



# LEGAL BRIEFS

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## THE DOCTRINE OF CORPORATE LIABILITY

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This column previously discussed the trend of modern courts to abandon various theories that were used to impose liability on surgeons for things that went wrong in hospitals. In the early days of modern healthcare, hospitals were often charitable institutions. The courts protected charities from suits for negligence under the theory of charitable immunity. The courts worried that people would not donate to a charity if they believed that their funds could be used to pay claims of litigants. Patients harmed by wrongdoing in a hospital could not recover from the hospital. On the other hand, the courts were also reluctant to deprive persons harmed by the negligence of hospital employees of recourse. Negligent hospital employees seldom had enough funds to pay judgments. The courts' solution was to place liability on a "deep pocket," the surgeon. The courts created a variety of theories under which surgeons were held liable for the negligence of hospital employees working on the surgeons' patients. The theories on which the courts relied included "Captain of the Ship," "Borrowed Servant," and others. At the base of these theories was an assumption that the surgeon controlled or had the power to

control the activities of the hospital employee treating the surgeon's patients.

Of course, like a lot of assumptions, this one was not true. Any number of activities went on in the hospital, many taking place outside of the operating room that surgeons had nothing to do with. Even in the operating room, if the assumption that the surgeon was in control was ever true, it became less and less true as operating rooms became more complex and the persons on whom the surgeon depended became more specialized and educated.

"Captain of the Ship" and "Borrowed Servant" began to die out as courts developed a better understanding of the modern business of healthcare. Moreover, although it is almost never mentioned by the courts, the presence of insurance began to fill the gap between hospitals remaining economically viable while compensating victims of malpractice. Courts had to acknowledge that there were some hospital activities for which surgeons could not be held liable. Once a hospital had any liability, it had to purchase insurance. Once hospitals carried insurance, there was no need for courts to be so protective in malpractice cases. In addition, financing of healthcare became more institutionalized and less dependent on charity. Courts began to look more critically at attempts to hold surgeons, rather

than hospitals, liable. Was the negligence something the surgeon actually had the power to avoid? Or, were the courts just trying to find someone to blame other than the hospital? In recent years, the pendulum has swung so far the other way that the courts have developed a new theory, the Doctrine of Corporate Liability, that seeks to impose liability on hospitals for the negligence of surgeons and other physicians. What affect might this new doctrine have on nurse anesthetists?

### Standard of care

Consider, for example, the case of *Uhr v Lutheran General Hospital*, 226 Ill.App.3d 236, 589 N.E.2d 723, 168 Ill.Dec. 323 (Illinois) where the courts struggled to uphold a trial court verdict of \$1,870,000 against a hospital when a patient suffered excessive blood loss.

Laura, a 13 year old, was admitted to the hospital to remove a cyst from her femur and to graft bone tissue onto the femur. Some of the facts were disputed, but an anesthesiologist was responsible for monitoring blood loss. There was testimony that the standard of care required the nursing staff to weigh the dry sponges, weigh them again after they were used, and subtract the dry weight from the wet weight to keep track of blood loss. The standard of care also required that the nurses communicate the blood loss to the person in charge of

monitoring. According to the patient's chart, the nurses had concluded that there was an 1100 cc loss. The nursing staff testified that as sponges were removed from the patient, a running total of the blood loss was written on a tape placed on the wall in a location visible to the anesthesiologist. The anesthesiologist testified that he estimated the amount of blood loss by looking at the sponges as they were used and, keeping a mental note of the 70 sponges used in the operation. The anesthesiologist testified that he did not pay attention to what the nurses were doing but that if he had known that the blood loss was 1100 cc he would have taken action. The hospital's nursing expert testified that the failure to weigh sponges and communicate results would be a deviation from the standard of care. The court's reasoning seems strained and perhaps a little stubborn. Putting these 2 statements together and working backward, the court found a basis for believing that the nurses had not carried out their obligation. If the anesthesiologist did not take action to replace the blood loss, then he must not have known that the blood loss was 1100 cc. If he did not know the blood loss was 1100 cc, then the nurses must not have communicated the blood loss to him. In upholding the jury verdict against the hospital, the appeals court tried to explain its awkward logic:

Clearly, the jury could have determined from the testimony of [the anesthesiologist and the hospital's expert on nursing care] that the nurses had failed to weigh the sponges and had failed to communicate their blood loss estimates to him [the anesthesiologist] and that such failure would be a deviation from the standard of care.

There were several issues in this case that the court dealt with in a very orderly fashion. One of the issues involved the expert testi-

mony. The physician providing expert testimony had testified in his deposition that in his opinion, the hospital personnel had met the standard of care required of them. At trial, he testified that it was now his opinion that the hospital's nurses deviated from the standard of care by failing to communicate blood loss to the anesthesiologist. There was a statute in Illinois that prohibited expert witnesses from providing testimony at trial that was different than the testimony they gave in depositions. The hospital objected to the plaintiff's expert changing his mind about whether or not the hospital staff had met the standard of care. The plaintiff argued, and the appellate court agreed, that the expert was entitled to change his opinion because the anesthesiologist had changed his testimony and had testified at trial that the operating room nurses had failed to communicate the patient's blood loss to him. The anesthesiologist testified that if he had known there was an 1100 cc blood loss he would have taken action. As noted, the majority interpreted this to mean that since he took no action, this had not been communicated to him.

### **Dissent changes understanding of facts**

There was a dissent in this case and, as often happens, dissents not only make for interesting reading, they change your understanding of the facts underlying the decisions. The dissent disagreed with the majority opinion because the anesthesiologist's testimony at trial was largely unchanged from the anesthesiologist's testimony during depositions. The anesthesiologist had not said that the nurses did not communicate to him. He had said he was doing his own estimating and therefore did not pay attention

to what they were doing (and, therefore, their efforts to communicate with him). This casts a different light on the holding of the majority opinion that because the anesthesiologist took no action, the nurses must have failed to communicate. The dissent pointed out that the anesthesiologist's testimony also was consistent with the position that the anesthesiologist took no action because he was ignoring the efforts of the nurses to tell him they thought there had been a substantial blood loss.

The "change" in the anesthesiologist's testimony followed the anesthesiologist entering into a settlement agreement with the plaintiffs in which the anesthesiologist and his insurance company agreed to pay the insurance limit to the plaintiffs. At the time of trial, the only defendant was the hospital, and the plaintiff had to find some way of making the hospital liable for the failure to deal with the patient's blood loss. The majority opinion found justification for the hospital's liability.

The nature of the anesthesiologist's settlement with the plaintiff also became an issue. The hospital had originally wanted to question the anesthesiologist about his settlement agreement with the plaintiffs but the trial court denied it the right to do so. The hospital claimed that the denial was an abuse of the trial court's discretion. It was the hospital's position that because of the settlement, the anesthesiologist was now biased in favor of the plaintiff and his testimony should be viewed with skepticism. The hospital wanted an opportunity to make sure the jury was aware of the anesthesiologist's bias. The appellate court said it was reluctant to permit the hospital to ask about the settlement because public policy favors settlements. The appellate

court also noted that whether a settlement created bias in favor of a party was a matter of discretion for the trial court and that the trial court's discretion would not be disturbed unless there was good reason. It found cases where an appellate court had found that a settlement created bias where the settlement required a party to testify in favor of another party. However in this case, the anesthesiologist testified that the settlement agreement did *not* require that he testify against the hospital. Therefore, the court did not think this was a situation where there was evidence of bias. Once again, the dissent makes for interesting reading. The settlement with the anesthesiologist did not require testimony against the hospital, but it called for payment of the limit of the anesthesiologist's insurance policy. The limit, however, was only \$250,000. That turned out to be a relatively small portion of the jury verdict. If his insurance policy was too small to pay a jury verdict against him, the anesthesiologist's personal assets would have to pay any verdict. Would the anesthesiologist have testified differently if his personal assets were at risk? Would the anesthesiologist have been favorably inclined to a plaintiff willing to accept a payment from his insurance company and willing to forgo a claim against the doctor's personal assets? Whether the anesthesiologist viewed this as favorable and whether it created bias is something we will never know.

One of the major issues in the case was whether the anesthesiologist was the agent of the hospital for purposes of liability. The anesthesiologist was an independent contractor and under traditional laws of agency, the hospital's inability to control the means by which the anesthesiologist administered anes-

thesia should have been sufficient to keep the anesthesiologist from being the agent of the hospital. However, the court discussed a number of theories on which the hospital could have been liable for the negligence of the anesthesiologist. The patient argued that she did not select the anesthesiologist; the assignment of anesthesiologists was made by the hospital. Anesthesia policies were subject to the approval of the hospital's medical staff. Moreover, the patient had relied on the reputation of the hospital, not on knowledge of the anesthesiologist assigned to her case. Even so, noted the court, the course of patient treatment is not within the control of the hospital but at the discretion of the physician, an independent contractor. The things the hospital clearly controls (admissions, discharges, referrals, etc.) were not the kind of things that give rise to liability. The court then discusses the doctrines by which the hospital could be inferred to have the type of control that would create liability. They refer with favor to the Doctrine of Corporate Liability being developed by the Pennsylvania courts. They note that often patients choose hospitals based on the hospital's reputation rather than choosing the independent contractors who provide treatment in the hospital. The court notes that in this area there has been an expansion of hospital liability for negligent medical acts committed on its premises by healthcare providers who are "apparent or ostensible agents." The court then summarily concluded that the jury verdict was appropriate because the negligence of the anesthesiologist and the operating room nurses was clearly and amply established by independent testimony and either should be imputed to the hospital or that the hospital was liable for the negligence of nurses

employed by it who failed to inform the anesthesiologist of blood loss.

### **Duty to ensure patient's safety and well being**

The Doctrine of the Corporate Liability might have given the Court in the *Uhr* case the alternative of finding liability without having to find negligence on the part of the nurses. The Doctrine of Corporate Liability had its origin in the case of *Thompson v Nason Hospital*, 527 Pa. 330, 591 A.2d 703 (1991). A woman who had been in an auto accident was taken to the emergency room with head and leg injuries. Her husband advised the emergency room personnel that the woman was on Coumadin, had a permanent pacemaker, and that she took other heart medications. She was admitted to Nason Hospital, where they followed a very conservative, perhaps too conservative, treatment plan. The next morning she was unable to move her left foot and toes, evidence of an intracerebral problem. By the third day she had complete paralysis of the left side and was sent to another hospital. She had a large intracerebral hematoma. Even when she was finally discharged, she had not regained motor function on her left side. She brought suit against Nason Hospital for failing to adequately examine and treat her, for failing to follow its rules relative to consultations and for failing to monitor conditions during treatment. All of the matters of which Mrs Thompson complained were actions taken by physicians on the staff of the Nason Hospital. These physicians were independent contractors. The hospital filed a motion for summary judgment that was allowed by the trial court. Hospitals should not be liable, reasoned the trial court, for damages caused by independent contractors. On appeal, the patient claimed that the hospital should be

found liable on a theory of corporate liability for adverse effects of treatment or surgery, even if the doctors were not employees of the hospital. The hospital claimed that it had no direct duty to observe, supervise or control the actual treatment of the plaintiff.

The court reviewed the history of hospital liability. It noted that the hospital of today has assumed the role of a comprehensive health center with responsibility for arranging and coordinating the total healthcare of its patients. As a result of this metamorphosis, hospital immunity was eliminated. The court held that Nason Hospital owed a duty to patients to ensure the patients' safety and well being while at the hospital. The duties came down to 4 separate areas: (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 patients. The court noted that other jurisdictions had held hospitals liable for patient care including Arizona, North Carolina, New York, New Jersey, Ohio, and Washington.

There had been a prior case in Pennsylvania where a patient having a heart attack was taken to a hospital. He was examined by hospital staff and by his own physician who did not have privileges on the hospital staff. The personal physician wanted the patient transferred to another hospital where he had privileges. The patient died en route. The hospital was found liable for failure to object to a transfer it should have known was too dan-

gerous. Nason Hospital argued that unlike the prior case, no exceptional circumstance had arisen that required its intervention. The patient's family argued that Nason Hospital failed to ensure that the patient received adequate medical attention through physician consultations. Because this was a motion for summary judgment, it was not necessary for the court to decide if Nason violated its duty but if the duty existed, the motion for summary judgment would be lost. The court ruled the duty existed and a hospital could be held liable for the conduct of the physicians on its staff, even if they were independent contractors.

### **Limits on hospital's liability for staff physicians**

There have been a number of cases in Pennsylvania and elsewhere referring to the Doctrine of Corporate Liability. In addition to the states noted in the original *Thompson v Nason Hospital* decision, courts in California, Colorado, Florida, Georgia, Illinois, Michigan, Missouri, Nebraska, North Dakota, Tennessee, Texas, Washington, West Virginia, and Wisconsin also have recognized this new doctrine. In the most recent case decided in Pennsylvania, the court made clear that there are limits on the hospital's liability for physicians on its staff. In *Graham v Barolat*, 2004 WL 2668579 (E.D. Pa., 2004), a patient with facial pain had spinal cord stimulator implant surgery. A spinal stimulator device was implanted and the pulse generator secured in a Dacron pouch was inserted in the patient's chest. Because the pain continued, the surgeon removed the pulse generator. However, the surgeon failed to remove the Dacron pouch, and the patient continued to feel not only the pain in

her face but pain in her chest as well. Four years later the patient was admitted to a South Carolina hospital where surgeons removed the Dacron pouch. She brought suit against the surgeon and the Pennsylvania Hospital where the original surgery was performed.

The patient alleged that the hospital violated its duty to select and retain only competent physicians, to oversee all persons who practiced medicine within its walls, and to formulate, adopt, and enforce adequate rules and policies to ensure quality care for the patients. Referring to the *Thompson* case, the court examined these duties, one by one, to see if the hospital breached its duty to the patient. While there does not seem to be much doubt that the surgeon's treatment of the plaintiff breached the accepted standard of care, there was no evidence that the hospital knew or should have known that the surgeon was incompetent. The mere fact that the surgeon made a mistake in this case is not proof that the surgeon is incompetent. The patient alleged that the surgeon had been sued a number of times before but introduced no proof. The mere allegation of prior negligence was insufficient to establish a violation of the duty to select and retain only competent physicians.

The patient also alleged that the hospital violated the third duty to oversee all persons who practiced medicine within its walls. Again, while there is evidence that the surgeon breached his duty to the plaintiff, it does not necessarily mean that the hospital was negligent in supervising the surgeon. However the court found that a question could be raised about the fourth duty, the duty to have policies in place to ensure quality of care for patients. The patient's expert testimony ques-

tioned whether the hospital had sufficient policies in effect to make sure that foreign bodies did not remain in patients, unless the patient would benefit from its presence or unless its removal would damage the patient. Consequently, the court ruled that it was inappropriate to grant summary judgment and the case will proceed for trial. In the *Graham* case, the Doctrine of Corporate Liability was especially important because it was unclear what the doctor's relationship with the hospital was. Although he performed all of his work at the hospital it was not clear whether he was an employee or an independent contractor of the hospital. Under the

Doctrine of Corporate Liability, the hospital can be found liable even if the surgeon was an independent contractor.

### **Significance for CRNAs**

It is much too early to tell whether this new theory of liability, holding hospitals liable for the negligence of providers, even independent contractors, who care for the hospital's patients, will have any impact on healthcare. Nurse anesthetists have sometimes encountered a fear on the part of a surgeon that some of the old legal theories will be invoked to make the surgeon liable for the negligence of the nurse anesthetist.

The fear of liability remains because of the legal constructs developed in the early days of modern healthcare to make surgeons liable for the damage their patients suffer in hospitals. If the Doctrine of Corporate Liability continues to grow making hospitals liable for mishaps that occur in their operating rooms, does the surgeon need to worry about the courts holding the surgeon liable as well? Will the hospital's liability replace the individual liability of the many people who take care of the hospital's patients? The Doctrine of Corporate Liability is less than 15 years old. We will have to wait and see.