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KNOWLEDGE AND AWARENESS OF VICARIOUS LIABILITY: VIEWS OF HEALTHCARE WORKERS IN GHANA

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Abstract

This study explored the knowledge and awareness of Ghanaian health workers on vicarious liability. It also explored the perceptions and experiences of Ghanaian healthcare workers on the incidence, scope, rationale and implications of vicarious liability in healthcare facilities in Ghana. Towards this end, structured questionnaires were administered to four hundred (400) respondents randomly sampled from one private and one public health facility in Ghana. Their responses were analyzed and qualitatively discussed within the context of relevant literature.

Study results show that healthcare workers in Ghana had limited knowledge on vicarious liability. Further, vicarious liability of healthcare facilities in Ghana were the result of treatment without consent, breach of patient's confidentiality, negligence, assault, battery, nuisance, patient abandonment, and wrongful diagnosis or treatment procedure by healthcare personnel.

Keywords: Health Workers, Healthcare Facilities, Tort, Vicarious Liability, Ghana

INTRODUCTION

In health care practice, liability suits rest on several counts of negligence, abandonment, assault, battery or trespass. In such instances, the wrong-doers are accosted for the results of their direct actions and/or inactions in the execution of their duties. However, there are instances where liability for actions or omissions of the guilty or defendants rest on another for whom he is under control. In such cases, the wrongdoer may be absolved of any legal suits while responsibility is brought to bear on the person, employer or institution who failed to enforce that duty. Also, there are instances where, even though the wrongdoer is not absolved, his employer is made to bear a greater magnitude of the sanctions imposed as a result of his error(s). These cases are based on a legal principle known as vicarious liability.

As explained by Neyers (2005), the doctrine of vicarious liability has been well entrenched in common law for several centuries even though the historical or jurisprudential origins of this liability are not entirely clear. In simple terms, vicarious liability is a liability that is imposed on one person (B) for the torts of another (A) in situations where B has not committed any legal wrong. However, in its nature, vicarious liability is underpinned by the doctrine of '*respondeat superior*' (let the master answer) and the principle *qui facit per alium facit per se* (he who works through others works for himself). Thus, vicarious liability does not express the wrong of person A or person B in isolation or unison but the extent to which person B is accountable for the wrongs of person A even though person B may not have directly done any legal wrong. That is why vicarious liability is referred to as a secondary liability –liability associated with enforcing a duty, rather than a direct wrongdoing.

Vicarious liability, in its nature and form, is very important in healthcare not only because of the difficulty in managing the diverse work groups and professions involved but also because of the

current trend where healthcare facilities contract independent persons and organizations to provide health services under their scope. Consequently, healthcare facilities stand a risk of being held liable for actions, not only of workers from different technical areas requiring different assessments of standards of care, but also of other service providers who may not be directly employed by the healthcare facility.

Because unprofessional conducts are pervasive amidst the maximum precautions and standards of practice in healthcare delivery, employers and employees must be aware of the vicarious nature of their actions in the course of their duties. This study therefore examines the knowledge and awareness of healthcare personnel in Ghana on vicarious liability.

RESEARCH PROBLEM AND OBJECTIVES

In modern healthcare delivery, claims of medical malpractice form an important part of general patient dissatisfaction (Saxton et al, 2008). This is because most physicians, and in fact health workers are predisposed to a misconduct at some time in their career in several capacities (EEOC, 2011). In support, Upadhyay et al (2007) assert that 78% of healthcare staff has been named as a defendant in at least 1 lawsuit alleging medical malpractice. Such incidents of misconduct/malpractice for which healthcare facilities may be held vicariously liable include negligence, leaving a patient unattended (patient abandonment), wrongful diagnosis or treatment procedure, false imprisonment, assault, battery of clients, and trespass.

In Ghana, anecdotal evidence and several counts of participatory observation highlight a growing concern of misconducts/malpractices in the healthcare sector. Beyou (2010) contributes that Ghanaian healthcare institutions in recent times have had to pay heavy penalties and compensations through vicarious liability in respect of the acts and omissions of unethical

healthcare professionals. Such financial losses could have been avoided if the employers had paid attention to and enforced acceptable standards of care on healthcare workers rather than leaving them under the control of their professional bodies. Again, evidence from Saxton et al (2008) suggests that knowledge and awareness of the existence, nature, form, implications and remedies of vicarious liability among healthcare workers is the key to ensuring adequate standard of care, increasing patient satisfaction with healthcare delivery and avoiding civil suits with its attendant costs to the facility. Quite apart from that, there exists a paucity of information on workers' knowledge and awareness of vicarious liability in the Ghanaian healthcare sector.

Drawing strength from the above, this study explores health workers' knowledge on vicarious liability. The study specifically investigates the incidence and causes of liability suits in health facilities and its attendant issues. Further, the study examines workers perceptions about the rationale, effects and ways of reducing the risks of vicarious liability in healthcare facilities.

LITERATURE REVIEW

Vicarious liability defined

Many employers are unaware that they can be liable for a range of actions committed by their employees in the course of their employment. These actions include bullying and harassment, violent or discriminatory acts or even libel and breach of copyright. It's also possible to take action against an employer for the behavior of third parties, such as clients and customers, provided these parties are deemed to be under the control of the employer (ACAS, 2012). This principle of holding employers for the wrongs of others is known as vicarious liability.

In the law of tort there is no statutory definition of vicarious liability (Rose, 2009); it is a paradigm of the common law evolving to meet changing needs and trends in society.

Consequently, vicarious liability has today evolved to cover virtually every area of the law - fraud, conversion and misrepresentation; personal injury caused by negligence; personal injury caused by intentional batteries or crimes; product liability claims; consumer protection laws and deceptive practices; consumer product and warranty claims; environmental clean-up liability; civil rights claims; trademark infringement; employment law including discrimination and harassment claims; as well as violations of various statutes and licensing laws (Beyer, 2006).

In simple terms, vicarious liability is the liability you may have for the acts and omissions of an employee or some other individual for whose conduct you are legally responsible. More specifically, Kumado (2009) defines vicarious liability as a form of strict secondary liability that arises under the common law doctrine of agency: the responsibility of the superior/employer for the acts of their subordinates/employees/servant. Booth (2007) also defines vicarious liability as a principal's liability for an agent's damages caused by a breach of some established duty or failure to follow through with contractual obligations. As used in this definition, a principal is a person or entity that embarks on a course of action, in part, using other individuals known as agents to accomplish this task.

Vicarious liability as a strict liability

In certain situations, people will be held responsible for damage/harm even though they did not act negligently or intend to cause any loss or harm. This is called strict liability: meaning liability without fault (the responsibility for an action). According to Hunter (2008), the principle of strict liability has gained prominence for its application to injuries caused by non-human entities (like animals) and dangerous activities (firing range operation, creating and managing reservoirs etc) which though may have caused damage, cannot be directly blamed or tasked with compensating

injured parties. Thus the principle acknowledges that persons must be held strictly liable for acts which though not inherently dangerous, could create damage, or mischief.

By inference, therefore, the key issue arising from strict liability is the need to hold someone (often the one who stands to benefit) accountable for the damage or injury caused by another entity or activity. As a matter of policy however, strict liability is founded upon the principle that imposes upon anyone who for his own purposes creates an abnormal risk of harm to his neighbors, the responsibility of relieving against that harm when it does happen (Dobbs, 2000; Kessler and Rubinfeld, 2007). Note, however that there cannot be strict liability if the plaintiff voluntarily puts himself in the way to be hurt knowing the probable consequences of his act, so that he may fairly be deemed to have brought the injury upon himself (Hunter, 2008) or for acts of God (like a tsunami) which owner had no reason to anticipate.

Deriving from the foregoing, vicarious liability is not merely a secondary liability but a *strict* form of secondary liability. As explained by Neyers (2005), the strictness of vicarious liability is what distinguishes it from other forms of liabilities and implies that there are certain conditions that must necessarily be met for a suit to succeed under this tort. Most importantly, strict liability means that a court may impose liability even though the defendant neither intentionally acted nor failed to live up to the objective standard of reasonable care that traditionally has been at the root of negligence law (Shavell, 2007). As a form of strict liability, vicarious liability is used to deter behavior, internalize the cost of business and advance the compensation function.

Proving vicarious liability

Over the years, the criteria for establishing whether employers may be held vicariously liable for the acts of their employees have been the subject of close scrutiny (McGregor, 2003; Stevens,

2007). While differences have been proven to exist in the application of the principles to various sectors and industries, these criteria for establishing vicarious liability have also varied from one country to another. However, it is generally held that an employer will be vicariously liable for a tortfeasor's actions if three criteria are met: the employee committed a tort; the tortfeasor is his employee; and the tort was committed during the course of employment (Clarkson et al, 2007; Beaver, 2003; Kumado, 2009; Klar, 2003).

As easy as it may seem, it is very difficult in determining whether the tortfeasor is an employee of the party being held vicariously liable. For this reason, consideration is given to the nature of the employment contract that exists between the employer and employee. Thus, whether the tortfeasor was indeed an employee (in which case the employer is vicariously liable) or whether the tortfeasor was an independent contractor (in which case the employer is not vicariously liable) is of key concern (McGregor, 2003; Mitchel, 2003; Stevens, 2007).

However, Binchy (2004) elucidates that the tidy compartmentalism of distinguishing between employers (on whom vicarious liability may be imposed) and parties engaging independent contractors (on whom vicarious liability may not be imposed) has to some degree been overtaken by a more generic test based on the reality of control being exercised by one party over another's conduct, regardless of the formalities of their contracts. In addition to the control test, Binchy (2004) identifies the nature of employment test, the integral part of business test and the allocation of financial risk/the economic reality/multiple test as the other tests that may be used in determining whether the tortfeasor was an employee.

The second criterion of concern in proving vicarious liability is whether the tort was committed during the 'course of employment'. Generally, the employer will be liable for acts so authorized

by him and done by the employee using the tools and equipment prescribed, and in a manner, time and location approved by the employer. The employer is however liable for detours and non-delegable duties but not frolics of employees (Kumado, 2009) or for criminal acts (Lunney and Oliphant, 2008).

In determining whether the tort was committed in the 'course of employment' the salmond rule (Kraakman, 1999; Williams, 2001; Neyers, 2005; White, 2010; Rose, 2009) is often used. As explained by Korkh (2010), the Salamond test requires proof that the tortious act was authorized by the employer or that unauthorized acts that are so connected with acts that the employer has authorized, that they may rightly be regarded as modes (though improper modes) of doing what has been authorized.

More recently the 'close and direct' test (Hepner, 2000; Korkh, 2010), which requires proof that there was a sufficiently 'close and direct' connection between what the employee was employed to do and the tort that was committed by the employee, is also used.

Justification/rationale for vicarious liability

According to Kumado (2009), a key justification for vicarious liability is its usefulness in advancing the compensation function. Rose (2009) further suggests that the compensation function is of particular importance in the context of cases involving deliberate wrongdoing or criminal activity on the part of the tortfeasor, who will usually be without funds. In such cases, unless an insured defendant can be found and made liable, a victim will be left without a remedy. Thus, it is often to an injured person's advantage to pursue an employer (who probably has insurance cover for the harm and, in general, greater financial wherewithal than the employee) for compensation rather than an employee. Note however in White's (2010) view that holding

the employer liable does not mean that the employee is left completely off the hook. Hence even when vicarious liability has been proved, the injured person still has a right to pursue the employee individually. In addition, the employer may well seek reimbursement for any amount paid to the injured person from the employee.

Another key justification for vicarious liability according to Shavell (2007) is the fact that the injurer may not have proper information about reduction of harm, whereas the vicariously liable party may have good, or at least superior, information and be able to influence the risk-reducing behavior of the injurer. This feature of vicarious liability might apply, for example, in regard to a parent in relation to a child (suppose a teenage child does not realize how dangerous using a motorboat might be to swimmers and that the parent can monitor the child's use of the boat), or in regard to a firm and its employees (suppose a worker does not understand how dangerous a toxic waste product is, but the firm does and thus controls how it is transported by the worker to a dump site).

Rodgers (2006) also explains that vicarious liability may be justified by the 'deep seated and intuitive idea' that someone who sets a force in motion generally for his own benefit, should take responsibility for its consequences. If there were no vicarious liability, then there would be no incentive for employers to minimize the risks created in the course of business. Kumado (2009) in agreement also puts forth that the person who, in a situation of uncertainty, has a degree of control over how it will turn out and who stands to gain if it goes in his favor, must bear the risk that it will turn out to harm another.

Other justifications of vicarious liability are provided by Jones (2000) and Hunter (2008) as ensuring greater deterrence by making sure that employers are responsible beyond 'reasonable

care'; fairness by ensuring that persons who engage in highly dangerous activities that impose non-reciprocal risks also bear the costs of these activities; and as a means of spreading loss/costs to consumers.

METHODOLOGY

A cross-sectional design was used in the study. This enabled data to be collected from a cross section of healthcare workers drawn from both private and public healthcare facilities in Ghana. One public (Ridge Hospital) and one private health facility (Nyaho Medical Center) were conveniently selected for the study. Both facilities were selected because of the broad scope of healthcare services they rendered, their size, and proximity. The population of the study therefore comprised of clinical, non-clinical and support services workers in the selected facilities. To get a fair sample that is representative of the heterogeneous population, a third of the estimated 1200 workforce in both facilities (900 from ridge and 300 from Nyaho) was randomly sampled. Thus 400 respondents (300 from Ridge and 100 from Nyaho) were randomly sampled for the study.

A structured questionnaire was used to collect data. The questionnaire was anonymous and solicited information on respondents' background as well as their knowledge and experiences on key issues of vicarious liability in healthcare facilities. The questionnaire used had three parts and included both open and closed ended questions (in a likert scale format) based on issues of vicarious liability reviewed in the literature. The questionnaire used was pre-tested among staff of the outpatient department of the University of Ghana hospital. Feedback obtained from the pretesting helped in redesigning the instrument and amending questions that were ambiguous.

A period of two weeks was used to collect the data with appropriate permissions from the management of both facilities. In both facilities, an administrative assistant was nominated by

the management to assist and facilitate the administration of the questionnaires. The administrative assistant served primarily as a guide and helped in introducing the research team to participants, as well as ensuring that the research team did not obstruct normal activities in the facility. The questionnaires were self-administered and took place at the work stations of respondents. Respondents who were unable to immediately complete the questionnaire were given a week to do so.

Participation in the study was voluntary and prospective participants regardless of their choice to participate in the study were briefed on the purpose, use and significance of the study. Appropriate consent was then sought from all final respondents before their involvement in the study.

The data collected was analyzed using SPSS version 16 with the key issues being presented in summary frequency tables. The analyzed data was then grouped under the relevant themes and discussed qualitatively. The qualitative analysis was done using the thematic analysis approach based on Braun and Clarke's (2006) assertion that it offers an accessible and theoretically-flexible approach to analyzing qualitative data. Using this approach, the data was reviewed and sorted out under the relevant themes based on the study objectives. Subsequently, the data was discussed under each theme within the context of relevant literature and with the aim of identifying other subthemes and patterns under each theme. Particular attention was also paid to comments and answers to follow up questions by respondents during the discussion.

RESULTS

A total of 400 questionnaires were administered: 300 to Ridge Hospital Staff and 100 to Nyaho Medical Center staff. Of this number, 305 questionnaires (218 from Ridge Hospital and 87 from Nyaho Medical Center) were retrieved.

The respondents consisted of doctors (8.9%), nurses (56.7%), pharmacists (2.3%), administrative personnel (10.2%), health assistants (6.9%), wardens / attendants (4.9%), laboratory technologists (2.6%), midwives (6.6%) and radiologists (0.9%). 55.1% of the respondents were female and 44.9% were male. 37% of the respondents had worked in their facilities for more than 10 years while 49.8% had worked for between 5 and 10 years. The remaining 9.6% and 3.6% of respondents had worked between 1 and 4 years and less than a year respectively. Details of the characteristics of the sampled respondents are shown in table 1 below.

Table 1: Characteristics of respondents

		Ridge hospital	Nyaho Medical	Total
Gender	Male	98	39	137 (44.9%)
	Female	120	48	168 (55.1%)
Profession	Doctors	17	10	27 (8.9%)
	Nurses	124	49	173 (56.7%)
	Pharmacists	4	3	7 (2.3%)
	Administrative staff	25	6	31 (10.2%)
	Health assistants	13	8	21 (6.9%)
	Wardens/ Attendants	9	6	15 (4.9%)
	Laboratory technologists	4	4	8 (2.6%)
	Midwives	20	0	20 (6.6%)
	Radiologists	2	1	3 (0.9%)
Number of years in employment	More than 10 years	93	20	113 (37%)
	5 to 10 years	105	47	152 (49.8%)
	1 to 4 years	20	9	29 (9.6%)
	Less than a year	0	11	11 (3.6%)

The results from the data gathered shows that 88.9% of respondents were aware of the liability of healthcare facilities for the actions and inactions of its employees. However, 56% of respondents were aware of strict liability (liability without fault) of healthcare facilities for the wrongs of its workers. Also, only 27% of respondents were able to identify the essential elements needed to prove vicarious liability. Further, 67% of respondents were aware that the liability of the healthcare facility covered torts committed employees in the ‘course of employment’. Additionally, 63% of respondents were aware that generally, employers were not liable for acts done by independent contractors or for criminal acts.

Study results also show that 93% of respondents had knowledge of incidents that had caused the healthcare facility to be held vicariously liable. 71% of respondents also reported that the healthcare facility faced 10 or more vicarious liability lawsuits every year. 83% of respondents also believed every healthcare employee was likely to be involved in an action leading to secondary liability of employers during their career. Only 29% of respondents believed that the hospital took action against employees whose activities exposed the hospital to vicarious liability suits.

86% of respondents agreed that holding hospitals vicariously liable for acts of employees was justified. All respondents (100%) agreed that vicarious liability affected the quality of service rendered by the facilities and patient satisfaction. All respondents also agreed that vicarious liability increased the insurance and other operating costs of healthcare facilities and employees.

Discussion

Knowledge and awareness of vicarious liability

Saxton et al (2008) have suggested that knowledge and awareness of the risk of being held vicariously liable is a key determinant in sustaining optimum standard of care in health facilities. More importantly, employees who are conscious of the implications of vicarious liability are less likely to engage in activities that may expose their employers to vicarious liability risks. Against this background, the study assessed respondents' knowledge on the basic issues in vicarious liability. Although the results obtained in this study suggest that majority of healthcare workers were aware that their facilities may be held vicariously liable for the actions/inactions of its staff, close to half of healthcare workers were not aware of the strict nature of vicarious liability. Respondents who were not aware of the strict nature of vicarious liability did not understand the rationale behind holding the healthcare facility responsible especially in cases when the facility had played no direct role in the tort committed by employee, or even had no knowledge of the tortious act being committed by employees. They further believed that the strict nature of vicarious liability was unfair and imposed unnecessary risks and supervision costs on facilities and ultimately shifted the burden of responsibility from the employee to the employer. Their views are supported by Rose (2009), who though extolling the strictness of the liability as a good device for distributing loss, also underscores its unfairness to employers because 'it is not premised on any culpable act or omission on the part of the employer; an employer who is not personally at fault is made legally answerable for the fault of the of his employee'.

Although aware of the concept of vicarious liability, only less than a third of respondents were able to identify the basic elements of concern in vicarious liability. This confirms Thornton's (2010) argument that though vicarious liability is commonly referred in employer-employee relations and discourse, its complex attributes and application are hardly understood. This is especially apparent in the healthcare sector, where lawsuits on vicarious liability from tortious

acts of healthcare staff abound. It was therefore not surprising that employees involved in the study had limited awareness of the tenets of vicarious liability.

Also of importance was the issue of the scope covered by vicarious liability. More than half of healthcare workers involved in the study identified that vicarious liability only covered torts committed in the course of employment by employees. Respondents in this group were mainly doctors, pharmacists and nurses who had been exposed to lessons on vicarious liability in the course of their training. The other health workers could not clearly define the extent to which their employers were vicariously liable. Follow up questions unearthed the wide differences in opinions as to what constituted course of employment especially in the healthcare sector. While some workers supported Kumado (2009) on the theory that determining the 'course of employment' was quite complex and should be handled on a case by case basis, while others supported Dobbs (2000) who believed the scope of employment was determined by whether the tortious activity was done with the authority of, and in a manner, time and location approved by the employer. Respondents also attributed the difficulty in defining the scope of employment to emerging human resource trends like job-sharing, working-from-home, out-station workers, out-reach workers and community health extension workers who lived and worked in rural communities rather than the healthcare facility.

The nature of relationship between the health worker and the healthcare facility is also a key determinant of vicarious liability. As explained by Levin (2005) the contractual relationship between a healthcare worker and the hospital where treatment takes place is a factor in determining whether a patient can hold the hospital liable for medical malpractice occurring on the hospital's premises. Often, the issue of contention has been on establishing whether or not the person committing the tortious act has a contract of service or a contract for service (Bal,

2009). An employee is said to have contract of service when he is in employment of the facility and is considered to be under the full direction, control and in the service (a servant) of the employer. On the other hand, a contract for services relates to an employee who is self-employed or in the employment of another employer but who, subject to terms, provides services to clients as an independent contractor. Generally, the conventional argument (see Kraakman, 1999; Shavell, 2007; Jones, 2000; Hepner, 2000) has been that employers are not vicariously liable for the tortious acts of independent contractors or employees with a contract for service. More than half of the health workers involved in this study supported the conventional argument and explained that once the independent contractor was under the direction and worked for the benefit of himself or another, other than the healthcare facility, imposing vicarious liability on the facility for his actions was unjust. Based on such arguments, and relying on the conventional notion of non-liability relating to independent contractors, many healthcare facilities have benefited from relationships with independent contractor workers while avoiding any risk of liability for medical malpractice committed by those same workers on the premises of the healthcare facility. There have therefore been advances towards establishing whether the nature of relationship between the employer and employee merits vicarious liability instead of solely considering the nature of employment contract. This is even more crucial in recent times where dramatic changes in the healthcare industry has created situations where hospitals now provide a wide array of medical services through independent contractors (Levin, 2005). As explained by some respondents, health facilities now have independent contractors providing almost every aspect of healthcare service in Ghana based on the private-public partnership orientation of the government. Nevertheless, some respondents believed that hospitals still benefitted from independent contractors and thus must be held vicariously liable for their actions. Other

arguments advanced by respondents include the fact that the independent contractors were given access to the patients by the healthcare facility which has the power and fiduciary mandate based on the duty of care owed patients, to ensure that patients are given the acceptable standard of care possible. Hospitals that shirk this responsibility must be made liable for the acts of these independent contractors. Rose (2009) also believes that patients come to the hospital for treatment and not to see the independent contractors. Proving vicarious liability must not therefore unnecessarily saddle the patient with the determination of the contractual statuses of employees since the patient had no way of determining who was an independent contractor at the point of treatment. Thus, the facility that charged money for the treatment must be made vicariously liable for the tort whether the employee was independent or not. To resolve these debates above, Binchy (2004) therefore advises that rather than lamely looking at the contractual statuses of employees in isolation, other tests like the integral part of business test and the allocation of financial risk/the economic reality/multiple test may be used in determining whether the tortfeasor was an employee.

Experiences and incidence of exposure to vicarious liability

With the implementation of the Ghanaian Patients Charter of rights and responsibilities in 2002, Ghanaian healthcare facilities have seen a drastic increase in lawsuits challenging the adequacy and quality of the services provided to patients. Owusu (2007) explains that aside improving the quality of service and protecting the rights of patients, the patient's charter was aimed at challenging the widely held perception that healthcare providers and their workers were sacrosanct and beyond reproach. Consequently, many Ghanaians are taking advantage of the charter to accost healthcare facilities and professionals for lapses in the services rendered. It was therefore not surprising that almost all respondents had firsthand knowledge of vicarious liability

suits against their facilities. Incidents that resulted in vicarious liability lawsuits ranged from treatment without consent, breach of patient's confidentiality, negligence, assault, battery, nuisance, patient abandonment, and wrongful diagnosis or treatment procedure. Of interest was a pending lawsuit filed by the family of a patient who died because of electricity failure during a major surgery in the hospital.

Follow up questions further confirmed Beyou (2010) comment about the high possibility of healthcare facilities being held vicariously liable. More than two-thirds of health workers involved in the study agreed that their healthcare facilities faced more than 10 vicarious liability suits every year. While the Ghana Health Service has heralded the increasing vicarious liability suits as an indication of increased patients' awareness of their rights under the patients' charter, some patient rights' groups have still maintained that several incidents of medical malpractice go unreported and unnoticed every year. In confirmation, respondents agreed many patients because of high illiteracy, perceived cost of the legal process, religious beliefs and other socio-cultural barriers refuse to report or pursue cases of malpractice against healthcare workers and facilities. Even in cases where the misconduct or malpractice of a healthcare worker has led to the death of patient, some families still attribute the death to the fate or destiny of the patient, or even refuse to pursue a case in negligence because they see it as a time and money wasting effort which will still not bring back the dead patient.

A significant majority of health workers involved in the study believed that every health worker was likely to be involved in an action or inaction that would expose the healthcare facility to a suit in vicarious liability during their professional career. This is confirmed by Upadhyay et al (2007) who found similar results in his study in the USA. Also, Kumado (2009) posits that employer's liability is hinged on recruitment of competent health professionals, availability of

materials/equipment for workers as well as proper and effective supervision. Thus, if these elements are absent in health care delivery, workers will be highly predisposed to commit unavoidable errors or misconducts. Yet, a cursory look the Ghanaian health care environment reveals understaffing issues, inadequate materials/equipment, laxity in supervision and monitoring, improper information management systems and slow response time. This is confirmed by the respondents who explained that the risk of committing a tort in Ghanaian healthcare practice was exacerbated by the inadequate number of healthcare personnel, poor supervision and training of personnel, inadequate logistics and infrastructure as well as the poor conditions of work.

Another issue of concern in vicarious liability discourse relates to employers taking action against the employees whose actions resulted in the vicarious liability suit. White (2010) supports the notion that the employer may well seek reimbursement for any amount paid to the injured person from the employee whose action resulted in the injury. Other administrative and punitive actions that may also be taken against the employee include retraining, reorientation, dismissal, suspension, demotion, fines and voluntary service, pay cuts, reduction in days off as well as withdrawal of professional licenses (Neyers, 2005; ACAS, 2012; Beyer, 2006). Evidence provided by the respondents indicates that usually no action is taken against employees who expose the healthcare facility to vicarious liability risks. A key raised was the fact that some healthcare professionals (especially doctors and pharmacists) owed allegiance and were shielded by their professional bodies and medical superintendents in their healthcare facilities. Subsequently, doctors and pharmacists in Ghana are often left even without caution when their actions and inactions expose the facility to secondary risks. On the other hand, orderlies and other non-clinical staff are often queried, suspended or dismissed if their actions expose the

healthcare facility to any vicarious liability. Further, the majority of healthcare facilities refused to take major actions against medical staff because of the limited number of medical personnel and healthcare specialists in healthcare facilities. The lack of action against tortious employees is a disincentive to efforts at reducing the financial risks and insurance costs of facilities, enhancing the quality of healthcare delivery and increasing patient satisfaction.

Generally, the study uncovered that wrongful actions of employees are covered up by management of the healthcare facility. Such actions were predicated on protecting the identity and reputation of the health facility in question. At best, management coerced patients who have been harmed as a result of negligence to make use of internal complaint avenues rather than civil lawsuits.

Justification of vicarious liability

Several arguments have been made in justification of vicarious liability in healthcare (Kumado, 2009; Shavell, 2006; White, 2010). However, counter arguments (see Owusu 2007; Davies and Dagbanja, 2009) have been made suggesting that vicarious liability suits sometimes inflates the expenditure of facilities (resulting in shifting funds from providing quality services to paying claims), and shifts burden of tort from irresponsible healthcare personnel and serves as a disincentive for healthcare personnel who often go out of the course of their duties to provide services for needy patients.

A significant majority of respondents believed that it was fair that healthcare facilities be held vicariously liable for the acts of employees. In all, reasons provided by the respondents supports Kumado (2009) that the primary justification for holding healthcare facilities vicariously liable stemmed from the duty of care owed to patients who patronize the facility as well as staff who

work in the facility. Thus, by virtue of the duty of care owed to patients and workers, the healthcare facility was legally bound to ensure the recruitment of competent work force, effective provision of monitoring and supervisory support as well as provision of adequate logistics or materials for working. Subsequently, if any tort occurs as a result the of lack of materials and maintenance of equipment, poor monitoring and supervision, or incompetence on the part of healthcare professionals, the burden of liability must rest on or be extended to the facility.

The fact that workers justified the liability of their employers by the Labour Act of Ghana, Act 651, is evident that employer's liability is not a new concept or issue in the health service industry. Drawing strength from the Act, management is generally the source of legal actions in the event when employees fall short of standard professional health care practice. The Act also mandates employers to provide worker materials, recruit competent staff, and maintain safety at workplace. In effect, if any harm arises as in instances where workers work in unsafe conditions without proper supervision, equipment or proper training, the employer will be ultimately culpable.

Other reasons provided by respondents supported Rose (2009) 'deep pockets' argument that the facility rather than the worker was better resourced to provide financial compensation to the victim. Thus, limiting liability to the worker will deprive the injured patient the needed compensation for the damage caused by the worker in the course of providing a service for the healthcare facility. Importantly, imposing vicarious liability on healthcare providers was justified by the ultimate beneficiary argument which recognizes that patients seeking treatment in a facility pay the facility (and not the workers) for services rendered by the workers. Consequently,

once the healthcare facility was the ultimate beneficiary of the employees' actions, it must be held ultimately liable from torts arising from the inactions of employees.

CONCLUSION AND THE WAY FORWARD

Vicarious liability remains a key concept in service provision, more so in the health sector where broad scopes of services are provided to patients who are often in a vulnerable state at the point of service provision. While professional codes and ethics exist to guide the conduct of healthcare professional and facilities in the discharge of their duties, the legal risks and liability in healthcare delivery provide the surest way to ensuring that facilities and professionals maintain the greatest standard of reasonable care possible. Healthcare institutions across the globe have therefore taken key interest in vicarious liability issues as a way of minimizing their costs and risks, enhancing patient satisfaction and building positive brands and reputations. Knowledge and awareness of healthcare personnel on the intricacies of vicarious liability is central to efforts at managing the risks inherent in healthcare provision.

The study based on its findings concludes that healthcare workers in Ghana had some knowledge on vicarious liability even though the knowledge was limited to the nature and concept of vicarious liability. Their knowledge did not extend to the requirements, scope, the strict nature, tests for determination and implications of vicarious liability for healthcare providers. Additionally, healthcare facilities in Ghana experienced more than 10 reported cases of vicarious lawsuits annually even though a greater number of potential lawsuits were not reported or pursued by patients. These lawsuits were the result of treatment without consent, breach of patient's confidentiality, negligence, assault, battery, nuisance, patient abandonment, and wrongful diagnosis or treatment procedure by healthcare personnel. Also, health workers in Ghana were likely to be involved in an action or inaction that would expose the healthcare

facility to a suit in vicarious liability during their professional career. This likelihood was further exacerbated by understaffing issues, inadequate materials/equipment, laxity in supervision and monitoring, improper information management systems and slow response time. The study findings also indicate that in most instances, little action is taken by the healthcare facility against workers whose activities impose vicarious liability risks on the facility. Importantly, imposing vicarious liability on healthcare facilities was justified by the duty of care owed patients and workers, the deep pockets and ultimate beneficiary arguments.

Based on this study, it is evident that healthcare facilities need to put more effort into creating an enabling environment for effective healthcare delivery and ensuring that patients and workers have minimal exposure to harm. Proper monitoring and supervision of all workers, whether under contract or in employment, is crucial to reducing the risks of vicarious liability. Importantly, continuous training and orientation for all healthcare workers on the inherent risks of their actions and inactions for their profession and for the healthcare facility is paramount in reducing employers' exposure to vicarious liability.

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