JULY

# CLAIMS Rx '25

RISK MANAGEMENT PERSPECTIVES

## Vicarious Liability:

Managing the Risks of Unexpected Applications in Healthcare

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# Vicarious Liability:
## Managing the Risks of Unexpected Applications in Healthcare

## INTRODUCTION

While the specific definition may vary by state, in the most general sense vicarious liability allows an injured patient to hold a third party financially responsible for the negligence of the person who caused the injury. In malpractice litigation, vicarious liability is most frequently associated with an employment relationship. The healthcare employer (e.g., hospital, clinic, group, sole practitioner physician) is deemed vicariously liable for patient injuries caused by an employee (e.g., physician, staff member, advanced practice professional (APP)). Vicarious liability for the employer is generally automatic and expected. However, vicarious liability arising from other healthcare work relationships can be unexpected. For example, although hiring an independent contractor ideally shields the hiring party from vicarious liability, physicians, groups, or facilities can be drawn into malpractice lawsuits based on injuries caused by independent contractors. Attending physicians can be vicariously liable for resident physician negligence. Collaborating physicians can be vicariously liable for APP negligence.

Vicarious liability is a dependent theory of liability—a finding of liability is not based on improper action by the principal. For example, if an employer physician appropriately hires, trains, and supervises a nurse, but the nurse still negligently causes a patient injury, the propriety of the physician's management of the nurse will not shield the physician from vicarious liability. Similarly, if the nurse did not negligently cause the patient injury, vicarious liability does not attach to the employer physician.

This article uses closed claims to introduce strategies for managing vicarious liability risk.



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## DEFINITIONS OF VICARIOUS LIABILITY TERMS

**Agency:** A relationship in which one party has legal authority to act for or represent another.[1] Employment is a type of agency relationship.

**Agent:** One who is authorized by another to act for them in an agency relationship.[1] An employee is an agent.

**Principal:** A person or entity that allows or directs another (e.g., an agent) to act for their benefit under their direction and control.[1] An employer is a principal.

**Independent Contractor:** By definition, independent contractors are not employees or agents. Unlike in an employment relationship, the party that hires an independent contractor ordinarily does not become vicariously liable for the negligent acts of the independent contractor. However, if the hiring party treats that person like an employee, and patients reasonably believe they are an employee, the hiring party may be vicariously liable for the independent contractor's actions.[2]

**Ostensible Agency:** Ostensible agency is an agency relationship that is implied, depending on the actions and perceptions of the parties involved. For example, an independent contractor physician may be considered an ostensible agent of a hospital if it appears that the physician is an employee. If the court determines that an ostensible agency exists, the principal may be vicariously liable for the wrongful acts of the ostensible agent. Managing ostensible agency vicarious liability risk in healthcare is directed at ensuring that patients understand their healthcare providers' relationships with the hospitals, groups, clinics, and offices where these non-agent providers are providing patient care.[2]

**Direct Liability:** Individuals are liable for their own negligence, whether they are employees, residents, or independent contractors. A healthcare employer who is vicariously liable for an employee's negligence also can be directly liable for a negligent patient injury when the employer's negligent actions or omissions caused or contributed to the injuries. Direct negligence claims against employers are usually associated with negligently hiring, training, supervising, or retaining the employee and inadequate or poorly enforced policies and procedures.[2] Supervision by attending physicians in teaching roles can also lead to direct negligence claims.



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## CASE ONE:
# Independent Contractor or Employee?

In a malpractice lawsuit involving an independent contractor physician or other clinician, the plaintiff (usually a patient) often argues that the physician was an employee of the entity in which their injury occurred. A plaintiff who makes this claim is often attempting to ensure coverage of damages amounts by increasing the number of defendants in the case, thus increasing the number of "pockets" from which to obtain payment.

> Think about independent contractors you have hired; could they be considered employees?

A complex surgical procedure was planned for an ambulatory surgical center (ASC). The surgical team included the surgeon, a surgery fellow, an anesthesiologist, and various surgical staff. Postsurgical monitoring would be handled by the ASC surgical nurse's home healthcare company. The surgeon was the sole proprietor of the ASC. The surgical nurse was an employee of the ASC but was also the sole proprietor of the home healthcare company. The ASC receptionist was an employee of the ASC and was also an employee of the home healthcare company. The fellow was an employee of a university. The anesthesiologist was an independent contractor with the ASC. The rest of the staff were employees of the ASC.



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Prior to surgery, the attending surgeon and anesthesiologist ordered various postoperative pain, anxiety, and sleep medications for the patient, which the patient filled in preparation for her postoperative recovery period. The surgery was uncomplicated, and the surgeon put the fellow in charge of the patient's postoperative care.

Later in the day the patient was discharged to her home. Her plan was to receive home healthcare from the surgical nurse. Shortly after she arrived home the patient contacted the fellow to report she was having trouble swallowing and couldn't take oral medications. The fellow, who did not realize the anesthesiologist had placed a bupivacaine pain pump during surgery, prescribed a fentanyl patch.

That evening, because the patient seemed stable, the surgical nurse arranged for the ASC receptionist to stay overnight with the patient. Before the nurse left, she applied the fentanyl patch. At some point during the night the patient died. When the receptionist awoke the next morning and discovered the patient was not breathing, she called the nurse. After disposing of various pain medications at the patient's house, the nurse called 911. Later that day the nurse made an inaccurate and self-serving entry in the patient's medical record. The autopsy indicated the patient died of an opioid overdose.

The patient's family filed a lawsuit against various members of the surgical team. In addition to direct negligence claims, the patient's family alleged the surgeon/ASC was vicariously liable for 1) the nurse's negligent delegation of postoperative monitoring to the receptionist, 2) her destruction of evidence, and 3) her fraudulent documentation. Other defendants, including the fellow, were dismissed or settled, which left the surgeon/ASC, surgical nurse, and home healthcare company as the remaining defendants in the case.

## DISCUSSION

The defense of the ASC (essentially the surgeon) for the surgical nurse's alleged negligence was complicated. Experts were particularly critical of the nurse's decision to leave the patient with the receptionist after she had applied the fentanyl patch. A jury finding of the nurse's direct liability seemed inevitable. During the discovery phase of litigation, the parties to the lawsuit discovered the home healthcare business did not have liability insurance coverage for itself, the surgical nurse, or the receptionist. The discovery prompted the plaintiff's attorney to target the ASC for the recovery of damages. He argued the nurse, while providing home healthcare services to the patient, was an employee, not an independent contractor.

The surgeon believed the nurse was an independent contractor because that is what she called herself. He had entrusted the nurse with the appropriate management of the relationship between the ASC and her home healthcare business. It was not until litigation that the surgeon became aware of the extent of the entanglement between his ASC and the nurse's business. The defense team believed a jury would most likely determine the nurse, despite her and the surgeon's beliefs that she was an independent contractor, was, in fact, an employee when she provided home healthcare services.

There are various ways to determine whether an independent contractor is an employee. In most healthcare claims, the alleged employer's control over the independent contractor's provision of patient care is a major consideration.[3] In this case the factors that weighed in favor of the nurse being an independent contractor were:

- She invoiced the ASC for her services, and her payment for invoiced services was separate from her salary payments.
- She independently scheduled and compensated her subcontractors.
- She performed her duties off-site and without guidance from the surgeon.



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However, the defense team believed factors that supported a finding of her being an employee were more persuasive, including:

- Arrangements for home healthcare were made by the ASC administrative staff.
- Home nursing services were discussed along with the other services provided by ASC employees.
- The ASC billed health insurance carriers for home healthcare.
- The nurse did not carry her own liability insurance.
- The nurse provided services exclusively for the ASC.

The defense team further believed that, in front of a jury, the disorganized practice management and inadequate patient safety practices would reflect poorly on the surgeon as owner of the ASC, and that would influence jury determinations. Due to negative standard of care reviews and the likely finding of an employment relationship, the vicarious liability claims against the surgeon/ASC were settled.

## RISK REDUCTION STRATEGIES

Consider the following strategies:

- Have a healthcare business attorney review independent contractor agreements.
- Do not treat independent contractors as if they were employees.
- Evaluate patient care provided by independent contractors to confirm it complies with patient safety standards.
- Ensure your practice and the independent contractors you work with are appropriately insured for malpractice claims.
- Contact your broker or underwriter with coverage questions or concerns about your practice situation.



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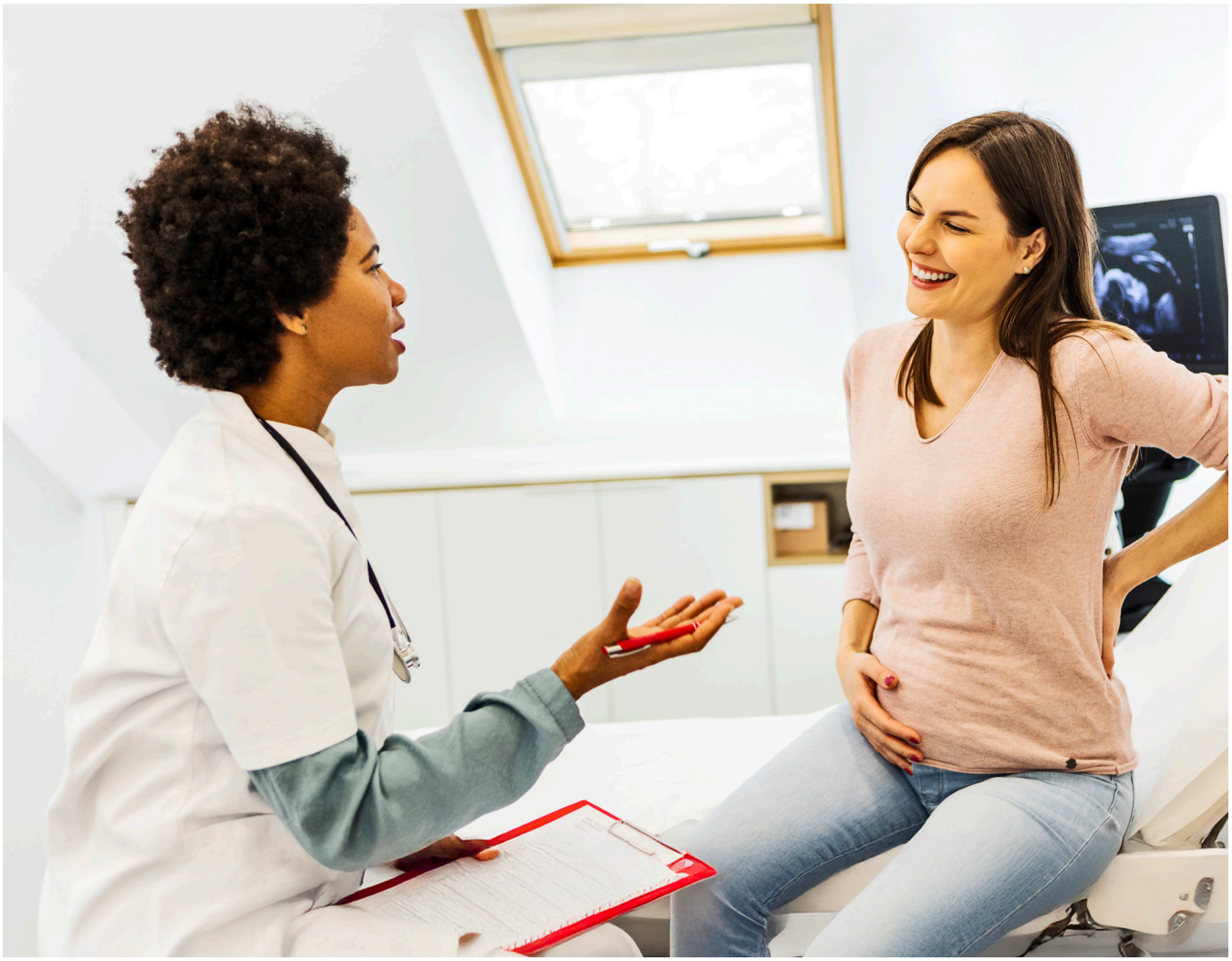

# CASE TWO:
## Vicarious Liability for an Ostensible Agent

When damages are expected to exceed a target independent contractor defendant's malpractice insurance liability limits, plaintiffs' attorneys often additionally sue the entities/physicians who hired the independent contractor, based on allegations of ostensible agency. Ostensible agency in a treatment scenario is primarily determined based on how things would reasonably appear to the patient.[3] If the medical group owner in the following case had evaluated the *appearance* of his affiliation with the independent contractor obstetrician-gynecologist (ob-gyn) he had hired, he most likely would have realized that patients easily could assume the ob-gyn was an employee.

While reviewing this case study, consider the strategies the medical group could have implemented to signal to patients that the ob-gyn was not an employee.



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An Rh-negative patient received prenatal treatment from an ob-gyn at a family medicine practice. The family medicine physician (FP) had hired the ob-gyn as an independent contractor to provide prenatal and labor and delivery services for pregnant patients of the practice.

A nurse at the practice informed the patient that the practice's ob-gyn would deliver her baby at a specific hospital. When the patient reached 18 weeks of gestation, the ob-gyn referred her to a maternal fetal medicine specialist for an amniocentesis. Following the amniocentesis the patient was not given RhoGAM®. The ob-gyn then failed to order Rh antibody titers. As a result of Rh incompatibility, the infant suffered severe brain injuries that would require lifetime care. Cost estimates for this care were in the millions. The parents filed a lawsuit contending the ob-gyn and maternal fetal medicine specialist were directly liable and the practice was vicariously liable for the negligent failure to ensure RhoGAM was administered to the maternal patient.

## DISCUSSION

The maternal fetal medicine specialist settled early in litigation, leaving the ob-gyn and FP owner as the sole defendants. Experts believed the ob-gyn had a duty to ensure the patient's development of Rh antibodies was discovered and treated. Further, they opined that his failure to do so was a cause of the infant's injuries. Experts did not believe the medical group staff or the FP owner were directly negligent. Although the ob-gyn was hired by the FP owner as an independent contractor, the law of the state in which the case was litigated, as well as the facts of the case, supported a finding that the ob-gyn was an ostensible agent. For example, there was no patient notification of the ob-gyn's independent contractor status, and the staff referred to the ob-gyn as "our ob-gyn." There were no outward signs that the ob-gyn was anything but an employee.

The defense team for the FP owner expected damages to exceed the ob-gyn's malpractice insurance policy limits. They also expected the ob-gyn to settle for his policy limits, which he ultimately did. Because of the risk of a verdict in excess of the FP owner's policy limits and negative expert reviews concerning liability, the vicarious liability claims against the FP owner were also settled.



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## RISK REDUCTION STRATEGIES

Ostensible agency depends on the actions and perceptions of the parties involved. Therefore, it is important to ensure that patients understand the relationship between their physicians and the individuals, groups, clinics, and hospitals that hired them. If patients could reasonably believe an independent contractor is an employee, the risk of vicarious liability exists. Consider the following strategies:

- Do not let independent contractors wear clothing or badges with the practice name or logo on them.
- Strongly consider requiring all independent contractors to maintain their own medical malpractice liability insurance. (Some states have laws that mandate specific medical malpractice insurance requirements and limits. Follow the laws in your state.)
- Send patients referral letters that include language in large, conspicuous print regarding a physician's independent contractor status. Consider including the sentence: "Please be advised that this individual is not our employee or agent but is an outside contractor who has contracted with this practice to provide services."
- Include a statement in the practice's bylaws or other rules or regulations indicating that independent contractors are not employees or agents.
- Have independent contractors bill for patient services under their own company names, not the names of the physicians or groups with which they contract.
- Post signs informing patients that the independent contractors who may treat them are not the practice's employees or agents.
- Put a disclaimer in bold, conspicuous print in annual patient communications regarding the services available from the practice. Consider including the sentence: "Any third-party contracted provider you see is not our agent or employee."
- Provide lists of specialists to patients that include statements that the specialists are not agents or employees, and that they exercise independent judgment.
- When referring a patient, do not describe a consultant in a way that could create the appearance of agency. Avoid statements such as "We're going to refer you to one of our physicians" or "We're sending you to Dr. X., who handles all of our vascular surgery patients."
- Ensure staff are aware of the difference between employees and independent contractors.
- Consult with an attorney to discuss the specific state laws and regulations that address vicarious liability and ostensible agency as they pertain to contracts and agreements with independent contractors.
- Ensure that all contracts and agreements clearly articulate the working relationships of the involved parties.



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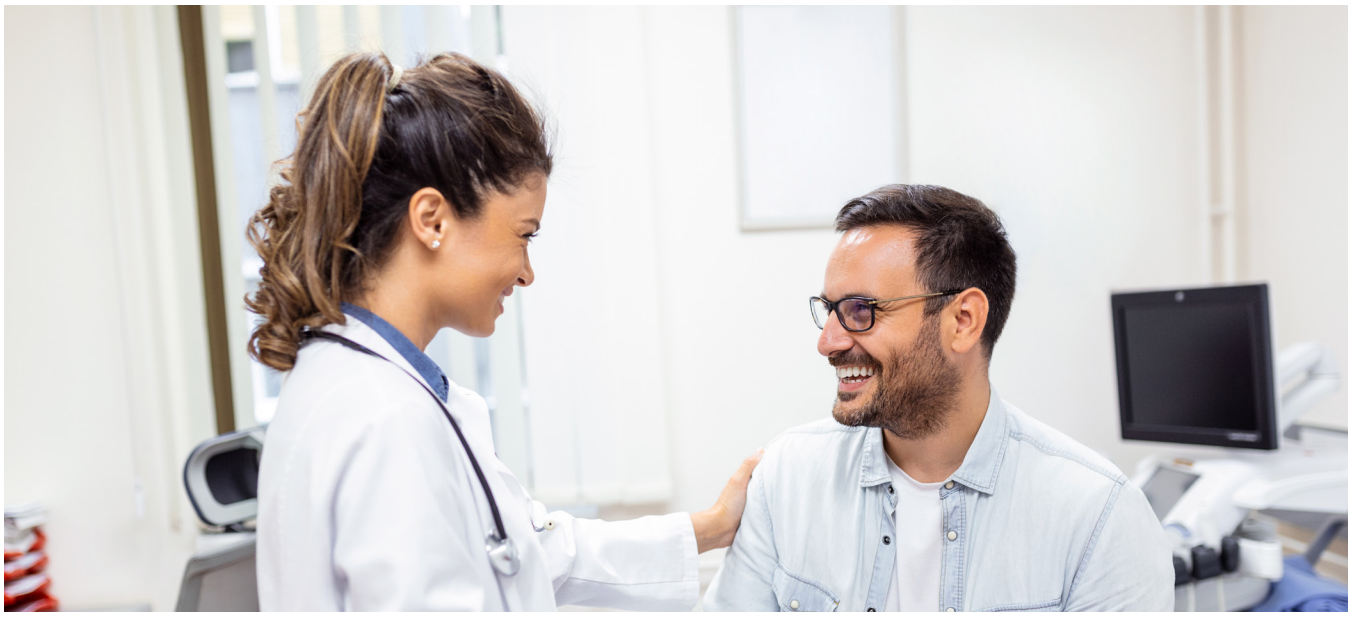

## CASE THREE:
# Vicarious Liability for a Physician in Training

In the teaching environment, vicarious liability for resident physician negligence may be attributed to the attending physician, the entity sponsoring the resident, and, if the negligence occurs during a resident's external rotation, the away site.[4]

When a resident is negligent, the vicarious liability of other parties depends on the nature of the relationships among those involved in the residency program and vicarious liability laws, which vary from state to state. Determining who "controls" the resident (much like the way an employer "controls" an employee) can be a complex matter. This involves examining the residency program's educational arrangements, agreements between a medical school and the entity in which the resident is being supervised, employment contracts, and supervisory policies. The employer of the resident would presumably be vicariously liable for the resident's negligence, just like any other employer-employee relationship. However, attending physicians may be deemed to step into the shoes of the employer during the times they are supervising or have a right to supervise the resident. The transfer of the control of the resident from employer to attending can shift vicarious liability to the attending physician (i.e., the attending can be deemed the "captain of the ship").[5]

In the following case, the attending physician was named in the lawsuit which alleged he was directly and vicariously liable for a resident's errors. The patient was being seen by a third-year resident who the attending was responsible for supervising. However, the attending had no personal contact with the patient.

As you read this case study, identify the points at which the attending physician and resident could have changed their course to avoid the patient injury.



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In 2010 a 30-year-old patient presented to a clinic for a persistent cough and rib pain. He was examined by a third-year resident. The resident was employed by a medical center. The attending physician was employed by the clinic. The attending supervised the resident at the clinic. The clinic had a contract with the medical center to run an internal medicine residency program.

The resident ordered a rib series (she suspected the patient might have fractured a rib while coughing) and a chest x-ray for suspected pneumonia. The radiologist noted a fractured rib and, in the right lung, a 2 cm x 2 cm opacity with varying densities throughout. The radiologist expressed doubt about the opacity being pneumonia and recommended follow-up with additional imaging to assure complete resolution. Despite the radiologist's doubts, the resident diagnosed and treated the patient for pneumonia and rib fracture. The patient's symptoms improved over the next six weeks, and at the final follow-up appointment with the resident he appeared to be symptom-free. The patient was not seen again in the clinic. Nine years later, the patient was informed that he had a malignant mass in his right lung, which was in the same location as the opacity identified in the 2010 chest x-ray. The mass had doubled in size and metastasized. The patient sued all the physicians who had provided treatment to him, and their employers. As the trial date neared, only the attending physician and his employer (the clinic), and the resident's employer (the medical center) remained in the case.

The patient made the following vicarious liability allegations: by virtue of being the supervising physician, the attending physician was vicariously liable for the resident's negligence. Because the medical center was the employer of the resident, it too was vicariously liable for the resident's negligence. Because the clinic was the employer of the attending, it was vicariously liable for the attending's negligent supervision of the resident.

The discussion below focuses on vicarious liability based on the relationship between the attending and resident.

## DISCUSSION

According to experts who reviewed the treatment provided by the resident, the standard of care mandated informing the patient that he needed to obtain follow-up radiological studies. Had the studies been performed, it was more likely than not that the lung malignancy would have been diagnosed. If the cancer had been treated at that time, the patient's survival rate would have been significantly increased.

Because he was in a supervisory relationship with the resident, the attending physician could be vicariously liable if the resident was directly liable for the patient's injuries, which is what expert review indicated. Working through the direct and vicarious liability allegations against them required analyzing both the attending's and the resident's supervision policies and procedures, and whether they had been followed in this case.

According to the resident supervision policy and protocols in place at the time, residents were required to present all patients to an attending physician and create a progress note. This note was to be routed to the attending physician for review and signature. The resident testified that this was generally her practice. Although she did not always obtain a signature after she had completed her note, she always indicated with which attending she consulted. Because the attending was listed on the patient's progress note the resident authored, the resident assumed she had presented the case to him. Despite there being supervision protocols requiring resident note review, the attending testified that he would typically only review a resident's note under certain circumstances. These included when the resident was in their first year, when a resident needed remediation, or when the attending was unfamiliar with a resident's work. The attending would also review when there was a difficult or conflicting case or when he questioned some aspect of the patient's condition. None of these scenarios appeared to apply to the visit at issue. However, questions were raised during litigation about whether the resident was adequately trained relative to follow-up on radiology recommendations. In the attending's opinion, the fact that he was listed as the attending physician on the resident's note did not indicate that he reviewed the note, or that he necessarily had any interaction with the resident relative to this patient. Some residents in the program were in the practice of listing their attending, whether or not a review had occurred. The testimony of the resident and attending showed that the existing policy and protocols were not being followed.



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According to the resident's deposition testimony, the lung opacity finding was the type of finding she would have reported to the attending. However, at his deposition, the attending testified that if he had seen or been told about the finding and recommendation in the radiology report, he would have followed up himself, or ensured the resident followed up. Since no follow-up occurred, the attending assumed he never knew about the report or the information it contained. There was no way to prove which defendant failed to act consistently with what would have been their standard practices. The outcome of the case could depend in large part on which defendant the jury believed. The consensus among the defense team members was that the jury would probably hold them both liable: the attending for negligent supervision and the resident for the negligent failure to follow up. Vicarious liability claims would align with the direct negligence.

Throughout the litigation process, the attending physician questioned why he was not dismissed from the case. The answer was twofold. On one hand, he failed to catch the resident's error—a direct supervision issue. If he had caught the error, there would be no lawsuit. On the other hand, there was the vicarious liability issue. Even if the supervision were determined to be consistent with the standard of care, the attending could still be vicariously liable for the resident's actions. Like most vicarious liability cases, there is a real synergy between the principal's direct efforts to manage risk exposure created by agents and their vicarious liability. In other words, if a principal can prevent the agent from causing an injury, the principal prevents vicarious liability, because there is no direct liability. Thus, principals (attending physicians) have an interest in managing risk at the agent (resident physician) level.

## RISK REDUCTION STRATEGIES

This case highlights the potential for patient injury when resident physicians are reaching a point in their education that appears to require less involvement by an attending physician. The attending physician in this case admitted to allowing third-year residents to essentially practice without his proactive supervision. Residents are trainees. The independence they need to gain competency must be balanced against patient safety, which requires supervision when appropriate—including competency with systems issues, patient safety strategies, and liability risk management.

Consider the following strategies:[6]

- Encourage residents to ask for guidance.
- Create a supportive culture in residency programs.
- Ensure residents follow up with any laboratory or radiology tests that they order.
- Be sure residents inform the attending, patient, and the patient's primary care physician of incidental findings and document that they informed each party.
- Teach residents to document thoroughly and completely, including when an attending physician was present or when an attending physician reviewed a treatment plan.
- Actively supervise resident physicians to help ensure their patient treatment meets the standard of care.
- Comply with resident physician supervision policies and protocols for attending physicians, and ensure resident physicians are complying with the supervision policies and protocols that apply to them.
- When working with physicians in training, ensure there are no gaps in understanding relative to their status as employees, independent contractors, or something else while they are working with you.
- Have a healthcare business attorney review all contracts involving residency programs to ensure the most protective language, including possibly that indemnification agreements are in place.
- Inform your professional liability carrier of any contracts involving supervision of students, residents, or other healthcare personnel.



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## Managing the Risks of Unexpected Applications in Healthcare

## CONCLUSION

Medical malpractice lawsuits may be inevitable, but implementing the recommendations in this article can reduce the risk that vicarious liability claims will be filed. These strategies can put employers, physician proprietors, and supervising attending physicians in an improved position to defend malpractice claims. As with all liability risk management, patient safety is paramount. Excellent contracts will not prevent patient injuries, but they may facilitate a quicker dismissal from a lawsuit when liability should rest with a different party. Business and legal advisors can identify vicarious liability risk exposure that may not be obvious, and they can recommend solutions for change. Finally, it is important to have appropriate medical liability coverage for times when patient care does not progress as planned.



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# ENDNOTES

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

Please note that content in this article originally appeared in the September 2015 *Claims Rx* entitled "Vicarious Liability Risk Management."


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