For The Defense

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Emerging Trends in Vicarious Liability

As hospitals and physicians redefine and restructure their relationships, the independent contractor-employee dichotomy in many jurisdictions will break down.

Customarily in a hospital setting, a patient is admitted by his or her doctor, and then the doctor provides care at the hospital as an independent contractor. In the past, the doctor’s relationship with the hospital often consisted of little more than admitting privileges. The admitting physician wrote orders, which the nurses, who were employed by the hospital, followed while drawing from their nursing training and the following the hospital’s policies and procedures. Charge nurses, a nursing director, or both, controlled the nurses carrying out the doctor’s orders. The physician did not exercise control over the manner and means by which the nurses rendered the nursing care. A nurse is often called the “eyes and ears” of the doctor, but he or she does not make medical decisions outside of his or her nursing training. Many states prevent nurses from making a medical diagnosis. This is the usual or historic division of labor upon which medical liability cases in hospital settings have been grounded.

Increasingly we hear from our clients during conferences around the country about how the practice of medicine is changing. You have heard from your own clients that the trend is moving toward classifying doctors as “inpatient” versus “outpatient” physicians. More and more, physicians want to work in either larger independent groups or hospital-owned practices. See Molly Gamble, How Has the Rise of Physician Employment Changed Hospitals’ Recruitment Strategies?, Becker’s Hosp. Rev. (Nov. 29, 2012). In fact, the number of independent physicians or providers with a financial stake in their practice shrunk from 57 percent in 2000, to 39 percent in 2012, and has been projected to shrink to 30 percent in 2013, according to data from Accenture. Id.

Many will remember a similar trend that occurred in the early 1990s when hospitals around the country acquired the practices of primary care physicians. While that trend did not last, hospitals now want to employ the types of physicians that support...
their most profitable inpatient and outpatient services, such as hospitalists, radiologists, emergency room physicians, and even specialists such as cardiothoracic surgeons, cardiologists, neurosurgeons, orthopedic surgeons, and general surgeons. See Nathan Laufer, The Employment of Doctors by Hospitals—Indentured Servitude or Practice Salvation?, Maricopa County Med. Soc’y (Nov. 2011), http://www.mcmsonline.com/president/nathan-laufer-md/employment-doctors-hospitals-%202080%2093-indentured-servitude-or-practice-salvation (last visited June 17, 2013). As Dr. Laufer notes, “[i]n the past, specialists had little interest in being employed. But that’s changed as well. Specialists with high medical malpractice exposure are increasingly looking at hospital employment as a way out.” Id.

Another trend is that the number of mid-level providers such as nurse practitioners and nurse anesthetists is increasing. The nurse practitioner population will nearly double by 2025, according to an analysis published in Medical Care, the official journal of the medical care section of the American Public Health Association. See Victoria Stagg Elliot, Sharp Increase Expected in Number of Nurse Practitioners, AmericanMedicalNews.com (July 2, 2012), http://www.amednews.com/article/20120702/business/307029951/6 (last visited June 17, 2013). Primary care is an area where the increased presence of nurse practitioners is expected to be particularly profound. Id.

The changing relationships between healthcare providers will strain the rules that many jurisdictions have developed to determine when one provider can be vicariously liable for another provider’s acts or omissions. Whether you defend hospitals, doctors, or mid-level providers, you need to know the vicarious liability rules as they stand and how the relationships among healthcare providers are changing. With this information, you can assess how the changing relationships affect your jurisdiction’s rules and most effectively defend cases with vicarious liability implications. This article seeks to give the reader an overview of vicarious liability law in several illustrative jurisdictions and discuss how evolving relationships between healthcare providers implicate vicarious liability rules. Because changes in the law often lag behind changes in society, this article also seeks to alert the reader that this is an area of the law that is expected to evolve over the next five to 10 years.

**Hospital Liability for Physician Conduct**

Historically, most states have applied traditional rules of vicarious liability to a hospital setting, and thus, a hospital may only become liable for the acts or omissions of physicians who act with direction from or under the control of the hospital. John D. Hodson, Annotation, Liability of Hospital or Sanitarium for Negligence of Physician or Surgeon, 51 A.L.R. 4th 235 (1987). Likewise, hospitals traditionally did not typically become liable for physicians deemed independent contractors. Id. There are, of course, exceptions to these general rules. For example, in many states a hospital can be liable for the negligence of an independent contractor-physician when the hospital “holds itself out” to a patient or the public as providing a particular medical service or group of physicians in such a way that the public believes that the physicians involved are hospital employees. Id. Courts have also recognized exceptions when a physician’s malpractice occurred while the physician acted as a contractor through whom a hospital sought to discharge its responsibilities under a contract with a third party to provide medical services when the negligence of the physician was foreseeable by the hospital. Id. at §§6, 8.

Some states recognize doctrines such as the “corporate practice of medicine doctrine,” which practically preclude vicarious liability for hospitals. In other states, such as Illinois, the doctrine does not apply if a hospital is also licensed. See Carter-Shields, M.D. v. Alton Health Inst., 777 N.E.2d 948, 957 (Ill. 2002) (“[T]he public policy concerns supporting the prohibition against the corporate practice of medicine do not arise where a licensed hospital enters into an employment agreement with physicians.”). In other states, whether a hospital is vicariously liable for a physician’s conduct turns on the perception of the public. For example, in Hardy v. Brantley, the Mississippi Supreme Court explained:

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No longer are hospitals merely physical facilities where physicians practice their professions. Hospitals hold themselves out to the public as offering and rendering quality health care services... It goes without saying that hospitals such as Hinds General are corporate entities capable of acting only through human beings whose services the hospital engages... We say this in the context of the fact that patients often seek emergency care and treatment from the hospital, not from any particular physician. The patient entering the hospital emergency room seldom knows the name of the physician who will treat him. Although there may be important

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factual variations from case to case, a patient’s non-selection of his physician is often the rule in the case of anesthesiologists, radiologists and particularly emergency room physicians. [The plaintiffs] testified that they had never heard of Dr. Brantley, but were content to accept his care as in their view he had been furnished by the hospital. Under such cir-

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cumstances, it seems only reasonable that the hospital should be estopped to deny responsibility for the neglect of its emergency room physicians. 471 So. 2d 358, 371 (Miss. 1985) (citing Smith v. St. Francis Hospital, Inc., 676 P.2d 279, 282 (Okla. Ct. App. 1983)). Although the Mississippi Supreme Court did not refer to the doctrine by name, it nonetheless held that the corporate practice of medicine doctrine did not apply under Mississippi’s statutory framework. Hardy, 471 So. 2d at 373 (citing Miss. Code Ann. §579-9-1 et seq. (1972)).

While the specific circumstances under which a hospital is vicariously liable for the conduct of a physician varies among states, two general principles underpin the law on this issue: (1) the extent of the control exerted by the hospital over the doctor; and (2) whether the public reasonably perceives the doctor as an employee of the hospital. The Texas Court of Appeals, for example, has noted in a medical malpractice case that “[t]he right of control is the ‘supreme test’ for determining whether a master-servant relationship exists.” Far-
and adjust the advice that they give to clients as the changes occur.

**Physician Liability for Nurse Conduct**

Plaintiffs have historically attempted to place liability on a physician for the conduct of a nurse through doctrines such as the “captain of the ship” doctrine and the “borrowed servant” doctrine. Under the captain of the ship doctrine, a physician is vicariously liable for the negligence of others who were involved in caring for the same patient but were not under the doctor’s control or supervision. See, e.g., Ochoa v. Vered, 212 P.3d 963, 966 (Colo. App. 2009) (noting that the captain of the ship doctrine applies when the surgeon assumes supervision and direction in the operating room). When the borrowed servant doctrine applies, a doctor is deemed to have “borrowed” the nurse from the hospital because the doctor was in fact exerting control over the nurse at the relevant time. Settle v. Basinger, No. 11-CA-1342, 2013 WL 781110, at *4–6 (Colo. App. Feb. 28, 2013) (discussing how under borrowed servant doctrine, a person or entity may be liable for negligent acts committed by someone employed by another person or entity if the person or entity has the employer’s consent to supervise and control the employee and is in a position to do so) (citing Kiefer Concrete, Inc. v. Hoffman, 193 Colo. 15, 18, 562 P.2d 745, 746 (1977)). Some states have eschewed the captain of the ship doctrine, preferring the borrowed servant doctrine. See, e.g., Sparger v. Worley Hosp., Inc., 547 S.W.2d 582, 585 (Tex. 1977) (disapproving of the captain of the ship doctrine because it holds that a surgeon’s mere presence in the operating room makes him liable as a matter of law for the negligence of other persons, and yet acknowledging the borrowed servant rule and holding operating surgeons and hospitals are subject to the principles of agency law which apply to others, including the borrowed servant doctrine).

In reality, the captain of the ship doctrine and the borrowed servant doctrine overlap significantly, and the critical question is whether the captain of ship doctrine can be used to extend the borrowed servant doctrine to cover instances when the control exerted by the physician is not sufficient to trigger the normal rules of agency, including the borrowed servant doctrine.

The Tennessee Court of Appeals, Middle District at Nashville, aptly summed up the more pervasive rationale with the following holding:

We are of the opinion that the use of the term “Captain of the Ship” with respect to the liability of a surgeon for the negligent acts of others in or around the
operating room is unnecessarily confusing and should be avoided. We think the surgeon’s liability for the acts of others should rest on the more familiar concepts of master and servant; “[o]perating surgeons and hospitals are subject to the principles of agency law which apply to others.”


While _For The Defense_ readers are undoubtedly well aware of their jurisdictions’ current vicarious liability rules, it remains to be seen how courts will apply or alter these rules as a result of the increasing use of mid-level providers, many of whom have a duty in their own right to provide care consistent with the applicable standard of care. In general, the traditional rules of vicarious liability should still apply when a mid-level provider is directly employed by a hospital or a physician. But a new paradigm that is becoming increasingly common involves an arrangement under which a nurse practitioner provides primary care in a stand-alone building with little contact with his or her “sponsoring physician.” Certain, the doctor in this situation is not present and is not directly supervising the “manner and means” through which the nurse practitioner renders care. Consider the following hypothetical circumstances under such an arrangement:

_During the height of allergy season, a patient sees a nurse practitioner and presents with sinus drainage, sore throat, and a severe headache. The nurse practitioner takes a history, does a physical examination, and decides that the patient has a sinus infection. He or she prescribes antibiotics and decongestants, but fails to notice the patient’s nuchal stiffness. Because nurse practitioner’s sponsoring physician is not present he has not assessed the patient and was not even available to do so. It turns out that the patient actually had meningitis that was masked by seasonal allergies. A lawsuit is filed against the sponsoring physician under a theory of vicarious liability._

Assuming that the nurse practitioner committed malpractice, can the sponsoring physician be held vicariously liable? While the general rules of vicarious liability dealing with public perception and control, discussed above, will provide the starting point for this analysis, your state’s rules regarding nurse practitioners will be important.


When assessing a physician’s potential vicarious liability for a nurse practitioner’s conduct, control is the issue that an attorney must handle carefully. When a nurse practitioner delivers care in a stand-alone building without a physician present, it would seem easy to disclaim control and blame the physician’s absence, but many states’ regulations make it difficult to do so. Disclaiming control could lead to regulatory violation findings. As an increasing number of nurse practitioners begin practicing without physical proximity to the “supervising” physician, the current vicarious liability rules will need reexamining, and some jurisdictions will need to alter the rules to reflect the changing realities of the healthcare delivery.

Concluding

The law of vicarious liability among healthcare providers has been largely developed based on the traditional relationships between healthcare providers, but those relationships are changing. In general, a hospital has not been vicariously liable for physicians who are independent contractors of a hospital as opposed to employees. But as hospitals and physicians redefine and restructure their relationships, the independent contractor-employee dichotomy in many jurisdictions will break down, which will, in turn break down vicarious liability rules. Similarly, the evolving relationships between physicians and nurses will require reexaming the vicarious liability rules pertaining to those relationships. As defense counsel, it is critical to monitor these evolving relationships, assess how they affect vicarious liability, and tailor representation accordingly.