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Physician Liability for the Actions of Others: A Primer

Sugarman Law Firm LLP

There are two legal theories under which a physician can be held liable for medical negligence and malpractice. First, a physician may be liable to a patient for the physician's own negligence, which is known as "direct liability." Second, a physician may also be held responsible for the negligent acts of others (such as residents, physician assistants, nurses and independent contractors) without any personal wrongdoing, which is known as "vicarious liability." In many medical professional liability claims, it is common for the allegations against the physician to involve one regarding his or her own medical negligence (direct liability) and another regarding the

negligence committed by a physician's employee or agent (vicarious liability).

In cases involving direct liability, a physician may be held liable for something he or she actually did or should have done. If a patient is able to establish that a physician deviated from the applicable standard of care, and that the deviation was a substantial factor in causing a patient's injuries, a physician can be held directly liable for medical malpractice. Examples of direct liability include diagnosing, treating, giving instructions or directions, and supervising another person's activities.

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MLMIC Insurance Company Receives AM Best Financial Strength Rating of A+

MLMIC Insurance Company has received an A+ (Superior) Financial Strength Rating and a Long-Term Issuer Credit Rating of "aa-" from AM Best, a global credit agency rating and information provider with a focus on the insurance industry. As of December 18, 2018, AM

Best reports that "the outlook assigned to these Credit Ratings is stable."

"We are very pleased with the A+ rating from AM Best," says Dr. John Lombardo,

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In situations involving vicarious liability, a physician may be held responsible for the actions of others, such as residents, physician assistants, and nurse practitioners. To be vicariously liable, a physician need not have engaged in any negligent conduct. Instead, liability is based upon the relationship between the physician and the person who actually committed the negligent act. One of the most common situations where vicarious liability exists is the employer/employee relationship. However, other situations can result in vicarious liability as well. If it is determined that a physician exercised control over another person, that physician may be vicariously liable for the person's actions.

Under the principle of respondeat superior, an employer will be held responsible for the negligence of its employee as long as the employee was acting within the scope of his/her employment.¹ Whether an employee was acting within the scope of his or her employment at the time of the event may require a case-by-case determination.

If, for example, a nurse employed by a physician runs a red light and gets into a motor vehicle accident on her day off, the nurse will most likely not be acting within the scope of her employment, and thus there will be

1. Riviello v. Waldron, 47 NY2d 297 (1979).



no vicarious liability on the part of the physician. If, on the other hand, the nurse inadvertently runs a red light and gets into a motor vehicle accident on the way to visit a patient at the direction of her employer, the nurse will likely be considered to have been acting within the scope of her employment at the time of the accident, and the employer may be held vicariously liable for her negligence. In everyday practice, physicians work with, supervise, collaborate with, or employ a number of other individuals, including residents, physician assistants, nurses, and office staff. The following discusses circumstances in which physicians may be held liable for the negligent acts of these persons.

Residents

Generally speaking, a resident is legally responsible for his or her own conduct if the resident exercised independent medical judgment in the care

of a patient.² However, an attending physician will be held responsible for the medical malpractice of a medical resident who works with or under the supervision of that physician if the resident did not exercise independent medical judgment and the attending is exercising control in fact over the resident.³ An example of a physician exercising control in fact over a resident is an attending physician performing an emergency Caesarian section who allowed a third-year resident to make the incision across

2. *Nasima v Dolen*, 149 A.D.3d 759 (2d Dep't. 2017) (A resident who assists a doctor during a medical procedure, and who does not exercise any independent medical judgment, cannot be held liable for malpractice so long as the doctor's directions did not so greatly deviate from normal practice that the resident should be held liable for failing to intervene).
3. *Nasima*, supra.

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MLMIC Releases Healthcare Weekly

MLMIC Insurance Company is pleased to announce the release of its new online publication, Healthcare Weekly.

Comprised of informative and current topics of discussion from the MLMIC.com Blog, as well as healthcare-related insights and articles from throughout the industry, Healthcare Weekly topics

are presented as quick, easy-to-digest titles that give the big picture. Readers wanting to dig in for further details are encouraged to click the provided links to view the full articles.

Healthcare Weekly is emailed each Thursday to all MLMIC policyholders, as well as to leading New York State

healthcare practitioners and organizations. Should you wish to receive Healthcare Weekly in your inbox each week and are not a MLMIC policyholder, please click here to sign up. Only your email address is required.

Questions? Email klagano@mlmic.com

Improper Delegation Involved in Loss of Eye

Kristen Guarente

Senior Claims Examiner

MLMIC Insurance Company

This case involves a then 67-year-old male who was referred to a MLMIC-insured professional corporation (PC) in October 2014 for a central vein hemorrhage in his left macula. The MLMIC-insured ophthalmologist who examined the patient diagnosed macular branch retinal vein occlusion of the left eye, and also noted some early macular edema. The plan was to observe the patient. By March 2015, the patient demonstrated more macular edema, and Eylea injections were commenced. Over the ensuing months, the patient continued to have injections without complications.

On 8/31/15, the patient presented to our insured ophthalmologist for a routine Eylea injection. At that time, the patient was on a six- to eight-week regimen of injections. The patient's best corrected vision in both eyes was 20/20. Intraocular pressure (IOP) in the right eye was 24 and 14 in the left. The ophthalmologist noted the patient had some fluid on the optical coherence tomography (OCT), but had improved. The plan was to proceed with the injection, and the ophthalmologist discussed the potential for infections or sterile endophthalmitis.

The ophthalmologist began the procedure by anesthetizing the eye using topical Proparacaine followed by topical Betadine. A lid speculum was inserted. 10% Betadine was then applied to the area to be injected. Our insured then proceeded to inject Eylea (2.0 mg and 0.05cc volume) through the pars plana. After the needle was withdrawn, a Betadine-soaked Q-tip was applied to the area of the injection for 10 seconds. Following the injection, the central artery was patent. The patient's visual acuity was confirmed as being light perception or better. The patient tolerated the procedure well and was scheduled to return

to the office in six to eight weeks for reinjection. The patient was provided with instructions to call the office immediately should he note any decrease in vision or an increase in floaters after 24 hours.

The patient returned to the office on 10/19/15 for another injection. Visual acuity in the right eye was 20/20 and 20/50+2 in the left. Pinhole vision was 20/25 in the left eye. IOP in the right eye was 5 and in the left eye 6. The patient stated his visual acuity had improved. Our insured noted there was fluid evident on the OCT, which was basically unchanged. An injection was carried out without complication, and the patient was instructed to return in 6 to 8 weeks for reinjection.

The patient telephoned the office on 1/13/16 with complaints that he had lost vision in his left eye.

The patient returned to the office on 1/11/16 for reinjection. Visual acuity was 20/20 in the right eye and 20/25 in the left eye. Pinhole vision in the left eye was 20/20. The ophthalmologist noted that the patient's retinal swelling had improved, and the Eylea injection was given without complication.

On 1/12/16, the patient called the office and spoke with a receptionist, reporting that he had an injection the day before. He complained of soreness, blurry vision, and tearing in the left eye. The call was triaged by an LPN. The patient noted that with prior injections the symptoms usually went away in a couple of hours. He denied pain or swelling. The LPN instructed the patient to apply

a cold compress to his eye, take Advil to relieve symptoms, and to call should he have new or worsening symptoms.

The patient telephoned the office on 1/13/16 with complaints that he had lost vision in his left eye. The eye was also painful and swollen shut. The call was triaged, and an appointment was made with another insured ophthalmologist in the group that same day.

The patient presented for the scheduled appointment on 1/13/16 and advised the ophthalmologist that his left eye had been swollen shut with decreased vision and excruciating pain that he considered to be 9/10. The pain had gotten worse that morning, and the patient noted a lot of mucus discharge from the eye. The ophthalmologist noted that the visual acuity in the right eye was 20/20 with correction and light perception in the left eye. IOP was 18 in the right eye and 36 in the left. A slit lamp examination of the left eye revealed 2+ injection. There was evidence of diffuse corneal edema with some microcystic edema as well. There was limited opacification 360 degrees and a 8.5mm micro-hyphema. 3+ cells were seen in the anterior chamber with 3+ fibrinous strands. There was a 2-3+ nuclear sclerotic cataract. Biomicroscopy revealed no view of the posterior pole. A B-scan revealed evidence of vitreous debris, but no retinal detachment.

The ophthalmologist's impression was acute endophthalmitis versus TASS syndrome. The plan was to treat the patient as acute endophthalmitis. The ophthalmologist performed a vitreous tap and anterior chamber tap for culture and sensitivities. The left eye was injected with vancomycin, ceftazidime and dexamethasone. The patient was advised

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to use gentamicin drops and Pred Forte drops in the left eye four times a day. The patient was also advised to follow up with another ophthalmologist colleague the following morning. In addition, the patient was advised to remain NPO in case his condition worsened, which would necessitate a pars plana vitrectomy. Tylenol #3 was recommended for pain every 4 to 6 hours.

On 1/14/16, the patient followed up with another insured ophthalmologist as planned. He reported the pain in the left eye was much better but complained of some nausea and increasing pain that started that morning. Visual acuity in the left eye was no light perception. The patient refused having his IOP taken. A slit lamp exam of the left eye revealed 360-degree hypopyon. There was only a cloudy view of the anterior chamber. There was no view on ophthalmoscopy. The ophthalmologist's impression was endophthalmitis of the left eye with gram-positive cocci and a decrease in vision. The cultures later grew 2+ alpha hemolytic strep on fluid culture and isolate 2+ streptococcus viridians. The ophthalmologist recommended urgent vitrectomy and contacted the MLMIC-insured ophthalmologist who had seen the patient on 1/11/16.

Our insured ophthalmologist met with the patient prior to surgery and examined the external portion of the eye. His assessment was endophthalmitis, left eye. The risks and benefits were explained to the patient, who signed a consent form. The ophthalmologist performed a left eye pars plana vitrectomy, anterior chamber washout and antibiotic injection of vancomycin and ceftazidime.

Postoperatively, the patient reported the pain in his left eye had improved, although he had a "foreign body sensation" in this eye. On 2/1/16, visual acuity in the left eye was no light perception. Intraocular pressure was 11 and 14. Slit-lamp examination revealed 1+ injection of the conjunctiva and engorgement

of the sub-episcleral vessels. The cornea was opacified and scarred and offered no view of the anterior chamber. The patient had a bandage contact lens placed on 2/25/16 by our insured ophthalmologist. Subsequently, the patient continued to complain of intermittent, recurring pain in the left eye. By 3/3/16, the pain had worsened.

The patient obtained a second opinion for possible enucleation and was evaluated on 3/7/16. Evisceration of the left eye was recommended as there was no chance for visual recovery for the patient. The left eye was eviscerated on 3/21/16, and he was fitted with a prosthetic eye thereafter.

As of 2017, the patient's limitations included not being comfortable driving long distances. He drives short distances in good weather. He has changed all of the lighting in his residence to LED lighting to be able to see better in the house. In general, the limitations to his eye have had more of an emotional and psychological effect than physical. He has been a volunteer firefighter for 35 years and will still answer calls during the day if it is good weather.

The patient commenced a lawsuit in which he claimed the MLMIC-insured ophthalmologist and PC failed to properly advise the patient of the risks, hazards and alternatives to the care and treatment of his eye; failed to obtain the patient's history in the proper manner; and failed to obtain an appropriate medical history of the patient. Further, the patient alleges that our policyholders were negligent in failing to properly and accurately document pertinent events and failing to communicate among the defendant's agents and employees about the patient's condition. The patient further alleges that our policyholders failed to seek timely and appropriate consultations and failed to take proper actions in the face of foreseeable complications.

This file was reviewed by MLMIC's in-house ophthalmologist, who stated

the main thrust of the allegation against our insured physician was that the patient was expressing symptoms that were extraordinary in that they did not match what was expected based on his previous experience with these injections. A second weakness was the fact that it appeared that our insured physician did not speak directly to the patient when the patient called on 1/12/16. Considering what transpired over the following 24 hours, this may prove difficult to defend.

An outside retinal specialist reviewer stated that the indications for the injections and the technique utilized by our insured physician were all appropriate. Based on the information recorded by the LPN on 1/12/16, our expert felt that an appropriate response and advice were provided to the patient. This was a very unfortunate case, and the determinative factor in the loss of the patient's vision was the aggressive nature of the organism which caused the infection, not any delay in treating the infection.

A decision was made to settle the case on behalf of the PC as the LPN practiced beyond the scope of practice allowed by the Department of Health. Clearly, the LPN performed a triage phone call and assessed the patient.

The plaintiff's original demand was \$1.5 million. A settlement was reached on behalf of the PC in the amount of \$750,000.

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CASE STUDY

A Legal & Risk Management Analysis

Marilyn Schatz, Esq.

Fager Amsler Keller & Schoppmann, LLP
Counsel to MLMIC Insurance Company

The initial reviews of this case by defense counsel and the outside expert were supportive of the care and treatment provided by the defendant physician and the LPN. The ultimate loss of the patient's vision and eye was more likely the result of a known and acceptable risk of the procedure and an aggressive complication, rather than a failure to timely diagnosis and treat the infection. Even if the patient had been treated on the day he called and spoke to the LPN, the outcome would probably have been the same, but the lawsuit may have been more defensible.

Given the patient's familiarity with the symptoms he experienced after previous injections, he was in the best position to know that his latest complaints differed significantly in intensity, severity and duration. Instead of communicating with the defendant physician about the nature of the patient's concerns, the LPN triaged him and gave an appointment for the following day. She also provided medical advice. Of note, the LPN was following pre-established protocols implemented by her employer and she was working within those parameters.

This was a dangerous case to present to a jury and allow the sympathetic aspects of the patient's injuries to be factored into a verdict. However, engaging in settlement negotiations was unlikely with a demand of \$1.5 million. Defense counsel was prepared to go to trial. The patient's attorney managed to gain the upper hand based solely on the actions and inactions of the LPN. Any potential for a successful defense was offset by the fact that the LPN was acting outside the scope of her license by triaging the patient and providing instructions based on his complaints. The



LPN failed to consult with the defendant physician when she should have.

By law, an LPN's scope of practice does not include assessment, interpretation, or triage, all of which she performed in this case. One of the most significant aspects of MLMIC's decision to settle was the leverage the patient's attorney obtained by threatening to report the LPN to the Office of Professional Discipline (OPD). Any investigation undertaken by OPD would have resulted in misconduct findings. In turn, OPD would have likely reported the physician to the Office of Professional Medical Conduct to investigate him for misconduct.

The case was settled with full payment being made on behalf of the defendant PC only. The physician was fortunate that no payment was made on his behalf, thereby avoiding reporting to the National Practitioner Data Bank. The LPN was not named in the lawsuit. The defendant physician and the practice's board of directors were entirely supportive of the LPN since she acted within the guidelines they had established. Prior to this case, the physician group had been unaware that the duties assigned to the LPN were deemed to be outside

the scope of her license. Subsequently, they hired an RN to perform triage.

It is important to point out that the liability of a provider or a practice may arise not only from direct patient care but also from staff acting outside the scope of their licensure, and/or failure to properly supervise ancillary personnel. The physician was vulnerable to claims of inappropriate delegation of duties to an LPN based on the legal principle of vicarious liability. Inappropriate use of staff in a medical practice potentially exposes healthcare providers to litigation; the delegating provider to a charge of inappropriate assignment of professional responsibilities; and licensed staff to a charge of acting outside the scope of their practice.¹

The services provided by LPNs and others, such as RNs, nurse practitioners, CRNAs and medical assistants, are invaluable to enhance efficient operations of a medical practice. These individuals provide expertise based on their education, training and experience. They assist physicians to more efficiently meet the ever-increasing demands of effectively managing a

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Managing Negative Online Reviews

Healthcare providers recognize that along with their practice websites, public websites such as Yelp, Healthgrades, and Rate MDs, and social media sites like Facebook and Twitter, can be used as marketing tools to inform the public of their services. The online community, however, is then afforded an opportunity to respond, rate, and, at times, complain about those services. These statements and reviews are readily accessible to anyone with an internet-ready device to open and read.

While there is a basic instinct to immediately respond to negative online reviews, healthcare providers must remember that privacy rules make a complete response via social media inappropriate, and responding directly to an online post puts the healthcare provider at risk of disclosing protected health information (PHI). Your response may not contain any identifying statements, but the mere recognition of a patient-provider relationship is a potential HIPAA violation.

The follow tips will help you successfully and appropriately respond to negative online reviews:

1. Critically review all social media posts for accuracy and authenticity. While some negative statements regarding the performance of you or your staff may be difficult to

read, evaluate these reviews to determine if there is any opportunity for learning or process change.

2. Do not become engaged in online arguments or retaliation—especially if the comments made are particularly negative and potentially detrimental to the reputation of the facility or physician.
3. According to federal and state confidentiality and privacy laws, providers are precluded from identifying patients on social media. In order to protect patient privacy, all patient concerns and complaints should be resolved by the practice by contacting the patient directly and not through social media.
4. If you do choose to respond via social media, use a standard response that also serves as a marketing opportunity for your practice. Some examples include:
 - a. “[Insert name] Medical Group is proud to have been providing comprehensive and compassionate care in the community since [insert year] and takes our treatment of its patients and their privacy seriously. Because federal privacy laws govern patients’ protected health information, it is not the policy of [insert name]

Medical Group to substantively respond to negative reviews on “ratings” websites, even if they provide misleading, unfair or inaccurate information. We welcome all our patients and their families to address any concerns/requests or information about their care with us directly, as we strive to continue to provide individualized care in our community.”

- b. “At our medical practice, we strive for patient satisfaction. However, we cannot discuss specific situations due to patient privacy regulations. We encourage those with questions or concerns to contact us directly at [insert phone number].”

5. If you feel the patient’s complaint has disrupted the physician-patient relationship, consider discharging the patient from your practice. This action may be viewed as retaliatory by the patient and may set off a new series of negative posts. Attorneys at Fager Amsler Keller & Schoppmann, LLP are available to assist you to make this decision.
6. Notify your local authorities if you feel at any time that your safety, the safety of your staff or your family is threatened or at risk.

MLMIC Insurance Company Receives AM Best [continued from page 1](#)

president of MLMIC Insurance Company. “We look forward to continuing to deliver value to healthcare professionals and facilities in New York State.”

According to the AM Best announcement, “The ratings reflect MLMIC’s

balance sheet strength, which AM Best categorizes as strongest, as well as its adequate operating performance, limited business profile and appropriate enterprise risk management.”

The agency also says that leadership

has maintained “MLMIC’s leading market position within New York,” one of the “most challenging market environments” in the country.

[Click here to view the AM Best news release.](#)

Spring 2019 Update

The MLMIC Research Library's services are available to all policyholders on a complimentary basis. Policyholders may submit a research request at the library link on MLMIC.com's homepage.

Along with offering research services, MLMIC owns a large collection of medical malpractice risk management book and DVD titles available to borrow for a five week loan. Please

visit the MLMIC Research Library online to learn more about newly added titles, process a loan request, or send your risk management research question using Ask the Librarian.

To reach the Library directly, please contact Judi Kroft, Library Administrator, at 800-635-0666 ext. 2786 or jkroft@mlmic.com.

Recent Additions:

- **2019 hospital accreditation standards.**
Joint Commission Resources; 2019 (Hosp Adm 312-032 2019).
- **2019 standards for ambulatory care.**
Joint Commission Resources; 2019 (Amb Care 068-049 2019).
- **ASHRM health care claims and litigation playbook.**
American Hospital Association; 2018 (R M 151-153).
- **Emergency department compliance manual, 2017.**
Rusty McNew. Aspen Publishers, Inc.; 2017 (E R Svcs 079-028 2017).
- **The EMTALA answer book 2018.**
Jeffrey C. Moffat. Wolters Kluwer; 2018 (Medicolegal 330-023 2018).
- **Environment of care essentials for health care: Environment of care, emergency management, equipment management and life safety.**
Joint Commission Resources; 2019 (Safety 152-078 2019).
- **Guidelines for perioperative practice.**
Association of Operating Room Nurses, Inc.; 2018 (Surgery 167-003 2018).
- **HIPAA compliance handbook 2018.**
Patricia I. Carter. Aspen Publishers, Inc.; 2018 (Medicolegal 330-019 2018).
- **Legal manual for New York physicians.**
Patrick Formato, Joel M. Greenberg & Donald R. Moy. New York State Bar Association; 2018 (Medicolegal 330-032 2018 v. 1 & 2).
- **Long Term Care State Operations Manual.**
HCPro; 2017 (LTC 104-148 2017).
- **Optimal resources for surgical quality and safety.**
David B. Hoyt, et al. American College of Surgeons; 2017 (Surgery 167-038 2017).
- **Theft prevention guide for senior living.**
Stefanie Corbett. HCPro; 2017 (LTC 104-152).



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The attorneys at Fager Amsler Keller & Schoppmann, LLP are available during normal business hours to assist MLMIC insureds with a wide range of legal services, including, but not limited to, advisory opinions concerning healthcare liability issues, liability litigation activities, lecture programs, and consulting services.

Healthcare law, regulations, and practices are continually evolving. The information presented in Dateline is accurate when published. Before relying upon the content of a Dateline article, you should always verify that it reflects the most up-to-date information available.

the mother's uterus. The resident lacerated the baby's forehead, causing permanent scarring. In this scenario, the mother sued the attending physician on behalf of the baby and the jury determined that the resident was acting under the attending's direct supervision and, therefore, the attending exercised control in fact, which was upheld by an appellate court.⁴

Physician Assistants

Under New York law, a physician assistant (PA) is permitted to perform medical services when under the supervision of a physician and only when the acts and duties assigned to him/her are within the scope of practice of the supervising physician.⁵ Although this supervision must be continuous, the physical presence of the supervising physician is not always required.⁶

Department of Health regulations specifically provide that a physician who supervises or employs a PA will be medically responsible for the medical services performed by the PA.⁷ Though a physician's liability for the actions of a PA will depend upon the nature of their relationship. If the physician employs the PA, vicarious liability will exist.⁸ If the physician supervises hospital-employed PAs, the physician may be held directly liable for failing to supervise the PA. If the physician is found to have control in fact over the PA, then vicarious liability will exist.⁹ A New York County Court ruled that the doctor, who employed the PA who treated a patient, wrote illegible notes regarding the treatment, and did not adequately follow up with the patient, was appropriately sued for the PA's possible deviations from the standards of care due to the nature of vicarious liability.⁹



Nurse Practitioners

Nurse practitioners (NPs) have slightly more autonomy. In addition to performing the duties of a registered nurse, a NP may diagnose illnesses and physical conditions, perform therapeutic and corrective measures, and prescribe medication.¹⁰ NPs do not need to be supervised by a physician, but they must perform these services in collaboration with a licensed physician according to a written practice agreement and written practice protocols that comply with statutory requirements.¹¹ Where this practice agreement does not contain explicit provisions for the resolution of disputes between the NPs and the physician's diagnosis, then responsibility for the diagnosis rests with the physician.¹² Thus, physicians can be exposed to direct liability as a result of their collaborative relationships with NPs. The written practice agreement between the NP and the collaborating physician is critical in managing this liability.

Even where only the NP examines the patient rather than the physician but then presents the patient's case to the physician later; there will be liability for the physician.¹³ Cooperation between

the NP and the physician created a physician-patient relationship, even though the physician never physically examined the patient. The diagnosis was then rendered with the physician's approval. Because the practice agreement was silent, the ultimate responsibility for the diagnosis and treatment rested with the physician, even though he had never personally examined the patient.¹⁴

Hospital Employed Nurses/Certified Registered Nurse Anesthetists

Physicians often work with nurses who are employed by a hospital. As a general rule, a physician will not be liable for the actions of a nurse not within his/her employ. However, liability may exist if the physician directly supervised or controlled a nurse's activity. This calls for a fact-specific inquiry. The key question is whether a nurse's allegedly negligent act involved a procedure that called for close medical supervision and instruction.

In one case, a patient was hospitalized for a tonsillectomy and his doctor prescribed a specific post-operative diet, which prohibited the consumption of hot tea. A nurse knew of this prescription;

4. Ross v. Mandeville, 45 AD3d 755 (2d Dep't. 2007).

5. New York Education Law § 6542(1).

6. New York Education Law § 6542(2).

7. 10 NYCRR § 94.2(f).

8. Gaspari v. Sadeh, 61 AD3d 405 (1st Dep't. 2009); Polanco v. Commission of the Dept. of Social Service, 212 AD2d 443 (1st Dep't. 1995).

9. Gaspari v. Sadeh, supra.

10. New York Education Law § 6902(3)(a);

11. New York Education Law § 6902(3)(a)(i); See 8 NYCRR § 64.5.

12. Quirk v. Zuckerman, 196 Misc. 2d 496 (Sup. Ct. Nassau Co. 2003); New York Education Law § 6902(3)(a)(i).

13. Quirk, supra.

14. Banks v. Barkoukis, 231 AD2d 598 (2d Dep't. 1996); See Striano v. Deepdale Gen. Hosp., 54 AD2d 730 (2d Dep't. 1976).

however, for her own convenience, she ordered the patient a complete liquid diet, which included hot water for tea. The nurse intended to remove the hot water from the tray before the patient began to eat; however, before she could do so, the patient knocked over the hot water and burned his ankle. Based on these facts, the court held that the doctor was neither directly liable nor vicariously liable for the nurse's actions. The physician was not vicariously liable for failing to supervise the nurse because serving a meal did not involve a medical procedure that called for close supervision and instruction. Moreover, the physician was not directly liable because the nurse acted against his instructions and was under the supervision of the hospital, not the physician.¹⁵

In another case, the patient was in a hospital undergoing surgery by the defendant surgeon. A circulating nurse was adjusting a surgical light for the surgeon when she dislodged an I.V. pole, which then struck the patient in the eye. The patient argued that the surgeon was directly liable, as well as vicariously liable, for the nurse's negligence because the nurse was under the surgeon's direction and control. On appeal, the court found that the surgeon was not directly or vicariously liable for the nurse's actions because neither the I.V. pole's presence, nor the fact that it was dislodged, was a deviation by the surgeon from the applicable standard of care. The court re-stated the general rule that a surgeon may not be held vicariously liable for the negligence of a nurse who is not in his employ, unless the act giving rise to the injury is one requiring close supervision and instruction. The adjustment of the surgical light was not such a procedure and, therefore, the surgeon could not be held vicariously liable for the nurse's negligence.¹⁶

The circumstances are slightly different

when a physician works with a certified registered nurse anesthetist (CRNA). A CRNA is a registered nurse who has additional training to administer anesthesia, but only under appropriate supervision.^{17,18} New York State regulations require that in order to supervise a CRNA, a physician must be found qualified and competent to do so under the hospital's credentialing process and must accept responsibility for such supervision. Hospitals determine whether a physician possesses the necessary qualifications on a case-by-case basis. Therefore, the physician is directly overseeing the CRNA's work and will be held directly liable for his or her failure to supervise a CRNA and will be vicariously liable if control in fact exists over the CRNA.

Independent Contractors

It is becoming increasingly common for physicians or a physician group practice (entity) to retain independent contractors to assist the practice. These independent contractors are not employees, but they may use space in the physician's office. Generally speaking, a physician is not liable for the acts of an independent contractor. A physician or entity may be held liable, however, if it is found that an "apparent agency" relationship exists between the physician/entity and the contractor. In this scenario, the physician or entity will be deemed the "principal," and the contractor will be the "agent." In the context of a medical professional liability action, an apparent agency relationship may exist where the patient reasonably believed that the personnel treating him/her were provided by the principal (i.e., the physician or entity) and that they were acting on the principal's behalf.¹⁹ This would result in vicarious liability on the part of the

entity for the actions of the contractor.

Several elements are required to legally establish apparent agency. First, the principal must use words or conduct to communicate with the patient in a way that creates the appearance and belief that the independent contractor has the authority to act on the principal's behalf. This may be as simple as referring to the independent contractor in a way that leads the patient to assume that the contractor is an agent or employee. Second, the patient must reasonably rely on the appearance of authority based on words or conduct by the principal; words or conduct by the independent contractor are insufficient to create an apparent agency. Third, the patient must accept the independent contractor's services in reliance upon the perceived relationship between the principal and the independent contractor, not in reliance on the independent contractor's skill.²⁰

The existence of an apparent agency situation is determined by the relevant factual circumstances in each unique situation. For example, a patient was injured after he became dizzy and fainted when he had his blood drawn by a phlebotomist at the Center for Pulmonary Critical Care and Sleep Medicine (PCC). This patient sued PCC, arguing they were responsible for the phlebotomist's negligence. This phlebotomist was an independent contractor for PCC and worked in a laboratory that was located within PCC. As an independent contractor, the phlebotomist was not employed by PCC. Instead, she was employed by an independent third party, Lloyd Staffing, which staffed the laboratory. In analyzing whether PCC could be held liable for the phlebotomist's negligence, the court stated the general rule that an entity is not vicariously liable for the

17. NY Code Title 10, § 405.13.

18. NYCRR § 405.13(a)(1)(iv).

19. *Casucci v. Kenmore Mercy Hospital*, 144 A.D.2d 910 (4th Dep't. 1988) (The applicability of the doctrine depends upon whether the plaintiff could have reasonably believed, based upon all of the surrounding circumstances, that the treating physician was provided by the defendant hospital or clinic or was otherwise acting on the defendant's behalf).

20. *Dragotta v. Southampton Hosp.*, 39 A.D.3d 697 (2d Dep't. 2007).

21. *Dragotta*, supra.

15. Striano, supra.

16. Banks, supra.

negligence of an independent contractor.²¹ The court found, however, that the patient could have reasonably believed that the phlebotomist was employed by PCC because she did not wear a Lloyd Staffing badge; there were no billing slips from Lloyd Staffing; the patient paid his copay to PCC; and there were no signs indicating that the blood work would be performed by an outside agency. In fact, the contract between PCC and Lloyd Staffing prohibited any such disclosures from being made to patients. As a result, the court found it was best left for a jury to determine whether PCC could be held vicariously liable for the phlebotomist's negligence based upon all the circumstances.

- When signing off on mid-level providers' reports, notes, or

recommendations, be sure to first thoroughly review the patient's history, then consider the mid-level providers' assessment and plan, and ensure that they have considered all of the potential risks and consequences with the particular patient to avoid potential future liability.

- With independent contractors in your practice, it is important to consider how the patient or a reasonable person will perceive the relationship. Therefore, it is important to make clear that the independent contractor is not an employee. It may be worth considering patient registration documents that specifically include language regarding the status of an independent contractor who

may potentially treat the patient, similar to an informed consent document. Clearly defining the role of the independent contractor in advance may be helpful in addressing perceived agency later.

The imposition of liability upon physicians for the actions of others is not limited to the cases and circumstances discussed above. Therefore, it is important that you exercise caution when selecting the physician assistants, nurses, and other personnel, including administrative personnel, whom you employ, supervise, and/or control. Physicians are legally responsible for the errors of individuals they employ and those whom they direct and control.

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busy practice. It is the responsibility of all healthcare professionals to practice within their scope and licensure. Failure to do so is considered professional misconduct. In the office practice setting as well as in hospitals, it is essential that policies and procedures are clearly delineated for all health care staff functions. This case emphasizes the importance of this process.

Physicians have professional, legal, and ethical obligations to appropriately delegate duties. Strict adherence to assigned responsibilities will benefit all parties on a healthcare team.

What services can a licensed practical nurse provide?²

According to New York State Education Law § 6902, licensed practical nurses (LPNs) perform tasks and responsibilities within the framework of case finding, health teaching and health counseling, and provide supportive and restorative care under the

direction of a registered professional nurse (RN), clinical nurse specialist, physician, nurse practitioner, licensed midwife, physician assistant, specialist assistant, dentist or podiatrist. An LPN typically provides the following types services under the direction of an RN or other qualified practitioner (assuming that the LPN is personally competent to do so):

- Administers most types of medications and immunizations and blood (with additional training).
- Provides bedside nursing care in hospitals and residential healthcare facilities.
- Observes, measures, records, and reports data relating to a patient's health status.
- Performs clinical procedures, such as urinary catheterizations, oral or tracheal suctioning, sterile dressing changes, and starting a peripheral IV (with additional training).

- Supervises unlicensed care staff, such as certified nurse aides (CNAs) in nursing homes.
- Identifies patient goals for consideration by the RN for possible inclusion in a patient's care plan.

New York law does not allow LPNs to determine nursing diagnoses, develop or change nursing care plans, perform triage, or perform any service that the LPN is not personally competent to perform. There are many additional services not listed here that LPNs may or may not be allowed to perform, and there are many New York laws and regulations that impact the practice of LPNs.

Endnotes:

1. Regents Rules 29.1(b)(9), (10).
2. NYSED.gov (Office of the Professions) <http://www.op.nysed.gov/prof/nurse/nursepracticefaq.htm>.

Event Calendar 2019

In 2019, MLMIC will be participating in the following events throughout New York State. For more information on MLMIC's involvement in these events and others, please contact Pastor Jorge, Manager, Marketing Services, at 212-576-9680.

Kings County Medical Society - Annual Doctor's Recognition Day

March 26, 2019 (Rex Manor, Brooklyn, NY @ 6 PM - 10 PM)

American Academy of Pediatrics - New York Chapter 2 - Executive Committee Meeting

March 28, 2019 (NYU Winthrop Hospital, Mineola, NY @ 6 PM - 7M)

(AHRMNY) The Association of Healthcare Risk Management of New York

March 28, 2019 - Lenox Hill Hospital - Einhorn Auditorium @ 5 PM - 9 PM)

Bronx County Medical Society - 2019 16th Annual Doctor's Day

March 28, 2019 (Mercy College, Bronx, NY)

New York MGMA - NE/Albany Local Chapter Event

April 2, 2019 (The Century House, Latham, NY @ 8 to 10 AM)

New York State Osteopathic Society - 2019 Regional Osteopathic Convention

April 4, 2019 - April 7, 2019 (Hyatt Regency Long Island Hotel, Hauppauge, NY)

HFMA - Hudson Valley New York Chapter - 2019 Annual Institute

April 4, 2019 (Westchester Marriott, Tarrytown, NY)

New York MGMA - Central Chapter - "Combating Cybersecurity Challenges"

April 4, 2019 (OneGroup Center, Syracuse, NY @ 8:00 AM to 10 AM)

Monroe County Medical Society - "Ask The Carriers Conference"

April 10, 2019 (RIT INN & Conference Center, Henrietta, NY)

Medical Society of the State of New York (House of Delegates - HOD)

April 12, 2019 - April 14, 2019 (Westchester Marriott, Tarrytown, NY)

Eastern Pain Association - 2019 Spring Assembly "Bring It All Together"

April 13, 2019 (SUNY Global Center - 116 E. 55th Street)

New York MGMA - Rochester Chapter & HFMA Joint Event

April 25, 2019 (Monroe Golf Club, Rochester, NY)

Monroe County Medical Society - 198th Annual Meeting

May 1, 2019 (Locust Hill Country Club, Pittsford, NY)

Erie County Medical Society - Annual Dinner

May 1, 2019 (Statler City, Buffalo, NY @ 5PM)

Onondaga County Medical Society - "Ask The Carriers Conference"

May 9, 2019 (Holiday Inn, Liverpool, NY)

New York State Pain Society - 2019 Annual Meeting & Scientific Sessions

May 17, 2019 - May 19, 2019 (Renaissance Westchester Hotel, West Harrison, NY)

Northstar Network - 2019 Cracking the Code on Healthcare

May 17, 2019 (Locust Hill Country Club, Pittsford, NY @ 7:30 AM - 11:00 AM)

NYIA - New York Insurance Association - 2019 Annual Conference

May 29, 2019 - May 31, 2019 (The Sagamore Resort, Bolton Landing, NY)

New York Cardiological Society - 2019 12th Annual Cardiovascular Team Symposium

June 7, 2019 (The Socony-Mobil Building, @ 150 E. 42nd Street, NY)

American Academy of Pediatrics - New York Chapter 2 Meeting

June 13, 2019 (NYU Winthrop Hospital, Mineola, NY @ 6 PM - 9M)

New York MGMA - 2019 State Conference

June 26, 2019 - June 28, 2019 (Turning Stone Resort & Casino Event, Verona, NY)

New York State Society of Orthopaedic Surgeons (NYSSOS) - 2019 Annual Meeting

September 21, 2019 - September 22, 2019 (Gideon Putnam @7 AM - 5 PM)

NYACP - New York American College of Physicians - 2019 Annual Scientific Meeting

Saturday, October 12, 2019 (Westchester Hilton Hotel, Rye Brook, NY)

ACOG - District II - 2019 Annual Meeting

October 18, 2019 - October 20, 2019 (Grand Hyatt Hotel, New York, NY)

NorthStar Network - Cracking the Code on Healthcare

October 31, 2019 (Locust Hill Country Club, Pittsford, NY @ 7:30 AM - 11:00 AM)

New York Metro ASC Symposium - 6th Annual 2019 NY Metro ASC Symposium

November 1, 2019 (Marriott Marquis, New York City)

Onondaga County Medical Society - 2019 Annual Dinner Meeting

November 7, 2019 (Embassy Suites by Hilton Syracuse Destiny, Syracuse, NY Starting @ 6 PM)

NYSSA Post Graduate Assembly in Anesthesiology (PGA 73)

December 13, 2019 - December 17, 2019 (NY Marriott Marquis - NYC)

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