BY S.Y. TAN, M.D., J.D.

## LAW & MEDICINE

# Vicarious Liability

**Question:** A patient developed severe headache and neck stiffness, which the emergency department (ED) doctor (ED-1) incorrectly diagnosed as a viral infection. The patient went home, but her condition did not improve, so her husband called the ED, where the on-call doctor (ED-2) answered some questions but did not encourage reevaluation because the ED was extremely busy at the time. The patient's condition deteriorated rapidly; she subsequently died, and autopsy revealed a massive subarachnoid bleed. Her husband sued both of the ED doctors as well as the hospital for malpractice. Neither ED-1 nor ED-2 is a hospital employee; they work as independent contractors and derive no salary or fringe benefits from the hospital. A prominent sign at the hospital entrance features these words: "Emergency Services: Physician on duty 24 hours." Which of the following choices is correct?

**A.** ED-1 is not liable because he met the standard of care.
**B.** ED-2 is not liable because there was no doctor-patient relationship.
**C.** The hospital cannot be liable because it is not a person.
**D.** The hospital may be vicariously liable for the negligence of both ED-1 and ED-2 because they are akin to being employees.
**E.** The hospital may be vicariously liable for the negligence of both ED-1 and ED-2 because they are perceived as agents.

**Answer: E.** Whether ED-1 is liable will depend on whether the original medical history and physical findings were sufficient to raise the diagnosis of a subarachnoid bleed, and whether appropriate studies were undertaken. ED-1 will be judged by the standard ordinarily expected of any physician under similar circumstances. Although ED-2 did not directly examine the patient, there was a discussion with the husband, so it is likely ED-2 will be deemed to have established a doctor-patient relationship. Whether ED-2 breached the standard of care by failing to ask the patient to immediately return to the hospital will depend on the questions asked and the answers received. However, a busy ED is insufficient reason to dissuade a patient from being reevaluated if customary standards so dictate.

Any entity, not only a person, can be held liable for civil damages. Hospitals can therefore be asked to pay damages for any number of reasons, such as direct negligence, premise liability, etc. Vicarious liability is indirect legal liability, typically arising from an employer-employee relationship, which is not the situation here. However, vicarious liability can also arise from a principal-agent relationship, and under some circumstances, an independent contractor can be deemed to be an agent. The plaintiff will likely plead this theory by casting the ED physicians as ostensible agents; in other words, the hospital has held itself out to the public as a provider of care, as evidenced by the hospital sign that ED doctors were on duty 24 hours a day.

How can hospitals be held liable for the negligent acts of its doctors and staff? Vicarious liability is a legal doctrine in which a party is held legally responsible for the negligence of another because of its relationship to the wrongdoer. Courts have generally used the employer-employee or the agency principle to hold a hospital vicariously liable for the negligence of its health care providers. Where there is an employer-employee relationship (e.g., nurses and some doctors hired by the hospital), *respondeat superior* is the basis for liability. Respondeat superior means "let the master answer." The idea behind this rule is to ensure that the employer, as supervisor, will enforce the proper work standards to avoid risk of harm.

Where the negligent actor is an independent contractor rather than an employee, respondeat will not apply. An institution usually does not exercise substantial control over the actions of independent contractors. Most doctors who work in private hospitals are independent contractors, as they do not draw a hospital salary, nor are their work hours and work duties controlled or defined by the hospital. Having physicians as independent contractors in-

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## The Office of the Surgeon General's Call to Action Against Deep Vein Thrombosis and Pulmonary Embolism

**The high incidence of deep vein thrombosis (DVT) and pulmonary embolism (PE), collectively known as venous thromboembolism (VTE), has a devastating effect on patients and their families. The Surgeon General has announced a Call to Action to raise awareness about the risk factors and prevention of VTE.**

*"DVT/PE are major national health problems that have a dramatic, negative impact on the lives of hundreds of thousands of Americans each year."*[1]

Rear Admiral Steven K. Galson, MD, MPH, US Public Health Service, Acting Surgeon General

According to the Surgeon General's Call to Action, VTE is a major cause of morbidity and mortality among hospitalized patients.[1,2] It is the third leading cause of cardiovascular death in the United States, following myocardial infarction and stroke.[2]

- There are up to 600,000 cases of DVT and PE annually, resulting in at least 100,000 deaths per year[1]
- More annual deaths are attributed to VTE than breast cancer and AIDS combined[3]
- Many patients with VTE do not have any clinical signs or symptoms, with 25% of patients presenting with sudden death[4]

Even when accurately diagnosed, complications due to VTE can be long-standing and reduce quality of life, despite adequate treatment. The first step in reducing the incidence of DVT is to increase awareness among the public as well as health care providers about risk factors that may lead to DVT. By understanding patient risk factors, appropriate prophlaxis may be initiated.

*"The majority of DVT/PE events are related to specific, identifiable triggering events…"*[1]

**Partial list of risk factors associated with DVT and PE**[5,6]

- Restricted mobility
- Age >40 years
- ICU admission
- Obesity
- Surgery
- Varicose veins
- Prior history of VTE (DVT and/or PE)
- Chronic lung disease
- Inflammatory bowel disease
- Smoking

Table 1. Partial list of risk factors. Clinicians are advised to consider other risk factors or conditions that may predispose to DVT/PE.

*"Much is known today about how to prevent DVT/PE, and how to minimize the impact for those patients who suffer from these conditions. If this knowledge were applied consistently, the burden could be reduced substantially."*[1]

### Advancing DVT Awareness

According to the American Public Health Association Deep-Vein Thrombosis Omnibus Survey, 74% of adults had very little or no awareness of DVT.[7] Even among those mindful of DVT, 57% did not know of any risk factors associated with DVT. Surprisingly, 95% of respondents said their physician had never discussed the importance of DVT with them.[7]

Both patients and physicians must educate themselves about the dangers of DVT. It is important for health care providers to routinely assess DVT risk in hospitalized patients as well as screen high-risk patients more thoroughly. All hospitalized patients are at risk of developing DVT. Patients not receiving prophylaxis and undergoing certain general, urologic, gynecologic, or surgical procedures have a 15% to 40% risk of developing DVT.[5] For hospitalized acutely ill medical patients, the risk is 10% to 20%. Patients having hip or knee arthroplasty are at even higher risk, 40% to 60% without prophylaxis.[5] Given the high prevalence of DVT in hospitalized patients, all patients should periodically be risk assessed for DVT.

*"Individuals, families, and their communities need to understand DVT and PE, the risk factors for these diseases, and how to reduce these risks."*[1]

### DVT Prophylaxis Reduces the Incidence of DVT, Which May Lead to PE

The use of anticoagulation therapy has been shown to significantly reduce the risk of VTE by as much as 52%[8]; however, implementation and lack of appropriate prophylaxis in at-risk medical patients continue to be problematic,[9] despite evidence-based DVT/PE guidelines (Table 2).

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stead of employees thus inoculates the hospital from vicarious liability.

However, depending on the facts, some courts have used an underlying agency relationship to impute liability to the hospital (*Sword v. NKC Hospitals, Inc.*, 714 N.E. 2d 142, Ind., 1999). Agency may be established if there is some degree of control, even if minimal, that is exerted on the doctor, especially where patients are not informed that their treating doctors are independent contractors. The relationship may be construed as an apparent or ostensible agency, where there is some representation that the doctor works for the hospital. Alternatively, when the patient relies on the hospital in seeking treatment, it is called agency by estoppel. Finally, courts have occasionally used the legal doctrine of nondelegable duty to find a hospital liable, holding that the services provided, as in the radiology or emergency departments, are a hospital's "inherent function."

A recent Florida case that received prominent media coverage illustrates the issue of vicarious liability: The ship's doctor aboard a Carnival cruise ship failed to diagnose acute appendicitis in a 14-year-old girl with several days of abdominal symptoms. The patient's appendix ruptured, which eventually resulted in sterility. The parents sued the cruise line as a codefendant, which denied liability because the doctor was not an employee, a fact specifically disclosed on the cruise ticket. Although the doctor's contract stated that he was an independent contractor, the District Court of Appeal of Florida reasoned that in a claim based on agency, it is the right of control rather than actual control itself that matters. It therefore held that "for purposes of fulfilling cruise line's duty to exercise reasonable care, ship's doctor is an agent of cruise line whose negligence should be imputed to cruise line, regardless of contractual status ascribed to doctor" (*Carlisle v. Carnival Corp., et al.*, 864 So.2d 1, 2003). However, the Florida Supreme Court subsequently quashed this decision because federal maritime law protects shipowners from liability flowing from the medical negligence of shipboard physicians (*Carlisle v. Carnival Corp., et al.*, 953 So.2d 461, 2007). ■

DR. TAN *is professor of medicine and former adjunct professor of law at the University of Hawaii, Honolulu. This article is meant to be educational and does not constitute medical, ethical, or legal advice. It is adapted from the author's book, "Medical Malpractice: Understanding the Law, Managing the Risk" (2006). For additional information, readers may contact the author at siang@hawaii.edu.*

PE resulting from DVT is the most common cause of preventable death among hospitalized patients.[5] In the DVT FREE study funded by sanofi-aventis, which included 5451 patients with ultrasound-confirmed DVT, 71% did not receive any prophylaxis within 30 days of diagnosis.[10] Moreover, nonsurgical patients were much less likely than surgical patients to receive appropriate DVT prophylaxis.[10] The American College of Chest Physicians (ACCP) evidence-based clinical practice guidelines recommend that, for every general hospital, a formal, active strategy that addresses the prevention of VTE be developed (**Grade 1A**).[5]

***"Providing preventive treatment (or primary prophylaxis) to these individuals can dramatically reduce the likelihood of a blood clot or PE."***[1]

## Recommendations for VTE Prophylaxis in Select Hospitalized Patients[5] (Adapted From 2008 ACCP Guidelines)

### Prophylaxis of DVT in medical patients with restricted mobility during acute illness[5,11,a]

- For acutely ill medical patients admitted to hospital with congestive heart failure (CHF) or severe respiratory disease, or who are confined to bed and have one or more additional risk factors, including active cancer, previous VTE, sepsis, or inflammatory bowel disease: ACCP recommends thromboprophylaxis with low-molecular-weight heparin (LMWH) or low-dose unfractionated heparin (LDUH) (all **Grade 1A**)

### Prophylaxis of DVT following abdominal surgery[5,11,a]

- For higher-risk general surgery patients undergoing a major procedure for cancer: ACCP recommends thromboprophylaxis with LMWH or LDUH three times daily (each **Grade 1A**)
- For patients undergoing major general surgical procedures: ACCP recommends thromboprophylaxis continue until discharge from hospital (**Grade 1A**)

### Prophylaxis of DVT following hip- or knee-replacement surgery[5,11,a]

- For patients undergoing total hip replacement (THR) or total knee replacement (TKR): ACCP recommends routine thromboprophylaxis with LMWH (at the usual high-risk dose) or adjusted-dose vitamin K antagonist (VKA) (international normalized ratio [INR] target, 2.5; INR range, 2.0 to 3.0) for at least 10 days (all **Grade 1A**)
- For patients undergoing THR: ACCP recommends thromboprophylaxis be continued beyond 10 days and up to 35 days after surgery with LMWH (**Grade 1A**) or a VKA (**Grade 1B**)

Table 2. ACCP 2008 Guidelines: recommendations for VTE prophylaxis.

**LOVENOX® (enoxaparin sodium injection) is indicated for the prophylaxis of DVT, which may lead to PE:**

- **In medical patients who are at risk for thromboembolic complications due to severely restricted mobility during acute illness**
- **In patients undergoing abdominal surgery who are at risk for thromboembolic complications**
- **In patients undergoing hip-replacement surgery, during and following hospitalization**
- **In patients undergoing knee-replacement surgery**

## Two Clinical Trials Showed LOVENOX® Provided Effective VTE Prophylaxis in Medically Ill Patients

MEDENOX (Prophylaxis in Medical Patients With Enoxaparin) was a multicenter, multinational, double-blind study that included 1102 acutely ill medical patients randomized to either LOVENOX® or placebo for 6 to 14 days during hospitalization.[12] The incidence of DVT or PE was significantly lower in patients treated with LOVENOX® than placebo (5.5% vs 14.9%, respectively).[12] The use of LOVENOX® was associated with a 63% reduction in risk of VTE.[12]

There was no statistically significant difference in major bleeding events[b,c] or thrombocytopenia comparing LOVENOX® with placebo.[12,13]

**MEDENOX efficacy data[12]**

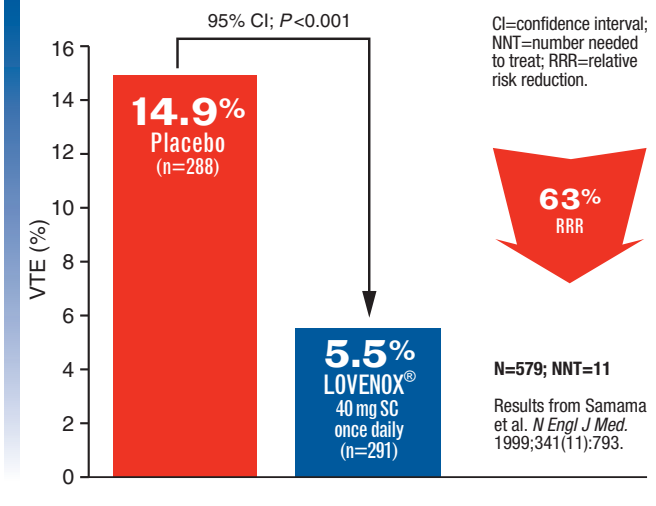


Figure 1. Short-term incidence and RRR of VTE in medical patients treated with LOVENOX® (40 mg) vs placebo. *P* values are for RRR.

[a] Grades of recommendation – 2008 Guidelines: ACCP Evidence-Based Clinical Practice Guidelines (8th edition)—**Grade 1A**-strong recommendation based on high-quality evidence; **Grade 1B**-strong recommendation based on moderate-quality evidence; **Grade 1C**-strong recommendation based on low- or very low-quality evidence.[11]
[b] Based on the rate of major bleeding on LOVENOX® up to 24 hours after the last dose.[13]
[c] Hemorrhage was classified as major if bleeding was overt and was associated with the need for transfusion of 2 or more units of packed red blood cells or whole blood, or with a decrease in the hemoglobin concentration of 2.0 g/dL or more from baseline, or if bleeding was retroperitoneal, intracranial, or fatal.[12]

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