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Direct Liability in Healthcare:

Risk Exposure Hiding in Plain Sight

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Direct Liability in Healthcare:
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INTRODUCTION

Direct liability means that a person or entity is held responsible for their own or its own acts or omissions. Causing a perforation during surgery or making a medication error are obvious examples where a physician may be held directly accountable for a patient injury. However, physicians and the entities they own and serve may not realize the numerous ways they may subject themselves to direct liability allegations, even when not performing hands-on care or treatment. Everything from negligent facilities management, to hiring and supervision, to policies and procedures may lead to unanticipated outcomes that plaintiffs' counsel might pursue as direct liability cases. This article will discuss some of the ways individual physicians and healthcare entities may find themselves facing a direct liability claim and provide risk management strategies intended to prevent scenarios that result in such claims.

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DIRECT LIABILITY VS. VICARIOUS LIABILITY:

Recognizing Different Kinds of Risk Exposures

Direct liability involves acts or omissions committed by an entity or person that result directly in harm, usually to a patient. In claims based on employee acts, "[t]his means that some negligent act or omission of the employer was a cause of, allowed, or led to the negligence of the employee, thereby causing injury to the claimant."[1] "Direct negligence claims against a healthcare provider-employer include failure to train employees, failure to enforce accepted standards of care, and failure to employ protocols to ensure quality care for patients. Direct liability claims also include allegations of negligent supervision."[2]

Vicarious liability results when an entity or person is held responsible for the actions or omissions of a third party, where the liability is not based on any improper action by the entity or person. In contrast to a direct liability claim, in a vicarious liability claim an employer faces liability for the actions of an employee rather than the actions of the employer.[1]

Keep in mind that while the above quotations relate to employer-employee situations, both vicarious and direct liability claims arise from a variety of situations. Partnerships, agency/ostensible agency, independent contractors, educational supervision, and the like, can produce liability claims. Providers may develop a false sense of security when careful and conscientious with their own encounters with patients and when guarding against vicarious liability. However, the case studies that follow demonstrate why physicians and healthcare entities must also guard against other lapses in their own behavior to avoid patient harm and direct liability allegations.

FAKE NURSES: SOMEONE ELSE'S FRAUD CAN CAUSE YOUR RISK

In January 2023 the United States Department of Health and Human Services Office of Inspector General and connected law enforcement set in motion Operation Nightingale—an investigation regarding individuals selling fraudulent nursing degree transcripts and diplomas. At least three nursing schools in Florida closed due to involvement in the scam, and the alleged fraudsters circulated as many as 7,600 fake transcripts and diplomas. Obtaining the fake documents allowed buyers to sit for the national nursing board examination and, upon passing, seek licenses and employment in various states as registered nurses and licensed practical nurses.[3,4]

It would have been extremely difficult for the hospitals caught up in Operation Nightingale to have independently discovered the nurses' fraudulent credentials during the hiring process. However, it serves as a reminder of the vigilance required when evaluating the qualifications of potential hires. ProAssurance's article, Operation Nightingale Uncovers Alleged Fraud Scheme, provides more information on how fraudulent activity like this could expose hospitals to allegations of negligent hiring or negligent retention (if they do not terminate the employment of unqualified employees).

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Hiring/Supervision/Oversight:

How an Employer's Failure to Act May Cause Injury

Healthcare professionals and entities require vigilance in hiring, supervision, and other oversight to avoid direct liability claims. Staff or other personnel acting beyond the scope of their skills, experience, and education, or even committing crimes, can result in claims directed at the employer. "This direct or independent liability of the employer generally arises from a claim that it negligently hired, trained, supervised, or retained the employee in question. These claims can also involve allegations that proper policies and procedures were not implemented or enforced and that those failures caused the injury at issue."[1] In other words, the failure of the employer to act may lead to the injury of a patient: examples include failure to conduct criminal background checks; failure to verify training, experience or credentials; or a failure to heed reports of inappropriate behavior or practices.

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CASE ONE

Allegation: Lack of supervision leads to direct liability claim for sexual advances.

A patient with a chronic health condition returned to a clinic expecting to obtain lab results after a blood draw. In the patient's experience, such a visit ordinarily lasted approximately ten minutes and did not include a physical examination. On the day in question, a nurse took the patient's vital signs and placed him in a private exam room where he waited on a chair for the physician, who would discuss the lab tests with him. The patient remained in his street clothes rather than changing to a gown. The physician entered the room with the patient, and they discussed the tests, after which the patient stood to leave, believing the visit had concluded. The physician explained to the patient that a physical examination was required, then asked the patient to remove his pants. The patient complied and took down his trousers. The physician asked the patient to turn his head and cough, and as the patient did so and felt the doctor touching his testicles, he realized the doctor was not wearing gloves for the exam. Moving away from the doctor, the patient told the doctor she should be wearing gloves. The physician approached the patient and told him she wanted to have sex with him. The patient refused, immediately pulling up his trousers and attempting to leave the exam room. Due to the size of the room, the physician was able to hold the door closed as the patient tried to open it, begging him not to report her behavior.

DISCUSSION

In this case the patient alleged that the clinic negligently investigated and hired the physician and failed to properly train and supervise her. Additional allegations included failure to provide a safe environment for the patient. Taken together, these allegations formed the foundation of the patient's claim that the clinic breached the duty and standard of care owed to him. The patient claimed that due to these failures he suffered increased medical expenses and emotional distress, including humiliation, fear, and physical harm. During the investigation, defense counsel discovered that the physician moonlighted at another clinic at the same time she worked at the clinic in question. Three additional patients at the clinic under investigation and two patients at the other clinic came forward with allegations of inappropriate sexual advances by the physician. The physician admitted to a relationship with yet another patient at the clinic under investigation but claimed she did not realize the person was a patient at the facility and the relationship was consensual. The physician denied all allegations from the other patients at both clinics.

No chaperone policy existed that might have prevented the inappropriate behavior of the physician. While a code of conduct prohibited any form of sexual harassment of patients, no system monitored whether physicians and staff were required to refresh their familiarity with the policy and acknowledge doing so.

Since the clinic conducted a rigorous background check of the physician prior to hiring, the allegations generated alarm and surprise with management. No chaperone policy existed that might have prevented the inappropriate behavior of the physician. While a code of conduct prohibited any form of sexual harassment of patients, no system monitored whether physicians and staff were required to refresh their familiarity with the policy and acknowledge doing so. Further, the clinic failed to produce clear documentation showing the timeline for learning of and investigating the allegations, versus when they removed the physician from patient interactions and fired her. For these reasons and doubts about the physician's denials, defense counsel considered the case dangerous to take before a jury, and settlement resulted.

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RISK REDUCTION STRATEGIES

The previous case illustrates the difficulties hiring and managing employees can present in terms of avoiding direct liability claims. To some extent the entity is forced to rely on the integrity of the applicant or employee. However, consider the following strategies:[1,5]

- Conduct complete background checks of any applicant considered for an offer of employment.
- Use primary source verification to validate the education, experience, and credentials of all potential employees.
- Develop a clear policy for outside employment.
- Maintain an employee code of conduct and have all employees review and sign off on their review at regular intervals.
- Take all reports of inappropriate behavior seriously, investigate thoroughly and in a timely manner, and document all steps taken to address complaints.
- Create an environment where employees feel safe speaking up.
- Ensure employees know how to report concerns for patient/employee safety or well-being.
- Consider using a chaperone system to protect patients as well as physicians and staff.
- Evaluate whether the physical environment is conducive to inappropriate behavior.
- Require physicians or providers to explain procedural touch before making physical contact with a patient.
- Do not assume that patient silence means consent to procedural touch.
- Educate patients to inform you or staff if any process or procedure makes them uncomfortable.

FACILITIES MANAGEMENT: FROM HARDSCAPE TO SOFTWARE

Proper maintenance of facilities may not be the first example that comes to mind when considering direct liability. However, failure to maintain facilities to the proper standards can lead to devastating outcomes. Infections, patient and visitor injuries, and cyberattacks[6] are just a few possibilities. In Germany, for example, a ransomware attack on University Hospital Düsseldorf in September 2020 resulted in at least one death during rerouting of patients.[7] In another case a woman in Alabama sued a hospital following a ransomware attack she alleged caused her baby to suffer a brain injury and die.[8]

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Policies and Procedures:

How Inadequacies May Contribute to Claims

Most medical providers can appreciate the fact that making an error while providing treatment directly to a patient—for example, operating on the wrong limb—might generate a medical malpractice claim. After all, one of the most basic tenets of medicine is to first do no harm.[9] Less obvious perhaps, direct liability claims often result from issues not ordinarily associated with hands-on treatment. Inattention to everything from infection control protocols to environmental conditions, to unfulfilled continuing educational requirements raises the possibility of unexpected injury to a patient. In the following case the policies and procedures of a practice contributed to a tragic outcome.

CASE TWO

Allegation: Insufficient policies and procedures contributed to the death of an infant.

A married 28-year-old woman presented to an OB/GYN practice for confirmation of a pregnancy, the second child for her family. During the visit, the patient filled out a

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questionnaire reporting no personal or family history of congenital heart defects and denied any other known medical problems for her own and her husband's sides of the family. The practice had provided prenatal care and delivered the patient's first child. During that pregnancy a physician (Physician A) from the practice placed a note in the patient's chart: "brother with heart defect and sister stillborn." Despite placing this note into the electronic charting system, Physician A did not red flag the entry to alert any other provider subsequently reviewing the chart.

The physician (Physician B) at the practice who delivered the patient's first child assumed care for her during the second pregnancy. The patient underwent three ultrasounds (US) during the pregnancy, signing consent forms for each examination. The consent forms described the limitations of the US conducted at the practice, stating the exam was "not designed to detect birth defects of the heart (amongst other stated organs)" and provided the option for referral to a maternal fetal medicine (MFM) provider for US specifically designed to detect birth defects. The patient declined the referral option each time. Per usual practice Physician B relied on a sonographer employed by the practice to point out any concerns or problems, without attending the US exams or personally reviewing the results of the tests. The US the patient received at the practice offered only a "[4] chamber view of the heart" and did not provide imaging of the "ventricular outflow tracts" of the heart, described as a requirement in an American College of Obstetricians and Gynecologists (ACOG) practice bulletin published four years prior to the pregnancy. Neither the sonographer nor Physician B observed the note by Physician A about family history in the patient's chart from the first pregnancy. Further, the patient denied any knowledge of family history of heart defects under additional verbal questioning prior to each US.

At 37 weeks Physician B diagnosed the patient with mild polyhydramnios with a plan of close observation and fetal nonstress testing, and the intent to induce at 40 weeks. Two weeks later, the patient went into spontaneous labor and vaginally delivered a 7 lbs., 4 oz. baby boy with Apgar scores of 5, 7, and 8. A pediatrician chosen by the patient saw the infant in the hospital and at two well-baby visits in his office, where no issues were detected with the infant's heart. The patient brought the afebrile infant into the pediatrician's office for a third "sick" visit at 29 days old, due to a vomiting episode and diarrhea the prior evening, as well as a dry cough. The patient and pediatrician discussed more frequent, smaller feeds.

Two days later after arriving home from a family lunch, the parents discovered the infant cool and unresponsive upon removing him from his car seat. Despite extensive resuscitative effort by emergency medical services and at the hospital, physicians pronounced the infant dead at 31 days of age. A subsequent autopsy revealed the infant's cause of death to be truncus arteriosus.

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DISCUSSION

The infant's parents brought direct liability claims against both Physician B and the practice. Several defense experts initially offered some support for both Physician B and the practice. Notably the patient repeatedly denied both personal or family history of heart defects for herself or the baby's father, and she refused all offers by the defendants for more rigorous US screening that would almost certainly have uncovered the heart defect. Physician B later speculated that the patient possibly refused additional screenings as she was determined to go through with the pregnancy regardless of any information that might cause someone else to consider termination. An MFM consultant opined that despite these facts both Physician B and the practice fell below the required and appropriate standard of care. Other experts criticized the practice's electronic health records (EHR) protocols for failing to locate significant facts like family history, where subsequent providers would automatically review the information.

Regarding Physician B, the consultant stated that declining to personally review the US results and instead relying on the sonographer employed by the practice to interpret the images and bring forward any concerns breached the required standard of care. While not critical of the images the sonographer collected, the consultant insisted the final interpretation of the exam must rest with the provider, not with the technician. Defense counsel polled a group of eight OB/GYNs and MFM specialists who pointed out that guidelines for ACOG, American Institute of Ultrasound Medicine, American College of Radiology, Society for Maternal-Fetal Medicine, and Society of Radiologists in Ultrasound all require the elevated level of US. They opined that the failure to order such a study prevented not only the discovery of the defect but a referral to an MFM provider and additional screenings and tests, which might have led to a plan to treat the newborn infant.

The consultant's opinion supported the allegation that the infant suffered harm as a direct result of the practice's policies and procedures, which failed to require physicians to stay abreast of the current standard of care related to screening tests, and to review exam results rather than relying on technicians to report problems.

Further, the MFM consultant criticized Physician B for failure to stay current with requirements for second-trimester US and the necessity to obtain views of a fetus's left and right ventricular outflow tracts. The consultant noted that when Physician B began at the practice the standard of care did not require the more extensive US, but this changed several years prior to the pregnancy in question, as reflected in the clinical guidelines mentioned above. While the consultant conceded that treatment for the infant's condition did not guarantee survival, a plan of treatment upon birth would have provided him a much higher chance.

Regarding the practice, the consultant indicated that policies and procedures in place labeled Physician B on the "OB report" and billing sheet as the "performing physician" and the "supervising provider" respectively. Yet despite these designations, nothing required Physician B to review the images in real-time, which the consultant deemed "shocking." Further, the consultant criticized the practice's routine use of US exams that did not comply with the societal guidelines previously described, which required an attempt to visualize and report on a fetus's left and right ventricular outflow tracts. The consultant's opinion supported the allegation that the infant suffered harm as a direct result of the practice's policies and procedures, which failed to require physicians to stay abreast of the current standard of care related to screening tests, and to review exam results rather than relying on technicians to report problems.

When the defense could not engage support for the standard of care provided by Physician B or by the practice, the cases settled.

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RISK REDUCTION STRATEGIES

No set of policies and procedures will be foolproof. However, consideration or anticipation of when and how confusion or miscommunication might occur can go a long way toward preventing the types of issues described in the case just discussed.

In addition, consider the following strategies:

- Ensure all staff in your practice or entity stay up to date on required continuing education, certification, and clinical guidelines associated with their profession, and document compliance in personnel files.
- Fund continuing education efforts for staff and medical professionals.
- Create policies and procedures to require appropriate oversight and review of all screening or diagnostic examinations.
- Highlight the importance of documenting relevant history in the appropriate sections of the EHR to ensure any intentional carryover functionality is optimized.
- Create protocols for using flagging systems in the EHR. Remember, flagging systems should not be a substitute for proper documentation elsewhere. Consider a system that will allow any problem list/notes in the electronic record system to be viewed by all future providers.
- As part of signed informed consent, address questions, doubts, or confusion patients may have about the benefits and limitations of a given test or procedure.
- Take the time to provide education to better understand and overcome patient hesitancies to recommended screenings, tests, or procedures.
- Utilize signed informed refusal when patients decline tests or treatment.
- Document all discussions with patients regarding informed consent and refusal.

STAFFING/BOARDING/BURNOUT: ISSUES WITH BOARDING

Failure to adequately staff can lead to longer wait times and lack of patient care under a variety of scenarios. Emergency departments provide one current example where staffing issues create the potential for patient injury or death due to the problem of patient boarding and inadequate monitoring. When hospital bed or staff shortages force staff to board patients within the emergency department or, worse, in hallways or other nonclinical areas, confusion may arise as to who is responsible for patient monitoring and continued care. Staff may be unable to respond quickly and appropriately to a decompensating patient, unable to protect themselves from injury and infection, and unable to keep up the pace. Personnel report patient injury and death because of these conditions, which are often created as the result of entity financial decisions. Ironically, if the entity's cost cutting interferes with the staff's ability to provide appropriate care to patients, direct liability threatens to disrupt the bottom line.[10,11]

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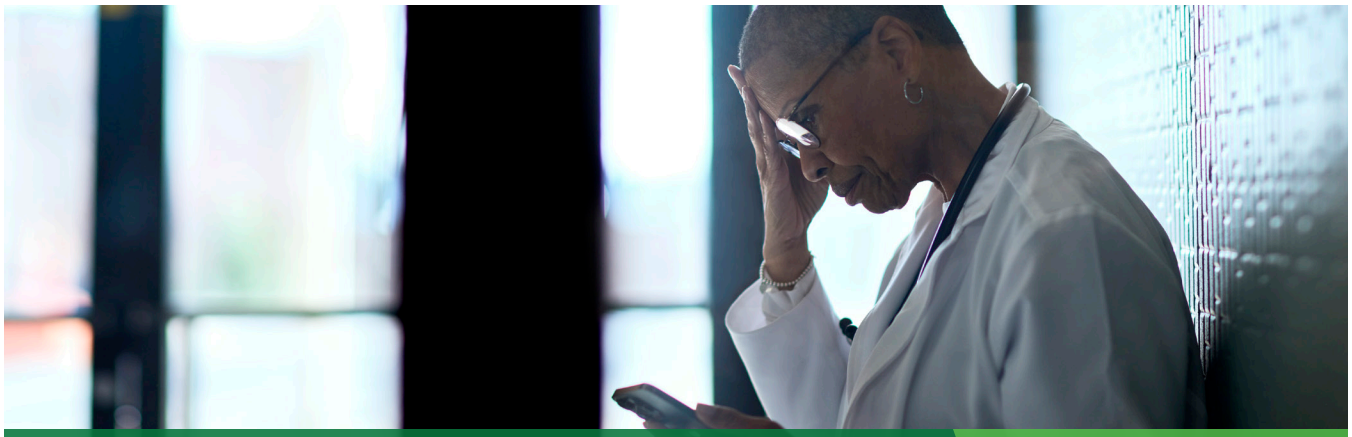

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CONCLUSION

At first glance avoiding direct liability claims might appear simple and obvious. After all, most clinicians and medical entities intend to provide attentive and skillful care and treatment to patients, resulting in excellent outcomes. However, patient harm resulting in a direct liability claim against a healthcare entity may stem from circumstances even conscientious individuals fail to consider. Measures like strenuous hiring protocols, continual review and updating of policies and procedures, scanning facilities for dangerous conditions, knowledge of federal and state regulations and clinical guidelines, and taking a universal view of entity protection can help prevent unanticipated results. What's more, these measures demonstrate a commitment to the appropriate standards and duties of care. Such actions strengthen entity and individual provider defenses in the event of a claim of direct liability.

See page 12 for details on how to earn continuing medical education credit for completing this course.

ENDNOTES

The documents referenced in this article, along with many other risk management resource documents and past editions of *Claims Rx*, are available by calling Risk Management at 844-223-9648 or by email at RiskAdvisor@ProAssurance.com.

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