 915, 919 (2011)).

78 *Id.*

79 *Id.*

80 *Id.*

81 *Id.* at 1781–82 (citing Walden v. Fiore, 571 U.S. 277, 291 (2014)).

82 Witt v. Reynolds Metals Co., 240 Va. 452, 454, 397 S.E.2d 873, 875 (1990).

83 Simmons Sporting Goods, Inc. v. Lawson, 138 S. Ct. 237, 238 (2017).

84 Lawson v. Simmons Sporting Goods, Inc., 2018 Ark. App. 343, 9, 553 S.W.3d 190, 195 (2018).

85 *Id.* at 9, 553 S.W.3d at 196.

86 Durant v. Peterson, No. [unpublished], 2019 U.S. Dist. Lexis 9063, at *3 (S.D. Ind. Jan. 18, 2019).

only connection the defendant had with the forum state was that the patient was a resident.[87] The court declined to exercise personal jurisdiction over the out-of-state doctor, noting that "a plaintiff's contacts with the forum state do not establish jurisdiction over the defendant."[88]

C. PRACTICAL CONSIDERATIONS IN DETERMINING JURISDICTION FOR TELEMEDICINE

As telemedicine is used more frequently, the body of jurisdictional case law discussed here must be adapted to new facts and circumstances. An important first step is familiarity with the existing case law in this area. For example, some courts have held that a patient traveling to another forum for healthcare should expect that a lawsuit arising from negligent medical care would be in the healthcare provider's state and not the patient's place of residence.[89] Conversely, a radiologist who knowingly provides teleradiology services to an out-of-state hospital is likely subject to suit in that jurisdiction (and should likely become licensed there).[90]

But what if the healthcare provider never knows where the patient is (or will be) located during a telemedical visit? Or what if the patient never travels to the doctor's physical office because the healthcare relationship occurs solely via telehealth? Even if Virginia advanced practitioners care for Virginia residents exclusively, their patients could be anywhere during telemedical visits. Depending on the nature and extent of the contact, could traveling patients succeed in making the advanced practitioner subject to suit in any foreign forum?

Assuming general jurisdiction does not exist, the analysis of telemedical claims under personal jurisdiction forces courts to decide where the medical negligence occurred: at the location of the medical provider, where the patient is located when they receive the advice, or in both places such that jurisdiction would be proper in either forum. From a licensing standpoint, the Virginia Board of Medicine's guidance states that "[t]he practice of medicine occurs where the patient is located at the time telemedicine services are used," as the Virginia Code defines the term *telemedicine services*.[91] If courts adopted this definition to determine jurisdiction (which the authors do not endorse), it would make it difficult for Virginia advanced practitioners to provide any telemedical care without first confirming that the patient was in a suitable jurisdiction—even

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[87] *Id.*

[88] *Id.*

[89] *See*, *e.g.*, Gelineau v. New York Univ. Hosp., 375 F. Supp. 661, 667 (D.N.J. 1974); Hume v. Durwood Med. Clinic, Inc., 282 S.C. 236, 242, 318 S.E.2d 119, 122 (S.C. Ct. App. 1984).

[90] *See* Scott B. Berger and Barry B. Cepelewicz, *Medical-Legal Issues in Teleradiology*, 166 AM. J. ROENTGENOLOGY 505, 509 (1996) ("Courts will most likely find that teleradiology consultants who give advice that is used in a specific state will be subject to the jurisdiction of that state because the teleradiologist practiced in that state and that is where the alleged injury occurred.").

[91] VIRGINIA BOARD OF MEDICINE, TELEMEDICINE, at 2 (2021), *available at* https://www.dhp.virginia.gov/media/dhpweb/docs/med/guidance/85-12.pdf; VA. CODE ANN. § 38.2-3418.16(B) (definition of *telemedicine services*).

for patients whose primary residence is in Virginia or who originally traveled to Virginia to see the advanced practitioner. An advanced practitioner who did not confirm the patient's location before starting the visit would risk being sued wherever the patient happened to be located.

But courts' analysis of personal jurisdiction generally differs from the analysis the Board of Medicine uses when licensing. While the specifics will vary by case, it is valuable to analyze how courts in Virginia and beyond have analyzed personal jurisdiction in the setting of these various contacts. Usually, if an out-of-state advanced practitioner (or the practitioner's employer) is being sued in Virginia on the basis of specific jurisdiction, "general connections with [Virginia] are not enough" even if those connections are "continuous."[92] Accordingly, plaintiffs' counsel will look at specific contacts with the patient in the forum state as well as the defendant's general contacts with the forum state when seeking jurisdiction.

Defense counsel will need to delve into the facts in each case, including how, when, or if the defendant knew where the patient was when the relevant medical advice was provided. These facts will all be grist for the mill when the court evaluates whether the advanced practitioner is subject to jurisdiction in Virginia or the plaintiff is attempting to apply "a loose and spurious form of general jurisdiction."[93] In doing so, counsel should pay particular attention to the tests for "purposeful availment" discussed in *Bristol-Myers Squibb*[94] and the factors considered in *Consulting Engineers Corp.*, including "the burden on the defendant of litigating in the forum."[95] From a practical standpoint, advanced practitioners should consider how they interact with patients (phone, video conference, email, *etc.*) and how they document those contacts (*i.e.*, the reason for the form of contact as well as the content of the contact).

D. EXAMPLES OF POTENTIAL JURISDICTIONAL "HOOKS" IN TELEMEDICAL CASES

A plaintiff suing an out-of-state advanced practitioner in Virginia needs to establish a "hook"—some significant contact related to the claimed negligence with the plaintiff in Virginia—that justifies a Virginia circuit court's exercise of personal jurisdiction over the advanced practitioner. Even before telemedicine, medical care involved phone calls, letters from healthcare providers sent across state lines, as well as email and text communications with patients. Accordingly, courts have examined these forms of contact through the lens of jurisdiction. Going forward, neegligence cases will likely continue to involve traditional contacts, although they will more often occur alongside other types of telemedical interactions. For example, a plaintiff may allege the evaluation by an out-of-

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92 Bristol-Myers Squibb Co. v. Superior Court, 137 S. Ct. 1773, 1781 (2017).

93 *Id.* at 1776.

94 *Id.* at 1781–82.

95 Consulting Eng'rs Corp. v. Geometric Ltd., 561 F.3d 273, 279 (4th Cir. 2009).

state advanced practitioner during an in-person or telemedical visit was negligent, and the resulting treatment plan included virtual or telephonic follow-ups and a prescription sent to a Virginia pharmacy.

The decisions noted below illustrate courts' reactions to some of these forms of contact, and they can provide a helpful framework for analyzing others. As the reader will discover, the decisions follow a general theme: defendants who merely respond to contacts initiated by the plaintiff are usually not subject to personal jurisdiction in another state. Awareness of this theme may help advanced practitioners communicate with patients, and document those communications, in a way that could prevent them from be misconstrued as a jurisdictional hook.

1. Phone Calls to the Patient in Virginia

Phone calls to a patient in the forum state alone—especially in response to a patient need—are unlikely to establish personal jurisdiction. In *Clark v. Remark*, the patient underwent breast augmentation surgery in Florida and subsequently moved to Virginia.[96] The patient sued the surgeon in Virginia, but the surgeon contested jurisdiction. Despite two letters and a call from the surgeon to the plaintiff in Virginia, the U.S. Court of Appeals for the Fourth Circuit held that the defendant physician did not have the requisite minimum contacts with Virginia to make jurisdiction here appropriate.[97] The Fourth Circuit found it significant that the defendant's letter and calls were merely responses to the plaintiff's correspondence—"[t]he focus, therefore, should be on the actions that [the defendant surgeon] initiated; his responses to [the patient's] solicitations are irrelevant insofar as they only addressed [the patient's] inquiries."[98]

Two years later, the Alleghany County Circuit Court held that it had no jurisdiction over a Pennsylvania defendant in a breach of contract case despite eight phone calls between the Virginia plaintiff and Pennsylvania defendant regarding the contract.[99] Again, the initial phone contact was made by the plaintiff, and the court held that there was "no evidence that defendant 'purposefully directed' his activities at Virginia."[100] Likewise, the U.S. District Court for the Eastern District of Virginia has held in several cases that telephone calls, faxes, and letters are not sufficient to support a finding of jurisdiction, even when those communications are in furtherance of a contract negotiation between the parties.[101] If possible, and given clinical realities, advanced practitioners com-

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[96] No. 92-1682, 1993 U.S. App. LEXIS 10043, at *2 (4th Cir. Apr. 29, 1993).

[97] *Id.* at *9.

[98] *Id.* at *10.

[99] Healthcare Everywhere, Inc. v. Edwards, 37 Va. Cir. 77, 77 (Alleghany Co. 1995).

[100] *Id.* (citing Burger King Corp. v. Rudzewicz, 471 U.S. 462, 476 (1985)).

[101] Initiatives, Inc. v. Korea Trading Corp., 991 F. Supp. 476, 479 (E.D. Va. 1997); Superfos Investments Ltd. v. Firstmiss Fertilizer, Inc., 774 F. Supp. 393, 397–98 (E.D. Va. 1991) (rejecting plaintiff's argument that negotiation of the contract by correspondence, telephone calls, and facsimile transmissions to Virginia was sufficient to establish personal jurisdiction); Unidyne Corp. v. Aerolineas Argentinas, 590 F. Supp. 391, 396 (E.D. Va.

municating with patients—in-state or out-of-state—should thoroughly document the reason for the call, by whom it was initiated, as well as the content of the call itself.

2. Emails, Text Messages, and Patient Portal Messages to a Patient in Virginia

To the extent the defendant initiates contact, courts may analyze the relative importance of the contact in the overall context of the case. In Virginia, "the law is well settled that mere emails and telephone calls directed at Virginia do not amount to transacting business in Virginia."[102] In *FireClean, LLC v. Tuohy*, the out-of-state defendant sent "numerous emails, text messages, Facebook messages, and occasionally phone calls" to the plaintiff in Virginia,[103] then used these communications as the basis for some allegedly defamatory statements the defendant made on his Facebook page and blog concerning the plaintiff.[104] Even though the defendant initiated the communications, the U.S. District Court for the Eastern District of Virginia found that they were "minimal in quantity" from a "due process [jurisdiction] perspective" because they were referenced only in passing in the defendant's allegedly defamatory statements.[105] Because these contacts played a limited role in the overall context of the plaintiff's allegations, the court held that specific jurisdiction was inappropriate because the defendant "did not purposefully avail himself of Virginia."[106]

Regarding patient portal websites, the U.S. Court of Appeals for the Fourth Circuit has held that such websites confer personal jurisdiction only if they specifically target residents of a particular state.[107] In *Fidrych*, Marriott's website was available for commercial transactions for any Internet user, including those

1984) (finding that telephone calls, telex messages, and letters did not form a basis for personal jurisdiction); Williams Crane & Rigging, Inc. v. B & L Systems, Ltd., 466 F. Supp. 956, 957 (E.D. Va. 1979) (holding that a single phone call and letter to forum did not warrant personal jurisdiction).

102 Nathan v. Takeda Pharms. Am., Inc., 83 Va. Cir. 216, 225 (Fairfax County 2011) (holding that multiple emails sent to plaintiff in Virginia insufficient to establish that defendants were transacting business in Virginia (citing *Superfos Invest., Ltd.*, 774 F. Supp. at 397–98 and *Unidyne Corp.*, 590 F. Supp. at 396)); *see also* Micropicture Int'l, Inc. v. Kickartz, No. 3:05-CV-00034, 2006 U.S. Dist. Lexis 3714, at *9–10 (W.D. Va. Jan. 17, 2006) (holding that seven emails and a letter sent to plaintiffs in Virginia formed insufficient basis for specific personal jurisdiction); Alton v. Wang, 941 F. Supp. 66, 67 (W.D. Va. 1996) (holding that no personal jurisdiction existed because no act related to the tort was physically committed in the forum state, rather, defendant's acts consisted entirely of emails into the forum state).

103 FireClean, LLC v. Tuohy, No. 1:16-cv-0294, 2016 U.S. Dist. Lexis 96294, at *16 (E.D. Va. July 21, 2016).

104 *Id.* at *16–18.

105 *Id.* at *18.

106 *Id.* at *25; *see also* Fyfe Co., LLC v. Structural Group, No. CCB-13-176, 2013 U.S. Dist. Lexis 75685, at *11–12 (D. Md. May 30, 2013) (holding that text messages and other communications initiated into Maryland not enough for personal jurisdiction in Maryland).

107 *See* Fidrych v. Marriott Int'l, Inc., 952 F.3d 124, 141 (4th Cir. 2020); Reed v. Beverly Hills Porsche, 307 F. Supp. 3d 494, 506 (W.D. Va. 2018) ("'in the Internet context,' there must be proof 'that the out-of-state defendant's Internet activity is expressly targeted at or directed to the forum state.'" (quoting Young v. New Haven Advocate, 315 F.3d 256, 262-63 (4th Cir. 2002))).

in South Carolina.[108] The court noted that the website at issue did not target South Carolina residents; instead it merely "ma[de] itself available to anyone who [sought] it out."[109] Thus, Marriott had not "'purposely directed [its] activities at residents of the forum"' via the website.[110] In addition, the court held that "the connection between the defendant and the forum must arise out of contacts that the defendant *himself* creates with the forum state."[111]

Looking at phone, email, text, and patient portal contacts generally, to the extent the patient initiates that contact, it is unlikely that patient portal communications will confer jurisdiction in the patient's home state in a malpractice action. Nevertheless, advanced practitioners should be aware that these contacts will be evaluated if they are sued outside their home state. Preventative documentation should include the reasons for such contacts as well as their content. Advanced practitioners and defense counsel should also be aware of courts' analysis of classic forms of contact like paper letters sent through the physical mail.

3. Letters Mailed to a Patient in Virginia

Generally, "sending letters to Virginia is an insufficient basis to assert personal jurisdiction,"[112] although, like the types of contacts discussed above, the question whether a defendant has benefitted from contact into the forum state is a significant factor.[113] In 2007, the U.S. District Court for the District of Maryland held that it was immaterial that the patient in a medical malpractice case was referred to the Illinois medical provider by his doctor in Maryland, that some of the Illinois provider's advertising reached Maryland residents, that the provider's website could be accessed by Maryland residents, or that the Illinois medical provider sent an informational packet to the decedent in Maryland before beginning treatment.[114] Instead, the court held that these contacts, even combined with phone and mail communications from the out-of-state medical provider to the Maryland patient, did "not provide sufficient minimum contacts for the exercise of personal jurisdiction."[115]

In general, out-of-state advanced practitioners do not specifically seek out Virginia residents for treatment. Instead, it is more likely that a Virginia resident will have voluntarily chosen to seek treatment with that healthcare provider.

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108 *Fidrych*, 952 F.3d at 141.

109 *Id.*

110 *Id.* at 142 (quoting Burger King Corp. v. Rudzewicz, 471 U.S. 462, 472 (1985)).

111 *Id.* at 143 (citing Walden v. Fiore, 571 U.S. 277, 284 (2014)) (emphasis in original).

112 Loria v. Regelson, 38 Va. Cir. 283, 288 (Richmond Cty. 1995) (citing Superfos Investments Ltd. v. Firstmiss Fertilizer, Inc., 774 F. Supp. 393, 397–98 (E.D. Va. 1991) and Unidyne Corp. v. Aerolineas Argentinas, 590 F. Supp. 391, 396 (E.D. Va. 1984)).

113 *Id.* at 287–88.

114 Weistock v. Levin, No. CCB-06-3034, 2007 U.S. Dist. Lexis 18240, at *2, *3, *9, *10 (D. Md. Mar. 13, 2007).

115 *Id.* at *10.

And the inverse is likely true for out-of-state patients traveling into the Commonwealth for healthcare or who happen to receive healthcare while in Virginia. Thus, routine letters sent to a patient from an out-of-state advanced practitioner should be insufficient to show targeting of the Virginia resident and should be insufficient to support jurisdiction in the patient's home state.

4. Prescriptions Sent to a Virginia Pharmacy for a Virginia Patient

Like letters, writing a prescription to a Virginia patient is unlikely to support an allegation of practicing without a license or, without more, personal jurisdiction over an out-of-state advanced practitioner. In 2007, the U.S. District Court for the Western District of Virginia held that "[prescriptions] are merely a component of the treatment performed in the doctor's office. A plaintiff cannot use the location where prescriptions are filled as a means to establish personal jurisdiction over the physician in another location when the plaintiff's action is the reason the prescriptions are filled in that location."[116] Other federal circuit and district courts have likewise recognized that the location where a prescription is filled is not a basis for exercising personal jurisdiction.[117] And the Code of Virginia specifically allows pharmacists here to fill prescriptions written by an out-of-state advanced practitioner if the prescription complies with Virginia law.[118]

III. Other Unique Issues for Advanced Practitioners in Litigation

Advanced practitioners are a unique category of healthcare provider; they must be treated uniquely as defendants and experts, and they are subject to unusual claims. One such claim is practicing without a license. Occasionally, a plaintiff may argue that an advanced practitioner's actions in a particular case fell outside the scope of the practice agreement and thus constituted the practice of medicine without a license.

For advanced practitioners without an autonomous practice designation, the practice agreement lays out the conditions under which they must collaborate about patients with either a specific physician or a physician in their designated patient care team. In some clinical settings, like emergency departments, the collaborating physician may be available for immediate face-to-face consultation with the advanced practitioner. In other settings the collaborating physician may be available immediately only by phone but may be on-call for in-person consul-

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116 Boyd v. Green, 496 F. Supp. 2d 691, 701 (W.D. Va. 2007).

117 *See*, *e.g.*, Wright v. Yackley, 459 F.2d 287 (9th Cir. 1972) (holding that Idaho had no personal jurisdiction in a medical malpractice case where the plaintiff moved to Idaho and filled a prescription issued by South Dakota doctor); Ruhe v. Bowen, No. 2:15-cv-03792-DCN, 2016 U.S. Dist. Lexis 131064, at *11–12 (D.S.C. 2016) (holding there was no personal jurisdiction in South Carolina over a Colorado doctor who filled the patient's prescriptions in South Carolina, noting that this would be "fundamentally unfair"). *But see* Hageseth v. Superior Court, 150 Cal. App. 4th 1399 (Cal. Ct. Ap. 2007) (holding (before *Bristol-Meyers Squibb*) that a doctor who practiced in Colorado and prescribed a drug over the Internet after reviewing a questionnaire forwarded by a Florida company from a person who identified himself as a California resident was subject to personal jurisdiction in California for a criminal charge stemming from the prescription).

118 Va. Code Ann. § 54.1-3303(F).

tation if needed. As advanced practitioners provide more care remotely, physician collaboration may occur remotely more often as well. Each medical specialty can define the level of supervision for each specific advanced practitioner providing telemedical care through practice agreements.

In any case involving an advanced practitioner, defense counsel should obtain and analyze the advanced practitioner's practice agreement as soon as possible. Practice agreements are usually broadly worded so as to allow physician assistants and nurse practitioners to "utilize [their] professional judgment" to determine whether and when to consult the collaborating physician or patient care team physician.[119] But plaintiffs may still claim that an advanced practitioner's care and treatment of a patient fell outside the scope of their practice agreement, therefore constituting the unauthorized practice of medicine, and thus falling outside the Medical Malpractice Act ("the Act") and its attendant damages cap.[120]

Even a broadly worded practice agreement must provide for physician "input" or "involvement."[121] PAs are specifically cautioned to "[p]erform only those medical care services that are within the scope of the practice and proficiency of the patient care team physicians or podiatrists as prescribed in the physician assistant's practice agreement"[122] and not to "[p]erform procedures or techniques that are outside the scope of [their] practice or for which [they are] not trained and individually competent."[123] And NPs who have "exceeded the[ir] authority as a licensed nurse practitioner" are subject to discipline by the Board of Nursing.[124]

In any case, defense counsel's mission is to place the question of when and how an advanced practitioner seeks the "input" or "involvement" of a physician securely within the defendant advanced practitioner's discretion. If the timing and type of consultation is discretionary, the question whether an advanced practitioner appropriately sought physician consultation in any given situation is a question whether the practitioner met the standard of care. Defense counsel should carefully frame the plaintiff's claim within the statutory definition of *malpractice*; that is, that the suit claiming that advanced practitioner failed to consult a physician is a "tort action . . . based on health care . . . service[ ]," the

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119 18 VA. ADMIN. CODE § 90-30-10.

120 VA. CODE ANN. § 8.01-581.15.

121 18 VA. ADMIN. CODE § 90-30-120(D)(2) (nurse practitioners' practice agreements must "include provisions for . . . [a]ppropriate physician input in complex clinical cases and patient emergencies and for referrals"); *see* 18 VA. ADMIN. CODE § 85-50-101(A)(1) (As to physician assistants, "[a]ny such practice agreement shall take into account such factors as . . . the nature of the [supervising] physicians' or podiatrists' availability in ensuring direct physician or podiatrist involvement at an early stage and regularly thereafter.").

122 18 VA. ADMIN. CODE § 85-50-115(A)(1).

123 18 VA. ADMIN. CODE § 85-50-179(A)(1).

124 18 VA. ADMIN. CODE § 90-30-220(3).

physician consultation, "which should have been rendered . . . to a patient" by the defendant advanced practitioner.[125]

While not directly on point, the Circuit Court for the County of Suffolk in *Monahan v. Obici Medical Management Services* considered whether the alleged malpractice of a nurse practitioner created, via the practice agreement, a cause of action for negligence against her supervising physician where the supervising physician had no contact with the patient.[126] In coming to his opinion that it did not, the circuit court judge, now Supreme Court of Virginia Justice Arthur Kelsey, discussed the meaning of the term *supervision* as it applies to the relationship between nurse practitioners and physicians with whom they have a practice agreement. Then-Judge Kelsey pointed out that "as used in the chapter dealing with the prescriptive authority of nurse practitioners, the term 'supervision' means that the nurse practitioner has access to the 'physician documents' for consultation—with the physician nonetheless 'maintaining ultimate responsibility for the agreed-upon course of treatment and medications prescribed.'"[127]

Under this reading, face-to-face or even voice-to-voice discussions are not necessary for supervision or consultation as those terms are used to describe the relationship between advanced practitioners and physicians. Instead, all that is required is that the physician be available to the advanced practitioner if needed. This interpretation has the added weight of consistency with the Virginia Administrative Code.[128]

Imagine a case where an advanced practitioner is alleged to have gone outside the scope of the practice agreement by failing to consult a physician about a specific patient. The plaintiff argues that because the advanced practitioner never consulted any physician, the AP practiced outside the scope of the Department of Health Professionals' regulations, thereby practicing medicine without a license—a tort falling outside the Act. The plaintiff may even argue that expert testimony regarding whether the advanced practitioner's actions fell within the statutes and regulations is inappropriate testimony regarding a legal conclusion.[129]

First, defense counsel can argue that the claim is nothing more than an impermissible negligent supervision claim masquerading as practicing medicine with-

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125 VA. CODE ANN. § 8.01-581.1 (the Medical Malpractice Act's definition of *malpractice*).

126 59 Va. Cir. 307 (Suffolk 2002).

127 *Id.* at 311 (quoting 18 VA. ADMIN. CODE § 90–40–10 (2000)). Please note that in 2015 the definition of *supervision* was removed from this section. 31 Va. Reg. Regs. 1879 (June 15, 2015). In 2019, a Supreme Court of Virginia decision authored by Justice Kelsey declined to create a negligent supervision tort in Virginia, thus supporting *Monahan*'s 2002 holding that "[t]his new species of medical malpractice claim, based entirely on supervisory liability, is wholly unknown in the common law." *Id.* at 312; *see A.H. v. Church of God in Christ, Inc.*, 297 Va. 604, 630, 831 S.E.2d 460, 475 (2019) ("In Virginia, there is no duty of reasonable care imposed upon an employer in the supervision of its employees under these circumstances and we will not create one here." (internal quotation marks and citations omitted)). *But see* Morvillo v. Shenandoah Mem'l Hosp., 547 F. Supp. 2d 528, 533-36 (W.D. Va. 2008) (holding plaintiff's request to amend complaint to assert a claim of supervisory liability against an anesthesiologist regarding a CRNA's treatment was not futile).

128 *See* 18 VA. ADMIN. CODE § 90-30-120(D)(1) & (2).

129 VA. CODE § 8.01-401.3.

out a license.[130] Further, applying the reasoning in *Monahan*, the advanced practitioner could raise the defense—assuming it is supported by the practice agreement—that the patient care team physician's "periodic review of patient charts or electronic patient records" provided the required opportunity for "[a]ppropriate physician input"[131] "based on the [defendant advanced practitioner's view of the] clinical conditions of the patient to whom care is provided."[132] Accordingly, whether the defendant advanced practitioner's assessment of a given patient's clinical condition was reasonable, or whether the opportunity for chart review was a reasonable opportunity for input in a given case, should be questions answerable within the framework of Code section 8.01-581.20—that is, within the Act and subject to its cap on damages.

Even when firmly within the realm of a malpractice claim, another notable danger exists when defending an advanced practitioner accused of failing to seek adequate physician input. Perhaps unsurprisingly, a physician's view of this question is likely to be different—and less forgiving—than that of a fellow advanced practitioner. Accordingly, defense counsel should try to frame the procedure at issue narrowly to an act or acts performed only by advanced practitioners.[133] For example, the procedure at issue could be an advanced practitioner's consultation of a physician for a specific set of facts pursuant to an advanced practitioner's education, training, and practice agreement. While any physician might make consultations to other physicians, they are less likely to have made consultations in the setting of a practice agreement. And it is unlikely that the opposing expert physician will testify that their education and training are the same as an advanced practitioner's.

IV. The Future of the Advanced Practitioner

"Professional licensing for telemedicine practitioners is often cited as a barrier to the expanded use of telehealth and telemedicine."[134] To address this barrier during the Covid pandemic, Governor Northam issued Executive Orders 57 and 84, both of which allowed "[h]ealth-care practitioners with an active license issued by another state [to] provide continuity of care to their current patients who are Virginia residents through telehealth services." But following the expiration of Virginia's Covid state of emergency the Commonwealth generally requires healthcare providers providing telemedicine services to patients located

130 *See A.H.*, 297 Va. at 630, 831 S.E.2d at 475.

131 18 Va. Admin. Code § 90-30-120(D)(1) & (2).

132 18 Va. Admin. Code § 90-30-86(G).

133 Virginia courts evaluate both the active clinical practice requirement and the knowledge requirement for standard of care experts by first defining *procedure at issue*. *See* Holt v. Chalmeta, 295 Va. 22, 809 S.E.2d 636 (2018); Wright v. Kaye, 267 Va. 510, 593 S.E.2d 307 (2004); Sami v. Varn, 260 Va. 280, 535 S.E.2d 172 (2000).

134 Christian D. Becker, *et al.*, *Legal Perspectives on Telemedicine Part 1: Legal and Regulatory Issues*, Perm J. (2019), *available at* https://www.thepermanentejournal.org/files/2019/18-293.pdf.

in Virginia to hold a Virginia license.[135] The Virginia Board of Medicine's stance on the issue with regard to licensing is clear: "the practice of medicine occurs where the patient is located at the time telemedicine services are used . . . . Therefore, a practitioner must be licensed by, or under the jurisdiction of, the regulatory board of the state where the patient is located and the state where the practitioner is located."[136]

Regardless whether an advanced practitioner's treatment of an out-of-state patient falls within the Board of Medicine's guidance for licensed practice, the question whether that treatment subjects the advanced practitioner to jurisdiction in the patient's home state requires a different analysis. At present, without some other solution, that important question can be answered only by critical analysis of the advanced practitioner's contacts with the patient and the patient's state. Some other solution may be a legislative or regulatory change (federal or state), a forum agreement with the patient executed before any telemedicine interaction, or some combination of the two.[137]

The demand for access to healthcare in Virginia likely precludes the Commonwealth from taking baseball's approach in developing the Infield Fly Rule—an "essentially conservative" method where "problems are solved very slowly" that "reaps few rewards" but "also runs few risks."[138] Even if the two-year clinical practice requirement for nurse practitioners to apply for an autonomous practice designation sunsets on July 1, 2022, the push for greater independence for NPs and PAs in Virginia is unlikely to subside.

Nationally, regulations for advanced practitioners are trending away from a "restricted practice" model and toward a "full practice model."[139] Full

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[135] As of April 2022, two new exceptions exist. First, for some "behavioral health services" as discussed *supra* note 47. Second, for established patients of out-of-state practitioners who meet certain criteria. VA. CODE ANN. § 54.1-2901(A)(33) (2022).

[136] VIRGINIA BOARD OF MEDICINE, TELEMEDICINE, at 2 (2021), *available at* https://www.dhp.virginia.gov/media/dhpweb/docs/med/guidance/85-12.pdf.

[137] *See generally*, J. Kelly Barnes, *Telemedicine: A Conflict of Laws Problem Waiting to Happen*, 28:2 HOUS. J. INT'L. L. 491 (2006); Mindy Nunez Duffourc & Matthias Haag, *German Telemedicine for an American Patient: The Validity of Venue Selection and Choice-of-Law Clauses in International Telemedical Contracts*, HARV. INT'L L. J. BLOG (Aug. 30, 2019), *available at* https://harvardilj.org/2019/08/german-telemedicine-for-anamerican-patient-the-validity-of-forum-selection-and-choice-of-law-clauses-in-internationaltelemedical-contracts/.

[138] William S. Stevens, Comment, *The Common Law Origins of the Infield Fly Rule*, 123 U. PA. L. REV. 1474, 1481 (1975).

[139] AMERICAN ASSOCIATION OF NURSE PRACTITIONERS, STATE PRACTICE ENVIRONMENT (2021).

practice for nurse practitioners is "recommended by the National Academy of Medicine, formerly called the Institute of Medicine, and the National Council of State Boards of Nursing" and has been adopted by twenty-five of fifty states.[140] Physician assistants are likewise pushing for more autonomy.[141] This push comes partially as a reaction to the growth of nurse practitioner autonomy and partially as a natural response to the increase in patient need.[142]

Ultimately, as advanced practitioners grow in numbers and gain independence, they will become more frequent targets of medical negligence allegations. Defense attorneys must become familiar with the unique opportunities and challenges these lawsuits may present and must be flexible enough to apply existing principles to defend this valuable, rapidly changing group of healthcare team members.

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140 *Id.*

141 Dale J. Bingham, *What's the Future of the Physician Assistant?*, MEDPAGE TODAY (Mar. 7, 2020), *available at* https://www.kevinmd.com/2020/03/whats-the-future-of-the-physician-assistant.html; Nicole Mason, *Does the PA Profession Have a 2030 Expiration Date?*, PA FORUM (Feb. 6, 2021), *available at* https://www.physicianassistantforum.com/topic/58632-pa-future/.

142 *Id.*