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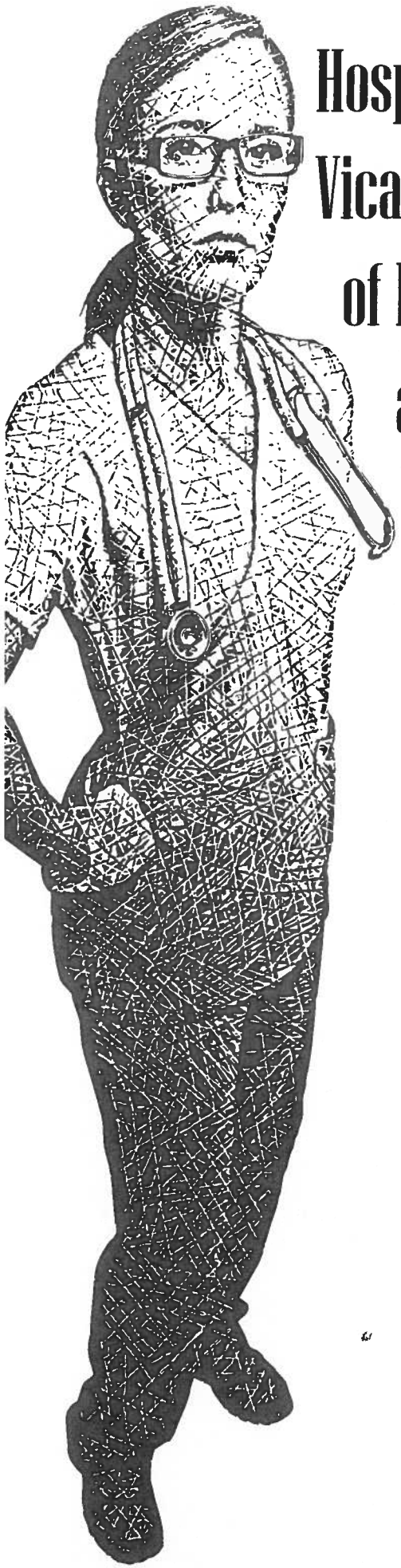

Hospitals', Surgical Centers', and Clinics' Vicarious Liability for Acts and Omissions of Doctors, CRNAs, Physician's Assistants, and Nurses

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Who is liable when a patient suffers an adverse medical outcome in a hospital, outpatient surgery center, or clinic? Obviously the treating physician is liable for his or her breaches of the standard of care. Usually, if the physician is a member of a group, the group is also liable under *respondeat superior*. But what about part-time emergency room physicians or CRNAs, physician's assistants, or nurses who deviate from the standard of care? Is the hospital, surgery center, or clinic liable to the patient for deviations by part-time professionals and staffers?

This article examines numerous theories for imposing liability upon the entities most capable of paying for the harm and suffering they cause.

I. The Hospital Corporate Liability Doctrine Imposes Liability for Negligence

A starting point is to look to the institutional defendant for its own negligence in hiring and employing the medical professional whose negligence caused the injury or death. The Alabama Supreme Court adopted the hospital corporate liability doctrine in *Humana Medical Corp. v. Traffanstedt*, 597 So. 2d 667 (Ala. 1992). The Court described this theory of recovery as follows:

> The liability of the hospital is based on its independent negligence in appointing to its medical staff a physician who is incompetent or otherwise unfit or in failing to properly supervise members of its medical staff. The action is not one in which the hospital is sought to be vicariously liable for the negligence of a staff physician. The distinction between a hospital's negligence in selecting or supervising its medical staff ("corporate negligence" is the term commonly used) and vicarious liability for the negligence of its employees is important because, typically, physicians on the staff of a hospital are considered independent contractors rather than employees. Therefore, vicarious liability does not attach to a hospital for the negligent acts of medical staff members.

Id. at 669. The Court applied this doctrine in *Parker v. Collins*, 605 So. 2d 824, 827-28 (Ala. 1992). This doctrine therefore provides a basis for liability when the hospital's direct negligence in the way it went about

hiring, retaining, or supervising puts the physician, CRNA, or nurse in the position to cause harm.

Proof of negligent hiring, retention, or supervision can be made difficult by operation of § 22-21-8, Ala. Code 1975, and cases such as *Ex parte Krothapalli*, 762 So. 2d 836 (Ala. 2000) and *Ex parte Qureshi*, 768 So. 2d 374 (Ala. 2000). The Court in *Krothapalli* held (though not in a corporate liability doctrine case) that the trial court erred in ordering production of the "'*personnel* files of Dr. Krothapalli, including, but not limited to, all contracts of employment and privileges between Dr. Krothapalli' and the two hospitals" because they were exempted from discovery by operation of the credentialing privilege statute. 762 So. 2d at 837 (emphasis in original). In *Ex parte Qureshi*, the Court rejected the plaintiff's argument "that because she has asserted a claim against Vaughan Regional alleging the negligent hiring and/or negligent credentialing of Dr. Qureshi ... § 22-21-8 is unconstitutional in that it bars her from prosecuting a claim against Vaughan Regional for the injuries she sustained as a result of the hospital's alleged negligence in hiring and/or credentialing Dr. Qureshi." 768 So. 2d at 378-79. However, *Krothapalli*, like *Qureshi*, and *Ex parte Anderson*, 789 So. 2d 190 (Ala. 2000), *all* recognize that documents (including personnel records) are obtainable from original sources such as the physician, CRNA, or nurses themselves.

In *Ex parte Mendel*, 942 So. 2d 829 (Ala. 2006), the Supreme Court of Alabama granted mandamus as to the plaintiff's attempt to obtain materials from the Alabama Board of Dental Examiners, but denied the petition to the extent of allowing plaintiff to obtain discovery from the defendant Dr. Mendel. Plaintiff alleged that Dr. Mendel failed to obtain the plaintiff's informed consent to perform dental-implant surgery on the plaintiff because he did not tell her "'that his license had been suspended on numerous occasions by various dental boards in more than one state.'" *Id.* at 832 (quoting the complaint). Plaintiff also alleged that Dr. Mendel committed fraudulent misrepresentation or suppression by "represent[ing] to her that he was 'as competent, skilled and capable of performing the various phases of the implant surgery as other dentists.'" *Ibid.* Dr. Mendel was ordered to "produce in response to paragraph 18 of the Mendel subpoena all materials in his possession, as the original source, 'which would in any way relate to any revocation, suspension, or termination of any medical or dental license held by [Dr. Mendel] in any State or Country.'" *Id.* at 841 (quoting plaintiff's request for production). Thus, particular allegations against the negligent physician, CRNA, or nurse may provide a basis for discovery of evidence that will support an allegation against the hospital that it negligently hired, supervised, or retained the negligent individual.

II. Apparent Authority or Ostensible Agency

Institutional defendants can also be held vicariously liable under the doctrine of apparent authority or ostensible agency. Under an apparent authority or ostensible agency theory of recovery, "an individual's status as an employee or independent contractor does not determine liability." Weiner, Earlene P., *Managed Health Care: HMO Corporate Liability, Independent Contractors, and the Ostensible Agency Doctrine*, 15 J. Corp. L. 535, 546 (Spring, 1990). The crucial determining factor is appearances. *Id.* Specific factors courts can examine are: "(1) the restriction on the patient's choice of the physician [or CRNA or nurse]; (2) the performance of an inherent integral function of the hospital; and (3) the hospital's holding out of the contractor as an employee." *Id* at 548.

Alabama's law regarding this theory, embodied in Alabama Pattern Jury Instruction – Civil, No. 3.04, provides that:

> Apparent Authority, for which a principal is responsible to a third party for the act of his agent, is that authority which arises when the principal, by his acts, words, or conduct, reasonably interpreted, causes such third party to believe that authority had been given to an agent in his behalf and such authority cannot be established solely by the acts of the agent.

Apparent authority of an agent arises from the acts of the principal, either by omission or commission, and such authority is implied where the principal passively permits the agent to have the authority to act on his behalf.

> Whether one is the agent of another is a question of fact. *Hatton v. Chem-Haulers, Inc.*, 393 So. 2d 950 (Ala. 1980); *Cashion v. Ahmadi*, 345 So. 2d 268 (Ala. 1977). Questions of apparent authority are generally questions of fact that are properly submitted to a jury for its consideration. *Wood, supra*, at 176 (citing *System Investment Corp. v. Montview Acceptance Corp.*, 355 F.2d 463 (10th Cir. 1996)¼

Chamlee v. Johnson-Rast & Hays, 579 So. 2d at 554 (Hornsby, C.J., dissenting).

Questions of apparent authority, like questions of agency, are generally questions of fact that are properly submitted to a jury:

> Alabama law recognizes that a finding of an agency relationship arising out of apparent authority must be based upon the conduct of the principal and not that of the agent in the transaction at issue. *Gray v. Great American Reserve Ins. Co.*, 495 So. 2d 602 (Ala. 1986); *American Standard Credit, Inc. v. National Cement Co.*, 643 F.2d. 248 (5th Cir. 1981) (applying Alabama law); *Automotive Acceptance Corp. v. Powell*, 45 Ala. App. 596, 234 So. 2d 593 (1970). In addition to the manifestations of authority by the principal, the insured party must reasonably believe that the agent has authority to bind the principal. *Wood v. Holiday Inns, Inc.*, 508 F.2d 167 (5th Cir. 1975).

Chamlee, 579 So. 2d 580, 583 (Ala. 1991) (Hornsby, C.J., dissenting).

Manifestations of apparent authority or ostensible agency may be found by the way the principal holds the agent out to the public:

> An agency relationship may arise

> from acts and appearances which lead others to believe that such relationship has been created¼ This concept of apparent authority is based upon manifestations by the alleged principal to third persons, and reasonable belief by those persons that the alleged agent is authorized to bind the principal¼ The manifestations of the principal may be made directly to the third person, or may be made to the community, by signs or advertising.

Wood v. Holiday Inns, Inc., 508 F.2d 167, 176 (5th Cir. 1975) (citations omitted).

In *Brown ex rel. Brown v. St. Vincent's Hospital*, 899 So. 2d 227 (Ala. 2004), a plurality opinion discusses the application of apparent authority to a hospital regarding an allegation of malpractice against an obstetrician. Ms. Brown, on behalf of her son who was born with shoulder dystocia resulting in permanent nerve damage, alleged that her obstetrician was the agent of the hospital under apparent authority or agency by estoppel. The plurality opinion quotes *Malmberg v. American Honda Motor Co.*, 644 So. 2d 888, 891 (Ala. 1994), for a discussion indicating that there is no real difference between agency by estoppel or agency by apparent authority. The opinion also distinguishes a number of cases from other jurisdictions that were decided on grounds that the *Brown* plurality did not expressly disapprove:

> [M]ost of those cases involved [1] patients who arrived at a hospital emergency room and were referred to the "on call" emergency physician ...; [2] patients who were treated by physicians whose practice was necessarily hospital-based, frequently under an "exclusive service contract" with the hospital, and as to whom the patient frequently had no knowledge or choice in selection, such as anesthesiologists, pathologists, and radiologists ...; and [3] patients treated at hospitals that had conducted massive advertising campaigns designed to create the impression that the hospital vouched for the competence of the physicians practicing in specialty departments of the hospitals.

Brown, 899 So. 2d at 235 (citations omitted; bracketed numbers added). In *Brown*, however, the plurality found an absence of sufficient evidence that Ms. Brown relied on the advertising that she cited as evidence that St. Vincent's Hospital held the obstetricians out as its agents:

> [W]e see no reason, under the facts of this case, to abandon our rule that "before there can be apparent authority that implies an agency relationship, the 'authority' be 'apparent' to the complaining party and that party must have relied on the appearance of authority; he cannot rely on an appearance of authority that he was ignorant of.'

899 So. 2d at 238 (citation omitted). The Court elsewhere stated the principle as follows:

> A plaintiff relying on apparent agency or agency by estoppel must "show that he was misled by the appearances relied upon. It is not enough that he might have been, ... so misled. It must also appear that he had reasonable cause to believe that the authority existed; mere belief without cause, or belief in the face of facts that should have put him on his guard is not enough.'"

899 So. 2d at 241 (citations omitted). Even though *Brown* is only a plurality opinion, it operates as a caution that a plaintiff is not likely to be able to establish that a physician was an apparent agent of the hospital based on advertising by the hospital unless the plaintiff saw and relied on that advertising. Nevertheless, it also lists, without rejecting, the three types of cases in which a hospital may be found liable for apparent agency: emergency rooms; hospital-based physicians such as anesthesiologists, pathologists, and radiologists; and massive advertising campaigns, with reliance by the plaintiff.

III. Vicarious Liability Based on Evidence of Agency

Another theory of liability against the institutional defendant is its vicarious liability for the acts or omissions of a physician, CRNA, or a nurse who is not directly employed by the hospital, surgical center, or clinic. The typical circumstances in which such vicarious liability may be found are in regard to the acts or omissions of emergency room physicians, anesthesiologists and CRNAs working in exclusive practice groups (the same principles may be applicable to other exclusive fields of practice such as pathologists or radiologists), and to physician assistants and nurses employed by such practice groups.

A. Contracts Between the Institution and Physicians

In many cases, a practice group such as anesthesiologists, radiologists, and the like provide coverage for hospitals, surgical outpatient centers, or clinics pursuant to a contractual agreement. Such an agreement is likely to contain the following provisions:

- The group is to provide licensed and qualified physicians and support personnel for the (emergency, pulmonary, anesthesiology or other) department twenty-four hours per day, seven days per week.
- Most likely, each and every physician provided by the group must be a member of the hospital's medical staff.
- The physicians will almost certainly agree on behalf of themselves and their staffers, as a condition of staff privileges, to be bound by the institution's bylaws, rules, regulations, policies, and procedures.
- The hospital, surgery center, or clinic will require adherence to the rules and regulations it sets for both the group and its physicians.
- A given physician, CRNA, or

nurse in a group will likely be an employee of the group, and as such may work *only* for the group at the institution.

- The agreement may provide that the physician group is the exclusive provider of such designated medical services at the institution.
- The institution likely will supply the group with all the equipment and personnel they require.
- The institution may even reserve the right to direct the physicians' and staffers' activities.

Language in the agreement between the hospital and the physician group may suggest that the group and its physicians are independent contractors. However, Alabama law is clear that the legal determination about an agency relationship is not affected by the way parties characterize their relationship. Rather, a court's focus must be on the underlying facts that establish the legal relationships between the parties.

The hospital, surgery center, or clinic may also argue that plaintiff has no evidence that it had direct control over the hands-on methods of treatment or patient care provided the plaintiff or the plaintiff's decedent. Such an argument would be mistaken in its reliance upon cases concerning the test for agency in cases other than professional services cases like this one. Alabama law is clear that direct control over hands-on medical treatment is not the applicable test. Courts look instead to other indicia of control rather than hands-on patient care in cases involving health care providers.

B. The Hospital May Be Vicariously Liable for the Acts And Omissions of a Physician under General Agency Principles

1. It Is Immaterial How a Hospital and a Physician Group Characterize the Relationship

"[W]hether an agency exists is determined from the facts, not by how the parties choose to characterize their relationship." *Tyson Foods, Inc. v. Stevens*, 783 So. 2d 804, 808 (Ala. 2000). *See also, Stewart v. Bay Minette Infirmary*, 501 So. 2d 441, 44344 (Ala. 1987); *Briggins v. Shelby Medical Center*, 585 So. 2d 912, 91415 (Ala. 1991); and *Curry v. Welborn Transport*, 678 So. 2d 158, 161 (Ala. Civ. App. 1996). "If the facts establish the relationship of principal and agent, the intention of the parties is immaterial, and the character of the relationship is not affected by an agreement between the parties that an agency does not exist, or that some other relation does exist." *Ragsdale v. Life Ins. Co. of North America*, 632 So. 2d 465, 468 (Ala. 1994) (quoting *Semo Aviation, Inc. v. Southeastern Airways*, 360 So. 2d 936, 940 (Ala. 1978)).

"Independent contractor" language in an Agreement with a physician group therefore cannot control a question of agency. The parties' characterization of their relationship is simply in no way material or dispositive. The examination continues to focus on whether the facts and circumstances amount to substantial evidence of control by the hospital over aspects of its relationship with the physician group other than the provision of "handson" medical care.

2. The Test for Agency in Professional Services Cases is Overall Control

While the reserved right of control over the manner and method of work is the determinative test in nprofessional cases, *see, e.g., Sharpe v. AMF Bowling Centers, Inc.*, 756 So. 2d 874 (Ala. 2000); *Danford v. Arnold*, 582 So. 2d 545 (Ala. 1991), it is distinctly not the test where medical professions are concerned. The Alabama Supreme Court expressly recognizes that there can be no "control" over the way a physician exercises professional judgment in the care and treatment of patients; therefore, courts must examine other indicia of control when determining the existence of agency among health care professionals.

In *Brillant v. Royal*, 582 So. 2d 512 (Ala. 1991), the Court cited a Tenth Circuit Court of Appeals decision with approval, *Lilly v. Fieldstone*, 876 F. 2d 857 (10th Cir. 1989), for its recognition of this crucial distinction. In *Brillant*, the Supreme Court noted as follows:

> In *Lilly*, the Tenth Circuit Court of Appeals recognized that a determination of whether a physician was an individual contractor or was an employee of the Government did not depend strictly on the "control" exerted by the Government because "[i]t is uncontroverted that a physician must have discretion to care for a patient and may not surrender control over certain medical details." 876 F.2d at 859. Therefore, the analysis employed by that court centered on "whether other evidence manifests an intent to make the professional an employee subject to other forms of control which are permissible." *Id.* In making that determination, the court in *Lilly* analyzed the following questions: (1) Did the physician have an arrangement with the hospital whereby he was always required to see patients there? (2) Did the physician bill the Army separately at his standard rates or did the physician reduce his fees when treating a military patient? (3) Could the physician maintain a private offbase office? (4) Did the physician have exclusive control over his patients and records? (5) Did the Government furnish the physician with permanent and private office space or secretarial help at the hospital? (6) Did the physician work under a written contract with the Government? (7) Was the physician regularly scheduled on the hospital duty roster? and (8) Did the physician maintain regular or prescribed office hours as a civilian physician?

Id. at 51516 (emphasis added). The Alabama Supreme Court then applied the *Lilly* rationale to the facts in *Brillant*.

Other courts have similarly recognized, like the Alabama Supreme Court in *Brillant* and the Tenth

Circuit in *Lilly*, that there can be no employer control over professional decisionmaking:

> When a professional person such as an attorney or a physician and surgeon is required by a professional code of ethics to exercise his or her independent judgment in the best interest of his or her client or patient respectively, the professional may not be controlled by the employer. If the employer were to control the independent judgment in the decisionmaking process and the performance of the professional's duties, the employer's control might conflict with the professional's primary and unequivocal duty to exercise his or her independent judgment.

Quilico v. Kaplan, 749 F.2d 480, 48485 (7th Cir. 1984).

Thus the test for agency is not whether a hospital had direct control over the manner and methods with which a physician rendered hands-on patient care. The proper test is whether there were other indicia of control aside from patient care issues from which the jury could conclude that a physician group and its physicians were the agents, servants or employees of a hospital.

3. The Elements For Testing Whether A Physician Group And Its Personnel Were Agents of a Hospital

Briggins v. Shelby Medical Center and Stewart v. Bay Minette Infirmary, cited above, are the two principal decisions that establish when jury questions are present on the issue of agency in the medical liability setting. *See Briggins*, 585 So. 2d 912; *Stewart*, 501 So. 2d 441. These two cases demonstrate that a jury question is deemed to exist on the issue of agency when a plaintiff can prove some or all of the following facts:

1. The physician, CRNA or nurse was on the hospital's "staff";
2. The institution provides personnel, equipment and supplies;
3. The institution bills for the physician's fee;
4. The institution requires the physician, CRNA, or nurse to follow its rules and regulations; and/or
5. The physician, CRNA, or nurse works solely at the hospital, surgical center, or clinic.

These facts, and others like them, will usually be established within the four corners of the professional services contract between the institution and the health care provider.

4. Courts Uniformly Hold That the Existence of Agency Is a Question of Fact for the Jury's Determination

On evidence such as that set forth above, the principle should apply that "whether an agency exists is determined from the facts, not by how the parties choose to characterize their relationship." *Tyson Foods, Inc. v. Stevens*, 783 So. 2d 804, 808 (Ala. 2000); *Ragsdale v. Life Ins. Co. of North America*, 632 So. 2d 465 (Ala. 1994); *Briggins v. Shelby Medical Center*, 585 So. 2d at 915.

Courts from other states have held hospitals liable for the acts of physicians under agency principles in many reported opinions. For example, the Supreme Court of California stated that a nurse employed by a physician may be deemed the servant of the hospital, thus resulting in liability under the doctrine of *respondeat superior*. *Rice v. California Lutheran Hospital*, 27 Cal.2d 296, 163 P.2d 860 (1945). The Supreme Court of Kentucky in *Paintsville Hospital Co. v. Rose*, 683 S.W.2d 255 (Ky. 1985), reversed a summary judgment in favor of a hospital upon concluding that a physician working in its emergency room was an agent. In *Kelly v. Rossi*, 395 Mass. 659, 481 N.E.2d 1340 (1985), the Supreme Court of Massachusetts held a resident physician at a hospital was a "servant" of the hospital, thus potentially exposing the hospital to liability for torts committed within the line and scope of her employment. The Supreme Court of Minnesota rejected the argument that a physician could never be deemed an agent or servant of a hospital because of the requirement that he exercise his own independent judgment. *Moeller v. Hauser*, 237 Minn. 368, 54 N.W.2d 639 (1952). Instead, the Court declared it unreasonable to characterize the physician as an independent contractor while performing "the routine hospital functions for which he is hired." The Court concluded that under such circumstances a physician who is paid by the hospital for providing medical care as part of the regular hospital routine is a servant such that the hospital is liable under the doctrine of *respondeat superior*. *See, also, e.g., Bing v. Thunig*, 2 N.Y.2d 656, 163 N.Y.S.2d 3, 143 N.E.2d 3 (1957); *Morwin v. Albany Hospital*, 7 App. Div.2d 583, 185 N.Y.S.2d 85 (3d Dept. 1959); *Klema v. St. Elizabeth's Hospital*, 170 Ohio St. 519, 166 N.E.2d 765 (1960); *Sloan v. Metropolitan Health Council*, 516 N.E.2d 1104 (Ind. Ct. App. 1987); *Dunn v. Praiss*, 606 A.2d 862 (N.J. Super. Ct. App. Div. 1992); John D. Hodson, Ph.D., J.D., Annot., *Liability of Hospital or Sanitarium for Negligence of Physician or Surgeon*, 51 A.L.R. 4th 235 (1987); Martin C. McWilliams, Jr., Hamilton E. Russell, III, *Hospital Liability for Torts of Independent Contractor Physicians*, 47 South Carolina Law Review 431 (Spring, 1996).

C. A Hospital Has a NonDelegable Duty to Provide Safe and Effective Care to its Patients

In addition to a hospital's vicarious liability under a contract for a physician's actions, the hospital is directly liable for breach of its *nondelegable duty* to provide safe and effective emergency treatment.

Nondelegable duties may be imposed as a matter of law or by contract. *DuPont v. Yellow Cab Co. of Birmingham, Inc.*, 565 So. 2d 19094 (Ala. 1990); *Elder v. E. I. DuPont de Nemours & Co.*, 479 So. 2d 1243, 124849 (Ala. 1985); *Holly v. St. Paul Fire & Marine Ins. Co.*, 396 So. 2d 75, 80 (Ala. 1981). In *Dickinson v. City of Huntsville*, 822 So. 2d 411, 418 (Ala. 2001), the Court quoted the following statement from *Baccari v. De Santi*, 70 A.D.2d 198, 203, 431 N.Y.S.2d 829, 832 (1979): "When a

specific duty has been imposed upon a person or governmental entity by statute, responsibility for misfeasance cannot be avoided by delegating the performance of the duty to an independent contractor."

A hospital's nondelegable duty to provide competent medical care may arise from one or more of the following: (1) regulations imposed upon all hospitals which are recipients of federal funding under Medicare/ Medicaid; (2) the fact that the hospital voluntarily undertook to provide emergency medical care to the patient; and (3) the fact that the Alabama Legislature has imposed a minimum standard of care upon all health care providers who operate in this State pursuant to Ala. Code § 65584(a) (1975).

1. Medicare/Medicaid Regulations

By accepting Medicare and Medicaid funds from the United States government, a hospital assumes a nondelegable duty to provide for safe patient care, including safe emergency care and treatment. A hospital that accepts these funds is subject to federal regulations imposed by the Department of Health and Human Services' Health Care Financing Administration concerning Conditions of Participation for Hospitals. 42 CFR Parts 405, 412, 416, 417, 440, 441, 456, 482, and 489. Under these regulations, it is a condition of the hospital's participation in the Medicare and Medicaid programs that it bears the non-delegable responsibility for all contracted services.

The requirements on the governing body of the hospital as "conditions of participation" in Medicare and Medicaid programs are dictated in Section 482.12. The section begins with the statement that "The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution." 42 CFR § 482.12, first sentence. Section 482.12 mandates that a hospital "must be responsible for services furnished in the hospital whether or not they are furnished under contracts":

> (e) Standard: Contracted services. The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services.
>
> (1) The governing body must ensure that the services performed under a contract are provided in a safe and effective manner.
>
> (2) The hospital must maintain a list of all contracted services, including the scope and nature of the services provided.

42 CFR § 482.12(e).

As specifically regards the provision of anesthesia services, 42 CFR § 482.52 states:

> If the hospital furnishes anesthesia services, they must be provided in a well-organized manner under the direction of a qualified doctor of medicine or osteopathy. The service is responsible for all anesthesia administered in the hospital.

The comments contained in the Federal Register adopting the regulations clearly make the governing body of the hospital responsible for contracted services furnished in the hospital.

Standard for Contracted Services (§ 482.12(e))

NPRM Provisions. The 1983 NPRM was intended to clarify that the hospital has ultimate responsibility for services, whether they are provided directly, such as by its own employees, by leasing, or through arrangement, such as formal contracts, joint ventures, informal agreements, or shared services. Because many contracted services are integral to direct patient care and are important aspects of health and safety, a hospital cannot abdicate its responsibility simply by providing that service through a contract with an outside resource. For purposes of assuring adequate care, the nature of the arrangement between the hospital and the "contractor" is irrelevant. The NPRM, therefore, proposed to specify that the governing body must be responsible for these services and that the services must be provided in a safe and effective manner . . .

51 *Fed Reg* 116 (1986), 22015 (emphasis added). It follows that a hospital is strictly liable for the "safe and effective" provision of emergency, anesthesia, or other services at its hospital regardless of whether those services were actually rendered by contractors, joint venturers, or anyone else.

If the hospital holds itself out to the public as providing emergency or anesthesia services (and perhaps others as well), and is a recipient of Medicare/Medicaid funding, it may not delegate the safe provision of emergency care to physician groups as a matter of law. Instead, as the recipient of federal funding, the hospital bears liability for the care rendered in its emergency department.

2. Voluntarily Undertaking to Provide Medical Services

Alabama recognizes the doctrine that one who volunteers to act, though under no duty to do so, is thereafter charged with the duty of acting with due care and is liable for negligence in connection therewith. *Dailey v. City of Birmingham*, 378 So. 2d 728, 729 (Ala. 1979). This common law principle has application in virtually any factual scenario, e.g., hospitals (*Chandler v. Hosp. Authority of City of Huntsville*, 548 So. 2d 1384 (Ala. 1989); *Bowden v. Wal-Mart Stores, Inc.*, 124 F.Supp.2d 1228 (M.D. Ala. 2000). A hospital that provides a full service emergency medical facility that is open to the public has a duty to provide such services within the standard of care. Any breach of that voluntarily assumed duty of care

which proximately causes injury will necessarily lead to liability. See *Chandler, supra.*

The voluntary undertaking theory may be applied to any institutional health-care provider that puts physicians, CRNAs, physician's assistants, and nurses in the position where their voluntary undertakings result in harm.

3. The Alabama Legislature Imposes a Minimum Standard of Care on Hospitals

In Ala. Code § 65484(a) (1975), the Alabama Legislature defined the degree of care owed to a patient by hospitals:

> Degree of Care Owed to Patient
>
> a. In performing professional services for a patient, a physician's, surgeon's, or dentist's duty to the patient shall be to exercise such reasonable care, diligence and skill as physicians, surgeons, and dentists in the same general neighborhood, and in the same general line of practice, ordinarily have and exercise in a like case. In the case of a hospital rendering services to a patient, the hospital must use that degree of care, skill and diligence used by hospitals generally in the community.

Id. (emphasis added). The Supreme Court interpreted this statute to mean that a hospital owes those present in connection with care and treatment a duty to exercise that degree of care, skill and diligence had and exercised by those hospitals engaged in the same kind of operation, in similar conditions, or under similar circumstances. *Lamont v. Brookwood Health Servs., Inc.*, 446 So. 2d 1018 (Ala. 1983). The word "community" means the "national hospital community." *Coleman v. Bessemer Carraway Methodist Medical Ctr.*, 589 So. 2d 703 (Ala. 1991). The jury instructions about a hospital's standard of care in such cases is typically:

> Hospital Duty to Patient Services
>
> In rendering services to a patient, a hospital must use that degree of care, skill and diligence used by hospitals in the same general neighborhood under the same or similar circumstances. The same general neighborhood means the national hospital community.

Alabama Pattern Jury Instruction No. 25.07.

Because a hospital invites patients to come to the hospital for medical treatment and contractually undertakes to provide emergency services for such patients, the hospital may be held directly liable for any deviations from the standard of care imposed by the Alabama Legislature for the provision of such services at the hospital.

4. The Hospital May Have Breached its Duties Contractually Undertaken in its Agreement with an Emergency Physician Group

The Alabama Supreme Court recognized that parties may enter a contract which imposes duties upon them to act for the benefit of third parties in *Lance, Inc. v. Ramanauskas*, 731 So. 2d 1204 (Ala. 1999):

> The parents direct our attention to *Harris v. Board of Water & Sewer Comm'rs of City of Mobile*, 294 Ala. 606, 320 So. 2d 624, 630 (1975), where this Court, citing *Havard v. Palmer & Baker Engineers, Inc.*, 293 Ala. 301, 302 So. 2d 228 (1974), held that 'where one party to a contract assumes a duty to another party to that contract, and it is foreseeable that injury to a third party not a party to the contract may occur upon a beach of that duty, the promissor owes a duty to all those within the foreseeable area of risk.' The foreseeability of injury to others upon the negligent performance of a contract is the touchstone of tort liability to a third party. *See Berkel & Co. Contractors, Inc. v. Providence Hospital*, 454 So. 2d 497 (Ala. 1984).

Id. at 12089. When a hospital and a physician group enter into a contract to provide emergency medical care for patients at the hospital, that contract, along with Ala. Code § 6-5-484, defines the standard of care owed to those patients. Injuries to those patients when the parties deviate from the requisite standard of care are certainly foreseeable. Thus, a hospital may be liable for deviations from the standard of care defined in its contract which proximately cause injury to a patient.

D. The Hospital May Be Liable For Its Nurses' Failure to Advocate for the Patient When A Physician Gives Incompetent Care

Another source of liability of the hospital that is akin to vicarious liability for a physician's negligence is really an example of the hospital's direct liability for the actions of its nursing-staff employees.

1. A Hypothetical Example

Consider an example: An elderly woman on Coumadin, an anticoagulant, falls and hits her head. She goes to the emergency room with an obvious head wound, but the emergency room physician elects not to order a CT scan, choosing instead to place the woman in the hospital for observation.

The next day, over the course of five hours, the patient deteriorates neurologically. On four different occasions, the nurse informs the attending physician, who is out of the hospital, of the progressive deterioration, but the doctor elects not to visit the patient and instead enters phone orders for medications. The woman becomes comatose and is transferred to another hospital, where she receives a CT scan, and a subdural hematoma is discovered. The woman dies.

When the woman's family files suit, they learn that the physicians have woefully inadequate insurance coverage. Is there a way to impose liability on the hospital for the acts and omissions of its nurses even though the physicians arguable were principally at fault? One area of potential nursing

liability that plaintiff lawyers should thoroughly explore is whether the nurse failed to fulfill his or her duty as an advocate for the patient.

It is axiomatic that nurses serve as advocates for their patients. When something goes wrong and a doctor breaches the standard of care, the nurse has a duty to speak up.

> The ANA's *Code of Ethics for Nurses* describes this duty:
>
> As an advocate for the patient, the nurse must be alert to and take appropriate action regarding any instances of incompetent, unethical, illegal, or impaired practice by any member of the health care team or the health care system or any action on the part of others that places the rights or best interest of the patient in jeopardy. To function effectively in this role, nurses must be knowledgeable about the Code of Ethics, standards of practice of the profession, relevant federal, state, and local laws and regulations, and the employing organization's policies and procedures.

Am. Nurses Ass'n, *Code of Ethics for Nurses with Interpretive Statements*, § 3.5, at 14 (A. Nurses Publ'g 2001).

In our hypothetical scenario, this duty required the nurse to follow a chain-of-command protocol to seek consultation with another physician to protect the patient from the attending physician's negligence. Hospitals routinely have policies and procedures in place that outline the steps to be followed. The nurse's failure to act as an advocate for the patient was a breach of duty that exposed the hospital to liability for the patient's injuries.

2. Evolution of the Duty

An early and oft-cited case on the subject of a nurse's duty to question a doctor's orders is the Illinois Supreme Court's 1965 decision in *Darling v. Charleston Community Memorial Hospital*, 211 N.E.2d 253 (Ill. 1965). The plaintiff in that case went to a hospital with a broken leg. After a cast was placed on it, he experienced great pain and his toes became swollen and dark, then cold and insensitive. Ultimately, his leg had to be amputated below the knee.

In his lawsuit against the hospital, the plaintiff claimed 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." *Id.* at 256. The jury found for the plaintiff.

Upholding the verdict, the Illinois high court found that the jury could reasonably have concluded that skilled nurses would have recognized the dangerous circulation problems and informed hospital authorities if the attending physician failed to act. *Id.* at 258. Many jurisdictions cite the holding in the *Darling* case on this point.

In 1968, the Court of Appeals of New York ruled in *Toth v. Community Hospital at Glen Cove* that "the primary duty of a hospital's nursing staff is to follow the physician's orders," but then stated in a footnote that "an exception to the rule would exist where the hospital staff knows that the doctor's orders are so clearly contraindicated by normal practice that ordinary prudent [sic] requires inquiry into the correctness of the orders." *Toth v. Cmty. Hosp. at Glen Cove*, 239 N.E.2d 368, 449 n. 3 (N.Y. 1968).

Despite the clear statements of a nurse's duty to question a physician's orders in both *Darling* and *Toth*, few cases were reported on the subject until a 1977 case triggered the rule's resurrection.

In *Utter v. United Hospital Center, Inc.*, the West Virginia Supreme Court reinstated a verdict against a hospital, holding that credible evidence existed that the hospital's nursing staff negligently provided care for a patient. The court noted that the patient's "deterioration continued even though the nurses called the treating physician and he, on some occasions, visited and treated the patient." *Utter v. United Hosp. Ctr.*, 236 S.E.2d 213, 215 (W. Va. 1977). The court relied largely on a nursing manual, noting, "When the doctor did nothing further, the nurse did not call the departmental chairman or any other doctor as required by the pertinent provision of the nursing manual." *Id.* The opinion includes this strong language:

> Nurses are specialists in hospital care who, in the final analysis, hold the well-being, in fact in some instances, the very lives of patients in their hands. In the dim hours of the night, as well as in the light of day, nurses are frequently charged with the duty to observe the condition of the ill and infirm in their care. If that patient, helpless and wholly dependent, shows signs of worsening, the nurse is charged with the obligation of taking some positive action.

Id. at 216.

Numerous other state courts have applied a similar duty of care to nurses. In *Bost v. Riley*, the Court of Appeals of North Carolina cited *Darling* and held that a hospital has a duty "to make a reasonable effort to monitor and oversee the treatment which is prescribed and administered by physicians practicing at the facility," and that a nurse "has the duty not to obey instructions of a physician which are obviously negligent or dangerous." *See Bost v. Riley*, 262 S.E.2d 391, 396 (N.C. App. 1980). The Indiana Court of Appeals followed *Darling* and *Toth* in *Poor Sisters of St. Francis Seraph of Perpetual Adoration, Inc. v. Catron.*, 435 N.E.2d 305 (Ind. App. 1982). The court held that hospital employees' failure to recognize and report changes in a patient's condition may constitute a breach of the standard of care. *Id.* at 308 (citing *Toth*, 239 N.E.2d 368); *see also Vogler v. Dominguez*, 624 N.E.2d 56, 63 (Ind. App. 1993), (stating that "[i]f a nurse or other hospital employee fails to report changes in a patient's condition and/or question a doctor's orders when they are not in accord with standard medical practice and the omission results in injury to the patient, the hospital will be liable for its employee's negligence"). The Kentucky Court of Appeals held in *NKC Hospitals, Inc. v. Anthony* that "the defense that the hospital's nurses were only following a 'chain of command' by doing what Dr. Hawkins ordered

is not persuasive. The nurses were not the agents of Dr. Hawkins. All involved had their independent duty to [the patient]." *NKC Hosps., Inc. v. Anthony*, 849 S.W.2d 564, 569 (Ky. App. 1993).

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