CLINICAL JURISPRUDENCE COLUMN

# Vicarious liability. Second of 2 parts: When a colleague is out of line

What obligations do you have?

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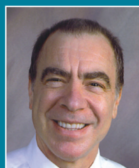
Last month, we began consideration of the obligations of physicians and health-care organizations to take action concerning colleagues who are out of line. In part 1, we looked at a recently reported case of "The gynecologist who wore an unusual pen." He admitted taking more than 1,000 videos and images of patients using a tiny camera embedded in a pen or key fob that he wore around his neck. This serious misconduct continued for many years without being noticed.

A class-action lawsuit against the medical center and physician resulted in a settlement of $190 million, despite the fact that the physician had not transferred the images to others. Here, we look at the obligation of the medical profession to notice and manage colleagues who are creating a risk to patients or the institution. What are the legal consequences of your relationships with your colleagues, and why is it so important for physicians and health-care centers to be alert to inappropriate conduct and deal promptly with those problems?

In this quarterly column, these medical and legal experts and educators present a case-based discussion and provide clear teaching points and takeaways for your practice.



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## CASE Well-respected clinician turns increasingly grumpy toward colleagues and patients

In your role as president of the practice, you have been asked to comment on a colleague's behavior. You've known him for a long time. Dr. X has been in practice for more than 20 years, and always has been well respected in the community. Over his career he has served as residency program director for a large community hospital. He has been, in essence, a role model for physicians in training.

Over the past 6 months, a number of complaints have been brought to your attention as practice president. The primary concern is Dr. X's temper, which he seems to be having trouble controlling. Nurses have stopped you in the hallway to discuss his change in attitude. "What's with Dr. X?" they ask. "We are noticing a change in the way he handles patients and residents in the program."

Now, the threat of a lawsuit because of his negative behavior has been brought to your attention.

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## Vicarious liability

This case scenario is becoming more frequent as time and reimbursement pressures mount. Learning to deal with it all in a meaningful manner can be a challenge.

What "checks and balances" do you have regarding colleagues' behavior in your practice? Ethics come into play here, as we all hear about the cases, although not typical, of the clinician who has sex with his patient, sexual abuse accusations, and so forth. But there are significant legal issues even in much less extreme cases.

### When the clinician is not an employee

In part 1, we discussed how and why an employer is responsible for the actions of its employees. In many circumstances, however, hospitals grant privileges to physicians who are not employees. Suppose the gynecologist in "The case of the unusual pen" had not been an employee of the hospital, but had staff privileges. Would the hospital have been liable?

Typically, a clinician with hospital privileges who is not an employee is an "independent contractor" rather than an "agent" of the hospital. As such, the vicarious liability that is a hallmark of a principal-agent arrangement is absent. However, the hospital still may be responsible for the clinician's misconduct if that liability arises from the hospital's own carelessness. For example, suppose the hospital had given privileges to a clinician without adequately reviewing his or her credentials, qualifications, and past conduct. Imagine that this clinician had a history of abusing patients but the hospital had failed to ascertain that fact.

A hospital that unreasonably fails to find information that would have prevented a clinician from being given privileges or that would have resulted in the limitation or removal of privileges may be liable for the harm done by the clinician, even when that person is an independent contractor. Furthermore, the failure to observe and assess the professional practice of the independent contractor may result in liability to the hospital.

**Review process for hospital privileges.** The National Practitioner Data Bank (NPDB) was developed to help hospitals find information about physicians who have been disciplined or had malpractice problems. A query to the NPDB may not be sufficient to discover all relevant information, however. Indeed, the NPDB itself notes that "the information from the Data Bank should be used in conjunction with, not in replacement of, information from other sources."[1] Most institutions have standard protocols for performing background checks on anyone applying for privileges; those processes must be followed carefully and reviewed on a regular basis.

The appointment procedure is the beginning, not the end, of the review process. An ongoing assessment of performance is formalized in committees in all hospitals. In addition, there are formal reappointment processes to assure continued competency and compliance with hospital standards and regulations.

And all of this is good—but still not enough.

### Are you responsible for reporting your colleagues' behavior?

An important part of a hospital's or practice's quality assurance is the day-to-day observations of physicians, nurses, and staff members. Courts have been increasingly insistent that an institution may be liable when its physicians or nurses witness inappropriate medical practice but fail to take action to protect patients. Inappropriate practices include:

- undertaking procedures for which the clinician is not qualified or credentialed
- violating hospital or practice policy or procedures
- causing problems for patients or others.

In "The case of the unusual pen," the plaintiffs claimed that the institution failed to "discover, stop and report" the physician because its staff was not trained to recognize and report inappropriate conduct. For example, the physician routinely may have performed gynecologic exams without a medial assistant in the room. The hospital described the physician as a "rogue" employee whose actions could not have been discovered,

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according to the facts we know—but the plaintiffs claimed that the hospital should have known what the physician was doing. Whatever the details of this actual case, the continued, undiscovered misconduct of a physician is, at best, bound to raise questions as to why the hospital or practice did not know about it and take action.

That brings us back to the hypothetical situation that began this article:

**CASE Next steps to confront the issue**

**In your role as president of the practice, you are asked to comment on a colleague's questionable behavior.**

**Do you issue a statement regarding that behavior and let the matter ride, or is more action advisable?**

From a legal standpoint, the suggestion that a clinician's problem behavior is being brought to the attention of the president of the practice is positive. Identifying the problem is only the first step, however. Being asked to comment on the colleague will not be enough. Your responsibility to the practice has now been triggered and you must undertake appropriate procedures. Summarily (and inappropriately) dismissing the colleague may result in all kinds of problems, not to mention a lawsuit. Yet just observing the situation for a few months carries other legal risks. The practice or institution undoubtedly has a standard set of procedures, and you immediately should begin implementing them. These procedures usually involve informal steps—investigating the situation and giving the physician the opportunity to respond.

When the matter is outside of routine, as this case may be, we believe that it is worthwhile to consult a legal expert. Beyond the duty to patients, there are likely to be contractual obligations and complex business law issues. Ideally, the practice has an ongoing relationship with an attorney who is an expert in health matters. Knowing your practice, the attorney can be invaluable in helping you avoid problems and find a resolution to the problems that arise, and he or she should provide consultation if the matter requires formal processes.

These obligations are supported by sound legal principles. It is always important to remember that the purpose of these obligations is to avoid unnecessary harm, stress, and expense to patients who are putting their trust in your practice.


**Reference**

1. US Department of Health and Human Services, Health Resources and Services Administration. The National Practitioner Data Bank: about us. HRSA Web site. http://www.npdb.hrsa.gov/topNavigation/aboutUs.jsp. Accessed December 11, 2014.


## When an apology may be advisable

In some cases an apology may be in order when things go wrong with patient care—and sometimes it can help defuse the tensions that arise when a bad outcome happens. For example, in an article titled, "The Last Word: The Power of Apology" a clinician's thoughts are depicted as follows[1]:

> *I felt awful. I didn't know if there was any way I could have known or anything I realistically could have done, but part of me blamed myself.… After a brutal day at the office with a packed patient schedule, I had one more difficult stop to make before going home. I had to go tell a person whose family had entrusted me to be their doctor that "I'm sorry"… Walking up to the hospital room, I rehearsed in the stairwell what I was going to say. "I'm sorry." "I want to apologize." "This is indeed unfortunate what has happened."*
>
> *Where was the right balance between sincere apology and excessive self-blame? How would this patient and the family react? Would they kick me out of the room and open up the yellow pages to find the closest malpractice attorney? Maybe.*

The physician came up with a plan, reviewed it one last time right outside the door, took a deep breath and entered the room, "I'm so, so, so, sorry this happened to you."[1]

The hour that followed focused on what had happened and what other physicians had told the family when they weighed in. Bottom line? There was agreement that it was a complex and tragic case. As the doctor exited, the family inquired, "You'll still be our doctor, won't you? We love you. You are our friend."[1]

The tension left his shoulders as the physician reflected on the importance of honesty and humility and apologizing appropriately.[1]

Saying "I'm sorry" can be a rewarding experience.


**Reference**

1. Cohen ML. The last word: the power of apology. Fam Pract Manag. 2010;17(1):40–41.