

Respondeat Superior Tort Liability and Surgical Errors in Low Income Countries: An Overview.

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Abstract

A hospital can be held liable under the general doctrine of *respondeat superior* in a case when an employee commits malpractice. This tort liability is applicable even when the employer is without fault because the employee was acting in the scope of his or her employment when the negligent act or omission allegedly happened. Attending physicians working in hospitals are considered independent contractors rather than employees in some situations, making the theory of *respondeat superior* inapplicable, and the physician has to bear full liability when sued for malpractice while treating a patient in a hospital. More often than not, hospitals are implicated for negligently granting privileges to an unlicensed or incompetent physician. Hospitals in developing countries are increasingly implicated in malpractice litigation following the doctrine of *respondeat superior*. Due to the dramatic circumstances that surround them, surgical malpractice cases are a cause for concern to hospital administrators as well as the surgical staff. The legal programs covering surgical services at health care institutions in low income countries need strengthening to preempt increasing litigation activities as their populations become more aware of their medico-legal rights.

Key Words: Respondeat Superior, surgery, malpractice, tort liability, negligence, low income countries, hospitals.

1. Introduction

With the increasing use of information technology and the internet, the average citizen in low and middle income countries is more aware today of health care issues than a decade ago. This knowledge about health matters, in tandem with economic, educational, and social development has created a more educated citizenry who are very much aware of their legal rights. All these changes have impacted on the medico-legal landscape, as there have been an increasing number of malpractice law-suits in recent years especially in surgical and ob-gyn services. This trend is clearly indicated by the medical liability insurance for physicians which has exponentially increased in recent years in many African countries.

Hospitals are implicated in these suits either directly for not meeting standards of service or as *respondeat superior*--a doctrine in tort law that makes a master liable for the wrong of a servant--when employees are sued for malpractice cases occurring during hospital admissions. The lack of specific guidelines for clinical practice in many of the mushrooming private and public hospitals in low income countries has allowed physicians with varying backgrounds to practice independently with little supervision. We posit that hospitals in many low income countries are complacent in their legal programs and recommend accreditation of health care services to improve the quality and safety of health care delivery to minimize tort liability incidents.

2.0 Literature Review

2.1 Legal Structure of Health Care Organizations

The legal system in many Anglophone countries has parallels with that of the United States as they were both influenced by British law in their inception. The function of the legislative branch is to enact new laws and amend existing ones, the executive is to enforce and administer laws, and the judiciary adjudicates - deciding disputes in accordance with the law (Miller, 2006). The legislative creates and funds health programs and balances policy with other policy domains (Longest, 2006). The executive branch proposes, approves, or vetoes legislation, promulgates rules and regulations. The role of the Judiciary concerns the interpretation of constitutional and statutory law, develops body of case law, preserves rights, and resolves disputes (Longest). Health care organizations have governing bodies, often referred to as boards, which wield ultimate authority and legal responsibility for operations.

The board appoints the CEO and organized medical staff who also have minor governance roles. "Board members have a duty to exercise reasonable care and skill in the management of the entity's affairs and to act at all times in good faith and with complete loyalty to the entity" (Miller, 2006, P. 44). Hospitals are regulated by all levels of government besides being occasionally confronted with conflicting mandates. Many private groups develop standards, focused mainly on the quality and safety of services, and accredit institutions who meet their

standardization criteria.

Accreditation is not legally mandated in contrast to licensure which is a government regulation without which a hospital cannot operate. Health maintenance organizations (HMOs), nursing homes, ambulatory surgery centers, hospices, home health agencies, and clinical laboratories require a license to operate and must comply with licensing standards (Pozgar, 2011). Nonprofit hospitals do not generally operate to generate profit for distribution. Any profit must instead be used to improve the hospital environment, quality of care, and remuneration of employees.

Health care administrators need to be conversant with legal mandates in order to anticipate and avoid the inevitable legal tussles arising from civil liability suits. Today in the United States, health care services are among the most highly regulated industries and health care administrators are expected to correctly interpret the rules and regulations to avoid legal pitfalls (Miller, 2006). Recognition by an accreditation body usually indicates the standards of care are of good quality and compliant with the published guidelines. Limited compliance with health care regulations and inconsistent accreditation system are still a source for concern in low income countries.

2.2 Licensure and Accreditation of Health Care Organizations

Accreditation is a process by which a recognized body, usually an NGO, assesses and recognizes that a health care organization meets applicable pre-determined and published standards. Accreditation is a private function that is not legally mandated. On the other hand licensure is a governmental regulation which is established to ensure that an organization meets minimum standards to protect public health and safety. Various units in a hospital like the laboratory, pharmacy, and x-ray departments as well as individual health care providers may require different licenses. Accreditation standards are usually regarded as optimal and achievable, and are designed to encourage continuous improvement efforts within accredited organizations. Key components of the initiative that are currently part of the accreditation process by The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) include: Periodic Performance Review (PPR), Tracer methodology, Priority Focus Process (PFP), and unannounced survey (formerly announced). “The standards focus on important patient, client, or organization functions that are essential to providing quality care in a safe environment” (JCAHO, 2013). Compliance for these surveys is voluntary and the emphasis is on evaluation funded by provider fees focusing on identifying what the organization is doing right and how it could be improved. Accreditation systems are well developed and widely used in high income countries like the United States, Canada, and Europe. In the United States, licensure surveys are mandatory, annual, use tax funds, with an emphasis on inspection focusing on what the organization is doing wrong. Non-compliance has harsh punitive implications including withdrawal of the license. The licensing requirements are more stringent as licenses are only granted when facilities meet defined levels of quality certification. This is often a complex process as hospitals and other health care entities are among the most extensively regulated institutions by all levels of government and by numerous agencies within each level (Miller, 2006). It is possible to satisfy the requirements of one entity, just to be frustrated by another arm of government. This logistical problem has received more attention in recent times with relief provided in some areas (Miller), but conflicting mandates are likely to continue considering the intricate American legal system. Licensure and accreditation systems in low and middle income countries do exist on the same lines as the American system but are at best very limited in scope and application. This has medico-legal implications as it encourages unregulated substandard care that leads to serious recurrent errors.

2.3 Liabilities and Malpractice

Errors in the course of providing health care services lead to criminal law and civil penalties to health care professionals and entities. According to Miller (2006), the most common liability of health care professionals and institutions is the negligent tort. Negligence must however cause injury to establish liability. The less common criminal penalties relate to all health care decisions regardless of outcome, deaths or significant injuries associated with health care, and intentional end-of-life decisions (Miller). Notwithstanding the rights of the patient, this trend is impacting negatively on the provision of health care.

The allocation of huge awards for frivolous or otherwise claims in the health insurance industry has created a backlash in some specialties. Forty four states are cited by the American Medical Association to have varying degrees of problems, if not crisis, pertaining to liability coverage for physicians (Larkin, 2007). High risk specialties like OB-GYN are avoided by insurers or have to pay unaffordable high premiums. Early retirements and curtailing of practices by physicians due to the unrealistic escalating liability insurance costs, and demoralization, has restricted the public’s access to essential health services, notably delivery and trauma services (Larkin). With the current globalization of health care, there is empirical evidence that developing health care systems are increasingly experiencing medico-legal liability suits. Although *respondeat superior* applies only for negligent acts by hospital employees, it is not unusual for the plaintiff lawyers to enjoin the hospital with charges of faulty equipment or for allowing negligent physicians to use its facilities.

3. Minimizing Respondent Superior Liability in Developing Countries

3.1 Using Evidence-Based Practice Guidelines in Surgical Services

Performing procedures without adequate training is a liable act and hospitals need to protect themselves from such a liability by controlling access to and use of its facilities. Hospitals in developing countries can reduce liable surgical errors by introducing clinical guidelines derived from evidence-based practice for the surgical division.

An understanding of the quality continuum is essential for health care managers in order to acquire the skills necessary to achieve quality health care. A guiding philosophy for the entire organization from the leadership is required to achieve success at continuous quality improvement projects and defining clinical practice guidelines (Kelly, 2003). The quality continuum provides tools and techniques to help managers, health care providers, and organizations to do things right the first time and every time. The introduction of clinical guidelines would foster good practice and improve the quality of care. This translates to fewer mistakes and less litigation of physicians, nurses and hospitals. The results of the care provided also need continuous monitoring and auditing and the information used to improve the care of all patients. However, change initiatives need effective leadership able to manage the inevitable resistance to change which could be detrimental to organizational success.

Physicians are known to resist changes introduced by hospital managers especially when the changes are perceived to impact 'negatively' on their practice and/or put their performance under the microscope. Health care managers need to accept resistance as the norm recognizing and welcoming it as a healthy response and an opportunity to open debate possibilities. According to Atkinson (2005), a major problem in driving change in organizations is dealing with and managing the resistance encountered during all change initiatives. It should be treated as a powerful ally in facilitating the learning process (Atkinson). Senior members of the surgical staff are more often than not affixed to their routines and tend to view change initiatives with suspicion. Failure to accept evidence-based practice guidelines opens up the likelihood of tort liability for negligence and failure to provide the expected due care.

3.2 Addressing the Nursing Shortage

A threat to many surgical services in low income countries is the shortage of experienced OR nurses. A shortage of more than 4 million healthcare workers in 57 developing countries – most of them in Africa – is hampering efforts to combat HIV/AIDS, malaria and Tuberculosis (World Health Report, 2006). Performing complicated surgical procedures with inexperienced OR nurses and assistants often results in poor outcomes. The shortage of nurses translates to overwork and fatigue lowering the quality of care. The nursing shortage affecting high income countries in recent years comes as a blessing for third world nurses but is considered a major tragedy for their health care systems.

There is an urgent need to stop the exodus of nurses by offering them better remuneration and living conditions in low income countries. Nurses in general are central to the production of a safety culture system in a healthcare organization (Groves, Meisenbach, & Scott-Cawiezell, 2011). "Nurses intercept 86% of all medication errors made by physicians, pharmacists, and others prior to the provision of those medications to patients..... Insufficient monitoring of patients, caused by poor working conditions and the assignment of too few RNs, increases the likelihood of patient deaths and injuries" (Liape, et al, 1995). Surgical services have to retain experienced nurses especially OR nurses as this is vital to the provision of effective and safe health care in the surgical department.

Instruments and swabs left in body cavities may sound the stuff of newspapers, but do actually happen in environments where there is inexperience, ongoing training, and fatigue from overwork. According to Rappaport and Haynes (1990), the retained surgical sponge after intra-abdomen operations is a continuing problem with a grossly underestimated incidence despite precautions. Working in a high income country with optimal facilities the authors had four incidents of retained abdominal sponges in a 10 year period. Similarly, a Jordanian group found 11 cases of retained sponges over a 13 year period (Bani-Hani, Gharaibeh, & Yaghan, 2005). It does not take a lot of imagination to realize that such incidents would be manifold in a poor resource surgical environment as is usually seen in public hospitals in low income countries. Yet, adoption of criteria for performance excellence available through accreditation organizations can go a long way in minimizing errors in the surgical service irrespective of geographical location or wealth status.

3.3 Accreditation of Services

It has been shown in developed health care systems that accreditation strengthens community confidence in the quality and safety of care, treatment, and services. It also provides a competitive edge in the market place and improves risk management and risk reduction (JCAHO, 2013). An organization can benefit from conducting self-assessment using the appropriate criteria for performance excellence and taking action for improvement (Kelly, 2003). Health care criteria are designed to help organizations use an integrated approach to organizational performance management that results in delivery of ever-improving value to patients, other customers, and stakeholders, contributing to improved health care quality and organizational sustainability

(BNQP, 2013). In Sub-Saharan Africa, only some hospitals in South Africa have successfully applied for accreditation from bodies in Europe and the United States in an effort to improve their services and standards of care. Fewer mishaps would happen in the OR and other departments of a hospital if internationally accepted clinical guidelines are used in appointments of staff, conduct of invasive procedures, use of anesthetic equipment, application of appropriate nurse ratios, and regulation of working hours. These are usually stressed by accrediting bodies in their health care criteria.

The power of accreditation to compel hospitals to adhere to guidelines and regulations and therefore stay clear of legal mishaps is often underestimated. The model of accreditation in both low income and high income countries strives to promote improvements, standardization of processes, and providing feedback (Braithwaite, Shaw, Moldovan et al., 2012). The general logic is the same and the difference lies in specialized features. The introduction of accreditation in low income countries often meets resistance from health care managers due to the associated costs and the lack of immediate incentives. The fact that accreditation is voluntary and not legally required also makes it unattractive to the average hospital in low income countries.

4.0 Summary and Recommendations

Care should not vary illogically from clinician to clinician or from place to place. The benefits of evidence-based medicine in enhancing the overall quality of healthcare are tremendous (Institute of Medicine, 2001). This has directed medical practice away from consensus to scientifically proven methods in the management of patients. There are now clear guidelines and check-lists to follow for the management of most conditions which are backed by evidence based results from controlled studies. The guidelines are readily available in medical manuals, books, and journals as well as the internet. There is growing evidence that this combined with other tools like reminder systems can improve patient care. Evidence-based medicine can be used to minimize malpractice litigation during adverse surgical incidents in low income countries.

Firstly, hospitals can strengthen their criteria for the admission of surgical, anesthetic and ob-gyn staff to use hospital facilities; with emphasis on the system used to determine whether the applicants have the required qualifications, experience and practice licenses. The scope of procedures a surgeon should be allowed to perform is to be limited by experience and training as well as adherence to evidence-based guidelines for particular procedures. More efficient modalities of reporting errors to the ‘legal department’ and communication with patients and family need to be enacted and emphasized. An institutional annual review of the admitting staff performance and complications rate should be more stringent. Withdrawal of admission rights could be enforced more vigorously for negligent or incompetent practice while avoiding victimization of physicians by competing colleagues.

Secondly, the OR Users Committees which is usually composed of senior OR Nurses, Obstetricians and Gynecologists, Surgeons, and Anesthesiologists should regularly advise the management on the importance of resolving any concerns about the standards of care in the OR functions and their medico-legal implications. CMEs for all OR staff and surgeons should be held regularly and focus on standards of care issues, especially the ones which could lead to mistakes and possible liability suits.

Thirdly, the administration can, through financial and professional rewards attempt to retain experienced OR nurses. Simple measures like appropriate work loads, appreciation, emotional support, and sensitivity to their needs could yield positive results. These efforts to retain nurses usually fail when they get lucrative offers from hospitals in high income countries with promises of large pay checks and better standards of living. Moreover, there is an inherent risk in giving preferential treatment to OR nurses as it demoralizes nurses in other departments provoking further dissatisfaction and departures to competing hospitals. Proven conflict resolution techniques and models can help resolve these staff issues.

Finally, the main solution which stresses the introduction of evidence-based clinical practice to the surgical management of patients may be frustrated by various constraints. The nursing administration might not encourage the preferential treatment of OR nurses for the reasons mentioned earlier on both financial and logistical grounds. The CEO may find it difficult or risky to interact negatively with influential senior surgeons who might decline to use evidence-based guidelines for the management of surgical conditions. Yet, these issues should all be resolved as there are no other pathways to quality, effective, and safe healthcare provision.

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