



# LEGAL BRIEFS

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## CRNAs AS INDEPENDENT CONTRACTORS

One impact of the shortage of anesthesia personnel in the past few years has been the number of CRNAs who consider themselves as *independent contractors* rather than as *employees*. The shortage, together with the availability of moonlighting insurance coverage pioneered by AANA Insurance Services, has created a number of opportunities for CRNAs to provide services other than as full-time employees of hospitals or nurse anesthetist or physician groups. In some cases, nurse anesthetists no longer even have a primary employer but contract out their services to several parties as they are needed. The presence of nurse anesthetists who consider themselves as independent contractors rather than employees has given rise to a number of questions concerning the status of nurse anesthetists as independent contractors, such as who is liable for the rare episode of negligence? How has the US Internal Revenue Service (IRS) adapted to this new career option?

The difference between an employee and an independent contractor is *control*. An employer has the right to control an employee not only as to what shall be done but also how it shall be done. On the other hand, when

someone retains an independent contractor, he or she can control the *result* but not the *details* and *means*. The distinction between an employee and an independent contractor is often litigated in the areas of taxes and liability for negligence committed by the worker.

Employers are liable for the negligence of their employees “committed within the scope of employment.” The legal phrase is *respondeat superior*, the superior answers for the negligence of the employee. The justification is that since the employer controlled the employee it is fair to hold the employer responsible for negligence that arises under the employer’s control. Or, stated positively, by making the employer pay, society encourages the employer to exercise its control in a way that will not permit the negligence to happen again. Since an independent contractor is not controlled, it does not seem quite so fair to hold someone liable who had no ability to change the contractor’s behavior.

As applied to anesthesia, these relatively simple and straightforward concepts can become muddied. First, healthcare is often provided by very complex organisms. Being a healthcare employee is not like being an 18th century blacksmith’s apprentice or a 20th century factory worker who had a single boss. Who is the “boss” and whose employee are you if (1) your paycheck is signed by the hospital treasurer, (2) your hours and working days are dictated by the vice president for nursing (who may be employed by the hospital’s independent management services provider), (3) you

are assigned to an operating room by an independent physician who is chief of the hospital’s anesthesia department, and (4) in the operating room, yet another independent physician *supervises* you by dropping in and changing the settings on your anesthesia machine when you are not looking? Second, some states or hospitals have laws or policies requiring CRNAs to be supervised. How can someone be an independent contractor if the person has to be supervised?

## Tax considerations

In many areas a person’s legal status will have little or no bearing on what status the person has for tax purposes. For example, in some circumstances, corporations pay tax at a lower rate than do individuals. The tax laws allow the IRS to challenge whether an entity incorporated as a corporation under state law is a corporation for tax purposes, and the IRS has developed its own criteria. In determining whether someone is an employee, however, federal tax laws follow the same rules as everyone else (Rev. Rule 87-41).

The consequences of being an employee rather than an independent contractor for tax purposes can be rather dramatic. Employees are entitled to participate in employee benefit programs, while independent contractors often are not. Employers maintain workers’ compensation insurance on behalf of employees, while they do not for independent contractors. Employers pay payroll taxes on wages paid to employees, while they do not on payments to independent contractors. In addition, if the employer is a corporation rather than an indi-

vidual, an appropriate officer may have individual liability to the IRS if some of these responsibilities are not satisfied, even though an officer's personal liability may be rare in most other areas. Because some employers have tried to categorize their employees as independent contractors to secure favorable tax treatment, the IRS frequently audits relationships that are claimed to be independent contractors to see if they are really employment arrangements.

The basic difference between an employee and an independent contractor is that the contracting party normally controls only the *result* to be accomplished by an independent contractor but has the right to control the *details* and *means* by which an employee accomplishes the *result*. It may be helpful to consider examples in the area of anesthesia. Nurse anesthetists administering anesthesia for a surgeon may be told, "Keep him relaxed, keep him quiet, don't let him move!" or, "He's pushing! You better do something!" These *orders* reflect control only of the *result* to be accomplished. On the other hand, a person directing a nurse anesthetist might require that the nurse anesthetist "Administer 100 mg of Anectine because the patient is quite overweight." or "This looks like a difficult airway. Do an awake fiberoptic intubation!" These *orders* reflect control of not only the *result* to be accomplished but also the *details* and *means* by which it is to be accomplished.

Even the IRS admits that it is difficult to distinguish an independent contractor from an employee. While the issue of control is defining, the IRS has identified 20 factors that courts considered under common law cases in deciding whether a particular relationship is one of employment or

independent contracting. An employer can: (i) require the worker to comply with instructions about where, when and how the person is to work; (ii) train the worker; (iii) integrate the worker's services into its business operations; (iv) require a particular person to perform the services; (v) hire, supervise and pay assistants for the worker; (vi) have a continuing relationship with the worker; (vii) set the hours of work for the worker; (viii) require the worker to devote substantially full-time to the employer's business; (ix) require the worker to perform services on the employer's premises; (x) require the worker to perform services in a certain order or sequence; (xi) require the worker to submit regular or written reports; (xii) make payment by the hour, week or month instead of by the job or on a straight commission; (xiii) pay the worker's business and/or traveling expenses; (xiv) furnish tools and materials. An independent contractor often (xv) makes a significant investment in facilities that are used by the worker in performing services and are not typically maintained by employees; (xvi) realizes a profit or suffers a loss as a result of the worker's services; (xvii) performs services for a number of unrelated persons at a time; (xviii) makes his or her services available to the general public on a regular basis. An employer (xix) has a right to discharge a worker; and an employee has (xx) the right to end his or her relationship with his employer at any time he or she wishes without incurring liability (Rev. Rule 87-41).

Not only are these merely guides, but also there is no specific instruction as to how many factors need to be present for a relationship to be classified as employment or an independent

contract. Moreover, in any relationship it is possible to have a mix of factors—some indicating employment and others indicating independent contractor. Determining when a nurse anesthetist is an independent contractor can be very difficult for both courts and the IRS because, as we noted, in a complex healthcare organization, a number of unrelated entities may be responsible for different aspects of the relationship. But courts and the IRS also have been confused by various state laws and/or institutional policies that require that a nurse anesthetist be supervised or directed by a physician. As previous columns have discussed, a statutory requirement of supervision is not equivalent to a requirement of control. However, some institutions have drafted procedures that purport to require a supervising physician to *control* the nurse anesthetist. Such procedures can create liability for the physician or institution where none would otherwise have existed or may justify a finding that the nurse anesthetist was an employee for tax purposes.

### **Control or supervision?**

It also is difficult to determine whether a person is an independent contractor when the person for whom the services are performed has the ability to control certain aspects of the relationship but does not have the right to control others. To impose vicarious liability, courts must determine whether *control*, as opposed to mere *supervision*, actually exists. If it does, is it control over the *result* or the *details* and *means*? Finally, if it is control over the means, was the control directly related to the negligence? The fact that a CRNA may be supervised or even controlled in the operating room should not be the sole factor that

determines whether the CRNA is or is not an independent contractor. For all of the years when surgeons were *captains of the ship*, and nurses, anesthesiologists, and other personnel were *borrowed servants*, the IRS never suggested that surgeons should be paying federal withholding taxes or arranging workers' compensation insurance on their borrowed servants. Healthcare relationships are varied, complex, and often not susceptible to quick analysis. In healthcare, there are numerous examples that control in one area is not necessarily inconsistent with an independent contractor. The fact that a hospital administrator can require a CRNA to be in operating room 1 at 5:30 AM should not, in and of itself, make the hospital liable for a negligent intubation. The ability of a surgeon to tell a moonlighting CRNA that he or she wants this patient quiet and still or the ability of an anesthesiologist to order the use of a particular anesthetic agent should not, in and of itself, entitle a part-time CRNA to participate in the hospital's employee-only dental insurance program.

### **Employee or not – Courts and juries confused**

When reviewing cases that have been decided, it is apparent that both courts and juries are confused by anesthesia. Factors and circumstances that lead one court to conclude that the anesthetist is an employee are cited by other courts to prove the opposite. It would be foolish to pretend that the confusion is not there or that it is possible to structure the relationship in a way that courts and juries are guaranteed to uphold. The reality is that this is not an area with a high likelihood of predictability. Nevertheless, it is important to be

aware of the way in which courts and juries look at these structures.

In *Hohenleitner v Quorum Health Resources, Inc* (10 Mass. L. Rptr. 31, 1999), a woman suffered an angina attack. Believing that she had suffered a heart attack, she went to the hospital, where the nurse in charge of triage allegedly misread her electrocardiogram and delayed her examination by the doctor. When she was examined, she immediately went into cardiac arrest. The triage nurse's salary was paid by the hospital, but the hospital was being administered by Quorum, a hospital management services company. The patient attempted to collect damages from Quorum for the negligence of the triage nurse. Although the jury had found that Quorum had the right or power to control or direct the manner in which the nurse provided treatment to patients in the emergency room, the court granted judgment in favor of Quorum despite the jury's verdict. Quorum's specific responsibilities included the supervision and management of all employees of the hospital including the determination, from time to time, of the numbers, qualification, establishment of wage scales, rates of compensation, employee benefits, and other matters. The Massachusetts court noted that it was the hospital, not Quorum, that paid the nurse's salary and benefits, scheduled her hours of work, provided the facilities and equipment she needed to perform her job, and received payment for the services that she provided to patients. One of the key factors in the court's decision that Quorum did not control the nurse was the fact that Quorum could not, as a matter of law, control or direct medical decisions regarding patient care since none of Quorum's administrators

was a licensed physician or nurse.

In *Doctors Hospital v Bonner* (195 Ga. App. 152, 392 S.E. 2d 897, 1990), the Georgia Court of Appeals affirmed a jury verdict against a hospital and a group of anesthesiologists. The patient suffered a laryngospasm after the endotracheal tube was removed. The jury found the anesthetist had been negligent trying to reintubate the patient. The hospital objected to a finding that it was liable, claiming that the anesthesiologists who employed the anesthetist were independent contractors, as was clearly stated in their contract. The Georgia Appellate Court stated that labeling a relationship in a contract is not determinative of status. The jury was justified in determining that the anesthesiologists were, in fact, hospital employees, not independent contractors. The anesthesiologist group was required to treat all patients at the hospital who required anesthesia services; it could not choose. It had to provide its services in the hospital's 4 operating rooms during the time periods set forth in the contract. The hospital had the right to approve the rates charged. No other anesthesiologists were allowed to practice in the hospital. The hospital retained the right to approve anesthesiology services and the conduct and operation of the anesthesiology department. Most important, a provision of the contract stated that "to the extent required by the laws and regulations governing the operation of hospital, hospital retains professional and administrative responsibility for the [anesthesia] services provided hereunder."

In *Bird v United States* (949 F. 2d 1079, Oklahoma, 1991), a CRNA had been hired through a placement service to work at a govern-

ment hospital in Oklahoma. State and federal governments cannot be sued except with their consent. The Federal Tort Claims Act allows the federal government to be sued for acts of its employees but not for acts of independent contractors. The contract between the nurse anesthetist and the hospital provided that the nurse anesthetist would be an independent contractor and that the hospital would not be liable for the negligence of the nurse anesthetist. The court, however, considered other factors besides the terms of the contract. In particular, the court relied on the CRNA's testimony that his functions, attire, hours, and similar matters did not differ from those of other employees. The court also found, in determining that the CRNA was an employee, that he was required to work with patients designated by others, had no separate office, used hospital equipment exclusively, and could see patients in no other place.

The court also referred to an Oklahoma statute that provided that nurse anesthetists could only provide service under the *direct supervision and control* of a physician. The Oklahoma statute had already been amended, but the amendment did not go into effect until 5 days after the injury, which gave rise to the lawsuit. It now provides that nurse anesthetists can administer anesthesia "under the supervision of a medical doctor, an osteopath physician, or a dentist licensed in this state and under conditions in which timely onsite consultation by such doctor or dentist is available." Evidence showed that in reality whether or not there would be control depended on capacities, personalities, competency, and other factors. But the court also noted that the hospital medical staff rules provided that in the event of a dis-

agreement between the surgeon and anesthetist, the surgeon would make the final determination. The consideration of the effect of a statute requiring control reinforced the court's decision in this case because the supervisor was a hospital employee, but what would the court have done if the supervisor had been another independent contractor?

In *Skillman v Riskalla* (1994 W.L. 879645 (Mass., 1994)), an anesthesiologist who had negligently treated a patient was trying to take advantage of a Massachusetts statute that an employee of a government-owned hospital was not liable for his or her own negligence. The rationale behind the statute was that because government-owned institutions could not be sued (unlike the federal government, Massachusetts had not given its consent to be sued), if employees of state hospitals could be held liable, the employees would insist on being indemnified by the state government and patients would be able to accomplish indirectly what they could not do directly. Patients would obtain recovery from the employee who would be reimbursed by the state-owned hospital.

The hospital had contracted with a professional services corporation to obtain its anesthesia services. The contract specifically stated that the anesthetist provided by the service corporation would be an independent contractor and not an employee of the hospital. However, the chief of anesthesiology, a hospital employee, was required to monitor and review the quality of professional services and clinical judgments rendered by the anesthetists provided by the service corporation. The chief also set the on-call schedules, assigned members to specific surgical procedures, and supervised the continuing educa-

tion of doctors who worked in the anesthesiology department. The anesthesiologist who was being sued was paid a flat salary by the service corporation, and the salary did not depend on his patients' billings or his overall productivity. The court concluded that he was an employee because his work was governed and regulated in all respects by procedures dictated by the hospital's chief of anesthesiology. The question remained, even if he was an employee, whose employee was he? The court determined that the control possessed by the chief of anesthesiology, a hospital employee, was sufficient to make the anesthesiologist a hospital employee as well. As a hospital employee, the anesthesiologist was immune from suit for his negligence. Note that the court is choosing which of the possible employers was likely to have had the greater impact (and control) on the actions claimed to be negligent.

In *Briggins v Shelby Medical Center* (585 So. 2d 912, Alabama, 1991, Chief Justice Hornsby concurring), the question was whether the hospital could be liable for the negligence of a CRNA employed by an independent anesthesia service. The nurse anesthetist was subject to the hospital's regulations and procedural guidelines. In addition, the nurse anesthetist worked only at the defendant hospital. The court held that this was sufficient evidence to allow a jury to decide whether or not the nurse anesthetist was a hospital employee and whether the hospital was liable for the nurse anesthetist's negligence.

In *Drennan v Community Health Investment Corporation* (905 S.W. 2d 811, Texas, 1995), the court affirmed a motion for summary judgment that a hospital was not liable for the negligence of a nurse anesthetist where the nurse anesthetist was retained by the surgeon

and not by the hospital. The nurse anesthetist testified, without contradiction, that he was an independent contractor who determined the details of providing the anesthetic with the surgeon without control by the hospital. The court concluded that the hospital was not liable. "Where an employer is interested only in the results, and the contracting party independently determines the details of the method by which the desired results are obtained, an independent contractor relationship exists and the rule of *respondet superior* does not apply."

Hospitals seem intent on developing strategies to create liability for themselves where none would otherwise exist by adopting unnecessary policies or taking other acts. Even if a physician or healthcare professional is an independent contractor, the hospital can take actions that make the physician appear to be its agent. In those circumstances, the courts may rule that patients were misled by the hospital to believe that the independent contractor was the hospital's agent or employee and that the patient has the right to sue the hospital for the negligence of someone who is, admittedly, an independent contractor. For example, in *Sword v MKC Hospitals, Inc* (714 N.E. 2d 142, Indiana, 1999), a patient sued a hospital because of the violent headaches she suffered as a result of an epidural administered by an anesthesiologist. Although there was no question that the anesthesiologist was an independent contractor, the hospital heavily advertised its obstetrical services including the availability of anesthesiologists who were "experts in administering continuous epidural anesthesia." The Supreme Court of Indiana sent the case back for trial as to whether the anesthesiologist

had become the apparent agent of the hospital and whether the hospital should be liable for the anesthesiologist's negligent placement of an epidural.

But the most unusual independent contractor case is *Anesthesiologists Affiliated v Sullivan* (the Secretary of Health and Human Services), (941 F.2d 678, US Court of Appeals, 8th Circuit, 1991). Because employers do not have to pay withholding taxes on independent contractors, in much of the litigation over independent contractors, the United States government, through the IRS, frequently claims that the relationship is one of employment. In the *Anesthesiologists Affiliated* case, the federal government claimed that the anesthesia group had submitted 28 false claims for services provided by CRNAs as if the CRNAs were employees when the group should have known that the CRNAs were not employees. The court agreed with the government that the CRNAs were not employees. The evidence showed that the degree of control and supervision retained by the anesthesia group over the CRNAs was "minimal—and intentionally so." Not only were the CRNAs not considered by the group as employees, 2 of them were partners and a third had entered into a contract that explicitly stated that he was an independent contractor and not an employee.

### Conclusion

The fact that some states may require a nurse anesthetist to operate under a physician's supervision does not logically bear on whether a nurse anesthetist is an independent contractor or an employee. As we have noted many times in this column, supervision is not equivalent to control. Nonetheless, some hospitals have adopted require-

ments that require that nurse anesthetists not only be supervised by a physician but also be controlled. These requirements are unnecessary and serve only to create liability where none would otherwise exist. A second problem in the area is the basic mistake that surgeons make in failing to distinguish between their ability to control the result ("Keep him relaxed; don't let him move!") and the ability to control the details and means that are required to hold the surgeon liable for the negligence of the anesthesia provider. In many cases where surgeons were held liable for the negligence of the anesthesia provider, the surgeons were asked if they controlled the anesthesia. The surgeon's response, "Ultimately, I control the anesthesia" represents confusion between results and means. The surgeon is encouraged to answer in terms that make it sound like the surgeon controls the details and means. However, there is a huge difference between having ultimate control (and being liable) and having control over the ultimate result (for which there is no liability). Every surgeon knows what is needed from anesthesia ("Keep him relaxed, don't let him move!"), but it would be a rare surgeon who could tell a CRNA that a particular patient required 100 mg instead of 50 mg of Anectine.

CRNAs have been working as independent contractors for years, a relationship that would seem to be beneficial to surgeons and hospitals. Nonetheless, through ignorance or misdirection, surgeons and hospitals continue to be their own worst enemies, adopting policies that invite liability, failing to distinguish between control of results and control of detail and means, or assuming that state requirements of supervision have any bearing on the relationship.