CHAPTER 6

LIABILITY OF HEALTH CARE INSTITUTIONS

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I. INTRODUCTION

The hospital is the classic health care "institution". The U.S. has over 5,700 hospitals—almost 3,000 are nonprofit, 1,000 for-profit, and 1,200 are local, state and federal government owned. The remainder are psychiatric and long term care hospitals. See American Hospital Association, Fast Facts on U.S. Hospitals (2013).

Hospitals are major providers of emergency care and highly complicated surgical and other procedures. They are therefore the largest sources of patient harms in the U.S. system. Hospitals provide acute care in severe health crises and, given the possibility of errors and serious adverse events, we also think of institutional liability for those injuries.

The Affordable Care Act has created pressure on hospitals to coordinate care and move patients safely from acute care situations to other institutions—assisted living, long term care, or home. Hospitals have also been acquiring physician practices in response to the incentives of the Affordable Care Act and the pressures for a better coordinated health care system.

Faced with the high cost of the HITECH Act's mandate for electronic health records and other regulatory mandates, many free standing hospitals are joining systems; and these systems are merging to achieve market share and necessary economies of scale in an increasingly competitive environment. As a result, 3,000 of these hospitals are now in systems, defined as either a multihospital or a diversified single hospital system. A multihospital system is two or more hospitals owned, leased, sponsored, or contract managed by a central organization. Single, freestanding hospitals may be categorized as a system by bringing into membership three or more, and at least 25 percent, of their owned or leased non-hospital preacute or postacute health care organizations. Hospitals in systems are likely to have more resources to devote to patient safety, and system pressures are likely to push hospitals toward the adoption of safety-based standards more rapidly.

Health care delivery also includes institutional forms such as managed care organizations that finance health care and contract with physicians and hospitals to provide care, as well as ambulatory care facilities

such as surgicenters and physician offices. As more and more medicine is moved out of the hospital into less expensive settings, the liability of these institutional arrangements emerges as a new concern. Most caselaw has originated with hospitals as the predominant form of delivery of high technology high risk care—where the most severe patient harms can occur—and the courts are now adapting to changes in the delivery system.

See generally For an excellent extended discussion of the history of the hospital, see Paul Starr, The Social Transformation of American Medicine (1982), particularly Chapter 4.

II. AGENCY LAW AND THE TEST OF "CONTROL"

A. DEFINING "EMPLOYEE" IN THE HOSPITAL SETTING

Hospitals employ nurses, technicians, clerks, custodians, cooks, and others who are clearly employees of the hospital under agency principles. Their terms and conditions of employment are controlled by the hospital, which sets their hours, wages and working conditions. When employees are negligent, the hospital is vicariously liable for their acts as a result of the master-servant relationship of agency law. It is the relationship of physicians to the hospital that raises more complicated agency problems.

The hospital-physician relationship is an unusual one by corporate standards. A typical hospital may have several categories of practicing physicians, but the largest group is comprised of private physicians with staff privileges. Staff privileges include the right of the physicians to admit and discharge their private patients to and from the hospital and the right to use the hospital's facilities. See generally Chapter 11, *infra*.

These physicians have typically been independent contractors rather than employees of the hospital. This legal status means that the hospital is therefore not easily targeted as a defendant in a malpractice suit. Only if the doctor whose negligence injured a patient is an employee could the hospital be reached through the doctrine of vicarious liability. The hospital is independently liable only if it is negligent in its administrative or housekeeping functions, for example causing a patient to slip and fall on a wet floor. Otherwise, the hospital has been immune in the past from liability. This has changed as the courts have confronted the evolution of the modern hospital and expanded vicarious liability doctrine in the health care setting.

SCOTT V. SSM HEALTHCARE ST. LOUIS

Mo.App. E.D., 2002.
70 S.W.3d 560.

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Background

In 1994 Matthew Scott, then seventeen, sustained serious injuries as a result of a sinus infection that spread into his brain. Matthew was involved in a car accident and was taken to Hospital, where he was treated for minor injuries and released to his father. Two days later Matthew returned to Hospital's emergency room, complaining of a severe headache. Dr. Doumit was Hospital's emergency room physician who examined Matthew that day. Soon after Matthew arrived, a CT scan of his head was conducted. Dr. Richard Koch, a partner in RIC, read the CT film and concluded that the CT scan was normal. Matthew was diagnosed as having a mild concussion from the previous auto accident, was given medication for his headache and sent home.

The next day, Matthew's headache had not improved. His parents called Hospital three times and informed Dr. Doumit that Matthew was lethargic, nauseous and vomiting. Dr. Doumit told them that he was still exhibiting signs of a minor concussion, that he would probably improve within a few days, that they should continue to observe him, but that if they became very concerned about his condition they could bring him back to the emergency room.

Early the next morning, Matthew collapsed in the kitchen, unable to use the right side of his body. He was rushed by ambulance to Barnes Hospital in St. Peters, Missouri. A spinal tap and CT scan revealed an infection at the top of his brain, and his brain was swelling inside his skull. Matthew was taken to Barnes Hospital in St. Louis, where a number of surgeries were performed to remove infected brain tissue and portions of his skull. He remained in a coma for several weeks.

Eventually, after undergoing skull reconstructive surgery and an extensive program of rehabilitation, Matthew was able to achieve a considerable recovery. He also has sustained serious permanent injuries, however, including among others a significant degree of paralysis on the right side of his body, and the requirement of a permanent ventricular drainage tube in his brain.

Matthew and his mother filed this medical malpractice action against Hospital and others, alleging, *inter alia,* that the negligence of Dr. Doumit and Dr. Koch caused Matthew's injuries. Specifically, plaintiffs alleged that Dr. Koch had acted below the accepted standard of care in misreading the initial CT scan on September 24, and that Dr. Doumit had acted below the standard of care by failing to instruct Matthew's parents,

when they called with their concerns, to bring him back to the emergency room. Plaintiffs' suit further alleged that at all relevant times Dr. Koch had been acting as an agent for Hospital, notwithstanding the fact that he was formally employed by RIC, which had contracted to provide radiology services at Hospital. Plaintiffs' action also named Dr. Koch and RIC as defendants. Before trial, plaintiffs settled their claims against Dr. Koch and RIC for the sum of $624,800 (hereinafter, "the Koch settlement"). The case then proceeded to trial against Hospital.

[The court first found that the evidence at trial supported the allegations of medical negligence by the treating physicians. The jury found for the plaintiffs, having found that Dr. Koch was the Hospital's agent.]

Discussion

1. Sufficiency of Evidence on Issue of Dr. Koch's Agency

[The Court considered the differences between independent contractor status and employee. It noted that the employer-employee relationship is a fact question for the jury.]

* * *

Two elements are required to establish an agency relationship: (1) the principal must consent, either expressly or impliedly, to the agent's acting on the principal's behalf, and (2) the agent must be subject to the principal's control.[ ] In the context of a hospital-physician relationship, the primary focus is on whether the hospital generally controlled, or had the right to control, the conduct of the doctor in his work performed at the hospital.[ ] Additionally, our courts have also cited with approval a list of ten factors set forth in the Restatement (Second) of Agency, § 220(2) (1958), as a helpful aid in "determining whether one acting for another is a servant or an independent contractor."[ ]

In the case at hand, Hospital cites a handful of facts from the record which, arguably, could support the conclusion that RIC and Dr. Koch were acting as independent contractors rather than as agents of Hospital. Among them are: the relationship between Dr. Koch and Hospital was based upon a written contract, in which RIC agreed to provide radiology services to Hospital; RIC was a partnership, of which Dr. Koch was a partner and signatory to the contract; Hospital did not employ or pay Dr. Koch (RIC did); Hospital did not directly set Dr. Koch's hours at the Hospital; and Hospital did not bill patients for the services of Dr. Koch or the other RIC radiologists.

However, a jury question is presented when the evidence is sufficiently conflicting that reasonable minds could differ as to whether agency existed.[ ] The following evidence, all of it from the contract and/or testimony in the record, supports finding a principal-agent relationship between Hospital and Dr. Koch: (1) Hospital establishes the medical stand-

ards for the provision of radiological services at Hospital; (2) Hospital determines the qualifications necessary for Dr. Koch; (3) Hospital has the right to require Dr. Koch to submit reports regarding radiological services rendered according to standards established by Hospital; (4) Hospital sets the prices for Dr. Koch's services, and those prices cannot be changed without prior approval of Hospital; (5) Hospital required that Dr. Koch be "an active member" of Hospital's medical staff; (6) Hospital required that Dr. Koch maintain liability insurance in specific amounts; (7) in the event that Dr. Koch fails to procure such insurance, Hospital has the right to procure it for him at his expense; (8) Hospital has the right to terminate Dr. Koch if dissatisfied with his performance; (9) Hospital provides all nurses and technicians for the radiology department; (10) Hospital owns and provides all of the office space for the radiology department, as well as providing all of the radiology equipment, films, supplies and fixtures; (11) Hospital decides what type of film, film boxes and view jackets will be used; (12) the contract between Hospital and RIC is of infinite duration; (13) RIC has provided the only radiologists working at Hospital for over 60 years; (14) RIC exclusively provides all of the radiologists for Hospital, including even the doctor who serves as the administrative director of the radiology department; and (15) the RIC radiologist who was the director of the radiology department testified that he considered himself and the other RIC radiologists at Hospital to in effect be "employees of the hospital."

Despite these facts, Hospital argues that the evidence at trial was insufficient to establish agency because there was nothing in the record to show that Hospital controlled Dr. Koch specifically "in the performance of the act at the heart of plaintiffs' claim—his alleged negligent reading of Matthew Scott's CT scan." However, Missouri courts have long recognized that physicians must be free to exercise independent medical judgment; the mere fact that a physician retains such independent judgment will not preclude a court, in an otherwise proper case, from finding the existence of an employer-employee or principal-agent relationship between a hospital and physician.[ ] Courts in other states, as well, have strongly rejected the notion that such a relationship cannot be found merely because the hospital does not have the right to stand over the doctor's shoulder and dictate to him or her how to diagnose and treat patients. [ ]

In view of the foregoing principles of law, the evidence in this case and our standard of review, the trial court did not err in finding the evidence sufficient to present a jury question on the issue of Dr. Koch's agency. Point I is denied.

NOTES AND QUESTIONS

1. ***Physicians as Employees***. The general definition of the term "servant" in the Restatement (Second) of Agency § 2(2) (1957) refers to a per-

son whose work is "controlled or is subject to the right to control by the master." The Restatement's more specific definition of the term "servant" lists factors to be considered when distinguishing between servants and independent contractors, the first of which is "the extent of control" that one may exercise over the details of the work of the other. Id. The relevant factor for analyzing the hospital-physician relationship by agency tests is § 220(2)(a), which looks to "the extent of control which, by the agreement, the master may exercise over the details of the work." This becomes a fact-intensive analysis for the trier of fact.

Physicians need considerable autonomy in practice, given the complexity of their decisions and their relationship to particular patients. As a result, determining the degree of control necessary to create an employment relationship in a medical malpractice claim poses a unique set of difficulties. As the court writes in Lilly v. Fieldstone, 876 F.2d 857 (C.A. 10 Kan.),1989. " * * * [i]t is uncontroverted that a physician must have discretion to care for a patient and may not surrender control over certain medical details. Therefore, the 'control' test is subject to a doctor's medical and ethical obligations. . . . What we must do in the case of professionals is determine whether other evidence manifests an intent to make the professional an employee subject to other forms of control which are permissible. A myriad of doctors become employees by agreement without surrendering their professional responsibilities."

2. Hospitals employ approximately 212,000 physicians. Hospitals have a range of relationships with privileged physicians: 55.1 percent of physicians are not employed or under contract, while 20.3 percent are covered by a group contract; 17.3 percent are directly employed and 7.2 percent have individual contracts. See the 2012 edition of *AHA Hospital Statistics*. From 2003 to 2010, the proportion of hospitals with hospitalists on staff grew from 29.6 percent to 59.8 percent. From 2007–10, the proportion of hospitals employing intensivists grew from 20.7 percent to 29.7 percent. Many physicians are moving from practicing in small groups to some form of employee in a changing delivery system.

B. THE MEDICAL STAFF: VICARIOUS LIABILITY

Absent evidence of indicia of control sufficient to make a physician the employee of a hospital, courts have turned to traditional agency tests that evaluate whether the health care institution is vicariously liable for the negligence of its independent contractors.

BURLESS v. WEST VIRGINIA UNIVERSITY HOSPITALS, INC.

Supreme Court of West Virginia, 2004.
215 W.Va. 765, 601 S.E.2d 85.

DAVIS, JUSTICE:

In these two appeals from two orders of the Circuit Court of Monongalia County granting summary judgment to West Virginia University

Hospitals (hereinafter referred to as "WVUH"), the Appellants ask this Court to rule that the circuit courts erred in finding that no actual or apparent agency relationship existed between physicians employed by the West Virginia University Board of Trustees (hereinafter referred to as "the BOT") and WVUH. We find no error in the circuit courts' rulings that no actual agency existed. However, we find that the courts erred in granting summary judgment on the issue of apparent agency. In reaching this conclusion, we find that for a hospital to be held liable for a physician's negligence under an apparent agency theory, a plaintiff must establish that: (1) the hospital either committed an act that would cause a reasonable person to believe that the physician in question was an agent of the hospital, or, by failing to take an action, created a circumstance that would allow a reasonable person to hold such a belief, and (2) the plaintiff relied on the apparent agency relationship.

I. Factual Procedural History

Each of the two cases consolidated for purposes of this opinion involve a woman who gave birth to her child at WVUH under circumstances that she alleges resulted in severe birth defects to her child. The relevant facts of each case, as developed in the pleadings, depositions, affidavits, and exhibits, follow.

A. Jaclyn Burless

In July of 1998 Jaclyn Burless learned she was pregnant and sought prenatal care at the Cornerstone Care Clinic (hereinafter referred to as "the Cornerstone Clinic" or simply "the clinic") located in Greensboro, Pennsylvania. The Cornerstone Clinic was where Ms. Burless had routinely sought her primary medical care. Similarly, Ms. Burless elected to receive her prenatal care at the clinic. She received her prenatal care from Dr. Douglas Glover for approximately seven months.

In November, 1998, Dr. Glover sent Ms. Burless to WVUH for an ultrasound. At that time, Ms. Burless signed a WVUH consent form that stated: "I understand that the faculty physicians and resident physicians who provide treatment in the hospital are not employees of the hospital." Thereafter, in February of 1999 when she was at approximately 37 weeks of gestation, Ms. Burless experienced an elevated blood pressure and edema. On February 15, 1999, Dr. Glover advised Ms. Burless to report to the WVU Emergency Department for an evaluation. On February 17, 1999, Ms. Burless presented herself at the WVUH Emergency Department as instructed and, after an evaluation, was instructed to return to the High Risk Clinic, which is located on the WVUH premises, in two days with a urine sample for testing. Ms. Burless was also advised that she would receive the remainder of her prenatal care at the High Risk Clinic. She followed the instructions to return to the High Risk Clinic in two days. She was then instructed to return in one week for further eval-

uation. When she returned, on February 26, 1999, she was induced into labor at 7:50 p.m. Her labor was permitted to continue throughout the remainder of February 26 and until 4:00 p.m. on February 27. She alleges that during this time, doctors, residents, and nurses at WVUH noted variable decelerations in the fetal heart rate of her unborn daughter, Alexis Price. At 4:00 p.m. on February 27 the decision was made to deliver the baby via cesarean section, and such delivery was accomplished at 4:16 p.m. The child was born with an APGAR[2] score of two at one minute and six at five minutes. Soon after birth the child began to experience seizures and suffered a stroke. Ms. Burless has alleged that the doctors and hospital were negligent, *inter alia,* in failing to monitor her labor and delivery, which negligence caused severe and permanent mental, neurological, and psychological injuries to the infant, Alexis Price.

Ms. Burless later filed a negligence action, claiming breaches of the standard of care in connection with the management of her labor, against the BOT as the physicians' employer, and claiming vicarious liability on the part of WVUH based upon a theory of apparent agency between WVUH and the physicians who provided the allegedly negligent care. WVUH moved for summary judgment asserting, in relevant part, that there was no apparent agency relationship between it and the doctors and residents who provided care to Ms. Burless. Finding no just cause for delay, pursuant to Rule 54(b) of the West Virginia Rules of Civil Procedure, the circuit court granted summary judgment to WVUH by final order entered December 11, 2002. The circuit court found that there was nothing in the record demonstrating the creation of an apparent agency relationship between the physicians who treated Ms. Burless and WVUH. Ms. Burless appealed the order and this Court granted her petition for appeal. For purposes of rendering our decision, we consolidated her case with a similar appeal filed by Ms. Melony Pritt.

B. Melony Pritt

[Plaintiff Melony Pritt had an ovarian cyst, and scheduled a laparotomy and left ovarian cystectomy. She signed several consent forms, all of which contained the statement " "I understand that the faculty physicians and resident physicians who provide treatment in the hospital are not employees of the hospital." The surgery did not go well, and she suffered a massive abdominal infection, which infection caused premature labor. Her son was alleged therefore to have suffered severe permanent mental, neurological, and psychological injuries]

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[2] An APGAR Score is a newborn's first evaluation and serves as a predictive indicator of any potential problems. The infant is examined at one and five minutes after birth and ranked on a scale of zero to two on five characteristics: 1) skin color; 2) heart rate; 3) response to stimuli of inserting a catheter in the nose; 4) muscle tone; and 5) respiratory effort. Thus, the maximum score is 10 with most healthy newborns scoring an eight or nine. The five APGAR factors can be mnemonically summarized as *A*-ppearance, *P*-ulse, *G*-rimace, *A*-ctivity, *R*-espiration.[ ].

II.

[The court's discussion of the standard of review is omitted.]

III.

Discussion

Ms. Burless and Ms. Pritt assert that the circuit courts erred both in finding no actual agency relationship between the doctors who treated them and WVUH, and in finding no apparent agency relationship. We address each of these assignments of error in turn.

A. Actual Agency

[The court found no actual agency, since the hospital did not have "power of control" over the physicians who provided treatment to Ms. Burless and Ms. Pritt.]

B. Apparent Agency

Ms. Burless and Ms. Pritt next assert that the circuit courts erred in finding no apparent agency relationship between the doctors who treated them and WVUH. Because we have explained in the previous section that we find no *actual* agency relationship in these cases, we have concluded that the doctors were, in fact, independent contractors. Our cases have recognized that, as a general rule, "[i]f [a physician] is found to be an independent contractor, then the hospital is not liable for his [or her] negligence."[ ]

As with most general rules, there are exceptions to the independent contractor rule. We have previously recognized that

> One who by his acts or conduct has permitted another to act apparently or ostensibly as his agent, to the injury of a third person who has dealt with the apparent or ostensible agent in good faith and in the exercise of reasonable prudence, is estopped to deny the agency relationship.

[ ] In the instant cases, however, we are asked to determine the existence of an apparent agency relationship in the hospital/physician context. As explained in more detail below, modern hospitals and their relationships with the physicians who treat patients within their facilities are rather unique and complex. Thus, instead of relying on a general rule for apparent agency such as those quoted above, we believe a more particular rule is in order.

In the hospital/physician context, this Court has heretofore established that even where a physician charged with negligence is an independent contractor, the hospital may nevertheless be found vicariously liable where the complained of treatment was provided in an emergency

room.[ ] Although we have addressed using a theory of apparent agency to overcome the physician/independent contractor rule in the context of emergency room treatment, we have never expressly defined such a rule for use outside of the emergency room setting. We do so now.

1. Hospital/Physician Apparent Agency Outside the Emergency Room Setting. The public's confidence in the modern hospital's portrayal of itself as a full service provider of health care appears to be at the foundation of the national trend toward adopting a rule of apparent agency to find hospitals liable, under the appropriate circumstances, for the negligence of physicians providing services within its walls. As one court observed:

> In an often cited passage, a New York court explained: "The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact. Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. They regularly employ on a salary basis a large staff of physicians, nurses and interns, as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such services, if necessary, by legal action. Certainly, *the person who avails himself of 'hospital facilities' expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility*." . . . In light of this modern reality, the overwhelming majority of jurisdictions employed ostensible or apparent agency to impose liability on hospitals for the negligence of independent contractor physicians.

Mejia v. Community Hosp. of San Bernardino,[ ] (quoting Bing v. Thunig [ ] In fact), this Court has itself observed that

> "Modern hospitals have spent billions of dollars on marketing to nurture the image that they are full-care modern health facilities. Billboards, television commercials and newspaper advertisements tell the public to look to its local hospital for every manner of care, from the critical surgery and life-support required by a major accident to the minor tissue repairs resulting from a friendly game of softball. These efforts have helped bring the hospitals vastly increased revenue, a new role in daily health care and, ironically, a heightened exposure to lawsuits.[ ]"

[ ]

* * *

[ ] * * * [W]e now hold that for a hospital to be held liable for a physician's negligence under an apparent agency theory, a plaintiff must establish that: (1) the hospital either committed an act that would cause a reasona-

ble person to believe that the physician in question was an agent of the hospital, or, by failing to take an action, created a circumstance that would allow a reasonable person to hold such a belief, and (2) the plaintiff relied on the apparent agency relationship.

2. Hospital's Actions or Inactions. The first element of our test requires evidence that the hospital either committed an act that would cause a reasonable person to believe that the physician in question was an agent of the hospital, or, by failing to take an action, created a circumstance that would allow a reasonable person to hold such a belief. This portion of the test focuses on the acts of the hospital and is generally satisfied when "the hospital 'holds itself out' to the public as a provider of care."[ ] One court has explained that "[i]n order to prove this element, it is not necessary to show an express representation by the hospital. . . . Instead, a hospital is generally deemed to have held itself out as the provider of care, unless it gave the patient contrary notice."[ ]. The "contrary notice" referred to by the *Mejia* court generally manifests itself in the form of a disclaimer. As one court has acknowledged, "[a] hospital generally will be able to avoid liability by providing *meaningful written notice* to the patient, acknowledged at the time of admission."[ ]. It has been said that "[l]iability under apparent agency . . . will not attach against a hospital where the patient knows, or reasonably should have known, that the treating physician was an independent contractor."[ ] Thus, a hospital's failure to provide a meaningful written notice may constitute "failing to take an action" and thereby allowing a reasonable person to believe that a particular doctor is an agent of the hospital. Conversely, absent other overt acts by the hospital indicating an employer/employee relationship, an unambiguous disclaimer by a hospital explaining the independent contractor status of physicians will generally suffice to immunize the hospital from being vicariously liable for physician conduct.[14]

Turning to the cases before us, the circuit courts in both cases relied on the disclaimers signed by Ms. Pritt & Ms. Burless in granting summary judgment in favor of WVUH. In addition, the circuit court considering Ms. Pritt's case summarily concluded that WVUH had not "held the physicians out to be its employees." We disagree with these conclusions.

The disclaimer that WVUH required both Ms. Pritt and Ms. Burless to sign stated: "I understand that the faculty physicians and resident physicians who provide treatment in the hospital are not employees of the hospital." WVUH contends that this "disclaimer" was sufficient to une-

[14] Of course, "we do not hold that the existence of an [unambiguous] independent contractor disclaimer . . . is always dispositive on the issue [.]" [ ] A plaintiff may still be able to prove that, under the totality of the circumstances, an unambiguous disclaimer was insufficient to inform him or her of the employment status of a hospital's physicians.

quivocally inform Ms. Pritt and Ms. Burless that the physicians treating them were not employees of the hospital. We disagree.

We do not find the disclaimer language used by WVUH, which indicated that "faculty physicians and resident physicians who provide treatment in the hospital" are independent contractors, was sufficient to support a grant of summary judgment in their favor. The WVUH disclaimer provision presupposes that all patients can distinguish between "faculty physicians," "resident physicians" and any other type of physician having privileges at the hospital. In other words, for this disclaimer to be meaningful, a patient would literally have to inquire into the employment status of everyone treating him or her. Obviously, "[i]t would be absurd to require . . . a patient . . . to inquire of each person who treated him whether he is an employee of the hospital or an independent contractor."

Consequently, it was improper for the circuit court to grant summary judgment in favor of WVUH. Ms. Burless and Ms. Pritt have established a genuine question of material fact as to whether WVUH has either committed an act that would cause a reasonable person to believe that the physician in question was an agent of the hospital, or, by failing to take an action, created a circumstance that would allow a reasonable person to hold such a belief.

3. Reliance. The reliance prong of the apparent agency test is a subjective molehill. "Reliance . . . is established when the plaintiff 'looks to' the hospital for services, rather than to an individual physician."[ ] It is "sometimes characterized as an inquiry as to whether 'the plaintiff acted in reliance upon the conduct of the hospital or its agent, consistent with ordinary care and prudence.'[ ] This factor 'simply focuses on the "patient's belief that the hospital or its employees were rendering health care." ' " "[ ] However, this portion of the test also requires consideration of the 'reasonableness of the patient's [subjective] belief that the hospital or its employees were rendering health care.' " "This . . . determination is made by considering the totality of the circumstances, including . . . any special knowledge the patient[/plaintiff] may have about the hospital's arrangements with its physicians."[ ]

Mrs. Pritt and Ms. Burless provided evidence indicating that they believed that the physicians treating them were employees of WVUH.

In the deposition testimony of Ms. Burless she stated her belief that the people treating her at the hospital were employees, as follows: "Q. Did anyone do anything to make you believe that they were employees of WVU Hospital? A. They were all wearing their coats and name tags and in the building, so, you know, you know they're—they work there, they're employees." In the affidavit submitted by Ms. Pritt in opposition to WVUH's motion for summary judgment, the following was stated:

2. At the West Virginia University Hospitals, I was assigned doctors who treated me and consulted me through my prenatal care, surgery and delivery of my son Adam.

3. Throughout all of my treatment and consultations, I believed that the doctors and nurses who treated me and spoke to me were employees of the West Virginia University Hospitals.

Ms. Burless and Ms. Pritt have also established a genuine question of material fact on the issue of their reliance on the apparent agency relationship between WVUH and their treating physicians. Consequently, on the issue of apparent agency, it is clear that summary judgment should not have been granted in favor of WVUH.

NOTES AND QUESTIONS

1. *The Medical Staff*. The medical staff is a self-governing body charged with overseeing the quality of care, treatment, and services delivered by practitioners who are credentialed and privileged through the medical staff process. See Chapter 11. The medical staff must credential and privilege all licensed independent practitioners. The self-governing organized medical staff creates and maintains a set of bylaws that defines its role within the context of a hospital setting and clearly delineates its responsibilities in the oversight of care, treatment, and services. It elects its own officers, and appoints its own committees.

The organized medical staff is intimately involved in carrying out, and in providing leadership in, all patient care functions conducted by practitioners privileged through the medical staff process. The medical staff oversees the quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process. It recommends practitioners for privileges to perform medical histories and physical examinations. The hospital governing body approves such privileges.

The organized medical staff is not simply another administrative component of the hospital, and it has typically been subject to only limited authority of the governing board of the hospital. While the hospital board must approve the staff's bylaws and can approve or disapprove particular staff actions, it cannot usually discipline individual physicians directly or appoint administrative officers to exercise direct authority. A hospital's medical staff is therefore a powerful body within the larger organization.

2. *Patient Reliance*. The patient in most cases relies on the reputation of the hospital, not any particular doctor, and for that reason selects that hospital. See e.g., White v. Methodist Hosp. South, 844 S.W.2d 642 (Tenn.App.1992). If the negligence results from emergency room care, most courts have held that a patient may justifiably rely on the physician as an agent unless the hospital explicitly disclaims an agency relationship. Ballard v. Advocate Health and Hospitals Corporations, 1999 WL 498702 (N.D.Ill. 1999). A promotional campaign or advertising can create such reliance. See

Clark v. Southview Hospital & Family Health Center, 68 Ohio St.3d 435, 628 N.E.2d 46 (1994) (promotional and marketing campaign stressed the emergency departments); Gragg v. Calandra, 297 Ill.App.3d 639, 231 Ill.Dec. 711, 696 N.E.2d 1282 (1998) (unless patient is put on notice of the independent status of the professionals in a hospital, he or she will reasonably assume they are employees).

3. What can a hospital do to avoid liability under the *Burless* court's analysis? Will explicit notice to the plaintiff at the time of admission be sufficient? How about a large sign in the admitting area of the hospital? A brochure handed to each patient? If the hospital advertises aggressively, will the reliance created by such advertising overwhelm all of the hospital's targeted attempts to inform patients about the intricacies of the physicians' employment relationships with the hospital?

To avoid liability, a hospital can try to avoid patient misunderstanding by its billing procedures, the letterhead used, signs, and other clues of the true nature of the relationship of the physician to the institution. Cantrell v. Northeast Georgia Medical Center, 235 Ga.App. 365, 508 S.E.2d 716 (1998) (sign over registration desk stated that the physicians in the emergency room were independent contracts; consent form repeated this). The court is likely however to cut through these devices if the reliance on reputation by the patient is strong enough.

Explicit language in a patient consent form is the clearest way to put a patient on notice of the physician's legal status. A few states allow a clear statement in a consent form—that physicians in the hospital are independent contractors and not agents—to put a patient on notice. See Pendley v. Southern Regional Health System, Inc., 307 Ga.App. 82, 704 S.E.2d 198 (2010) (hospital had bolded the independent contractor disclaimers in both the General Consent for Treatment and the Routine Consent, and the Routine Consent also cautioned readers in bold: **"Important: Do not sign this form without reading and understanding its contents."** The court also noted that the defendant physician had made no representations to the plaintiff as to his employment status.)

4. *Nondelegable Duty Analysis*. Emergency room physicians are most often the source of vicarious liability claims against the contracting hospitals. In spite of various forms of notice as to the independent contractor status of emergency room physicians, many state courts have refused to allow the hospital to escape liability. The reasons typically given are based on the nature of patient reliance when entering a hospital for emergency care. As the court stated in Simmons v. Tuomey Regional Medical Center, 341 S.C. 32, 533 S.E.2d 312 (South Carolina, 2000), "[t]he point often made in the cases and commentary, either implicitly or explicitly, is that expecting a patient in an emergency situation to debate or comprehend the meaning and extent of any representations by the hospital—which likely would be based on an opinion gradually formed over the years and not on any single representation—imposes an unfair and improper burden on the patient. Consequently, we believe the better solution, grounded primarily in public policy reasons we ex-

plain below, is to impose a nondelegable duty on hospitals." (holding that a hospital owes a common law nondelegable duty to render competent service to its emergency room patients).

The nondelegable duty doctrine is similar to the "inherent function" test used by some courts to describe emergency room, radiology, or anesthesia services. These courts refuse to allow the independent contractor defense in such cases. See, e.g., Dragotta v. Southampton Hosp., 39 A.D.3d 697, 833 N.Y.S.2d 638 (N.Y.A.D. 2 Dept.,2007).

5. Other courts reach the same result by characterizing the duty of a hospital that uses physician independent contractors as a contractual or fiduciary duty to patients. See for example Pope v. Winter Park Healthcare Group, Ltd., 939 So.2d 185 (D.C. App.Florida, Fifth District, 2006). The plaintiff gave birth to an infant suffering from fetal-maternal hemorrhage, and compression of the umbilical vein. Resuscitation was delayed, and permanent brain damage resulted; the plaintiffs contended that the on-call neonatologist was negligent in failing to be present, in failing to communicate, in failing to order necessary tests, and in failing to order the necessary means of resuscitation.

The court concluded that " * * *if a hospital does undertake by contract to provide medical care, it cannot throw off that obligation simply by hiring an independent contractor. The use by hospitals of independent-contractor physicians eliminates "respondeat superior" liability, but it will not relieve the hospital of any contractual duties it has undertaken. A hospital can, by contract, undertake different duties or greater duties than those imposed by the common law of tort." See also Barragan v. Providence Memorial Hospital, 2000 WL 1731286 (Tex.App.–El Paso) (Nov. 22, 2000).

What does this mean for hospital liability? If the test is that a hospital is obligated by contract simply by agreeing to care for a patient, is anything left of the defense?

PROBLEM: CREATING A SHIELD

You represent Bowsman Hospital, a small rural hospital in Iowa. The hospital has until now relied on Dr. Headley for radiology services. It provides him with space, equipment, and personnel for the radiology department, sends and collects bills on his behalf, and provides him with an office. It also pays him $300 a day in exchange for which Dr. Headley agrees to be at the hospital one day a week. Bowsman is one of several small hospitals in this part of Iowa that use Dr. Headley's services. Bowsman advertises in the local papers of several nearby communities. Its advertisements stress its ability to handle trauma injuries, common in farming areas. The ads say in part:

"Bowsman treats patient problems with big league medical talent. Our physicians and nurses have been trained for the special demands of farming accidents and injuries."

What advice can you give as to methods of shielding Bowsman from liability for the negligent acts of Dr. Headley? Must it insist that Dr. Headley operate his own outside laboratory? Or furnish his own equipment? Pay his own bills? Should the hospital hire its own radiologist?

The Chief Executive Officer asks you to develop guidelines to protect the hospital from liability for medical errors of the radiologist. Your research has uncovered the following cases.

Estates of Milliron v. Francke, 243 Mont. 200, 793 P.2d 824 (1990). The plaintiff was referred to the hospital and the radiologist who practiced there by his family physician, for evaluation of prostatis and uropathy. The radiologist used an intravenous pyelogram, to which the plaintiff had a reaction. The patient suffered brain damage. The hospital provided space, equipment and personnel for the radiology department, sent and collected bills on his behalf, and provided him with an office. The court granted summary judgment for the defendant on the ostensible agency claim. The court noted that this was a small hospital in a rural area, and the radiologist rotated between this and several other small hospitals. This was an ordinary practice in smaller communities in Montana. The court concluded that "[p]roviding these traveling physicians with offices at the hospital simply helps ensure that these smaller and more remote communities will be provided with adequate medical care and is not a sufficient factual basis to establish an agency relationship." Id. at 827.

III. HOSPITAL LIABILITY

Patients may suffer injury in hospitals in many ways: they may fall out of bed, they may slip on the way to the bathroom, they may be given the wrong drug or the wrong dosage in their IV, the MRI machine may not be working, etc.. If expert testimony is not needed, that is, if an ordinary person could evaluate the failure, then the case may not be considered malpractice but rather ordinary negligence. Negligence may have a different statute of limitations and may not be subject to restrictive legislative restrictions on malpractice recovery such as certificates of merit, caps on noneconomic loss, or other restrictions.

Most hospital cases that involve treatment or diagnosis will require expert testimony of some sort. If the case involves the standard of care applicable to a hospital rather than one of the medical staff physicians, then the courts will look at the standard applicable to hospitals of that type, and inquire into the professional judgment of providers or decisions of a hospital governing body or the administration of the hospital. Such breaches of duty are considered malpractice, are subject to the rules pertaining to such cases, and require expert testimony.

A. NEGLIGENCE

WASHINGTON v. WASHINGTON HOSPITAL CENTER

District of Columbia Court of Appeals, 1990.
579 A.2d 177.

[The Court considered two issues: whether the testimony of the plaintiff's expert was sufficient to create a issue for the jury; and whether the hospital's failure to request a finding of liability of the settling defendants or to file a cross claim for contribution against any of the defendants defeated the hospital's claim for a pro rata reduction in the jury verdict. The discussion of the first issue follows.]

FARRELL, ASSOCIATE JUDGE:

This appeal and cross-appeal arise from a jury verdict in a medical malpractice action against the Washington Hospital Center (WHC or the hospital) in favor of LaVerne Alice Thompson, a woman who suffered permanent catastrophic brain injury from oxygen deprivation in the course of general anesthesia for elective surgery * * *

* * *

I. The Facts

On the morning of November 7, 1987, LaVerne Alice Thompson, a healthy 36–year–old woman, underwent elective surgery at the Washington Hospital Center for an abortion and tubal ligation, procedures requiring general anesthesia. At about 10:45 a.m., nurse-anesthetist Elizabeth Adland, under the supervision of Dr. Sheryl Walker, the physician anesthesiologist, inserted an endotracheal tube into Ms. Thompson's throat for the purpose of conveying oxygen to, and removing carbon dioxide from, the anesthetized patient. The tube, properly inserted, goes into the patient's trachea just above the lungs. Plaintiffs alleged that instead Nurse Adland inserted the tube into Thompson's esophagus, above the stomach. After inserting the tube, Nurse Adland "ventilated" or pumped air into the patient while Dr. Walker, by observing physical reactions—including watching the rise and fall of the patient's chest and listening for breath sounds equally on the patient's right and left sides—sought to determine if the tube had been properly inserted.

At about 10:50 a.m., while the surgery was underway, surgeon Nathan Bobrow noticed that Thompson's blood was abnormally dark, which indicated that her tissues were not receiving sufficient oxygen, and reported the condition to Nurse Adland, who checked Thompson's vital signs and found them stable. As Dr. Bobrow began the tubal ligation part of the operation, Thompson's heart rate dropped. She suffered a cardiac arrest and was resuscitated, but eventually the lack of oxygen caused catastrophic brain injuries. Plaintiffs' expert testified that Ms. Thompson

remains in a persistent vegetative state and is totally incapacitated; her cardiac, respiratory and digestive functions are normal and she is not "brain dead," but, according to the expert, she is "essentially awake but unaware" of her surroundings. Her condition is unlikely to improve, though she is expected to live from ten to twenty years.

* * *

The plaintiffs alleged that Adland and Walker had placed the tube in Thompson's esophagus rather than her trachea, and that they and Dr. Bobrow had failed to detect the improper intubation in time to prevent the oxygen deprivation that caused Thompson's catastrophic brain injury. WHC, they alleged, was negligent in failing to provide the anesthesiologists with a device known variously as a capnograph or end-tidal carbon dioxide monitor which allows early detection of insufficient oxygen in time to prevent brain injury.

* * *

II. Washington Hospital Center's Claims on Cross–Appeal

A. Standard of Care

On its cross-appeal, WHC first asserts that the plaintiffs failed to carry their burden of establishing the standard of care and that the trial court therefore erred in refusing to grant its motion for judgment notwithstanding the verdict.

* * *

In a negligence action predicated on medical malpractice, the plaintiff must carry a tripartite burden, and establish: (1) the applicable standard of care; (2) a deviation from that standard by the defendant; and (3) a causal relationship between that deviation and the plaintiff's injury. [ ] * * *

Generally, the "standard of care" is "the course of action that a reasonably prudent [professional] with the defendant's specialty would have taken under the same or similar circumstances." [ ] With respect to institutions such as hospitals, this court has rejected the "locality" rule, which refers to the standard of conduct expected of other similarly situated members of the profession in the same locality or community, [ ] in favor of a national standard. [ ] Thus, the question for decision is whether the evidence as a whole, and reasonable inferences therefrom, would allow a reasonable juror to find that a reasonably prudent tertiary care hospital,[3] at the time of Ms. Thompson's injury in November 1987, and according to national standards, would have supplied a carbon dioxide monitor to a patient undergoing general anesthesia for elective surgery.

[3] Plaintiffs' expert defined a tertiary care hospital as "a hospital which has the facilities to conduct clinical care management of patients in nearly all aspects of medicine and surgery."

WHC argues that the plaintiffs' expert, Dr. Stephen Steen, failed to demonstrate an adequate factual basis for his opinion that WHC should have made available a carbon dioxide monitor. The purpose of expert opinion testimony is to avoid jury findings based on mere speculation or conjecture. [ ] The sufficiency of the foundation for those opinions should be measured with this purpose in mind. * * *

* * *

* * * [WHC] asserts that * * * Steen gave no testimony on the number of hospitals having end-tidal carbon dioxide monitors in place in 1987, and that he never referred to any written standards or authorities as the basis of his opinion. We conclude that Steen's opinion * * * was sufficient to create an issue for the jury.

Dr. Steen testified that by 1985, the carbon dioxide monitors were available in his hospital (Los Angeles County—University of Southern California Medical Center (USC)), and "in many other hospitals." In response to a question whether, by 1986, "standards of care" required carbon dioxide monitors in operating rooms, he replied, "I would think that by that time, they would be [required]." As plaintiffs concede, this opinion was based in part on his own personal experience at USC, which * * * cannot itself provide an adequate foundation for an expert opinion on a national standard of care. But Steen also drew support from "what I've read where [the monitors were] available in other hospitals." He referred to two such publications: The American Association of Anesthesiology (AAA) Standards for Basic Intra–Operative Monitoring, approved by the AAA House of Delegates on October 21, 1986, which "encouraged" the use of monitors, and an article entitled *Standards for Patient Monitoring During Anesthesia at Harvard Medical School,* published in August 1986 in the Journal of American Medical Association, which stated that as of July 1985 the monitors were in use at Harvard, and that "monitoring end-tidal carbon dioxide is an emerging standard and is strongly preferred."

WHC makes much of Steen's concession on cross-examination that the AAA Standards were recommendations, strongly encouraged but not mandatory, and that the Harvard publication spoke of an "emerging" standard. In its brief WHC asserts, without citation, that "[p]alpable indicia of widespread *mandated* practices are necessary to establish a standard of care" (emphasis added), and that at most the evidence spoke of "recommended" or "encouraged" practices, and "emerging" or "developing" standards as of 1986–87. A standard of due care, however, necessarily embodies what a *reasonably prudent* hospital would do, [ ] and hence care and foresight exceeding the minimum required by law or mandatory professional regulation may be necessary to meet that standard. It certainly cannot be said that the 1986 recommendations of a professional association (which had no power to issue or enforce mandatory requirements), or an article speaking of an "emerging" standard in 1986, have no bearing on

an expert opinion as to what the standard of patient monitoring equipment was fully one year later when Ms. Thompson's surgery took place.

Nevertheless, we need not decide whether Dr. Steen's testimony was sufficiently grounded in fact or adequate data to establish the standard of care. The record contains other evidence from which, in combination with Dr. Steen's testimony, a reasonable juror could fairly conclude that monitors were required of prudent hospitals similar to WHC in late 1987. The evidence showed that at least four other teaching hospitals in the United States used the monitors by that time. In addition to Dr. Steen's testimony that USC supplied them and the article reflecting that Harvard University had them, plaintiffs introduced into evidence an article entitled *Anesthesia at Penn,* from a 1986 alumni newsletter of the Department of Anesthesia at the University of Pennsylvania, indicating that the monitors were then in use at that institution's hospital, and that they allowed "instant recognition of esophageal intubation and other airway problems. * * * " Moreover, WHC's expert anesthesiologist, Dr. John Tinker of the University of Iowa, testified that his hospital had installed carbon dioxide monitors in every operating room by early 1986, and that "by 1987, it is certainly true that many hospitals were in the process of converting" to carbon dioxide monitors.[5]

Perhaps most probative was the testimony of WHC's own Chairman of the Department of Anesthesiology, Dr. Dermot A. Murray, and documentary evidence associated with his procurement request for carbon dioxide monitors. In December 1986 or January 1987, Dr. Murray submitted a requisition form to the hospital for end-tidal carbon dioxide units to monitor the administration of anesthesia in each of the hospital's operating rooms, stating that if the monitors were not provided, the hospital would "fail to meet the national standard of care." The monitors were to be "fully operational" in July of 1987.[6] Attempting to meet this evidence, WHC points out that at trial

> Dr. Murray was *never asked to opine,* with a reasonable degree of medical certainty, that the applicable standard of care at the relevant

[5] In its reply brief, WHC argues that

> the fact that four teaching hospitals used CO_2 monitors during the relevant time period is almost irrelevant. Institutions with significantly enhanced financial resources and/or government grants which accelerate their testing and implementation of new and improved technologies would naturally have available to them items which, inherently, were not yet required for the general populace of hospitals.

In fact, Dr. Steen, in voir dire examination on his qualification as an expert on the standard required of hospitals in WHC's position in regard to equipment, testified that his review of WHC's President's Report for 1986–87 led him to conclude that WHC was a teaching hospital. Counsel for the hospital could have identified and probed fully before the jury any differences between WHC and the hospitals relied on to establish the standard of care. To the extent the record was not so developed, the jury could credit Steen's testimony that WHC was required to adhere to the standard applicable to teaching hospitals.

[6] As supporting documentation for the requisition, Dr. Murray attached a copy of the Journal of the American Medical Association article on standards at Harvard University. The requisitions, with attachments, were exhibits admitted in evidence.

> time *required* the presence of CO_2 monitors. Indeed, his testimony was directly to the contrary. Moreover, the procurement process which he had initiated envisioned obtaining the equipment * * * over time, not even beginning until fiscal year 1988, a period ending June 30, 1988. [Emphasis by WHC.]

Dr. Murray opined that in November 1987 there was *no* standard of care relating to monitoring equipment. The jury heard this testimony and Dr. Murray's explanation of the procurement process, but apparently did not credit it, perhaps because the requisition form itself indicated that the equipment ordered was to be operational in July 1987, four months before Ms. Thompson's surgery, and not at some unspecified time in fiscal year 1988 as Dr. Murray testified at trial.

On the evidence recited above, a reasonable juror could find that the standard of care required WHC to supply monitors as of November 1987. The trial judge therefore did not err in denying the motion for judgment notwithstanding the verdict.

NOTES AND QUESTIONS

1. Does the plaintiff present sufficient evidence that the carbon dioxide monitor is now standard equipment for tertiary care hospitals? The court seems to say that expert testimony is not critical, that the evidence of use by other institutions is something a lay juror could evaluate even if expert testimony is deficient?

2. A companion device to the carbon dioxide monitor is the blood-monitoring pulse oximeter, which has become a mandatory device in hospital operating rooms. In 1984 no hospital had them; by 1990 all hospitals used oximeters in their operating rooms. The device beeps when a patient's blood oxygen drops due to breathing problems or overuse of anesthesia. That warning can give a vital three or four minute warning to physicians, allowing them to correct the problem before the patient suffers brain damage. These devices have so improved patient safety that malpractice insurers have lowered premiums for anesthesiologists. The Joint Commission requires hospitals to develop protocols for anesthesia care that mandate pulse oximetry equipment for measuring oxygen saturation. See Revisions to Anesthesia Care Standards Comprehensive Accreditation Manual for Hospitals Effective January 1, 2001 (Standards and Intents for Sedation and Anesthesia Care).

3. Joint Commission standards often provide the basis for jury instructions in hospital negligence cases. See for example Tavares v. Evergreen Hospital Medical Center, 2010 WL 1541475 (Wash.App.Div.1, Unpublished, 2010). The plaintiff had sought prenatal care, and was a high risk pregnancy, having had an emergency cesarean section with her first child. The couple debated the risks of a vaginal birth after cesarean delivery (VBAC) or another cesarean section. They wanted to try a VBAC, if possible, despite contrary medical advice. The plaintiff began to experience contractions, and went to the hospital. She was put on a fetal monitor, decelerations were noted, and

the baby was delivered by emergency cesarean section. The baby had significant brain damage including cerebral palsy. The parents sued for medical and corporate negligence. Claims against the doctors were settled, and the jury found Evergreen liable to the plaintiff.

The jury instructions were at issue. Instruction 14 was taken from a Joint Commission standard: "The hospital is required to provide an adequate number of staff members whose qualifications are consistent with job responsibilities." The court held, following *Pedroza v. Bryant,* [ ] "that because hospitals are members of national organizations and subject to accreditation, the JCAHO standards are particularly relevant to defining the proper standard of care."

4. A health care institution, whether hospital, nursing home, or clinic, is liable for negligence in maintaining its facilities; providing and maintaining medical equipment; hiring, supervising and retaining nurses and other staff; and failing to have in place procedures to protect patients. Basic negligence principles govern hospital liability for injuries caused by other sources than negligent acts of the medical staff. As *Washington* holds, hospitals are generally held to a national standard of care for hospitals in their treatment category. Reed v. Granbury Hospital Corporation, 117 S.W.3d 404 (2003). They must provide a safe environment for diagnosis, treatment, and recovery of patients. Bellamy v. Appellate Department, 50 Cal.App.4th 797, 57 Cal.Rptr.2d 894 (5 Dist.1996).

a. Hospitals must have minimum facility and support systems to treat the range of problems and side effects that accompany procedures they offer. In Hernandez v. Smith, 552 F.2d 142 (5th Cir.1977), for example, an obstetrical clinic that lacked surgical facilities for cesarean sections was found liable for " * * * the failure to provide proper and safe instrumentalities for the treatment of ailments it undertakes to treat * * *."

b. Staffing must be adequate. Staff shortages can be negligence. See Merritt v. Karcioglu, 668 So.2d 469 (La.App. 4th Cir.1996) (hospital ward understaffed in having only three critical care nurses for six patients). If, however, existing staff can be juggled to cover a difficult patient, short staffing is no defense. See Horton v. Niagara Falls Memorial Medical Center, 51 A.D.2d 152, 380 N.Y.S.2d 116 (1976).

c. Equipment must be adequate for the services offered, although it need not be the state of the art. See Emory University v. Porter, 103 Ga.App. 752, 120 S.E.2d 668, 670 (1961); Lauro v. Travelers Ins. Co., 261 So.2d 261 (La.App.1972). If a device such as an expensive CT scanner has come into common use, however, a smaller and less affluent hospital can argue that it should be judged by the standards of similar hospitals with similar resources. This variable standard, reflecting resource differences between hospitals, would then protect a hospital in a situation where its budget does not allow purchase of some expensive devices. If an institution lacks a piece of equipment that has come to be recognized as essential, particularly for diagnosis, it may have a duty to transfer the patient to an institution that has the equip-

ment. In Blake v. D.C. General Hospital (discussed in Maxwell Mehlman, Rationing Expensive Lifesaving Medical Treatments, 1985 Wisc.L.Rev. 239) the trial court allowed a case to go to the jury where the plaintiff's estate claimed that she died because of the hospital's lack of a CT scanner to diagnose her condition. The court found a duty to transfer in such circumstances.

d. A hospital and its contracting physicians may be liable for damages caused by inadequate or defective systems they develop and implement, particularly where emergency care is involved. On-call systems in smaller hospitals are a recurring issue in the caselaw. Delays in contacting physicians may be negligent, without the need for expert testimony. In Partin v. North Mississippi Medical Center, Inc., 929 So.2d 924 (Miss.Ct.App.2005), the plaintiff became septic while in the hospital recovering from surgery; the nurses failed to notify the on-call physician for more than twenty hours, and the patient died.

5. An institution's own internal rules and safety regulations for medical procedures must be followed, and a failure to follow them may be offered as evidence of a breach of a standard of care for the trier of fact to consider. They are material and relevant on the issue of quality of care, but are usually not sufficient by themselves to establish the degree of care owed. Jackson v. Oklahoma Memorial Hospital, 909 P.2d 765 (Okl.1995). In Williams v. St. Claire Medical Center, 657 S.W.2d 590 (Ky.App.1983), the court held that a hospital owes a duty to all patients, including the private patients of staff physicians, to enforce its published rules and regulations pertaining to patient care. The nurse anesthetist was required under hospital rules to work under the direct supervision of a certified registered nurse anesthetist, and he was alone when he administered the anesthesia to the plaintiff. Because of problems with the administration, the plaintiff went into a coma. The court stated:

> * * * [W]hile the patient must accept all the rules and regulations of the hospital, he should be able to expect that the hospital will follow its rules established for his care. Whether a patient enters a hospital through the emergency room or is admitted as a private patient by a staff physician, the patient is entering the hospital for only one reason * * * "Indeed, the sick leave their homes and enter hospitals because of the superior treatment there promised them."

See also Adams v. Family Planning Associates Medical Group, Inc., 315 Ill.App.3d 533, 248 Ill.Dec. 91, 733 N.E.2d 766 (2000) (internal policies and procedures of family planning clinic admissible as evidence of standard of care).

B. DUTIES TO TREAT PATIENTS

The relationship of the medical staff to the hospital insulates the hospital from liability, while giving physicians substantial autonomy in their treating decisions. What happens when the patient's insurance or other resources are exhausted but the staff physician believes that the

standard of care requires continued hospitalization? Must the hospital accede to the doctor's request?

MUSE v. CHARTER HOSPITAL OF WINSTON–SALEM, INC.

Court of Appeals of North Carolina, 1995.
117 N.C.App. 468, 452 S.E.2d 589.

LEWIS, JUDGE.

This appeal arises from a judgment in favor of plaintiffs in an action for the wrongful death of Delbert Joseph Muse, III (hereinafter "Joe"). Joe was the son of Delbert Joseph Muse, Jr. (hereinafter "Mr. Muse") and Jane K. Muse (hereinafter "Mrs. Muse"), plaintiffs. The jury found that defendant Charter Hospital of Winston–Salem, Inc. (hereinafter "Charter Hospital" or "the hospital") was negligent in that, inter alia, it had a policy or practice which required physicians to discharge patients when their insurance expired and that this policy interfered with the exercise of the medical judgment of Joe's treating physician, Dr. L. Jarrett Barnhill, Jr. The jury awarded plaintiffs compensatory damages of approximately $1,000,000. The jury found that Mr. and Mrs. Muse were contributorily negligent, but that Charter Hospital's conduct was willful or wanton, and awarded punitive damages of $2,000,000 against Charter Hospital. Further, the jury found that Charter Hospital was an instrumentality of defendant Charter Medical Corporation (hereinafter "Charter Medical") and awarded punitive damages of $4,000,000 against Charter Medical.

The facts on which this case arose may be summarized as follows. On 12 June 1986, Joe, who was sixteen years old at the time, was admitted to Charter Hospital for treatment related to his depression and suicidal thoughts. Joe's treatment team consisted of Dr. Barnhill, as treating physician, Fernando Garzon, as nursing therapist, and Betsey Willard, as social worker. During his hospitalization, Joe experienced auditory hallucinations, suicidal and homicidal thoughts, and major depression. Joe's insurance coverage was set to expire on 12 July 1986. As that date neared, Dr. Barnhill decided that a blood test was needed to determine the proper dosage of a drug he was administering to Joe. The blood test was scheduled for 13 July, the day after Joe's insurance was to expire. Dr. Barnhill requested that the hospital administrator allow Joe to stay at Charter Hospital two more days, until 14 July, with Mr. and Mrs. Muse signing a promissory note to pay for the two extra days. The test results did not come back from the lab until 15 July. Nevertheless, Joe was discharged on 14 July and was referred by Dr. Barnhill to the Guilford County Area Mental Health, Mental Retardation and Substance Abuse Authority (hereinafter "Mental Health Authority") for outpatient treatment. Plaintiffs' evidence tended to show that Joe's condition upon discharge was worse than when he entered the hospital. Defendants' evidence, however, tended to show that while his prognosis remained guard-

ed, Joe's condition at discharge was improved. Upon his discharge, Joe went on a one-week family vacation. On 22 July he began outpatient treatment at the Mental Health Authority, where he was seen by Dr. David Slonaker, a clinical psychologist. Two days later, Joe again met with Dr. Slonaker. Joe failed to show up at his 30 July appointment, and the next day he took a fatal overdose of Desipramine, one of his prescribed drugs.

On appeal, defendants present numerous assignments of error. We find merit in one of defendants' arguments.

II.

Defendants next argue that the trial court submitted the case to the jury on an erroneous theory of hospital liability that does not exist under the law of North Carolina. As to the theory in question, the trial court instructed: "[A] hospital is under a duty not to have policies or practices which operate in a way that interferes with the ability of a physician to exercise his medical judgment. A violation of this duty would be negligence." The jury found that there existed "a policy or practice which required physicians to discharge patients when their insurance benefits expire and which interfered with the exercise of Dr. Barnhill's medical judgment." Defendants contend that this theory of liability does not fall within any theories previously accepted by our courts.

* * *

Our Supreme Court has recognized that hospitals in this state owe a duty of care to their patients. Id.In Burns v. Forsyth County Hospital Authority, Inc. [ ] this Court held that a hospital has a duty to the patient to obey the instructions of a doctor, absent the instructions being obviously negligent or dangerous. Another recognized duty is the duty to make a reasonable effort to monitor and oversee the treatment prescribed and administered by doctors practicing at the hospital. [ ] In light of these holdings, it seems axiomatic that the hospital has the duty not to institute policies or practices which interfere with the doctor's medical judgment. We hold that pursuant to the reasonable person standard, Charter Hospital had a duty not to institute a policy or practice which required that patients be discharged when their insurance expired and which interfered with the medical judgment of Dr. Barnhill.

III.

Defendants next argue that even if the theory of negligence submitted to the jury was proper, the jury's finding that Charter Hospital had such a practice was not supported by sufficient evidence. * * * We conclude that in the case at hand, the evidence was sufficient to go to the jury.

Plaintiffs' evidence included the testimony of Charter Hospital employees and outside experts. Fernando Garzon, Joe's nursing therapist at Charter Hospital, testified that the hospital had a policy of discharging patients when their insurance expired. Specifically, when the issue of insurance came up in treatment team meetings, plans were made to discharge the patient. When Dr. Barnhill and the other psychiatrists and therapists spoke of insurance, they seemed to lack autonomy. For example, Garzon testified, they would state, "So and so is to be discharged. We must do this." Finally, Garzon testified that when he returned from a vacation, and Joe was no longer at the hospital, he asked several employees why Joe had been discharged and they all responded that he was discharged because his insurance had expired. Jane Sims, a former staff member at the hospital, testified that several employees expressed alarm about Joe's impending discharge, and that a therapist explained that Joe could no longer stay at the hospital because his insurance had expired. Sims also testified that Dr. Barnhill had misgivings about discharging Joe, and that Dr. Barnhill's frustration was apparent to everyone. One of plaintiffs' experts testified that based on a study regarding the length of patient stays at Charter Hospital, it was his opinion that patients were discharged based on insurance, regardless of their medical condition. Other experts testified that based on Joe's serious condition on the date of discharge, the expiration of insurance coverage must have caused Dr. Barnhill to discharge Joe. The experts further testified as to the relevant standard of care, and concluded that Charter Hospital's practices were below the standard of care and caused Joe's death. We hold that this evidence was sufficient to go to the jury.

Defendants further argue that the evidence was insufficient to support the jury's finding that Charter Hospital engaged in conduct that was willful or wanton. An act is willful when it is done purposely and deliberately in violation of the law, or when it is done knowingly and of set purpose, or when the mere will has free play, without yielding to reason. [ ] * * * We conclude that the jury could have reasonably found from the above-stated evidence that Charter Hospital acted knowingly and of set purpose, and with reckless indifference to the rights of others. Therefore, we hold that the finding of willful or wanton conduct on the part of Charter Hospital was supported by sufficient evidence.

* * *

For the reasons stated, we find no error in the judgment of the trial court, except for that part of the judgment awarding punitive damages, which is reversed and remanded for proceedings consistent with this opinion.

No error in part, reversed in part and remanded.

NOTES AND QUESTIONS

1. Should the *Muse* duty extend to all situations in which the physician and the hospital administration are in conflict? If the physician always prevails, then how does a hospital control its costs and its bad debts? Why does the court treat health care as special in this case? Surely a grocery store does not have to give us free groceries if we are short of cash as the checkout counter, nor does our landlord have to allow us to stay for free if we cannot cover our next month's rent. Is it simply the advantage of hindsight here that impels the court's imposition of such a duty on hospitals?

A provision in many hospital admissions forms states:

> Legal Relationship Between Hospital and Physicians. All physicians and surgeons furnishing services to the patient, including the radiologist, pathologist, anesthesiologist, and the like, are not agents, servants, or employees of the above-named hospital, but are independent contractors, and as such are the agents, servants, or employees of the patient. The patient is under the care and supervision of his attending physician and it is the responsibility of the hospital and its nursing staff to carry out the instructions of such physician.

Could the *Muse* case have been brought as a breach of contract case by the plaintiff as third party beneficiary under the contract? Reconsider *Wickline* and *Murray* in Chapter 5 in this context.

2. Consider the medical staff relationship under the bylaws. It is a shared power arrangement between the hospital and its medical staff, and the hospital has independent duties under Joint Commission accreditation and federal law to supervise quality within its walls. Insurance payment, whether private or governmental, will cover most hospital treatment. What is the hospital obligated to do in such situations? Offer free care? Or is this analogous to the duty of physicians to not abandon their patients? Does this case impose a corporate fiduciary duty on hospitals to treat high risk patients when their money runs out? Is it the equivalent of the EMTALA mandate that requires hospitals to treat all patients in their emergency rooms without regard to their ability to pay or their insurance status?

3. Does such a duty extend as well to managed care organizations, whose very design is premised on mechanisms for containing health care costs? What would happen to the underlying premises of cost control in managed care organizations if the *Muse* doctrine were held to apply?

C. CORPORATE NEGLIGENCE

The stretching of vicarious liability doctrine to sweep in doctors as conduits to hospital liability led inevitably to the imposition of corporate negligence liability on the hospital. Courts had often been willing to hold hospitals liable for institutional failures, such as not using modern technologies (see *Washington*, *infra*), but had not examined the broader range of functions that a hospital engaged in as part of managing the safety of

its patients. It wasn't until the *Darling* case was decided in 1965 that hospital liability began to expand to encompass the problem of physician errors and medical system failures, and the hospital's responsibility for such failures. The focus on the functions of a modern hospital corporation moved the law from discussions of ordinary institutional negligence to a broader focus on corporate duties to manage a complex institution safely.

1. The Elements of Corporate Negligence

The next step was to hold the hospital directly liable for the failure of administrators and staff to properly monitor and supervise the delivery of health care within the hospital.

DARLING V. CHARLESTON COMMUNITY MEMORIAL HOSPITAL

Supreme Court of Illinois, 1965.
33 Ill.2d 326, 211 N.E.2d 253.

This action was brought on behalf of Dorrence Darling II, a minor (hereafter plaintiff), by his father and next friend, to recover damages for allegedly negligent medical and hospital treatment which necessitated the amputation of his right leg below the knee. The action was commenced against the Charleston Community Memorial Hospital and Dr. John R. Alexander, but prior to trial the action was dismissed as to Dr. Alexander, pursuant to a covenant not to sue. The jury returned a verdict against the hospital in the sum of $150,000. This amount was reduced by $40,000, the amount of the settlement with the doctor. The judgment in favor of the plaintiff in the sum of $110,000 was affirmed on appeal by the Appellate Court for the Fourth District, which granted a certificate of importance. 50 Ill.App.2d 253, 200 N.E.2d 149.

On November 5, 1960, the plaintiff, who was 18 years old, broke his leg while playing in a college football game. He was taken to the emergency room at the defendant hospital where Dr. Alexander, who was on emergency call that day, treated him. Dr. Alexander, with the assistance of hospital personnel, applied traction and placed the leg in a plaster cast. A heat cradle was applied to dry the cast. Not long after the application of the cast plaintiff was in great pain and his toes, which protruded from the cast, became swollen and dark in color. They eventually became cold and insensitive. On the evening of November 6, Dr. Alexander "notched" the cast around the toes, and on the afternoon of the next day he cut the cast approximately three inches up from the foot. On November 8 he split the sides of the cast with a Stryker saw; in the course of cutting the cast the plaintiff's leg was cut on both sides. Blood and other seepage were observed by the nurses and others, and there was a stench in the room, which one witness said was the worst he had smelled since World War II. The plaintiff remained in Charleston Hospital until November 19, when

he was transferred to Barnes Hospital in St. Louis and placed under the care of Dr. Fred Reynolds, head of orthopedic surgery at Washington University School of Medicine and Barnes Hospital. Dr. Reynolds found that the fractured leg contained a considerable amount of dead tissue which in his opinion resulted from interference with the circulation of blood in the limb caused by swelling or hemorrhaging of the leg against the construction of the cast. Dr. Reynolds performed several operations in a futile attempt to save the leg but ultimately it had to be amputated eight inches below the knee.

The evidence before the jury is set forth at length in the opinion of the Appellate Court and need not be stated in detail here. The plaintiff contends that it established that the defendant was negligent in permitting Dr. Alexander to do orthopedic work of the kind required in this case, and not requiring him to review his operative procedures to bring them up to date; in failing, through its medical staff, to exercise adequate supervision over the case, especially since Dr. Alexander had been placed on emergency duty by the hospital, and in not requiring consultation, particularly after complications had developed. Plaintiff contends also that in a case which developed as this one did, it was the duty of the nurses to watch the protruding toes constantly for changes of color, temperature and movement, and to check circulation every ten to twenty minutes, whereas the proof showed that these things were done only a few times a day. Plaintiff argues that it was the duty of the hospital staff to see that these procedures were followed, and that either the nurses were derelict in failing to report developments in the case to the hospital administrator, he was derelict in bringing them to the attention of the medical staff, or the staff was negligent in failing to take action. Defendant is a licensed and accredited hospital, and the plaintiff contends that the licensing regulations, accreditation standards, and its own bylaws define the hospital's duty, and that an infraction of them imposes liability for the resulting injury.

* * *

The basic dispute, as posed by the parties, centers upon the duty that rested upon the defendant hospital. That dispute involves the effect to be given to evidence concerning the community standard of care and diligence, and also the effect to be given to hospital regulations adopted by the State Department of Public Health under the Hospital Licensing Act [ ], to the Standards for Hospital Accreditation of the American Hospital Association, and to the bylaws of the defendant.

As has been seen, the defendant argues in this court that its duty is to be determined by the care customarily offered by hospitals generally in its community. Strictly speaking, the question is not one of duty, for " * * * in negligence cases, the duty is always the same, to conform to the legal standard of reasonable conduct in the light of the apparent risk.

What the defendant must do, or must not do, is a question of the standard of conduct required to satisfy the duty." (Prosser on Torts, 3rd ed. at 331.) * * * Custom is relevant in determining the standard of care because it illustrates what is feasible, it suggests a body of knowledge of which the defendant should be aware, and it warns of the possibility of far-reaching consequences if a higher standard is required. [ ] But custom should never be conclusive.

In the present case the regulations, standards, and bylaws which the plaintiff introduced into evidence, performed much the same function as did evidence of custom. This evidence aided the jury in deciding what was feasible and what the defendant knew or should have known. It did not conclusively determine the standard of care and the jury was not instructed that it did.

* * * [ ] The Standards for Hospital Accreditation, the state licensing regulations and the defendant's bylaws demonstrate that the medical profession and other responsible authorities regard it as both desirable and feasible that a hospital assume certain responsibilities for the care of the patient.

* * * Therefore we need not analyze all of the issues submitted to the jury. Two of them were that the defendant had negligently: "5. Failed to have a sufficient number of trained nurses for bedside care of all patients at all times capable of recognizing the progressive gangrenous condition of the plaintiff's right leg, and of bringing the same to the attention of the hospital administration and to the medical staff so that adequate consultation could have been secured and such conditions rectified; * * * 7. Failed to require consultation with or examination by members of the hospital surgical staff skilled in such treatment; or to review the treatment rendered to the plaintiff and to require consultants to be called in as needed."

We believe that the jury verdict is supportable on either of these grounds. On the basis of the evidence before it the jury could reasonably have concluded that the nurses did not test for circulation in the leg as frequently as necessary, that skilled nurses would have promptly recognized the conditions that signalled a dangerous impairment of circulation in the plaintiff's leg, and would have known that the condition would become irreversible in a matter of hours. At that point it became the nurses' duty to inform the attending physician, and if he failed to act, to advise the hospital authorities so that appropriate action might be taken. As to consultation, there is no dispute that the hospital failed to review Dr. Alexander's work or require a consultation; the only issue is whether its failure to do so was negligence. On the evidence before it the jury could reasonably have found that it was.

[The remainder of the opinion, discussing expert testimony and damages, is omitted.]

NOTES AND QUESTIONS

1. Consider the issues submitted to the jury. It is alleged that both the nurses and the administrators were negligent in not taking steps to curtail Dr. Alexander's handling of the case. How can a nurse "blow the whistle" on a doctor without risking damage to her own career? See the section on labor law in health care institutions, chapter11, section III, *infra*. How can a nurse exercise medical judgment in violation of Medical Practice statutes?

Nurses have independent obligations to care for patients. In Brandon HMA, Inc. v. Bradshaw, 809 So.2d 611 (Miss.2001), the plaintiff sued the hospital, alleging that while she was being treated for bacterial pneumonia she was treated negligently by the nursing staff leading to her permanent disability from brain damage. The staff failed to monitor her, report vital information to her doctor, and allowed her condition to deteriorate to a critical state before providing urgently needed care and life support. One nurse failed to take her vital signs on several visits to her room.

Nurses, as *Darling* indicates, have obligations to advocate for patients when care is substandard in a hospital. In Rowe v. Sisters of Pallottine Missionary Society, 211 W.Va. 16, 560 S.E.2d 491 (2001), a 17 year old boy presented to the hospital emergency room after a motorcycle accident. He had severe pain in his left knee and numbness in his foot, and no pulse in his foot. He was discharged and told to make an appointment to see an orthopedist several days later and come back to the hospital if the pain got worse. He got worse that night and was admitted to another hospital. He ended up with substantial impairment of his leg. The court held that the nurses had breached the standard of care by not adequately advocating for his interests when he was discharged with unexplained and unaddressed symptoms.

2. *Darling* disclosed the prevailing attitude of hospital administrators toward affiliated doctors, reflecting the earlier concept of the doctor as independent contractor. The hospital administrator was subjected to a prolonged cross-examination by the plaintiff's attorney exploring his obligations to evaluate doctor training and conduct. The administrator testified that he did nothing to review Dr. Alexander's techniques, ability, or other competence. He stated that " * * * I never made any effort to see that Dr. Alexander, or any other physician admitted to practice more than thirty years ago, read them." Darling v. Charleston Community Memorial Hosp., 50 Ill.App.2d 253, 295, 200 N.E.2d 149, 171 (1964).

How can a hospital administrator devise procedures to trigger an alarm when a physician is incompetent? Must the administrator himself be an M.D.? Can you think of methods that would have avoided the *Darling* tragedy? Consider the ideas developed by Leape in Chapter 1. What systems might you implement to prevent such errors? Consider the discussion of the Joint Commission credentialing triggers discussed in part B *infra*.

3. Some states have adopted corporate negligence for institutional providers. Florida, for example, has incorporated "institutional liability" or "corporate negligence" in its regulation of hospitals. Hospitals and other pro-

viders will be liable for injuries caused by inadequacies in the internal programs that are mandated by the statute. West's Fla.Stat.Ann. § 768.60.

It became increasingly clear that hospitals were often responsible for errors, and not only their physicians. One study found that the proportion of errors with interactive or administrative causes in the hospital was as high as 25 percent. *See* Lori B. Andrews et al., *An Alternative Strategy for Studying Adverse Events in Medical Care*, 349 Lancet 309, 312 (1997).

THOMPSON V. NASON HOSP.

Supreme Court of Pennsylvania, 1991.
527 Pa. 330, 591 A.2d 703.

ZAPPALA, JUSTICE.

Allocatur was granted to examine the novel issue of whether a theory of corporate liability with respect to hospitals should be recognized in this Commonwealth. For the reasons set forth below, we adopt today the theory of corporate liability as it relates to hospitals. * * *

* * *

Considering this predicate to our analysis, we now turn to the record which contains the facts underlying this personal injury action. At approximately 7 a.m. on March 16, 1978, Appellee, Linda A. Thompson, was involved in an automobile accident with a school bus. Mrs. Thompson was transported by ambulance from the accident scene to Nason Hospital's emergency room where she was admitted with head and leg injuries. The hospital's emergency room personnel were advised by Appellee, Donald A. Thompson, that his wife was taking the drug Coumadin, that she had a permanent pacemaker, and that she took other heart medications.

Subsequent to Mrs. Thompson's admission to Nason Hospital, Dr. Edward D. Schultz, a general practitioner who enjoyed staff privileges at Nason Hospital, entered the hospital via the emergency room to make his rounds. Although Dr. Schultz was not assigned duty in the emergency room, an on-duty hospital nurse asked him to attend Mrs. Thompson due to a prior physician-patient relationship. Dr. Schultz examined Mrs. Thompson and diagnosed her as suffering from multiple injuries including extensive lacerations over her left eye and the back of her scalp, constricted pupils, enlarged heart with a Grade III micro-systolic murmur, a brain concussion and amnesia. X-rays that were taken revealed fractures of the right tibia and right heel.

Following Dr. Schultz's examination and diagnosis, Dr. Larry Jones, an ophthalmologist, sutured the lacerations over Mrs. Thompson's left eye. It was during that time that Dr. Schultz consulted with Dr. Rao con-

cerning orthopedic repairs. Dr. Rao advised conservative therapy until her critical medical condition improved.

Dr. Schultz knew Mrs. Thompson was suffering from rheumatic heart and mitral valve disease and was on anticoagulant therapy. Because he had no specific training in establishing dosages for such therapy, Dr. Schultz called Dr. Marvin H. Meisner, a cardiologist who was treating Mrs. Thompson with an anticoagulant therapy. Although Dr. Meisner was unavailable, Dr. Schultz did speak with Dr. Meisner's associate Dr. Steven P. Draskoczy.

Mrs. Thompson had remained in the emergency room during this time. Her condition, however, showed no sign of improvement. Due to both the multiple trauma received in the accident and her pre-existing heart disease, Dr. Schultz, as attending physician, admitted her to Nason Hospital's intensive care unit at 11:20 a.m.

The next morning at 8:30 a.m., Dr. Mark Paris, a general surgeon on staff at Nason Hospital, examined Mrs. Thompson. He found that she was unable to move her left foot and toes. It was also noted by Dr. Paris that the patient had a positive Babinski—a neurological sign of an intracerebral problem. Twelve hours later, Dr. Schultz examined Mrs. Thompson and found more bleeding in her eye. He also indicated in the progress notes that the problem with her left leg was that it was neurological.

On March 18, 1978, the third day of her hospitalization, Dr. Larry Jones, the ophthalmologist who treated her in the emergency room, examined her in the intensive care unit. He indicated in the progress notes an "increased hematuria secondary to anticoagulation. Right eye now involved". Dr. Schultz also examined Mrs. Thompson that day and noted the decreased movement of her left leg was neurologic. Dr. Paris's progress note that date approved the withholding of Coumadin and the continued use of Heparin.

The following day, Mrs. Thompson had complete paralysis of the left side. Upon examination by Dr. Schultz he questioned whether she needed to be under the care of a neurologist or needed to be watched there. At 10:30 a.m. that day, Dr. Schultz transferred her to the Hershey Medical Center because of her progressive neurological problem.

Linda Thompson underwent tests at the Hershey Medical Center. The results of the tests revealed that she had a large intracerebral hematoma in the right frontal temporal and parietal lobes of the brain. She was subsequently discharged on April 1, 1978, without regaining the motor function of her left side.

* * * The complaint alleged inter alia that Mrs. Thompson's injuries were the direct and proximate result of the negligence of Nason Hospital acting through its agents, servants and employees in failing to adequately

examine and treat her, in failing to follow its rules relative to consultations and in failing to monitor her conditions during treatment. * * *

* * *

The first issue Nason Hospital raised is whether the Superior Court erred in adopting a theory of corporate liability with respect to a hospital. This issue had not heretofore been determined by the Court. Nason Hospital contends that it had no duty to observe, supervise or control the actual treatment of Linda Thompson.

Hospitals in the past enjoyed absolute immunity from tort liability. [ ] The basis of that immunity was the perception that hospitals functioned as charitable organizations. [ ] However, hospitals have evolved into highly sophisticated corporations operating primarily on a fee-for-service basis. The corporate hospital of today has assumed the role of a comprehensive health center with responsibility for arranging and coordinating the total health care of its patients. As a result of this metamorphosis, hospital immunity was eliminated. [ ]

Not surprisingly, the by-product of eliminating hospital immunity has been the filing of malpractice actions against hospitals. Courts have recognized several bases on which hospitals may be subject to liability including respondeat superior, ostensible agency and corporate negligence. [ ]

The development of hospital liability in this Commonwealth mirrored that which occurred in other jurisdictions. * * * We now turn our attention to the theory of corporate liability with respect to the hospital, which was first recognized in this Commonwealth by the court below.

Corporate negligence is a doctrine under which the hospital is liable if it fails to uphold the proper standard of care owed the patient, which is to ensure the patient's safety and well-being while at the hospital. This theory of liability creates a nondelegable duty which the hospital owes directly to a patient. Therefore, an injured party does not have to rely on and establish the negligence of a third party.

The hospital's duties have been classified into four general areas: (1) a duty to use reasonable care in the maintenance of safe and adequate facilities and equipment—Candler General Hospital Inc. v. Purvis, 123 Ga.App. 334, 181 S.E.2d 77 (1971); (2) a duty to select and retain only competent physicians—Johnson v. Misericordia Community Hospital, 99 Wis.2d 708, 301 N.W.2d 156 (1981); (3) a duty to oversee all persons who practice medicine within its walls as to patient care—Darling v. Charleston Community Memorial Hospital, *supra*.; and (4) a duty to formulate, adopt and enforce adequate rules and policies to ensure quality care for the patients—Wood v. Samaritan Institution, 26 Cal.2d 847, 161 P.2d 556 (Cal. Ct. App.1945). [ ]

Other jurisdictions have embraced this doctrine of corporate negligence or corporate liability such as to warrant it being called an "emerging trend". [ ]

* * *

Today, we take a step beyond the hospital's duty of care delineated in Riddle in full recognition of the corporate hospital's role in the total health care of its patients. In so doing, we adopt as a theory of hospital liability the doctrine of corporate negligence or corporate liability under which the hospital is liable if it fails to uphold the proper standard of care owed its patient. In addition, we fully embrace the aforementioned four categories of the hospital's duties. It is important to note that for a hospital to be charged with negligence, it is necessary to show that the hospital had actual or constructive knowledge of the defect or procedures which created the harm. [ ] Furthermore, the hospital's negligence must have been a substantial factor in bringing about the harm to the injured party. [ ].

The final question Nason Hospital raises is did Superior Court err in finding that there was a material issue of fact with respect to the hospital's duty to monitor and review medical services provided within its facilities. Nason Hospital contends that during Linda Thompson's hospitalization, it did not become aware of any exceptional circumstance which would require or justify its intervention into her treatment. The Hospital Association of Pennsylvania, as amicus curiae, argues that it is neither realistic nor appropriate to expect the hospital to conduct daily review and supervision of the independent medical judgment of each member of the medical staff of which it may have actual or constructive knowledge.

Conversely, Appellees argue that Nason Hospital was negligent in failing to monitor the medical services provided Mrs. Thompson. Specifically, Appellees claim that the hospital ignored its Rules and Regulations governing Medical Staff by failing to ensure the patient received adequate medical attention through physician consultations. Appellees also contend that Nason Hospital's medical staff members and personnel treating Mrs. Thompson were aware of her deteriorating condition, brought about by being over anticoagulated, yet did nothing.

It is well established that a hospital staff member or employee has a duty to recognize and report abnormalities in the treatment and condition of its patients. [ ] If the attending physician fails to act after being informed of such abnormalities, it is then incumbent upon the hospital staff member or employee to so advise the hospital authorities so that appropriate action might be taken. [ ] When there is a failure to report changes in a patient's condition and/or to question a physician's order which is not in accord with standard medical practice and the patient is injured as a result, the hospital will be liable for such negligence. [ ]

A thorough review of the record of this case convinces us that there is a sufficient question of material fact presented as to whether Nason Hospital was negligent in supervising the quality of the medical care Mrs. Thompson received, such that the trial court could not have properly granted summary judgment on the issue of corporate liability.

The order of Superior Court is affirmed. Jurisdiction is relinquished.

NOTES AND QUESTIONS

1. What does *Thompson* add to *Darling*'s discussion of the scope of corporate negligence? As you think about the typical hospital's complexity in both its administrative and operational structure, where do you think liability should best be focused? On its physicians? On the hospital? Joint liability? Or something different?

Thompson combines duties that can be found in isolation in the caselaw of other jurisdictions. Consider the nature of these hospital duties: (1) a duty to use reasonable care in the maintenance of safe and adequate facilities and equipment; (2) a duty to select and retain only competent physicians; (3) a duty to oversee all persons who practice medicine within its walls as to patient care; and (4) a duty to formulate, adopt, and enforce adequate rules and policies to ensure quality care for the patients.

2. Duty 2, Selection and Retention of Competent Doctors, is the core obligation of hospitals, and in many jurisdictions, it defines corporate negligence. Probably the most important function of a hospital is to select high quality physicians for its medical staff. We will discuss this duty in the next section.

3. Duty 1, Maintenance of Safe Facilities and Equipment, is really an extension of common law obligations of all institutions that invite the public onto their property. It encompasses slip-and-fall cases and all forms of injury that patients and visitors might suffer while in the hospital.

4. Duty 3, Supervision of All Who Practice Medicine in the Hospital, encompasses staff physicians and all other health professionals, acknowledging that modern medicine is a "team" operation. Courts increasingly recognize the team nature of medical practice in hospitals, and liability follows from this recognition. In Hoffman v. East Jefferson General Hospital, 778 So.2d 33 (La. App. 5 Cir. 2000), the plaintiff underwent two surgical procedures. Plaintiff suffered severe burns on her buttocks during the operation as the result of the use of a speculum that had been sterilized and was too hot. The hospital would sterilize the instruments and provide the means for cool down. It was the responsibility of hospital employees to communicate the status of the equipment—whether it was sufficiently cooled down—to the doctor, but that the final decision as to when to use the equipment was the doctor's. The court found that "the use of an instrument before it is sufficiently cooled after sterilization is a breach of the standard of care both for hospital employees and the doctor performing the surgery."

Institutional complexity requires accountability—a person in charge—often the attending physician in situations where residents are part of the care. In Lownsbury v. VanBuren, 94 Ohio St.3d 231, 762 N.E.2d 354 (2002), the parents sued a teaching hospital's attending physician for the injury to their adopted daughter. The physician as supervising physician had a duty to be familiar with the patient's condition and to review a contract stress test by the end of his scheduled working day and formulate a plan of management.

5.Duty 4, To Formulate, Adopt and Enforce Adequate Rules and Policies to Ensure Quality Care for the Patients", moves well beyond monitoring staff, drawing our scrutiny to how the institution operates as a system, and allowing plaintiffs to search for negligence in the very design of the operating framework of the hospital.

The language of Continuous Quality Improvement and Total Quality Management, the Joint Commission rules for hospitals—all suggest that the good aspects of the industrial model are being applied to hospitals. The problem with health care delivery is not just that patient care is complicated; it is rather that institutional politics and the inertia that seizes hospitals as they struggle for revenue in tough health care markets makes change difficult. The malpractice cases are often striking for their description of the level of errors that providers have tolerated in poorly managed institutions. See generally Chapter 1 as to the causes of medical errors, *supra*.

6. Hospitals need strong policies to ensure coordination among providers as a patient undergoes complex procedures. In Jennison v. Providence St. Vincent Medical Center, 174 Or.App. 219, 25 P.3d 358 (C.A. Oregon 2001), the plaintiff sued the hospital and physicians after she suffered severe brain injury while recovering from surgery. The Court of Appeals held that evidence supported the claim that the hospital was negligent in failing to have policies and procedures controlling verification of placement and use of central venous lines in hospital's post-anesthesia care unit. The court wrote:

> The hospital had no policy or procedure regarding the followup on central lines placed in the OR when a patient is transferred to the PACU. The call from radiology could potentially go to one of five different people, depending on whom the radiologist decides to call. Furthermore, no written documentation was required once one of those people received the call from radiology, thus precluding other people from knowing whether the call was ever actually made. Hospital's policy and procedure required verification, but it did not control what happened thereafter.

7. Expert testimony is required to establish a corporate negligence claim, unless it involves simple issues such as structural defects within the common knowledge and experience of the jury. See generally Neff v. Johnson Memorial Hospital, 93 Conn.App. 534, 889 A.2d 921 (Conn.App. 2006) (noting the complexity of the staff credentialing process, and holding that plaintiff needed an expert to determine what the standard of care was for a hospital in allowing a physician with three malpractice cases in his history to be recredentialed).

2. Negligent Credentialing

CARTER v. HUCKS–FOLLISS

North Carolina Court of Appeals, 1998.
131 N.C.App. 145, 505 S.E.2d 177.

GREENE, JUDGE.

Tommy and Tracy Carter (collectively, Plaintiffs) appeal from the granting of Moore Regional Hospital's (Defendant) motion for summary judgment entered 26 June 1997.

On 20 August 1993, Dr. Anthony Hucks–Folliss (Dr. Hucks–Folliss) performed neck surgery on plaintiff Tommy Carter at Defendant. Dr. Hucks–Folliss is a neurosurgeon on the medical staff of Defendant. He first was granted surgical privileges by Defendant in 1975, and has been reviewed every two years hence to renew those privileges. Though he has been on Defendant's staff for over twenty years, Dr. Hucks–Folliss never has been certified by the American Board of Neurological Surgery. Presently, Dr. Hucks–Folliss is ineligible for board certification because he has taken and failed the certification examination on three different occasions.

The credentialing and re-credentialing of physicians at Defendant is designed to comply with standards promulgated by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). In 1992, the time when Dr. Hucks–Folliss was last re-credentialed by Defendant prior to the neck surgery performed on Tommy Carter, the JCAHO provided that board certification "is an excellent benchmark and is [to be] considered when delineating clinical privileges."

On the application filed by Dr. Hucks–Folliss, seeking to renew his surgical privileges with Defendant, he specifically stated, in response to a question on the application, that he was not board certified. Dr. James Barnes (Dr. Barnes), one of Plaintiffs' experts, presented an affidavit wherein he states that Defendant "does not appear [to have] ever considered the fact that Dr. Hucks–Folliss was not board certified, or that he had failed board exams three times," when renewing Dr. Hucks–Folliss's surgical privileges. Jean Hill (Ms. Hill), the manager of Medical Staff Services for Defendant, stated in her deposition that board certification was not an issue in the re-credentialing of active staff physicians. There is no dispute that Dr. Hucks–Folliss was on active staff in 1992. Additionally, this record does not reveal any further inquiry by Defendant into Dr. Hucks–Folliss's board certification status (beyond the question on the application).

In the complaint, it is alleged that Defendant was negligent: (1) in granting clinical privileges to Dr. Hucks–Folliss; (2) in failing to ascertain whether Dr. Hucks–Folliss was qualified to perform neurological surgery;

and (3) in failing to enforce the standards of the JCAHO. It is further alleged that as a proximate result of Defendant's negligence, Tommy Carter agreed to allow Dr. Hucks–Folliss to perform surgery on him in Defendant. As a consequence of that surgery, Tommy Carter sustained "serious, permanent and painful injuries to his person including quadraparesis, scarring and other disfigurement."

The issue is whether a genuine issue of fact is presented on this record as to the negligence of Defendant in re-credentialing Dr. Hucks–Folliss.

Hospitals owe a duty of care to its patients to ascertain that a physician is qualified to perform surgery before granting that physician the privilege of conducting surgery in that hospital.[ ] In determining whether a hospital, accredited by the JCAHO, has breached its duty of care in ascertaining the qualifications of the physician to practice in the hospital, it is appropriate to consider whether the hospital has complied with standards promulgated by the JCAHO. Failure to comply with these standards "is some evidence of negligence."[ ]

In this case, Defendant has agreed to be bound by the standards promulgated by JCAHO and those standards provided in part that board certification was a factor to be "considered" when determining hospital privileges. Defendant argues that the evidence reveals unequivocally that it "considered," in re-credentialing Dr. Hucks–Folliss, the fact that he was not board certified. It points to the application submitted by Dr. Hucks–Folliss, specifically stating that he was not board certified, to support this argument. We disagree. Although this evidence does reveal that Defendant was aware of Dr. Hucks–Folliss's lack of certification, it does not follow that his lack of certification was considered as a factor in the re-credentialing decision. In any event, there is evidence from Dr. Barnes and Ms. Hill that supports a finding that Defendant did not consider Dr. Hucks–Folliss's lack of certification, or his failure to pass the certification test on three occasions, in assessing his qualifications to practice medicine in the hospital. This evidence presents a genuine issue of material fact and thus precludes the issuance of a summary judgment.[ ]

We also reject the alternative argument of Defendant that summary judgment is proper because there is no evidence that any breach of duty (in failing to consider Dr. Hucks–Folliss's lack of board certification prior to re-credentialing) by it was a proximate cause of the injuries sustained by Tommy Carter. Genuine issues of material fact are raised on this point as well. [ ].

Reversed and remanded.

NOTES AND QUESTIONS

1. Does Dr. Hucks–Follis's lack of certification speak to his skill and qualifications? How should a doctor's experience be weighed against his testing abilities? The court considers Joint Commission (formerly JCAHO) standards as an important source of duties with regard to hospital credentialing, and failure to comply "some evidence of negligence." Would it be sufficient if the hospital had noted the deficiencies and made a finding that the doctor's experience and references were enough to outweigh any negative implications of lack of certification?

2. The core function of a hospital is to select high quality physicians for its medical staff. See generally Chapter 11. The hospital's governing board retains the ultimate responsibility for the quality of care provided, but their responsibility is normally delegated to the hospital staff, and discharged in practice by medical staff review committees. The organization and function of these committees in accredited hospitals are described in publications of the Joint Commission.

3. The requirement of staff self-governance under Joint Commission standards maintains and reinforces this physician authority within hospitals. Courts have found, however, that the chief executive officer of a hospital and the governing board have the "inherent authority to summarily suspend clinical privileges to prevent an imminent danger to patients". See Lo v. Provena Covenant Medical Center, 342 Ill.App.3d 975, 277 Ill.Dec. 521, 796 N.E.2d 607, 614 (4 Dist. 2003).

4. *Joint Commission Prospective Monitoring of Quality*. The Joint Commission issued new standards on medical staff governance in 2010 that prescribe the relationship between the medical staff, the medical staff's Executive Committee, and the hospital's Board. Joint Commission standards have intensified the institutional focus on prospective monitoring of physician quality. One of the Standards, for example, specifically provides that the hospital must establish a system for collecting, recording, and addressing individual reports of concerns about individual physicians. See Joint Commission, Focused Professional Practice Evaluation, October 13, 2008.

The Joint Commission now requires a period of focused review for all new privileges and all new privileges for existing practitioners, without any exemption for board certification, documented experience, or reputation. Professional practice evaluation includes several elements: periodic chart review; direct observation; monitoring of diagnostic and treatment techniques; and discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing, and administrative personnel.

The duration of the period of review however can be varied for different levels of documented training and experience, e.g. practitioners coming directly from an outside residency program; practitioners coming directly from the organization's residency program; practitioners coming with a documented record of performance of the privilege and its associated outcomes; and

practitioners coming with no record of performance of the privilege and its associated outcomes.

The standard requires the organized medical staff to develop criteria to be used for evaluating the performance of practitioners when issues affecting the provision of safe, high quality patient care are identified. Criteria for performance issues, according to the Joint Commission, might include several triggering events:

- small number of admissions or procedures over an extended period of time that raise the concern of continued competence
- a growing number of longer lengths of stay than other practitioners
- returns to surgery
- frequent or repeat readmission suggesting possibly poor or inadequate initial management/treatment
- patterns of unnecessary diagnostic testing/treatments
- failure to follow approved clinical practice guidelines—may or may not indicate care problems but why the variance
- frequent or repeat readmission suggesting possibly poor or inadequate initial management/treatment
- patterns of unnecessary diagnostic testing/treatments
- failure to follow approved clinical practice guidelines—may or may not indicate care problems but why the variance

5. *Medicare Conditions of Participation*. Federal law requires among other things that hospital bylaws reflect the hospital governing board's responsibility to ensure that ". . . the medical staff is accountable to the governing body for the quality of care provided to patients." 42 C.F.R. § 482.12(a)(5)(2001). The federal government is also involved in credentialing issues through the 2008 *Medicare Improvement for Providers and Patients Act*, which removed permanent deemed status from the Joint Commission for hospitals and required it to periodically reapply for deemed status. This mandate has allowed CMS to engage the Joint Commission on its standards for hospitals. 20 BNA Health Law Rptr. 886 (June 9, 2011). (See discussion of accreditation generally in Chapter 3).

6. Under the Health Care Quality Improvement Act of 1986 (HCQIA), hospitals must check a national database maintained under contract with the Department of Health and Human Services, before a new staff appointment is made. This National Practitioner Data Bank contains information on individual physicians who have been disciplined, had malpractice claims filed against them, or had privileges revoked or limited. If the hospital fails to check the registry, it is held constructively to have knowledge of any infor-

mation it might have gotten from the inquiry. See discussion of staff privileges in Chapter 11, *infra*.

The Data Bank has been criticized by the Government Accountability Office as having unreliable and incomplete data. See U.S. Government Accountability Office (GAO), National Practitioner Data Bank: Major Improvements are Needed to Enhance Data Bank's Reliability. Some health policy researchers have even suggested that the Data Bank should be abolished. See William M. Sage et al., Bridging the Relational–Regulatory Gap: A Pragmatic Information Policy for Patient Safety and Medical Malpractice, 59 Vand. L. Rev. 1263, 1307 (2006).

7. *Liability of Boards of Directors of Hospitals*. Most American hospitals are incorporated as non-profits under Section 501(c)(3) of the Internal Revenue Code. As such, the duties of non-profit boards of directors have been limited by comparison to for-profit corporations. Compliance programs in the nonprofit health care context are usually for the purpose of detecting and preventing fraud in accordance with federal and state anti-fraud laws.

States typically also mandate that the governing board is responsible for the competence of the medical staff. See for example Lo v. Provena Covenant Medical Center, 342 Ill.App.3d 975, 277 Ill.Dec. 521, 796 N.E.2d 607, 614 (4 Dist. 2003) (holding that the hospital has an "inherent right to summarily suspend the clinical privileges of a physician whose continued practice poses an immediate danger to patients").

Corporate negligence might apply to boards of trustees of hospitals under the right set of circumstances. See e.g. Zambino v. Hospital of the University of Pennsylvania, Slip Copy, 2006 WL 2788217 (E.D.Pa.2006). The court noted that Pennsylvania courts ". . . have extended the doctrine of corporate liability to other entities in limited circumstances, such as when the patient is constrained in his or her choice of medical care options by the entity sued, and the entity controls the patient's total health care." See Shannon v. McNulty, 718 A.2d 828 (Pa.Super.1998) (extending doctrine to an HMO that provided health care services similar to a hospital).

The corporate negligence argument is based on the duty of a Board of Directors of a non-profit hospital not only to detect and prevent fraud, but to detect and prevent patient injury. The traditional board fiduciary duties of care and obedience can arguably include responsibility of nonprofit hospital directors to ensure that the hospital promotes health. This new interpretation blends the oversight obligations stemming from the duty of care with the duty of obedience requiring obedience with the laws.

For a general discussion of the obligations of nonprofit Boards of Directors, see generally Chapter 12, Section IV, *supra*. See also Arianne N. Callender et al., Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors (The Office of Inspector General of the U.S. Department of Health and Human Services and The American Health Lawyers Association, 2007).

PROBLEM: CASCADING ERRORS

Carolyn Gadner was driving her car on the highway when another car driven by Bob Sneed passed her, sideswiped her, ran her off the road, and drove off. Gadner caught up with Sneed and forced him to stop. She got out of her vehicle and started to walk to his car when he drove away. While Gadner was walking back to her car, Charles Otis struck her with his vehicle. Gadner was transported to Bay Hospital, a small rural hospital, where Dr. Dick Samson, a second-year pediatric resident, was the attending emergency room physician. Upon arriving at Bay, Gadner's skin was cool and clammy and her blood pressure was 95/55, indicative of shock. Gadner received 200 ccs per hour of fluid and was x-rayed. She actively requested a transfer because of vaginal bleeding. Nurse Gilbert voiced her own concerns about the need for a transfer to the other nurses in the emergency room. Dr. Samson did not order one.

Bay is a rural hospital and is not equipped to handle multiple trauma patients like Gadner. Bay had no protocol or procedure for making transfers to larger hospitals. Bay breached its own credentialing procedures in hiring a physician who lacked the necessary training, expertise, or demonstrated competence to work the ER. Dr. Bay, the hospital's chief of staff, had screened Samson, who was not properly evaluated before he was hired. A second-year pediatric resident is not normally assigned to an ER setting, give his lack of experience.

The nurses failed to notice that Gadner was in shock and that this failure was substandard. After they initially noted that she arrived with cool and clammy skin and a blood pressure of 95/55, they did not advise Dr. Samson that the patient was likely in shock; they failed to place her on IV fluids, elevate her feet above her head, and give oxygen as needed. Dr. Samson ordered the administration of 500 cc's of fluid per hour, but Gadner received only about 200 cc's per hour because the IV infiltrated, delivering the fluid to the surrounding tissue instead of the vein. The nursing staff normally would discover infiltration and correct it. Scanty nurses' notes revealed that vital signs were not taken regularly, depriving Dr. Samson of critical and ongoing information about Gadner's condition. Nurse Gilbert administered Valium and morphine to Gadner, following Dr. Samson's orders, a mixture of drugs counter-indicated for a patient with symptoms of shock. Nurse Gilbert did not notice or protest.

Three hours after arriving at Bay, Gadner "coded" and Dr. Samson tried unsuccessfully to revive her. After she coded, Dr. Samson attempted to use the laryngoscope, following standard practice, but the one provided was broken. He then ordered epinephrine, but there was none in the ER. An autopsy was performed, and Gadner died of treatable shock according to the coroner.

Consider the various theories of liability available to the plaintiff. Then develop a plan to improve the hospital from a patient safety perspective so that this kind of disaster will not happen again.

3. Peer Review Immunity and Corporate Negligence

Credentialing decisions may be the central feature of corporate negligence claims, but such decisions are often the most difficult to prove. Virtually all American jurisdictions have peer review immunity statutes that limit access to hospital decisionmaking about physician problems that have been discovered.

LARSON v. WASEMILLER

Supreme Court of Minnesota, 2007.
738 N.W.2d 300.

Opinion

HANSON, JUSTICE.

Appellants Mary and Michael Larson commenced this medical malpractice claim against respondent Dr. James Wasemiller, Dr. Paul Wasemiller and the Dakota Clinic for negligence in connection with the performance of gastric bypass surgery on Mary Larson. The Larsons also joined respondent St. Francis Medical Center as a defendant, claiming, among other things, that St. Francis was negligent in granting surgery privileges to Dr. James Wasemiller. St. Francis then moved to dismiss for failure to state a claim. The district court denied the motion to dismiss, holding that Minnesota does recognize a claim for negligent credentialing, but certified two questions to the court of appeals. The court of appeals reversed the district court's denial of the motion to dismiss, holding that Minnesota does not recognize a common-law cause of action for negligent credentialing. [ ] We reverse and remand to the district court for further proceedings.

In April 2002, Dr. James Wasemiller, with the assistance of his brother, Dr. Paul Wasemiller, performed gastric bypass surgery on Mary Larson at St. Francis Medical Center in Breckenridge, Minnesota. Larson experienced complications following the surgery, and Dr. Paul Wasemiller performed a second surgery on April 12, 2002 to address the complications. On April 22, 2002, after being moved to a long-term care facility, Larson was transferred to MeritCare Hospital for emergency surgery. Larson remained hospitalized until June 28, 2002.

The Larsons claim that St. Francis was negligent in credentialing Dr. James P. Wasemiller. Credentialing decisions determine which physicians are granted hospital privileges and what specific procedures they can perform in the hospital. *See* Craig W. Dallon, Understanding Judicial Review of Hospitals' Physician Credentialing and Peer Review Decisions, 73 Temp. L.Rev. 597, 598 (2000). The granting of hospital privileges normally does not create an employment relationship with the hospital, but it allows physicians access to the hospital's facilities and imposes certain professional standards. [ ]. The decision to grant hospital privileges to a

physician is made by the hospital's governing body based on the recommendations of the credentials committee. A credentials committee is a type of peer review committee. Minnesota, like most other states, has a peer review statute that provides for the confidentiality of peer review proceedings and grants some immunity to those involved in the credentialing process. [ ].

The district court noted that the majority of courts in other jurisdictions have recognized a duty on the part of hospitals to exercise reasonable care in granting privileges to physicians to practice medicine at the hospital. The court also noted that the existence of such a duty is objectively reasonable and consistent with public policy. The court therefore held that Minnesota "will and does recognize, at common law, a professional tort against hospitals and review organizations for negligent credentialing/privileging."

After denying St. Francis' motion to dismiss, the district court certified the following two questions to the court of appeals:

A. Does the state of Minnesota recognize a common law cause of action of privileging of a physician against a hospital or other review organization?

B. Does Minn.Stat. §§ 145.63–145.64 grant immunity from or otherwise limit liability of a hospital or other review organization for a claim of negligent credentialing/privileging of a physician?

* * *

A. Does Minnesota's peer review statute create a cause of action for negligent credentialing?

[The court concludes that " * * * the tort of negligent credentialing is inherent in and the natural extension of well-established common law rights." It further noted that more than half of the state courts have adopted the tort, and it has support in Restatement (Second) Tort sections such as section 320 and 411.]

3. Would the tort of negligent credentialing conflict with Minnesota's peer review statute?

St. Francis argues that the fact that a majority of other jurisdictions have recognized a negligent-credentialing claim is not dispositive because such a claim would conflict with Minnesota's peer review statute. Minnesota's peer review statute contains both confidentiality and limited liability provisions. [ ].

The Confidentiality Provision

The confidentiality provision of the peer review statute provides in part that

> [D]ata and information acquired by a review organization, in the exercise of its duties and functions, or by an individual or other entity acting at the direction of a review organization, shall be held in confidence, shall not be disclosed to anyone except to the extent necessary to carry out one or more of the purposes of the review organization, and shall not be subject to subpoena or discovery. No person described in section 145.63 shall disclose what transpired at a meeting of a review organization except to the extent necessary to carry out one or more of the purposes of a review organization. The proceedings and records of a review organization shall not be subject to discovery or introduction into evidence in any civil action against a professional arising out of the matter or matters which are the subject of consideration by the review organization.

[ ]. Credentialing committees are "review organizations" under the statutory definition. [ ]. Any unauthorized disclosure of the above information is a misdemeanor.[ ].

St. Francis argues that the prohibition on disclosing what information a credentialing committee relied upon precludes a claim of negligent credentialing because the precise fact question to be tried in a negligent-credentialing case is whether the hospital was negligent in making the decision on the basis of what it *actually knew* at the time of the credentialing decision. It argues that the confidentiality provision therefore makes it impossible for a hospital to defend against such a claim.

St. Francis' interpretation of the common law claim is too narrow because negligence could be shown on the basis of what was actually known or what *should have been known* at the time of the credentialing decision. [ ]. And Minnesota's confidentiality provision recognizes this broader concept, and addresses the problems of proof, by providing that

> [i]nformation, documents or records otherwise available from original sources shall not be immune from discovery or use in any civil action merely because they were presented during proceedings of a review organization, nor shall any person who testified before a review organization or who is a member of it be prevented from testifying as to matters within the person's knowledge, but a witness cannot be asked about the witness' testimony before a review organization or opinions formed by the witness as a result of its hearings. [ ].

Thus, although section 145.64, subdivision 1 would prevent hospitals from disclosing the fact that certain information was considered by the credentials committee, it would not prevent hospitals from introducing the same information, as long as it could be obtained from original sources. **

* * *

Although the confidentiality provision of Minnesota's peer review statute may make the proof of a common law negligent-credentialing claim more complicated, we conclude that it does not preclude such a claim.

The Limited Liability Provision

Minn.Stat. § 145.63, subd. 1 (2006) provides some immunity from liability, both for individual credentials committee members and hospitals, for claims brought by either a physician or a patient. Section 145.63, subdivision 1 provides that

> No review organization and no person who is a member or employee, director, or officer of, who acts in an advisory capacity to, or who furnishes counsel or services to, a review organization shall be liable for damages or other relief in any action brought by a person or persons whose activities have been or are being scrutinized or reviewed by a review organization, by reason of the performance by the person of any duty, function, or activity of such review organization, unless the performance of such duty, function or activity was motivated by malice toward the person affected thereby. No review organization and no person shall be liable for damages or other relief in any action by reason of the performance of the review organization or person of any duty, function, or activity as a review organization or a member of a review committee or by reason of any recommendation or action of the review committee when the person acts in the reasonable belief that the action or recommendation is warranted by facts known to the person or the review organization after reasonable efforts to ascertain the facts upon which the review organization's action or recommendation is made.
>
> * * *

We conclude that the liability provisions of section 145.63 do not materially alter the common law standard of care and that, although the confidentiality provisions of section 145.64 present some obstacles in both proving and defending a claim of negligent credentialing, they do not preclude such a claim.

> 4. Do the policy considerations in favor of the tort of negligent credentialing outweigh any tension caused by conflict with the peer review statute?

The function of peer review is to provide critical analysis of the competence and performance of physicians and other health care providers in order to decrease incidents of malpractice and to improve quality of patient care. [ ] This court has held that the purpose of Minnesota's peer review statute is to promote the strong public interest in improving health care by granting certain protections to medical review organizations,[ ] and to encourage the medical profession to police its own activi-

ties with minimal judicial interference,[ ]. This court has also recognized that "the quality of patient care could be compromised if fellow professionals are reluctant to participate fully in peer review activities."[ ].

* * *

We recognize that a claim of negligent credentialing raises questions about the necessity of a bifurcated trial and the scope of the confidentiality and immunity provisions of the peer review statute. We likewise recognize that there is an issue about whether a patient must first prove negligence on the part of a physician before a hospital can be liable for negligently credentialing the physician. But, in part, these are questions of trial management that are best left to the trial judge. [ ] Further, they cannot be effectively addressed in the context of this Rule 12 motion.

We conclude that the policy considerations underlying the tort of negligent credentialing outweigh the policy considerations reflected in the peer review statute because the latter policy considerations are adequately addressed by the preclusion of access to the confidential peer review materials. We therefore hold that a claim of negligent credentialing does exist in Minnesota, and is not precluded by Minnesota's peer review statute. We reverse the answer of the court of appeals to the first certified question, answer that question in the affirmative, and remand to the district court for further proceedings consistent with this opinion.

Reversed and remanded.

[Justice Barry, concurring, raised several concerns about the efficacy of negligent credentialing litigation generally. First, physicians are reluctant to participate in peer review: they receive no compensation for their time, face the tension of evaluating their peers, risk reprisals through lost patient referrals, and may face litigation for their decisions.

Second, peer review immunity statutes attempt to deal with these concerns, but "[i]t is open for debate, however, whether these measures actually promote effective peer review." Judge Barry notes that only documents created by the peer review process are off limits but not incident reports and information from the original sources. Physicians will be unwilling to create records if litigants can ultimately discover them.

Third, the qualified immunity of the statue requires evidence of reasonable efforts to ascertain the facts, and this means that a negligent credentialing case will proceed to the summary judgment state, requiring discovery and expert testimony.

Judge Barry suggested that legislative and executive action is required to collect data on these issues and to provide a better solution to peer review costs and benefits.]

NOTES AND QUESTIONS

1. *Hospital Committee Proceedings*. Plaintiffs in malpractice actions frequently seek discovery of the proceedings of hospital quality assurance committees, as the problem above illustrates. If the suit is against the hospital on a theory of corporate liability (i.e., claiming that the hospital itself was negligent in appointing or failing to supervise a professional), evidence of committee proceedings may prove vital to establishing the hospital's liability.

These discovery requests are usually met with a claim that information generated within or by hospital committees is not discoverable. In Coburn v. Seda, 101 Wash.2d 270, 677 P.2d 173 (1984), the court considered the plaintiff's discovery requests for the records of the hospital quality review committees.

> * * * The discovery protection granted hospital quality review committee records, like work product immunity, prevents the opposing party from taking advantage of a hospital's careful self-assessment. The opposing party must utilize his or her own experts to evaluate the facts underlying the incident which is the subject of suit and also use them to determine whether the hospital's care comported with proper quality standards.
>
> The discovery prohibition, like an evidentiary privilege, also seeks to protect certain communications and encourage the quality review process. As the court stated in Bredice v. Doctors Hosp., Inc., 50 F.R.D. 249, 250 (D.D.C.1970), aff'd, 479 F.2d 920 (D.C.Cir.1973):
>
> Confidentiality is essential to effective functioning of these staff meetings; and these meetings are essential to the continued improvement in the care and treatment of patients. Candid and conscientious evaluation of clinical practices is a *sine qua non* of adequate hospital care * * *. Constructive professional criticism cannot occur in an atmosphere of apprehension that one doctor's suggestion will be used as a denunciation of a colleague's conduct in a malpractice suit.

2. A number of statutes immunizing committee proceedings from discovery do not explicitly render information from those committees privileged from admission into evidence if the plaintiff can obtain it otherwise. But would such information be otherwise admissible? Would it be hearsay? If so, would it be subject to the business records exception? See Fed.R.Evid. 803(6). Might committee records indicating that a hospital was concerned about the performance of a physician be admissible as an admission in a subsequent corporate negligence action against the hospital? See Fed.R.Evid. 801(d)(2)(D). Might a plaintiff's expert be permitted to testify on the basis of information gleaned from committee records, even though those records were themselves hearsay? See Fed.R.Evid. 703. In a suit brought by one particular patient, would committee records documenting errors made by a physician in the treatment of other patients be relevant? Might opinions concerning a physician's negligence found in committee records or reports invade the prov-

ince of the jury? See, addressing these questions, Robert F. Holbrook & Lee J. Dunn, Medical Malpractice Litigation: The Discoverability and Use of Hospitals' Quality Assurance Records, 16 Washburn L.J. 54, 68–70 (1976).

3. *Hospital Incident Reports.* When a plaintiff seeks discovery of incident reports rather than committee proceedings, policy considerations are somewhat different. Hospitals have greater incentives to investigate untoward events than they have to carry on continuing quality review, and are less dependent on voluntary participation. The incident report would usually be more directly relevant to a single claim for malpractice than would general committee investigations. Possibly for these reasons, immunity statutes that protect committee proceedings less often protect incident reports, and courts have been less willing to immunize incident reports from discovery. On the other hand, since incident reports are more directly related to litigation of specific mishaps, two privileges can be asserted to protect them that would seldom apply to committee proceedings: the work product immunity and attorney client privilege.

4. *Hospital Sentinel Event Investigations*. Root cause investigations in compliance with Joint Commission guidelines have been denied discovery and confidentiality protections. In Reyes v. Meadowlands Hospital Medical Center, 809 A.2d 875 (N.J.Super. 2001), the defendant hospital argued that its root cause analysis of a sentinel event under Joint Commission guidelines should be protected from discovery. The plaintiff alleged that Meadowlands Hospital deviated from accepted standards of care in failing to properly diagnose and treat decedent, Debbie Reyes. Ms. Reyes was admitted to Meadowlands Hospital on August 1, 1998, and in the course of an attempted laproscopic colosceptomy she went into cardiac arrest and died. The Hospital moved for a protective order to shield from discovery information gathered through a process of "self-critical analysis," a "voluntary" investigation regarding the circumstances of Ms. Reyes' unanticipated death that followed Joint Commission guidelines for a root cause analysis. The hospital described this process as "the creation of a blame-free, protective environment that encourages the systematic surfacing and reporting of serious adverse events" as part of claiming a discovery shield.

The Hospital offered a statement from the General Counsel for the Joint Commission and a "Sentinel Event Policy" statement outlining the protocol governing the investigation and subsequent remedial measures taken in response to the unanticipated death or serious injury of a patient. The court described the process: " * * * A critical element of the Policy centered on health care organizations engaging in root cause analyses of such events. The basis of a root cause analysis is an industrial engineering model, and involves a thorough systems analysis to determine what, if any, systems changes a [sic] organization could put in place to make an unwanted event less likely to occur in the future."

> A twelve step process is utilized to analyze the event and propose systemic changes to avoid recurrence. The list of potential Sentinel Events includes "unexpected iatrogenic injury (i.e., in the course of

> treatment) resulting or likely to result in death or major permanent loss of function (physical, psychological or reproductive)." Conspicuously missing from the policy statement, however, is any statement that participants enjoyed an expectation of confidentiality as to statements made during the process.

The court noted that parties may obtain discovery for any matter that is not privileged, relevant to the subject matter at issue; however, " * * *privileges, because they stifle the pursuit of the truth, are disfavored."

The court discussed New Jersey caselaw, which requires a "a showing of particularized need that outweighs the public interest in confidentiality of the investigative proceedings, taking into account (1) the extent to which the information may be available from other sources, (2) the degree of harm that the litigant will suffer from its unavailability, and (3) the possible prejudice to the agency's investigation."

The court was skeptical. It noted that the defendant's motion,

> * * *although couched in language promoting the advancement of medical knowledge and the improvement of medical services, also serves the litigation interests of the defendants by depriving plaintiff from reviewing what would otherwise be clearly discoverable materials. Nor is the medical profession unique in its self-ascribed role as promoters and guardians of the public's welfare. Other professions can make a similar claim, i.e., engineers, architects, scientists, ecologists, educators, even lawyers.

The court rejected the defendants' argument that production of these files would " * * * severely prejudice the ability of St. Clares Riverside and its doctors to evaluate and criticize medical procedures in accordance with the overall public policy for improving medical care." It continued:

> Implicit in such a finding is the assumption that without this cloak of confidentiality the medical professionals taking part in this "self-critical analysis" would not have fully and candidly expressed their points of view about a given case. There is not a scintilla of evidence before me to support such a wholesale indictment of the medical profession. In fact, the current state of the law in this area supports the opposite conclusion. *N.J.A.C.* 8:43G–27.5 mandates hospitals to conduct medical peer review programs. * * *
>
> The creation and maintenance of peer review quality assurance processes are a condition of licensure by the State Department of Health. [ ]. The Code makes no provision for the results of such a process to be privileged. Therefore, those participating do so without any expectation of confidentiality.

The court observed that the hospital's argument about the Sentinel Events " * * * reveals more a desire by the Hospital to control the dissemination of potentially embarrassing information rather than a genuine interest

in the enhancement of patient care. In short, these "Sentinel Events," on their face, go far beyond the professed "advancement of medical knowledge" justification argued by defendants, and wander freely in the world of public relations. The court then held that " * * * the Sentinel Event Policy invoked by defendant Meadowlands Hospital does not create a self-critical analysis privilege, insulating any and all discussions and statements made and conclusions reached by the participants therein and actions taken by the Hospital pursuant thereto not subject to the Civil Rules of Discovery."

5. Most states have statutes affording hospital quality assurance proceedings some degree of protection from discovery. Statutes protecting committee proceedings from discovery are often subject to exceptions, either explicitly or through judicial interpretation. One common exception affords discovery to physicians challenging the results of committee action against them. Thus a physician whose staff privileges were revoked may discover information from the credentialing committee, Schulz v. Superior Court, 66 Cal.App.3d 440, 446, 136 Cal.Rptr. 67, 70 (1977).

The work product immunity protects materials prepared in anticipation of litigation. See Federal Rules of Civil Procedure 56. Courts look to the nature and purpose of incident reports. If they are regularly prepared and distributed for future loss prevention, they are not considered to be documents prepared in anticipation of litigation so as to invoke application of the work product exception to discovery. See St. Louis Little Rock Hospital, Inc. v. Gaertner, 682 S.W.2d 146, 150–51 (Mo.App.1984).

This attorney-client privilege protects communications, even if the attorney is not yet representing a client, provided that the communication was made between the client as an insured to his liability insurer during the course of an existing insured-insurer relationship. To be privileged, a communication between a client and his attorney, or between an insured and his insurer, must be within the context of the attorney-client relationship, with a purpose of securing legal advice from the client's attorney. See The St. Luke Hospitals, Inc. v. Kopowski, 160 S.W.3d 771 (Kentucky 2005) (Two nurses communicated about the post-delivery care of an infant who died at the hospital to the officer in charge of risk management, who had conducted the interviews of the nurses at the direction of the hospital's attorney. The court held that the communications were protected by the privilege.)

PROBLEM: PROCTORING PEERS

You have been asked by Hilldale Adventist Hospital to advise it on the implications of its use of proctors for assessing candidates for medical staff privileges. The hospital has used Dr. Hook, a surgeon certified by the American Board of Orthopedic Surgery, as a proctor during two different operations on the plaintiff at two different hospitals during the process of evaluation of Dr. Frank DiBianco for staff privileges. Dr. Hook had been asked to observe ten surgeries by Dr. DiBianco and then file a report. He observed an operation on the plaintiff during one of these observations. Two months later, he was again asked to proctor Dr. DiBianco at another hospital, and he again

observed a procedure on the plaintiff. Prior to each procedure, Dr. Hook had reviewed the x-rays and discussed the operative plan, but he otherwise had taken no part in the care and treatment of the plaintiff. He did not participate in the operations, did not scrub in, and always observed from outside the "sterile field." He got no payment for his proctoring efforts, and he had never met the plaintiff nor had any other contact with her.

Can Hilldale be liable for its use of Dr. Hook as a proctor? Can Dr. Hook be directly liable for failing to stop negligent work by Dr. DiBianco?

What if the process by which a hospital evaluates the credentials of a physician for staff privileges fails?

KADLEC MEDICAL CENTER V. LAKEVIEW ANESTHESIA ASSOCIATES

Fifth Circuit Court of Appeals, 2008.
527 F.3d 412.

REAVLEY, CIRCUIT JUDGE:

Kadlec Medical Center and its insurer, Western Professional Insurance Company, filed this diversity action in Louisiana district court against Louisiana Anesthesia Associates (LAA), its shareholders, and Lakeview Regional Medical Center (Lakeview Medical). The LAA shareholders worked with Dr. Robert Berry-an anesthesiologist and former LAA shareholder-at Lakeview Medical, where the defendants discovered his on-duty use of narcotics. In referral letters written by the defendants and relied on by Kadlec, his future employer, the defendants did not disclose Dr. Berry's drug use.

While under the influence of Demerol at Kadlec, Dr. Berry's negligent performance led to the near-death of a patient, resulting in a lawsuit against Kadlec. Plaintiffs claim here that the defendants' misleading referral letters were a legal cause of plaintiffs' financial injury, i.e., having to pay over $8 million to defend and settle the lawsuit. The jury found in favor of the plaintiffs and judgment followed. We reverse the judgment against Lakeview Medical, vacate the remainder of the judgment, and remand.

I. Factual Background

Dr. Berry was a licensed anesthesiologist in Louisiana and practiced with Drs. William Preau, Mark Dennis, David Baldone, and Allan Parr at LAA. From November 2000 until his termination on March 13, 2001, Dr. Berry was a shareholder of LAA, the exclusive provider of anesthesia services to Lakeview Medical (a Louisiana hospital).

In November 2000, a small management team at Lakeview Medical investigated Dr. Berry after nurses expressed concern about his undocumented and suspicious withdrawals of Demerol. The investigative team found excessive Demerol withdrawals by Dr. Berry and a lack of documentation for the withdrawals.

Lakeview Medical CEO Max Lauderdale discussed the team's findings with Dr. Berry and Dr. Dennis. Dr. Dennis then discussed Dr. Berry's situation with his partners. They all agreed that Dr. Berry's use of Demerol had to be controlled and monitored. But Dr. Berry did not follow the agreement or account for his continued Demerol withdrawals. Three months later, Dr. Berry failed to answer a page while on-duty at Lakeview Medical. He was discovered in the call-room, asleep, groggy, and unfit to work. Personnel immediately called Dr. Dennis, who found Dr. Berry not communicating well and unable to work. Dr. Dennis had Dr. Berry taken away after Dr. Berry said that he had taken prescription medications.

Lauderdale, Lakeview Medical's CEO, decided that it was in the best interest of patient safety that Dr. Berry not practice at the hospital. Dr. Dennis and his three partners at LAA fired Dr. Berry and signed his termination letter on March 27, 2001, which explained that he was fired "for cause":

> [You have been fired for cause because] you have reported to work in an impaired physical, mental, and emotional state. Your impaired condition has prevented you from properly performing your duties and puts our patients at significant risk. . . . [P]lease consider your termination effective March 13, 2001.

At Lakeview Medical, Lauderdale ordered the Chief Nursing Officer to notify the administration if Dr. Berry returned.

Despite recognizing Dr. Berry's drug problem and the danger he posed to patients, neither Dr. Dennis nor Lauderdale reported Dr. Berry's impairment to the hospital's Medical Executive Committee, eventually noting only that Dr. Berry was "no longer employed by LAA." Neither one reported Dr. Berry's impairment to Lakeview Medical's Board of Trustees, and no one on behalf of Lakeview Medical reported Dr. Berry's impairment or discipline to the Louisiana Board of Medical Examiners or to the National Practitioner's Data Bank. In fact, at some point Lauderdale took the unusual step of locking away in his office all files, audits, plans, and notes concerning Dr. Berry and the investigation.

After leaving LAA and Lakeview Medical, Dr. Berry briefly obtained work as a *locum tenens* (traveling physician) at a hospital in Shreveport, Louisiana. In October 2001, he applied through Staff Care, a leading *locum tenens* staffing firm, for *locum tenens* privileges at Kadlec Medical Center in Washington State. After receiving his application, Kadlec began its

credentialing process. Kadlec examined a variety of materials, including referral letters from LAA and Lakeview Medical.

LAA's Dr. Preau and Dr. Dennis, two months after firing Dr. Berry for his on-the-job drug use, submitted referral letters for Dr. Berry to Staff Care, with the intention that they be provided to future employers. The letter from Dr. Dennis stated that he had worked with Dr. Berry for four years, that he was an excellent clinician, and that he would be an asset to any anesthesia service. Dr. Preau's letter said that he worked with Berry at Lakeview Medical and that he recommended him highly as an anesthesiologist. Dr. Preau's and Dr. Dennis's letters were submitted on June 3, 2001, only sixty-eight days after they fired him for using narcotics while on-duty and stating in his termination letter that Dr. Berry's behavior put "patients at significant risk."

On October 17, 2001, Kadlec sent Lakeview Medical a request for credentialing information about Berry. The request included a detailed confidential questionnaire, a delineation of privileges, and a signed consent for release of information. The interrogatories on the questionnaire asked whether "[Dr. Berry] has been subject to any disciplinary action," if "[Dr. Berry has] the ability (health status) to perform the privileges requested," whether "[Dr. Berry has] shown any signs of behavior/personality problems or impairments," and whether Dr. Berry has satisfactory "judgement."

Nine days later, Lakeview Medical responded to the requests for credentialing information about fourteen different physicians. In thirteen cases, it responded fully and completely to the request, filling out forms with all the information asked for by the requesting health care provider. The fourteenth request, from Kadlec concerning Berry, was handled differently. Instead of completing the multi-part forms, Lakeview Medical staff drafted a short letter. In its entirety, it read:

This letter is written in response to your inquiry regarding [Dr. Berry]. Due to the large volume of inquiries received in this office, the following information is provided.

Our records indicate that Dr. Robert L. Berry was on the Active Medical Staff of Lakeview Regional Medical Center in the field of Anesthesiology from March 04, 1997 through September 04, 2001.

If I can be of further assistance, you may contact me at (504) 867–4076.

The letter did not disclose LAA's termination of Dr. Berry; his on-duty drug use; the investigation into Dr. Berry's undocumented and suspicious withdrawals of Demerol that "violated the standard of care"; or any other negative information. The employee who drafted the letter said at trial that she just followed a form letter, which is one of many that Lakeview Medical used.

Kadlec then credentialed Dr. Berry, and he began working there. After working at Kadlec without incident for a number of months, he moved temporarily to Montana where he worked at Benefis Hospital. During his stay in Montana, he was in a car accident and suffered a back injury. Kadlec's head of anesthesiology and the credentialing department all knew of Dr. Berry's accident and back injury, but they did not investigate whether it would impair his work.

After Dr. Berry returned to Kadlec, some nurses thought that he appeared sick and exhibited mood swings. One nurse thought that Dr. Berry's entire demeanor had changed and that he should be watched closely. In mid-September 2002, Dr. Berry gave a patient too much morphine during surgery, and she had to be revived using Narcan. The neurosurgeon was irate about the incident.

On November 12, 2002, Dr. Berry was assigned to the operating room beginning at 6:30 a.m. He worked with three different surgeons and multiple nurses well into the afternoon. According to one nurse, Dr. Berry was "screwing up all day" and several of his patients suffered adverse affects from not being properly anesthetized. He had a hacking cough and multiple nurses thought he looked sick. During one procedure, he apparently almost passed out.

Kimberley Jones was Dr. Berry's fifth patient that morning. She was in for what should have been a routine, fifteen minute tubal ligation. When they moved her into the recovery room, one nurse noticed that her fingernails were blue, and she was not breathing. Dr. Berry failed to resuscitate her, and she is now in a permanent vegetative state.

Dr. Berry's nurse went directly to her supervisor the next morning and expressed concern that Dr. Berry had a narcotics problem. Dr. Berry later admitted to Kadlec staff that he had been diverting and using Demerol since his June car accident in Montana and that he had become addicted to Demerol. Dr. Berry wrote a confession, and he immediately admitted himself into a drug rehabilitation program.

Jones's family sued Dr. Berry and Kadlec in Washington. Dr. Berry's insurer settled the claim against him. After the Washington court ruled that Kadlec would be responsible for Dr. Berry's conduct under *respondeat superior,* Western, Kadlec's insurer, settled the claim against Kadlec.

II. Procedural History

Kadlec and Western filed this suit in Louisiana district court against LAA, Dr. Dennis, Dr. Preau, Dr. Baldone, Dr. Parr, and Lakeview Medical, asserting Louisiana state law claims for intentional misrepresentation, negligent misrepresentation, strict responsibility misrepresentation, and general negligence. Plaintiffs alleged that defendants' tortious activity led to Kadlec's hiring of Dr. Berry and the resulting millions of dollars

it had to expend settling the Jones lawsuit. Plaintiffs' claim against LAA for negligence, based on a negligent monitoring and investigation theory, was dismissed before trial.

Plaintiffs' surviving claims for intentional and negligent misrepresentation arise out of the alleged misrepresentations in, and omissions from, the defendants' referral letters for Dr. Berry. These claims were tried to a jury, which returned a verdict in favor of the plaintiffs on both claims. The jury awarded plaintiffs $8.24 million, which is approximately equivalent to the amount Western spent settling the Jones lawsuit ($7.5 million) plus the amount it spent on attorneys fees, costs, and expenses (approximately $744,000) associated with the Jones lawsuit. The jury also found Kadlec and Dr. Berry negligent. The jury apportioned fault as follows: Dr. Dennis 20%; Dr. Preau 5%; Lakeview Medical 25%; Kadlec 17%; and Dr. Berry 33%. The judgments against Dr. Dennis and Dr. Preau were *in solido* with LAA. Because defendants were found liable for intentional misrepresentation, plaintiffs' recovery was not reduced by the percentage of fault ascribed to Kadlec. But the amount was reduced to $5.52 million to account for Dr. Berry's 33% of the fault. The district court entered judgment against Lakeview Medical and LAA.

III. Discussion

A. The Intentional and Negligent Misrepresentation Claims

The plaintiffs allege that the defendants committed two torts: intentional misrepresentation and negligent misrepresentation. The elements of a claim for *intentional* misrepresentation in Louisiana are: (1) a misrepresentation of a material fact; (2) made with intent to deceive; and (3) causing justifiable reliance with resultant injury. To establish a claim for intentional misrepresentation when it is by silence or inaction, plaintiffs also must show that the defendant owed a duty to the plaintiff to disclose the information. To make out a *negligent* misrepresentation claim in Louisiana: (1) there must be a legal duty on the part of the defendant to supply correct information; (2) there must be a breach of that duty, which can occur by omission as well as by affirmative misrepresentation; and (3) the breach must have caused damages to the plaintiff based on the plaintiff's reasonable reliance on the misrepresentation.

The defendants argue that any representations in, or omissions from, the referral letters cannot establish liability. We begin our analysis below by holding that after choosing to write referral letters, the defendants assumed a duty not to make affirmative misrepresentations in the letters. We next analyze whether the letters were misleading, and we conclude that the LAA defendants' letters were misleading, but the letter from Lakeview Medical was not. We also examine whether the defendants had an affirmative duty to disclose negative information about Dr. Berry in their referral letters, and we conclude that there was not an affirmative duty to disclose. Based on these holdings, Lakeview Medical did not

breach any duty owed to Kadlec, and therefore the judgment against it is reversed. Finally, we examine other challenges to the LAA defendants' liability, and we conclude that they are without merit.

1. The Affirmative Misrepresentations

The defendants owed a duty to Kadlec to avoid affirmative misrepresentations in the referral letters. In Louisiana, "[a]lthough a party may keep absolute silence and violate no rule of law or equity, . . . if he volunteers to speak and to convey information which may influence the conduct of the other party, he is bound to [disclose] the whole truth." In negligent misrepresentation cases, Louisiana courts have held that even when there is no initial duty to disclose information, "once [a party] volunteer[s] information, it assume[s] a duty to insure that the information volunteered [is] correct.".

Consistent with these cases, the defendants had a legal duty not to make affirmative misrepresentations in their referral letters. A party does not incur liability every time it casually makes an incorrect statement. But if an employer makes a misleading statement in a referral letter about the performance of its former employee, the former employer may be liable for its statements if the facts and circumstances warrant. Here, defendants were recommending an anesthesiologist, who held the lives of patients in his hands every day. Policy considerations dictate that the defendants had a duty to avoid misrepresentations in their referral letters if they misled plaintiffs into thinking that Dr. Berry was an "excellent" anesthesiologist, when they had information that he was a drug addict. Indeed, if defendants' statements created a misapprehension about Dr. Berry's suitability to work as an anesthesiologist, then by "volunteer[ing] to speak and to convey information which . . . influence[d] the conduct of [Kadlec], [they were] bound to [disclose] the whole truth." In other words, if they created a misapprehension about Dr. Berry due to their own statements, they incurred a duty to disclose information about his drug use and for-cause firing to complete the whole picture.

We now review whether there is evidence that the defendants' letters were misleading. We start with the LAA defendants. The letter from Dr. Preau stated that Dr. Berry was an "excellent anesthesiologist" and that he "recommend[ed] him highly." Dr. Dennis's letter said that Dr. Berry was "an excellent physician" who "he is sure will be an asset to [his future employer's] anesthesia service." These letters are false on their face and materially misleading. Notably, these letters came only sixty-eight days after Drs. Dennis and Preau, on behalf of LAA, signed a letter terminating Dr. Berry for using narcotics while on-duty and stating that Dr. Berry's behavior put "patients at significant risk." Furthermore, because of the misleading statements in the letters, Dr. Dennis and Dr. Preau incurred a duty to cure these misleading statements by disclosing to Kadlec that Dr. Berry had been fired for on-the-job drug use.

The question as to whether Lakeview Medical's letter was misleading is more difficult. The letter does not comment on Dr. Berry's proficiency as an anesthesiologist, and it does not recommend him to Kadlec. Kadlec says that the letter is misleading because Lakeview Medical stated that it could not reply to Kadlec's detailed inquiry in full "[d]ue to the large volume of inquiries received." But whatever the real reason that Lakeview Medical did not respond in full to Kadlec's inquiry, Kadlec did not present evidence that this could have affirmatively misled it into thinking that Dr. Berry had an uncheckered history at Lakeview Medical.

Kadlec also says that the letter was misleading because it erroneously reported that Dr. Berry was on Lakeview Medical's active medical staff until September 4, 2001. Kadlec presented testimony that had it known that Dr. Berry never returned to Lakeview Medical after March 13, 2001, it would have been suspicious about the apparently large gap in his employment. While it is true that Dr. Berry did not return to Lakeview Medical after March 13, this did not terminate his privileges at the hospital, or mean that he was not on "active medical staff." In fact, it appears that Dr. Berry submitted a formal resignation letter on October 1, 2001, weeks *after* September 4. Therefore, while the September 4 date does not accurately reflect when Dr. Berry was no longer on Lakeview Medical's active medical staff, it did not mislead Kadlec into thinking that he had less of a gap in employment than he actually had.

In sum, we hold that the letters from the LAA defendants were affirmatively misleading, but the letter from Lakeview Medical was not. Therefore, Lakeview Medical cannot be held liable based on its alleged affirmative misrepresentations. It can only be liable if it had an affirmative duty to disclose information about Dr. Berry. We now examine the theory that, even assuming that there were no misleading statements in the referral letters, the defendants had an affirmative duty to disclose. We discuss this theory with regard to both defendants for reasons that will be clear by the end of the opinion.

2. The Duty to Disclose

In Louisiana, a duty to disclose does not exist absent special circumstances, such as a fiduciary or confidential relationship between the parties, which, under the circumstances, justifies the imposition of the duty. Louisiana cases suggest that before a duty to disclose is imposed the defendant must have had a pecuniary interest in the transaction. In Louisiana, the existence of a duty is a question of law, and we review the duty issue here *de novo*.

* * *

Despite these compelling policy arguments, we do not predict that courts in Louisiana-absent misleading statements such as those made by the LAA defendants-would impose an affirmative duty to disclose. The de-

fendants did not have a fiduciary or contractual duty to disclose what it knew to Kadlec. And although the defendants might have had an ethical obligation to disclose their knowledge of Dr. Berry's drug problems, they were also rightly concerned about a possible defamation claim if they communicated negative information about Dr. Berry. As a general policy matter, even if an employer believes that its disclosure is protected because of the truth of the matter communicated, it would be burdensome to impose a duty on employers, upon receipt of a employment referral request, to investigate whether the negative information it has about an employee fits within the courts' description of *which* negative information must be disclosed to the future employer. Finally, concerns about protecting employee privacy weigh in favor of not mandating a potentially broad duty to disclose.

The Louisiana court in *Louviere* recognized that no court in Louisiana has imposed on an employer a duty to disclose information about a former employee to a future employer. [The court examined caselaw outside Louisiana, concluding that mere mondisclosure was never sufficient.] * * * These cases reinforce our conclusion that the defendants had a duty to avoid misleading statements in their referral letters, but they do not support plaintiffs' duty to disclose theory. * * *

3. Legal Cause

[LAA argued that legal causation could not be proven, on the grounds that "Kadlec's and Dr. Berry's intervening negligence precludes concluding that it is a legal cause of plaintiffs' injuries." The court found that "[t]he harm to Jones and the harm to plaintiffs that resulted from the LAA defendants' breaches are "easily associated" with Kadlec's liability. In fact, harm stemming from Dr. Berry's use of narcotic drugs while on-duty is the type of harm we would expect."

The Court then rejected LAA's argument that they should be absolved because of the superseding negligence of Kadlec and Berry. "Dr. Berry's hiring and his subsequent negligent use of narcotics while on-duty was foreseeable and "easily associated" with the LAA defendants' actions. He had used narcotics while on-duty in the past, and the LAA defendants could foresee that he would do so again if they misled a future employer about his drug problem." The court noted that while Kadlec had warning signs of Dr. Berry's erratic behavior, LAA had ". . . negligently *and intentionally* misled Kadlec about Dr. Berry's drug addiction. By intentionally covering up Dr. Berry's drug addiction in communications with a future employer, they should have foreseen that the future employer might miss the warning signs of Dr. Berry's addiction. This was within the scope of the risk they took."

The court concluded: "Indeed, both plaintiffs' and defendants' witnesses agreed at trial that narcotics addiction is a disease, that addicts try to hide their disease from their co-workers, and that particularly in the case

of narcotics-addicted anesthesiologists, for whom livelihood and drug supply are in the same place, colleagues may be the last to know about their addiction and impairment. This is not a case where a future tortious act is so unforeseeable that it should relieve the earlier tortfeasor of liability. In fact, this case illustrates why the comparative fault system was developed-so, as here, multiple actors can share fault for an injury based on their respective degrees of responsibility."]

* * *

D. Negligent Monitoring and Investigation

[The Court upheld the district court's holding that any duties under the HCQIA and Louisiana regulations do not reach these plaintiffs.]

E. Summary and Remand Instructions

The district court properly instructed the jury to find for the plaintiffs on their intentional and negligent misrepresentation claims if the jury concluded that the defendants' letters to Kadlec were intentionally and negligently misleading in a manner that caused injury to the plaintiffs. * * * The letters from Dr. Dennis and Dr. Preau were false on their face and patently misleading. There is no question about the purpose or effect of the letters. Because no reasonable juror could find otherwise, we uphold the finding of liability against Dr. Dennis and Dr. Preau. But because Lakeview Medical's letter was not materially misleading, and because the hospital did not have a legal duty to disclose its investigation of Dr. Berry and its knowledge of his drug problems, the judgment against Lakeview Medical must be reversed.

* * *

The judgment of the district court is REVERSED in part, VACATED in part, and REMANDED for proceedings consistent with this opinion.

NOTES AND QUESTIONS

1. The Fifth Circuit treated the case as just another employment case, applying a simple "materially misleading" test to the letter sent by Lakeview Medical, and finding it did not meet the test. As to a duty to disclose, the court found that ". . . . [t]he defendants did not have a fiduciary or contractual duty to disclose what it knew to Kadlec."

Why didn't the court consider the special fiduciary nature of health care, and the harm that a substance-abusing anesthesiologist can cause his patients? Can you make a strong argument for a special rule for a wide range of severe health care risks that transcend normal employment risks?

For a criticism of the case, see Sallie Thieme Sanford, Candor After Kadlec: Why, Despite the Firth Circuit's Decision, Hospitals Should Anticipate an Expanded Obligation to Disclose Risky Physician Behavior, 1 Drexel L. Rev. 383(2009).

2. In Douglass v. Salem Community Hospital, 153 Ohio App.3d 350, 794 N.E.2d 107 (2003), the hospital hired Wagner, a pedophile, as the assistant director of social services. It appears that in 1987, the police informed Western Reserve, his earlier hospital employer, that Wagner had been accused of exposing himself and molesting children and those accusations were being investigated at that time. Wagner resigned his employment on the condition that Western Reserve would state to those conducting reference checks in the future that he had voluntarily resigned. He then later resigned from Salem Hospital. A boy who had received counseling was invited to spend the weekend with Wagner, and his mother checked with an employee of Salem whom she knew, Williams; Williams told her that Wagner "would be good". Wagner sexually assaulted the boy and his cousin at his house over the weekend.

The court accepted the plaintiff's argument that Restatement (Second) of Torts (1965), § 323, negligent performance of an undertaking to render service, would apply in this situation of a failure to warn:

> One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of the other's person or things, is subject to liability to the other for physical harm resulting from his failure to exercise reasonable care to perform his undertaking, if * * * (b) the harm is suffered because of the other's reliance upon the undertaking.

The theory of recovery under § 323(b) is that "when one undertakes a duty voluntarily, and another reasonably relies on that undertaking, the volunteer is required to exercise ordinary care in completing the duty." [ ] In other words, "[a] voluntary act, gratuitously undertaken, must be * * * performed with the exercise of due care under the circumstances." [ ] This theory of negligence does not require proof of a special relationship between the plaintiff and the defendant, or proof of somewhat overwhelming circumstances. This type of negligence follows the general rules for finding negligence, with the addition of one extra element of proof, that of reasonable reliance by the plaintiff on the actions of the defendant.

Why were the various institutions so hypercautious, when the harm threatened was criminal in nature? Is this level of defensiveness something the law should tolerate?

3. Can you make an argument that a hospital should be responsible, under some circumstances, for the negligent acts of physicians in their private practice, so long as they have staff privileges? What if the hospital is on notice of a long history of malpractice claims against one of its staff, resulting from negligence in that physician's private practice? If the physician has performed adequately while treating patients within the hospital, should the hospital have any further responsibility?

Consider the case of Copithorne v. Framingham Union Hospital, 401 Mass. 860, 520 N.E.2d 139 (1988). The plaintiff, Copithorne, was a technologist at Framingham Union Hospital who was drugged and sexually assaulted

by a physician with staff privileges at the hospital. The Massachusetts Supreme Judicial Court imposed liability on the hospital. Helfant was a practicing neurosurgeon and a visiting staff member of the hospital, having been reappointed for seventeen years to the medical staff. The plaintiff Copithorne was a hospital employee. In the course of her employment, she injured her back, and, aware of Helfant's reputation within the hospital as a good neurosurgeon and a specialist in back injuries, she sought his professional assistance. In the course of treating her, Helfant made a house call to Copithorne's apartment, where he committed the drugging and rape for which he was convicted and which caused the injuries for which Copithorne sought compensation. The hospital had actual notice, and " * * * owed a duty of care to Copithorne, as an employee who, in deciding to enter a doctor-patient relationship with Helfant, reasonably relied on Helfant's good standing and reputation within the hospital community, and that the hospital violated this duty by failing to take sufficient action in response to previous allegations of Helfant's wrongdoing."

IV. LIABILITY AND THE AFFORDABLE CARE ACT

The rules governing hospital liability are largely based on the role of physicians and physician groups as independent contractors, and the hospital medical staff as an independent decision making body. The previous material has indicated that the courts have been increasingly willing to reject agency defenses for independent contractors in the health care setting. The ACA has no provisions that directly address agency relationships or corporate negligence, nor does it explicitly alter the existing common law rules relating to vicarious liability and independent contractors. What the ACA does do, however, is create strong pressures—through centers, demonstration projects, and Medicare reimbursement incentives—for providers to integrate and coordinate their delivery of health care for Medicare recipients. (See Chapters 10 and 11 for further discussion of some of these approaches.)

A. ACA COORDINATION REFORMS

The ACA offers coordination models to reduce fee-for-service medicine and decrease fragmentation in the U.S. health care system. Some of these are listed below.

1. *Centers.* Centers can fund research, disseminate findings, and create a powerful force for the diffusion of effective models. A *Center for Medicare and Medicaid Innovation* (CMI) will research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in each program. Centers such as the CMI can channel millions of dollars toward research and