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HOSPITAL LIABILITY

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Most medical negligence cases arise out of the hospital context, wherein a patient is treated at the hospital by a physician who is either an employee of the hospital or a staff physician. Yet, historically, hospitals were insulated from liability under theories of sovereign immunity and other doctrines that focused on the hospital as an administrative entity rather than as one capable of practicing medicine. However, over the last thirty years or so, the “liability envelope” has expanded significantly, with immunity becoming obsolete and novel theories of liability being applied to impose liability on hospitals for both direct and vicarious liability. Most recently, questions relating to the hospital’s responsibility for the negligence of its physicians have become more and more prevalent. Where once hospitals enjoyed almost complete protection from liability resulting from patient injury, they are now increasingly exposed to risk not only for the negligence of the nursing staff and other employees, but also for the acts or omissions of independent contractor physicians.

I. Physician Negligence

Because the principal’s right to control the tortfeasor is required to support a finding of liability under respondeat superior, the doctrine is theoretically problematic in the hospital context. Hospitals are prohibited from practicing medicine in almost every state. Nevertheless, a hospital may be found liable for the conduct of its physicians under a number of theories. A

court may find that liability arises from an implied employment or agency relationship between the hospital and the physician, or it may conclude that the hospital has breached its general duty to monitor the competence of the physicians on its medical staff. The proper mechanism to deal with the liability depends upon the type of relationship between the physician and the hospital.

Where the physician is an employee of the hospital, liability is fairly easily established - although it is rare for a physician to have a direct employer-employee relationship with a hospital these days. Instead, the hospital will typically defend a claim concerning a physician's conduct by raising the physician's status as an independent contractor. There are generally two categories of independent contractor physicians. First, there are physicians who admit their own patients to the hospital where the physician will undertake to treat the patient. Second, a physician may be involved in the care and treatment of a patient who happens to be at the hospital and, while there, benefits from the services of physicians such as emergency room doctors, radiologists, anesthesiologists and pathologists.

To succeed under the independent contractor defense, the hospital must establish that the doctor exercised his own individual clinical judgment without any supervision by hospital administrators or without reference to any of the hospital's own policies or procedures. As with any situation involving the theory of respondeat superior, the hospital has to focus on its lack of control over the physician. The general guidelines for determining whether an individual is an "employee" or an "independent contractor" have been difficult to apply to the murky area of a hospital's liability for a doctor's negligence. In Georgia, the Court of Appeals originally followed the minority view that, as a matter of law, a hospital cannot be liable for a physician's negligence as it relates to professional as opposed to administrative acts, because there can be no control by the hospital over the doctor's professional judgment. *See Pogue v. Hospital Authority*,

120 Ga. App. 230, 170 S.E.2d 53 (1969). That approach, applied solely in the medical context, however, was difficult to reconcile with just about every other case alleging respondeat superior, which by definition arises from the exercise of the employee's judgment (or failure to exercise such judgment) in some respect. Hence, the Court of Appeals later changed its analysis and discredited its earlier approach. *Newton County Hospital v. Nickolson*, 132 Ga. App. 164, 207 S.E.2d 659 (1974) (implying that the existence of a "right of control" in medical cases should be decided on the same basis as any other respondeat superior case - on a case by case basis).

Despite what may or may not in fact be the reality of the relationship, hospitals will inevitably put self serving language in their contracts with physicians to the effect that they retain no "right of control" over the doctor; however, this provides little protection to the hospital in the face of other, conflicting factors. *See, e.g. Lee v. Satilla Health Services*, 220 Ga. App. 885, 886, 470 S.E.2d 461 (1996) ("[T]he labels ascribed by a contract are not determinative of the parties' legal relationship.") Of course, the Joint Commission on the Accreditation of Hospitals requires that hospitals provide competent physicians. Nevertheless, most courts historically rejected the view that a hospital is generally responsible for supervising the medical treatment provided by a physician practicing in its facility, despite the JCAH standards to that effect. This is the area that has seen the most change in recent years and has set the stage for increasing liability against hospitals under a theory of direct corporate negligence. *See, e.g., Joiner v. Mitchell County Hosp. Auth.*, 125 Ga. App. 1, 186 S.E.2d 307 (1971), *aff'd* 229 Ga. 140, 189 S.E.2d 412 (1972) (holding the hospital liable for its failure to require satisfactory proof of the professional qualifications of its physicians).

1. Apparent Agency

Many jurisdictions have extended liability to a hospital for the negligence of non-employee physicians under a theory of apparent agency. Georgia is no exception.

In *Richmond County Hosp. Auth. v. Brown*, 257 Ga. 507, 361 S.E.2d 164 (1987), the Georgia Supreme Court held that the doctrine of apparent agency applies in medical malpractice cases. Thus, a hospital may be liable for a doctor's negligence, even though the doctor is an independent contractor, if the hospital represents or holds out the doctor as its agent and the patient relies on that representation. However, a plaintiff cannot rely upon an apparent agency theory if the plaintiff knew or should have known that the doctor was not an agent of the hospital. *Holmes v. Univ. Health Services*, 205 Ga. App. 602, 423 S.E.2d 281 (1992). In *Abdul-Majeed v. Emory Univ. Hosp.*, 213 Ga. App. 421, 445 S.E.2d 270 (1994), the Court of Appeals held that a fact question exists regarding whether the hospital holds out the doctor as its agent if the hospital provides the doctor without explicitly informing the patient that the doctor is not its employee.

With that background, the Court next had to answer the question of what a hospital must do to "explicitly inform" the patient of the doctor's non-employee status. That issue was addressed in *Sorrells v. Egleston Children's Hospital*, 222 Ga. App. 229, 474 S.E.2d 60 (1996), in which the plaintiff allegedly lost his eye due to the negligence of doctors who treated him at Egleston Hospital. When the plaintiff was admitted to the hospital, he was assigned to Dr. Sternberg, but was not informed that the doctor was not a hospital employee. However, during the course of the hospitalization, the plaintiff underwent three procedures for which his parents gave consent. On the back of the consent form, the parents acknowledged that physicians on staff were not employees of the hospital. The rest of the consent form pertained only to the specifics of the procedure..

Despite the general language on the consent form, the Court found the form insufficient to inform the plaintiffs of the status of the physicians. Because the language was contained on the back of an acknowledgement form “designed to elicit consent to a specific procedure,” which “did nothing to call attention to the acknowledgement,” it failed to properly disclaim any employment or agency relationship. 222 Ga. App. at 231. Of significance was the fact that the acknowledgement forms were signed only after the plaintiff was admitted and underwent treatment by the physicians, rather than at the time of admission. *Id.*

Although the Court’s ruling arguably places a heavy burden on hospitals, the Court found that it was necessary. “[T]he reality is that most people who are provided a doctor by a hospital expect that doctor to be the hospital’s employee or agent, and in the current environment in which hospitals prodigiously market themselves as providers of health care, we cannot say that expectation is unreasonable as a matter of law.” *Id.* at 231-232. *But see Cantrell v. Northeast Georgia Medical Ctr.*, 235 Ga. App. 365, 508 S.E.2d 716 (1998) (holding plaintiffs were properly informed of physician status because a sign was posted over registration desk advising patients that doctors were independent contractors and patient signed consent for treatment form which also stated that doctors were not hospital employees).

Illustrative of the trend to allow claims against a hospital based on the conduct of independent contractor physicians to proceed to a jury is *North Georgia Medical Center v. Stokes*, 238 Ga. App. 60, 517 S.E.2d 93 (1999). The plaintiff in *Stokes* sued his wife’s doctor and the hospital for failing to diagnose her heart condition. After recognizing that a hospital may be liable if it holds out the doctor as its agent, and the patient justifiably relies on the representation to his detriment, the Court then had to decide if those elements had been met. There was evidence of apparent agency; however, the hospital argued that the plaintiff did not

rely on any representation concerning the status of the physician, but merely selected the hospital because it was close. The plaintiff, on the other hand, stated that he not only took his wife to the hospital because of its proximity but also because he thought the physicians were hospital employees. This was sufficient for the Court to hold the hospital in. “The relevant question is not whether the Stokeses went to the hospital based on its proximity to them, but whether they relied on the hospital’s representation that Dr. Lingle was its agent in accepting his services.”

Georgia’s approach to hospital liability is not unique. Other jurisdictions are similarly extending liability to hospitals for the conduct of independent contractor physicians, largely on the basis of public policy concerns. Recently, for example, the Supreme Court of South Carolina held that hospitals have a non-delegable duty to render competent services to patients in their emergency departments, even if the hospital staffs its ER with independently contracted physicians. *Simmons v. Tuomey Regional Medical Center*, 1998 WL 57450. This was the ruling despite the fact that the plaintiff’s daughter had signed a release form specifically indicating that “independent physicians” staffed the emergency room and they were not employees of the hospital.

Three factors supported the ruling. First, the Court noted the public’s increasing reliance on hospital emergency rooms for their medical care and treatment and the fact that, in an emergency situation, patients generally cannot discriminate in choosing a hospital. Second, the public has come to consider a hospital as a single entity, providing multi-faceted medical services. Finally, the Court pointed out that the state’s minimum requirements for licensure require all hospitals, unless exempted, to maintain an open emergency room. Thus, a hospital has to have some accountability for maintaining that service.

Cases such as *Simmons v. Tuomey Regional* distinguish vicarious liability from direct liability. The hospital's non-delegable duty imposes liability on the hospital as the delegating party regardless of any fault on its own part; whereas, the corporate negligence theory is grounded on the theory of direct negligence by the hospital itself. The public policy language in cases like this suggests that the scope of liability for hospitals may well continue to expand.

II. Employee Action

Hospitals, like other employers, are liable for the negligent injuries that their employees cause. *Hoffman v. Wells*, 260 Ga. 588, 589, 397 S.E.2d 696 (1990). This liability stems from the employer's duty to direct and supervise the employee's work. The major area of liability for hospitals is the nursing staff. Most courts tend to divide nursing services into hospital-supervised activities and those supervised by the physician. Previously, hospitals were protected from liability for nursing negligence under the guise that all medical care rendered was essentially controlled by the physician. The theories of "borrowed servant" and "captain of the ship" were based on the premise that hospitals merely provided the facilities within which physicians could work. While the hospital did employ a staff, the staff acted only under the supervision of the physicians. Thus, if a nurse negligently injured a patient, the negligence was attributed to the supervising physician, who had "borrowed" the nurse. *See, e.g. Parker v. Hospital Authority of the City of Bainbridge*, 214 Ga. App. 113, 446 S.E.2d 766 (1994). The idea that the nurse was always under the control of the physician allowed a patient to sue the physician when the hospital was actually at fault. Even where the borrowed servant rule was applied, however, courts tended to differentiate between tasks that were administrative in nature and those in which nurses or other staff are required to exercise independent judgment. The hospital is relieved of liability only where professional skill is required. *E.g. Ross v. Chatham*

County Hospital Authority, 258 Ga. 234, 367 S.E.2d 793 (1988) (distinguishing between tasks involving professional skill and judgment, which are attributed to the physician, versus administrative acts, which are imputed to the hospital).

The “borrowed servant” theory, once used by hospitals to avoid liability, may prove to be a double-edged sword in today’s era, where hospitals routinely use services to provide support staff in addition to independent contractor physicians. For example, in *Brown v. StarMed Staffing*, 227 Ga. App. 749, 490 S.E.2d 503 (1997), the Court of Appeals considered to what extent the defendant nurse was acting as the borrowed servant of the defendant hospital as opposed to the defendant physician. The case offers an interesting insight into the analysis behind the Court’s holding a hospital accountable for negligent care rendered within its walls regardless of the individual at fault. The plaintiff in *Brown* asserted claims against a variety of defendants following her husband’s death from an allergic reaction to blood pressure medication. Mr. Brown was taken to the emergency room at Dekalb Medical Center with a swollen tongue and difficulty swallowing. Mr. Brown’s regular physician, Dr. Feingold, was called and Dr. Atluri, who handled Dr. Feingold’s after-hours calls, arrived at the ER to examine Mr. Brown. Dr. Atluri determined that Mr. Brown had likely suffered an allergic reaction to his blood pressure medication, ordered intensive care, asked that Mr. Brown’s wife call him with information on the blood pressure medication and ordered that Mr. Brown be given nothing by mouth. Mrs. Brown returned to the hospital with all of her husband’s medicine, which she gave to a nurse at the desk. A few hours later, Nurse Simmons gave Mr. Brown the blood pressure medication that Dr. Atluri thought might have caused the allergic reaction - although the nurse stated Dr. Atluri directed him to give the regular dose of the medicine.

Dr. Feingold arrived at the hospital later in the day and examined Mr. Brown. He, too, determined that Mr. Brown's reaction was probably caused by the blood pressure medication, Zestril. Mrs. Brown advised Dr. Feingold that a nurse had given Mr. Brown his Zestril that morning and wondered if this would be a problem. Dr. Feingold assured them that he would be all right and discharged the patient from the hospital with instructions to come to the office the next morning. Before Mr. Brown could return, he experienced another allergic reaction and choked to death on his "grossly swollen" tongue.

Mrs. Brown brought suit against the hospital, both doctors, Nurse Simmons and StarMed, the personnel staffing service that contracted with the hospital for Simmons to work in the ER. The plaintiff alleged that the hospital and StarMed were responsible for the nurse's negligence based on respondeat superior. As to what entity had control over Nurse Simmons, the Court first noted the following concerning StarMed's responsibility:

Although StarMed paid Nurse Simmons' wages, provided him with health insurance and workers' compensation coverage, and required Nurse Simmons to abide by its rules, the hospital's rules as well as all applicable professional standards, it is undisputed that the hospital had complete supervisory control over Nurse Simmons while he was watching over Mr. Brown and that the contract between StarMed and the hospital provided the hospital with exclusive right to discharge Nurse Simmons if his "performance does not meet the standards established for all professionals in the Hospital's employ."

227 Ga. App. at 752. The plaintiff, in an effort to hold the staffing service accountable, argued that Nurse Simmons was not the hospital's borrowed servant when he gave Mr. Brown the

medication because Dr. Atluri, not the hospital, ordered the medication. The Court found this argument to be “without merit because the critical undisputed fact (with regard to StarMed’s vicarious liability) is that StarMed did not control Nurse Simmons’ conduct when he administered ‘Zestril’ to Mr. Brown.” *Id.* Instead, the Court found that Nurse Simmons was the hospital’s “borrowed servant” at the time of his alleged negligence. *Id.*

That did not end the inquiry, however, because the Court similarly had to consider what effect Dr. Atluri’s role had on the hospital’s own exposure. Not surprisingly, the hospital claimed that it could not be liable for the actions of Nurse Simmons because he was Dr. Atluri’s “borrowed servant.” However, the Court found that there was evidence that the nurse was not acting under the direction and control of the doctor, which precluded summary judgment for the hospital on that issue. The Court further rejected the hospital’s argument that it could not be liable for Nurse Simmons’ negligence because he exercised his own professional judgment in deciding on in his own to give the medication. Noting that a hospital is liable for the negligence of its employees in the performance of administrative duties which are not subject to the direct supervision of the attending physician, the Court held that because it was not clear from the evidence *why* Nurse Simmons gave Mr. Brown the medication, the hospital was not entitled to summary judgment. *Id.* at 753. Finally, the Court held that Dr. Feingold’s discharge of Mr. Brown after learning that he had suffered an allergic reaction could not be said as a matter of law to be the sole proximate cause of death so as to relieve the hospital of liability. *Id.* at 754-755.

Nursing responsibilities have increased greatly and so has the level of the nurse’s accountability. Nursing has evolved from a profession that merely carried out orders of the physicians to one that assesses the patient’s condition, makes judgments based upon that assessment and acts according to professional judgment. Certainly, the immediate recognition of

potential threats to the patient's health and safety has become an important role of the nurse. With the changing role of the nurse has come a shift in responsibility for the nurses' actions from the physician to the hospital employer.

It cannot be disputed that under the present state of affairs, a hospital's liability stems from the nurse's individual duty to the patient. The nurse has a duty to provide patient care that comports with the legal standard of the profession and practice in compliance with the policies and procedures of the hospital. If the nurse fails to live up to the standards applicable to her, she will be held personally liable and the hospital will be found liable under the doctrine of respondeat superior. For example, a nurse has a duty to properly carry out a physician's orders. (It is interesting to note, however, that the Georgia Supreme Court recently held that a patient's allegation that nurses failed to follow a doctor's order involved ordinary, rather than professional negligence. *Dent v. Memorial Hosp. of Adel*, 270 Ga. 316, 509 S.E.2d 908 (1998)). While a doctor certainly owes a separate duty of care to the patient, neither the hospital or the nurse is insulated from liability simply by pointing to a doctor's involvement in the patient's care.

One of the major legal consequences of the recognition of nursing as an independent profession has been the establishment of the nurse's duty to review certain physician actions. For example, part of nurse's training includes instruction in the dosages and means of administering commonly used drugs. Therefore, a nurse has a duty to determine if a physician's drug order is reasonable, which means that if a physician orders an improper dosage, an inappropriate form, or an otherwise unacceptable drug, the nurse should not carry out the order. A nurse who knowingly carries out an incorrect order can be held personally liable for negligence. However, not only should the nurse question an inappropriate order and decline to carry it out; but what the nurse does from that point is critical. The nurse should also bring the

inappropriate order to the attention of a supervisor so that a proper order may be obtained; however, under no circumstances should the nurse take it upon herself to change the order. In the event a nurse injures a patient by intentionally changing an order, it will put the hospital in a legally indefensible position.

Certainly, any independently initiated care by a nurse that is harmful to the patient will expose the employee and the hospital employer to risk. When a nurse knowingly carries out an inappropriate order, the nurse may be personally liable; but so, too, will be the hospital and the physician. On the other hand, if the nurse initiates harmful care, only the hospital will share liability as the nurse's employer.

When the hospital's duty is a condition precedent to the nurse being able to fulfill her own duties to patients, for example providing for ample staff and appropriate equipment, the nurse is somewhat relieved of individual accountability. In such a case, liability for nursing negligence may be based on a theory of corporate negligence as opposed to respondeat superior.

III. Direct Liability: Corporate Negligence

Direct liability of a hospital entity is premised upon the hospital's non-delegable duties. Those duties generally include the following:

- (1) the duty to use reasonable care in the maintenance of safe and adequate facilities and equipment;
- (2) the duty to select and retain only competent physicians and staff;
- (3) the duty to oversee all persons who practice medicine within its facility as to patient care; and
- (4) the duty to formulate, adopt and enforce adequate rules and policies to ensure quality of care.

Thus, direct liability against a hospital may be the result of failures in the administrative process pertaining to the promulgation of policies and procedures as well as staffing and equipping the facility, and for the failure to ensure that all individuals subject to those policies and procedures carry them out in an acceptable fashion. The analysis of corporate negligence in the medical setting is no different than any other standard negligence analysis of duty, breach, causation and damages. *Blanton v. Moses H. Cone Mem. Hosp., Inc.*, 354 S.E.2d 455, 456 (N.C. 1987). It is important to note that corporate liability applies equally regardless of the status of the physician.

Several explanations for adopting the doctrine of corporate negligence have been offered by courts and commentators alike. “Since it is estimated that as many as 80 percent of all medical malpractice claims originate in hospitals, the institution is the logical starting place for addressing problems of professional incompetence.” *Pedroza v. Bryant*, 677 P.2d 166, 169-170 (Wash. 1984). Additionally, while state licensing boards certify physician competence, and professional standards review organizations exist to monitor and control physicians’ medical performance, hospitals are actually in a better position to observe physician conduct. *Id.* at 170. Another reason that is often expressed is the fact that hospitals are essentially becoming community health centers. There is no question that people are increasingly relying on hospitals for their healthcare needs. “It is the responsibility of the hospital to create a workable system whereby the medical staff of the hospital continually reviews and evaluates the quality of care being rendered within the institution.” *Id.* at 169. The role of the hospital is no longer limited to providing facilities and equipment for use by physicians in their treatment of private patients. Finally, because a hospital undertakes to render health care services to patients, if the hospital fails to exercise reasonable care in providing its services, then it should be held liable. Because

patients heavily rely on the hospital for its determination as to the quality of care rendered, the requirement of reasonable care by the hospital should be stressed.

[The] concept that a hospital does not undertake to treat patients, does not undertake to act through its doctors and nurses, but only procures them to act solely upon their own responsibility, no longer reflects the fact. The complex manner of operation of the modern-day medical institution clearly demonstrates that they furnish far more than mere facilities for treatment. They appoint physicians and surgeons to their medical staffs, as well as regularly employing on a salary basis resident physicians and surgeons, nurses administrative and manual workers and they charge patients for medical diagnosis, care, treatment and therapy, receiving payment for such services through privately financed medical insurance policies and government financed programs known as Medicare and Medicaid. Certainly, the person who avails himself of our modern “hospital facilities” (frequently a medical teaching institution) expects that the hospital staff will do all it reasonably can to cure him and does not anticipate that its nurses, doctors and other employees will be acting solely on their own responsibility.

Johnson v. Misericordia Community Hospital, (1981) 99 Wis.2d 708, 301 N.W.2d 156, 164 (1981); *See also Bing v. Thunig*, 2 N.Y.2d 656, 666-667, 143 N.E.2d 3, 8 (1957).

The seminal case establishing direct liability against a hospital is the Illinois Supreme Court’s decision in *Darling v. Charleston Community Hospital*, 211 N.E.2d 253 (Ill. 1965), *cert denied*, 383 U.S. 946 (1966). *Darling* involved an 18 year old college football player who broke

his leg during a game. He was taken to the emergency room of the defendant hospital on November 5 and treated by Dr. Alexander, who was on call. The doctor and hospital employees applied traction and placed the leg in a cast. The plaintiff began to experience significant pain, his toes became swollen and dark, and eventually they became cold and insensitive. On November 6, the doctor “notched” the cast around the toes, and the next day cut the cast approximately 3 inches from the foot. On November 8, he split the sides with a saw; and in so doing the plaintiff’s leg was cut on both sides. At that time, the nurses observed “blood and other seepage” and there was a stench, which one nurse described as “the worst he had smelled since World War Two.” The Plaintiff remained in the hospital until November 18, when he was transferred to another facility and treated by an orthopedic surgeon who immediately noted a lot of dead tissue in the leg, which he opined was caused by lack of circulation to the leg. Despite several vain attempts at surgical intervention, the leg ultimately had to be amputated.

The Court found that the hospital could be found liable under either of two theories. First, under respondeat superior, the Court found negligence on the part of the nursing staff for failure to take action to prevent the irreversible damage to the plaintiff’s leg. Specifically, the Court noted that the jury could have reasonably concluded that the nurses did not check for circulation frequently enough. The Court also stressed that the nurses had a duty to inform the doctor of the patient’s condition. If the doctor failed to act, then hospital authorities should have been notified. Second, the Court found the hospital directly and corporately responsible to the patient for its failure to review the doctor’s treatment or to require a consultation.

Since *Darling*, a minority of jurisdictions, including Georgia, have adopted the corporate liability theory. See *Candler General Hospital v. Purvis*, 123 Ga. App. 324, 181 S.E.2d 77, 79 (1971) (hospital has duty to use reasonable care in maintenance of safe facilities). See *Bost v.*

Riley, 262 S.E.2d 391, 396 (N.C. App. 1980) (suggesting that the doctrine of corporate negligence has been implicitly accepted and applied by the holding of a hospital to a duty of ordinary care in furnishing suitable supplies, equipment and facilities commensurate with the demands of a particular case). However, most courts that have adopted *Darling's* requirement that the hospital monitor the physician have limited the ruling in a variety of ways. Because the facts in *Darling* can be characterized as egregious, many have argued that the ruling should be confined to cases involving gross negligence. Recognizing the basic premise that hospitals are not insurers of the safety of patients, others have suggested that the hospital's duty to oversee the medical staff should be limited to the enforcement of rules and regulations to insure a smoothly run hospital and basic quality of care. Yet another caveat proposed is that the hospital's corporate duty to monitor a specific staff physician's performance should be triggered only when the hospital "knew or should have known" it had reason to act concerning a particular staff member or patient situation. Finally, by stressing the importance of the physician-patient relationship, many courts point out the unfairness in imposing liability on the hospital for its failure to intervene in question of professional judgment.

Some basic legal responsibilities have emerged from the case law. Hospital staff members have a duty to recognize and report abnormalities in a patient's condition and to advise hospital authorities if the physician fails to act after being informed. *Thompson v. Nason Hospital*, 591 A.2d 703, 709 (Pa. 1991). The failure to report a physician who is not acting in accordance with standard medical practice may therefore result in hospital liability. Some cases have emphasized that the hospital should be protected from liability when its staff follows the direct and explicit orders of the attending physician unless "the doctors orders are clearly contradicted by normal practice that ordinary prudence requires inquiry into the correctness of

the orders.” *Toth v. Community Hosp. at Glen Cove*, 239 N.E.2d 368, 374 n.3 (N.Y. 1968). However, the *Thompson v. Nason Hospital* decision does appear to reflect the trend over the last decade to expand liability against hospitals for the negligence of staff physicians.

In *Thompson*, the plaintiff was taken to the defendant hospital following a motor vehicle accident and admitted with head and leg injuries. The plaintiff’s husband advised the staff that she was taking Coumadin, had a pacemaker and that she took other heart medications. Dr. Schultz was asked by a nurse to look at the patient, as the patient was a former patient of his. Dr. Schultz consulted with others about the orthopedic injuries and her heart condition, and eventually admitted her to the ICU. The next morning, a general surgeon examined her and found that she was unable to move her left foot and toes and that she had neurological signs of an intracerebral problem. Dr. Schultz continued to monitor the patient and noted that the problem with her left leg was neurological. Within three days after the accident, the plaintiff had complete paralysis on her left side and Dr. Schultz transferred her to another facility where she could be under the care of a neurologist. Tests performed there revealed a large intracerebral hematoma. She never regained motor function on her right side.

The Court noted that under the doctrine of corporate negligence a hospital is liable if it fails to ensure a patient’s safety and well being while there, which is the proper standard of care owed the patient. Furthermore, that duty is a non-delegable duty, which the hospital owes directly to the patient; therefore, the patient need not rely on and establish negligence of the doctor.

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. (Cite) 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 action might be taken. (Cite) When there is a failure to report changes in the 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. (Cite).

Thompson v. Nason Hospital, 591 A.2d 703, 709 (Pa. 1991) (citations omitted).

At least one state's highest courts has refused to hold hospitals accountable for the medical decisions of doctors on the ground that to do so will require legislative initiative. In *Dafner v. Down East Community Hosp.*, No. WAS-99-2 (August 12, 1999), the Maine Supreme Court considered the plaintiff's allegations that the defendant hospital was liable under the theory of corporate liability for its failure to have a policy requiring doctors to consult with a specialist during high risk births and to monitor the quality of medical care provided at the hospital. The Court noted that "the legislature has not chosen to place upon hospitals a specific duty to regulate the medical decisions of the physicians practicing within the facility," and declined to create such a duty. The Court specifically noted that the legislature had created duties and guidelines for the actions of hospitals in a variety of areas and it was for the legislature to do so if appropriate in this context as well. "Before the expansion of tort liability into an area that has been significantly controlled by the legislature, we should allow the legislature to address the policy considerations and determine whether imposing such a duty constitutes wise public policy."

- 1. Hospital's Duty to Employ Competent Physicians**

The doctrine of corporate negligence has been utilized and expanded by the courts of several jurisdictions to generally impose upon a hospital a direct and independent responsibility to its patients of insuring the competency of its medical staff and the quality of medical care provided through the prudent selection, review and continuing evaluation of the physicians granted staff privileges. See, e.g., *Tucson Medical Center, Incorporated v. Misevch*, 113 Ariz. 34, 545 P.2d 958, 960 (1976); *Kitto v. Gilbert*, 39 Colo. App. 374, 570 P.2d 544, 550 (1977); *Johnson v. St. Bernard Hospital*, 79 Ill. App.3d 709, 399 N.E.2d 198 (1979); *Ferguson v. Gonyaw*, 64 Mich. App. 685, 236 N.W.2d 543, 550 (1975); *Corleto v. Shore Memorial Hospital*, 138 N.J. Super. 302, 350 A.2d 534, 537-538 (1975). In Georgia, the doctrine of corporate negligence was first applied to hold a hospital responsible for permitting an unqualified physician to serve on its staff in *Joiner v. Mitchell County Hospital Authority*, 125 Ga. App. 1, 186 S.E.2d 307, *affd. Mitchell County Hospital Authority v. Joiner*, 229 Ga. 140, 189 S.E.2d 412 (1972).

As have cases in other jurisdictions, we interpret *Joiner* as authority in support of the proposition that a hospital has a direct and independent responsibility to its patients to take reasonable steps to ensure that staff physicians using hospital facilities are qualified for privileges granted. *Johnson v. Misericordia Community Hosp.*, 99 Wis.2d 708, 301 N.W.2d 156, 165 (1981); see *Pedroza v. Bryant*, 01 Wash.2d 226, 677 P.2d 166, 169 (1984); *Elam v. College Park Hosp.*, 132 Cal. App.2d 332, 183 Cal. Rptr. 156, 164 (4th Dist. 1982). The hospital did owe a duty to plaintiff's decedent to act in good faith and with reasonable care to ensure that the surgeon was qualified to practice the procedure which he was granted

privileges to perform. While there is no evidence of the surgeon's curtailment or denial of staff privileges at other hospitals as in *Johnson*, or of any prior malpractice claim as in *Elam*, Candler does not dispute that there is a material issue of fact on the question of whether it was negligent in its grant of the staff privileges requested.

Candler Gen. Hosp. v. Persaud, 212 762, 442 S.E.2d 775, 766 (1994).

The granting of staff privileges could be deemed negligent for a variety of reasons. The criteria used by the hospital to evaluate the prospective physician may be insufficient to adequately determine the applicant's competence. If the hospital board is aware of the physician's incompetence, and employs him anyway, it will be held directly responsible for any injury resulting from that incompetence. Finally, the hospital may be liable if its board should have known of the physician's incompetence. The issue of whether a hospital "should have known" of a physician's lack of fitness is narrowly construed. It should be noted that evidence that a physician failed a board examination is not relevant to the issue of whether the physician complied with the standard of care and would therefore not alert the hospital of a level of competence one way or the other. *See, e.g. Williams v. Memorial Medical Center, Inc.*, 218 Ga. App. 107, 460 S.E.2d 558 (1995) (physician's inability to pass certification and licensure examinations does not make probable his negligent performance of a specific procedure). Typically, the "should have known" situation refers to circumstances where either the staff, or the administration through notice from the staff, is aware that the physician has had trouble meeting the requisite degree of care.

[T]he delegation of the authority to screen applicant for staff membership on the medical staff does not relieve the Authority of its responsibility,

since the members of such staff act as agents for the Authority, and whether it knew or from the information in its possession the incompetency of the physician was known, is a question of fact. If the physician was incompetent and the Authority knew, or from information in its possession such incompetency was apparent, then it cannot be said that the Authority acted in good faith and with reasonable care in permitting the physician to become a member of its staff.

Mitchell County Hosp. Auth. v. Joiner, 229 Ga. 140, 142-143. Of course, an obvious problem stems from the hospital's failure to check the credentials and employment history of a prospective physician. A hospital that fails to discover that an applicant's privileges had been revoked by another facility certainly has some exposure. However, the most likely scenario to impose liability comes when the hospital fails to act when it is aware of the physician's negligent treatment.

Whether the hospital is aware of the physician's incompetence, or should have known, its duty to provide skilled physicians is clearly recognized. "We can perceive of no reason why this established duty of due care does not encompass the duty asserted by [the plaintiff]; for, as a general principle, a hospital's failure to insure the competence of its medical staff through careful selection and review creates an unreasonable risk of harm to its patient." *Elam v. College Park Hospital*, 132 Ga. App.3d 332, 183 Cal. Rptr. 156 (1982). Inherent in this principle is that once the hospital grants privileges to a physician, it will continue to monitor the doctor's conduct to confirm continued competence. This, too, is a non-delegable duty. However, as was noted earlier, liability is not absolute and may be avoided by relying on other standards that apply to the hospital's operation.

For example, in *Sheffield v. Zilis*, 170 Ga. App. 62 (1984), the plaintiff sought to recover from the hospital for its alleged negligence in permitting a Dr. Zilis to practice medicine at the hospital. The plaintiff relied upon *Joiner v. Mitchell County Hosp. Auth.* for her claim of corporate negligence against the hospital. In response, the hospital maintained that it followed the generally accepted standards propounded by the Joint Commission on Accreditation of Hospitals (JCAH) in its approval of Dr. Zilis. As such, the Court found that the hospital acted in good faith and with reasonable care in appointing Dr. Zilis to its medical staff. 170 Ga. App. at 64.

2. Discovery Issues

There are a variety of obstacles to obtaining the necessary information to prevail against a hospital on a corporate negligence claim. In some cases, there may be federal protection for the hospital pursuant to the Professional Standards Review Organization (PSRO) sections of the Social Security Act, which provides immunity for physicians and hospitals reviewing medical care that is reimbursed by Medicare and Medicaid programs. 42 U.S.C. §§ 1320c-1 *et seq.*

Additionally, many states have passed shielding statutes that create a privilege for medical review information. *See* O.C.G.A. § 31-7-133. Thus, the files, minutes and discussions of the medical review committees that evaluate credentials, take disciplinary actions and evaluate medical care provided by staff physicians is generally not discoverable. *See Emory Clinic v. Houston*, 258 Ga. 434, 435, 369 S.E.2d 913 (1988); *Doe v. Unum Life Ins. Co. of America*, 891 F. Supp. 607 (N.D. Ga. 1995). However, the privilege is not absolute. *Fulton-Dekalb Hosp. Auth. v. Dawson*, 220 GA. App. 376, 380, 509 S.E.2d 28 (1998).

The purpose of these statutes is to promote frank, unfettered discussion and to maintain and improve health care, and, as such, it is important to limit the discovery and admissibility of

the information gleaned. However, they also appear to give a powerful advantage to potential malpractice defendants by shielding deliberations of the hospital that might be used to prove negligence. Even though it would seem that documentation of a hospital's review process should be admissible in an action alleging corporate liability resulting from an inadequate system, some courts have nevertheless held that the records are privileged. See *Matchett v. Petway*, 40 Cal. App.3d, 115 Cal. Rptr. 317 (1974); *Oviatt v. Archbishop Bergan Mercy Hosp.* 191 Neb. 224, 214 N.W.2d 490 (1974). Note, however, that the hospital's accreditation records are not immune. *Georgia Hosp. Ass'n v. Ledbetter*, 260 Ga. 477, 396 S.E.2d 488 (1990).

In order to avoid efforts to prevent the disclosure of this information, it is important to emphasize the purpose of the immunity afforded peer review materials. "The purpose of the medical review process privileges is to protect the process for the public good, not to protect physicians from being held accountable for their tortious conduct. It was never intended that the peer review process be used in such a way as to effectively bar a plaintiff's tort action." *Emory Univ. Hosp. v. Sweeney*, 220 Ga. App. 502, 506, 469 S.E.2d 772 (1996). As such, information that may be obtained from the original source does not become immune simply because it was utilized in a medical review proceeding. *Id.* It is also important to distinguish between litigation involving a physician's negligence and that involving the hospital's negligence when faced with the impediment of these statutes.

IV. Conclusion

While there is clearly a movement toward expanding liability for hospitals, under none of the prevailing theories are hospitals currently held strictly liable for malpractice of physicians. Nevertheless, with medicine becoming more and more specialized and depersonalized, and with health care providers attempting to open privileges to more individuals for the benefit of a

greater number of consumers, hospitals will inevitably be caught in the middle of this market in terms of litigation exposure.

Hospitals faced with this potential for expanded liability may view their situation as being caught between a rock and a hard place. Unfortunately, steps taken by hospitals to minimize the likelihood of liability under one theory often increase the likelihood of liability under a different theory. For example, if a hospital develops more stringent criteria for the evaluation, selection and retention of physicians on staff, in an effort to avoid a finding of corporate liability, that attempt to control a physician's practice may set itself up for a finding of vicarious liability under an agency theory. Or, perhaps the hospital may attempt to circumscribe its relationship with its physicians by contractually delineating the independence of the doctors, in which case the instrument itself may be used to demonstrate either control over the physicians or a direct employment relationship. On the other hand, if the hospital exerts no supervision over the doctor, it may be found in violation of its accreditation requirements for the monitoring of medical practice within its facility, in which case it may be directly liable under a corporate negligence theory.

Whether on the side of defending healthcare providers or prosecuting claims, the legal complexities of medical malpractice litigation continues to provide a challenging opportunity, especially where a hospital entity is involved.