

## HOSPITAL CORPORATE LIABILITY AND INSTITUTIONAL NEGLIGENCE

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### A. Employee Negligence

It is now well settled in North Carolina that a hospital, like any other employer, may be liable under the doctrine of *respondeat superior* for the negligent acts and omissions of its employees while acting within the course and scope of their employment. As with any case in which agency is an issue, the elements of agency must be established by evidence. In the typical malpractice case the battle usually rages over whether the offending provider is an agent (employee) of the hospital, or is an independent contractor. The hospital would have no liability in the latter case. In *Willoughby v. Wilkins*, 65 N.C. App. 626, 310 S.E.2d 90 (1983), *disc review denied*, 319 N.C. 631, 315 S.E.2d 697 (1984).

While it is generally true that physicians are treated as independent contractors, they may in some cases be agents of the hospital. Thus, where a hospital had contracted with an emergency room physician and under the terms of the contract the doctor was guaranteed a salary, his work was scheduled by the hospital including vacation and sick leave, and the hospital billed for and collected all the fees he generated, the hospital was deemed to have sufficient control over the doctor's work to create an agency. *Rucker v. High Point Mem. Hospital*, 20 N.C. App. 650, 202 S.E.2d 610, *aff'd* 285 N.C. 519, 206 S.E.2d 196 (1974). Likewise, in *Willoughby*, *supra*, the court found an agency relationship where the hospital 1) required the doctor to work a specified number of days in the emergency department, 2) the doctor's work schedule was subject to approval of the hospital, 3) the doctor, by the terms of his contract, could not maintain a private practice, and 4) the doctor was required to fulfill hospital quality assurance standards.

If the defendant physician is a resident, the relationship can sometimes be problematic. In *Smock v. Brantley*, 76 N.C. App. 73, 331 S.E.2d 714 (1985), *disc review denied*, 315 N.C.590, 341 S.E.2d 30 (1985) the defendants were the attending (Dr. Brantley) and a first-year resident (Dr. Henley). The claim was for damages for injury

suffered by a child at birth. The mother, in labor, went to the emergency room at defendant Nash General Hospital. She was not treated there, but was admitted and taken to the labor and delivery area. Dr. Henley was doing a two month rotation at the hospital in family practice. He had been assigned there by UNC School of Medicine. He was supervised and evaluated by the staff physicians at Nash General Hospital. His salary was paid by UNC. Dr. Henley did the initial workup and called the attending, Dr. Brantley, an obstetrician. Dr. Brantley was in private practice with staff privileges at the hospital. Dr. Henley assisted at the birth of the minor plaintiff. Things apparently did not go well and plaintiffs brought suit against Dr. Brantley and the hospital. They alleged both doctors to be agents of the hospital. The trial court granted summary judgment for the hospital. On appeal, the issue presented was whether either or both of the doctors were agents of the hospital.

The court, relying on *Smith v. Duke University*, 219 N.C. 628, 14 S.E.2d 643 (1941) held as a matter of law Dr. Brantley was not an agent of the hospital. As to Dr. Henley, he was identified to plaintiffs as resident from UNC and was paid by UNC. There was no evidence to suggest that Nash General in any way reviewed, evaluated or supervised Dr. Henley. The hospital had no rules or regulations governing residents. He was not an agent of the hospital.

Of course, if the allegedly negligent physician is an employee of the hospital, the hospital would be vicariously liable. *Waynick v. Reardon, et al.*, 235 N.C. 116, 72 S.E.2d 4 (1952).

A very interesting case is *University of North Carolina v. Shoemate*, 113 N.C. App. 205, 437 S.E.2d 892, disc. review denied, 336 N.C. 615, 447 S.E.2d 413 (1994) in which an individual, Shoemate, was hired by the UNC Hospital Department of Psychiatry based on forged documents and misrepresentation of his educational credentials. For more than a year he treated patients at the hospital before the fraud was discovered. A patient he had treated sued the hospital, and the hospital brought this declaratory judgment action alleging it was not obligated to provide Shoemate with malpractice coverage because its contract with him was void. The court ruled that the university had to provide coverage and that

the absence of a valid contract was immaterial.

The court found that the Trust Fund did not require valid employment as a condition of coverage, noting that “[a]n agent of UNC is not synonymous with an employee of UNC.” Shoemate had seen patients, ordered lab tests, ordered consultations, in short, acted fully as if he was a bona fide resident physician and at all times he was under the supervision and control of the hospital and its employees.

*Shoemate* was not technically a case arising under the doctrine of apparent or ostensible agency, although both the language of the case and the definition of the doctrine incorporate principles of equitable estoppel. The broad definition of this doctrine is enunciated in the Alaska case of *Fletcher v. South Peninsula Hospital*, 71 P.3d 833 (Alaska 2003). The Alaska court stated:

“One who employs an independent contractor to perform services for another which are accepted in the reasonable belief that the services are being rendered by the employer or his servants, is subject to liability for physical harm caused by the negligence of the contractor in supplying such services, to the same extent as though the employer were supplying them himself or by his servants.”

The North Carolina Court of Appeals defined the doctrine this way:

“An agent’s apparent authority is that authority which the principal has held the agent out as possessing, or which he has permitted the agent to represent that he possesses, and which the principal is estopped to deny.”

*McGarity v. Craighill*, 83 N.C. App. 106, 349 S.E.2d 311, 313 (1986). *Deal v. North Carolina State University*, 114 N.C. App. 643, 442 S.E.2d 360 (1994) was a claim by a college student for damages for injuries he sustained in a fall after receiving a measles vaccine. Due to an outbreak of measles at N.C. State, the university was ordered by the Wake County Health Department to immunize students who had not been vaccinated against measles. The vaccinations were administered by employees of the Health Department, employees of the university, and temporary nurses provided by temporary agencies. One of the temporary nurses administered the vaccination to plaintiff despite his having told her that he had been suffering from the flu, a counterindication for the injection. The court, applying principles of equitable estoppel, determined that plaintiff

failed to show the requisite reliance on the university for its medical expertise in the matter.

Lack of evidence of the requisite reliance also doomed the plaintiff in *Hoffman v. Moore Regional Hospital*, 114 N.C. App. 248, 441 S.E.2d 567, disc. review denied, 336 N.C. 605, 447 S.E.2d (1994) in which the patient was referred to the hospital for a renal arteriogram. The referring physician did not have staff privileges at the hospital so he made arrangements with a physician who held staff privileges to order the procedure. The procedure was to be performed by a radiologist, who was never identified to the plaintiff beforehand. The radiologist who did the procedure was a member of Pinehurst Radiology Group and the Group determined which of its members would work at the hospital at any given time. The radiologist met with the patient before the procedure, and then performed the angioplasty. The patient suffered complications of the procedure, ultimately resulting in her death. The court quickly concluded that the radiologist was not a hospital employee, and then considered whether the hospital was vicariously liable under the doctrine of apparent agency. There was no evidence that the patient had relied upon any representation that the radiologist was an agent of the hospital or that she would have sought treatment elsewhere had she known the radiologist was not employed by the hospital.

## **B. Non-Employee Negligence - Corporate Liability**

Prior to the 1966 case of *Darling v. Charleston Community Mem. Hospital*, 33 Ill.2d 326, 211 N.E.2d 253 (1965), cert. denied, 383 U.S. 946 (1966), a hospital generally had no duty to monitor a patient's leg was amputated following improper casting by a physician. Hospital nurses allegedly failed to monitor the leg's circulation as frequently as necessary and did not heed obvious signs of impaired circulation. The hospital contended it could not be held directly responsible (as opposed to being vicariously liable) since a hospital does not practice medicine and, consequently, the only duty it owed the patient was limited to using reasonable care in selecting medical doctors for its staff. The court didn't buy it:

“The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact. Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. They regularly employ on a salary basis a large staff of physicians, nurses and interns, as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such services, if necessary, by legal action. Certainly, the person who avails himself of ‘hospital facilities’ expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility.

*211 N.E.2d at 257.* The court went on to hold that the hospital had a duty to review the physician’s work or require a consultation.

The doctrine of corporate liability extends a hospital’s responsibility, in some cases, for the negligent acts of health care providers who are not employees of the hospital. North Carolina specifically adopted the doctrine in *Bost v. Riley, et al.*, *44 N.C. App. 638, 262 S.E.2d 391, disc. review denied, 300 N.C. 194, 269 S.E.2d 621 (1980)*. In *Bost*, the minor decedent was injured in a bicycle accident. He was taken to Catawba Memorial Hospital, where Dr. Riley diagnosed a delayed rupture of the spleen and did a splenectomy. Dr. Riley went on vacation and his partners cared for the child while he was gone. After a period of improvement, the child developed what was diagnosed as peritonitis, and he was treated with antibiotics. Following some improvement, he was taken out of ICU. He then worsened and exploratory surgery disclosed a volvulus requiring resection of about three feet of intestine. He failed to thrive and, following transfer to N.C. Baptist Hospital, he died. The trial court directed a verdict for the hospital.

The court noted evidence that the defendant surgeons failed to keep progress notes on the child’s condition for several days in violation of rules promulgated by the hospital. The hospital took no action in response to this failure. The court found 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.” Citing a number of older cases, the court enumerated these duties that a hospital owes to its patients:

1. The duty to make a reasonable inspection of equipment it uses in the treatment of patients and remedy any defects discoverable by such inspection. *Payne v. Garvey*, 264 N.C. 593, 142 S.E.2d 159 (1965).
2. The duty to provide equipment reasonably suited for the use intended. *Starnes v. Hospital Authority*, 28 N.C. app 418, 221 S.E.2d 733 (1976).
3. The duty not to obey instructions of a physician which are obviously negligent or dangerous. *Byrd v. Hospital*, 202 N.C. 337, 162 S.E.2d 738 (1932).
4. The duty to adequately investigate the credentials of a physician selected to practice at the facility. *Robinson v. Duszynski*, 36 N.C. App. 103, 243 S.E.2d 148 (1978).

These are all duties required of hospitals which flow directly to the patient and a breach of any of these duties is a basis for liability separate and apart from *respondeat superior*. As an aside, the directed verdict for the hospital was affirmed

In *Blanton v. Moses H. Cone Mem. Hospital*, 319 N.C. 372, 354 S.E.2d 455 (1987) the court reinforced the holding in *Bost*, especially as to the hospital's duty to exercise ordinary care in the selection of physicians. If a hospital grants clinical privileges to a surgeon to perform operations without first ascertaining that he/she is competent or qualified to perform them, the hospital can be held liable. The hospital has an obligation to enforce JCAOH standards.

Another potential area for hospital corporate liability lies in the realm of investigative or experimental procedures. For example, when a medical implant device is being investigated prior to obtaining approval of the Food and Drug Administration, the surgery may be performed only pursuant to an Investigational Device Exemption (IDE), 21 C.F.R. §812. The FDA requires that all surgeries be monitored by the hospital's Investigational Review Board (IRB), 21 C.F.R. §56. If the hospital is one in which the investigational device may be used, the regulations require the hospital to: 1) establish within its organization an IRB that is thoroughly versed in an understanding of the FDA

IRB/IDE regulations, and 2) establish a policy and understanding within the hospital that this board must be informed before an investigational device is used. The hospital must also seek out and monitor every new device utilized by surgeons to insure regulatory compliance. The FDA regulations also require the hospital to obtain an informed consent form from the patient acknowledging that the device to be used is investigational.

To my knowledge, no one has successfully pursued a claim against a hospital for damages arising out of the hospital's violation of these regulations.<sup>1</sup> Note that in *Osburn v. Sofamor-Danek Group, Inc., et al.*, 135 N.C. App. 234, 520 S.E.2d 88 (1999), the court held that a physician (and presumably a hospital) is not required by N.C.G.S. §90-21.13 to inform a patient that a surgical procedure is experimental in nature. It is sufficient if the physician informs the patient of the risks involved in the procedure "in accordance with the standards of practice" and in such a manner that a reasonable person, under the circumstances, would have enough information of the hazards to consent to the procedure. Presumably, that applies with equal force to any duty of informed consent on the part of a hospital. The court also held that plaintiff was precluded from bringing an action in state court to redress alleged violations of the Food, Drug & Cosmetics Act. 21 U.S.C. §337(a). However, evidence of violation of FDA regulations is admissible to substantiate a claim under state law, independent of the federal statute. Thus, evidence of a violation of the federal regulations, while not giving rise to an claim in and of itself, could be relevant in a claim against a hospital for negligent monitoring of hospital staff, discussed next.

### **C. Negligent Monitoring and Supervision of Staff Physicians**

As noted above, one of the duties imposed on a hospital under the doctrine of

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<sup>1</sup> There may be claims of preemption so anyone considering such a claim should become familiar with *Medtronic, Inc. v. Lohr*, 518 U.S. 470 (1996). The Court held that the Medical Devices Amendment to the Food, Drug & Cosmetic Act (MDA) did not deny a state the right to provide traditional remedies for violations of common law duties when those duties paralleled federal requirements. Preemption would have the effect of granting complete immunity from design defect liability to an entire industry that needed stringent regulation because there was no explicit private cause of action against manufacturers in the MDA. The Medtronic pacemaker involved in the case pre-dated the MDA.

corporate liability is the duty to select and retain competent physicians. This duty presents significant obligations for the hospital with respect to credentialing and recredentialing physicians who seek to obtain and keep hospital privileges.

Inquiries by the hospital granting privileges might include: references from prior employers and educators, letters of reference from colleagues, and queries to the National Practitioner Data Bank (required by statute in some states).

*Blanton* established in North Carolina that a hospital can incur liability by granting privileges to a physician who is not qualified. A hospital owes a duty to its patients to ascertain that a doctor “is qualified to perform an operation before granting him the privilege to do so.” The North Carolina Administrative Code, 10A N.C.A.C. §13B.3701 *et seq.* imposes several requirements on hospitals and hospital medical staffs to establish by-laws, procedures, rules and regulations for credentialing. In addition, The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) promulgates standards for credentialing with which a hospital must comply for accreditation purposes.

*Shelton v. Morehead Mem. Hospital, et al.*, 318 N.C. 76, 347 S.E.2d 824 (1986) involved plaintiff’s efforts to obtain discovery of the hospital medical review committee documents along with documents from the hospital Board of Directors. She had suffered a bladder laceration and other complications during a hysterectomy. The surgeon, Dr. Ross, had died in an automobile collision prior to the suit having been filed and plaintiff alleged that he was incompetent and that his incompetence was known both to medical staff and to the Board. The court held that the records and materials produced by the medical review committee were immune from production, although the plaintiff was not barred from obtaining documents considered by the committee from other sources. Documents generated by the committee were immune from production. The Board of Directors of the hospital was not a “medical review committee” within the meaning of N.C.G.S. §131E-95 and plaintiff could obtain discovery from the Board.

*Sharpe v. Worland, et al.*, 137 N.C. App. 82, 527 S.E.2d 75 (2000) is another discovery case. In *Sharpe* defendant anesthesiologist had participated in the Physician’s Health Program (PHP), a treatment program operated by the N.C. Medical Society to deal

with and provide treatment for physicians having such impairments as substance abuse, alcoholism, mental illness, sexual misconduct, etc. By statute, N.C.G.S. §90-21.22, records of the PHP are not subject to discovery or subpoena from the program. Plaintiff, however, sought discovery not from PHP, but from the hospital where defendant had privileges. The court held that the documents were privileged, distinguishing the case from *Shelton*. The statute under review in *Shelton*, N.C.G.S. §131E-95, contained language allowing plaintiff to secure the documents from other sources. N.C.G.S. §90-21.22 contained no such language. Public policy favors encouraging physicians to participate in the program and they might be reluctant to do so if they thought records in connection with their treatment would be discoverable.

Finally, *Carter v. Hucks-Follis, et al.*, 131 N.C. App. 145, 505 S.E.2d 177 (1998) considered whether a hospital's failure to consider a lack of board certification in granting privileges to a neurosurgeon could expose the hospital to liability if the surgeon was negligent in performing surgery at the hospital. The evidence showed that Dr. Hucks-Follis was not board certified, a fact he disclosed on his application for re-credentialing. He had also failed the boards three times before operating on plaintiff. JCAHO standards provided, in part, that board certification was a factor "to be considered" in passing on an application for hospital staff privileges. The trial court granted the hospital's summary judgment motion. The court held that awareness is not equivalent to consideration, and there was a genuine issue of material fact as to whether the hospital had, in fact, "considered" the doctor's lack of board certification in awarding him privileges.

The Health Care Quality Improvement Act, 42 U.S.C. §11101 *et seq.*, created the National Practitioner Data Bank. Under the Act, participants in profession review proceedings are given immunity from liability in any federal action arising on account of the peer review proceeding. The Act also requires reporting of malpractice payments, whether by settlement or judgment. Discovery of information provided to the Data Bank is generally not discoverable, unless negligent credentialing is an issue in the case. The Act provides that no presumption that malpractice occurred arises from any payment. The Act was promulgated in response to the practice within the medical community of incompetent

physicians simply moving from one state to another without disclosure or discovery of his/her previous incompetent performance. 42 U.S.C. §11101(2). The Data Bank is required to pass this information along to any hospital whenever a physician requests appointment to the medical staff. In some cases, the information may be given to a health care entity, such as an HMO which may be considering employing the physician. The information is not available to the public and cannot be obtained from the Data Bank. However, if it is alleged that the hospital failed to get the information from the Data Bank before awarding staff privileges, plaintiff may get the information concerning that physician. 45 C.F.R. §60.11(5).

#### **D. Nursing Negligence**

In the overall context of hospital liability, malpractice by a nurse employed by the hospital would expose the hospital to vicarious liability. This would include such errors as the failure to properly check an IV site and pump resulting in an infiltrate or slough, or failure to administer proper medication. Nurses are included in the definition of health care providers found in N.C.G.S. §90-21.11 and, therefore, expert testimony is required to establish a breach of the standard of care.

In *Haney v. Alexander*, 71 N.C. App. 731, 323 S.E.2d 430 (1984) the trial court directed a verdict in plaintiff administrator's claim against a hospital for negligent nursing care. Plaintiff had submitted two experts, an internist and a family practitioner with regard to the applicable standard of nursing care involved. Plaintiff's experts testified that they taught and worked with nurses and were familiar with nursing standards based on their day-to-day dealings with them. The court reversed the directed verdict for the hospital, holding that the experts demonstrated sufficient knowledge of the relevant standard of care to be deemed expert witnesses. Query whether this same result would obtain today, given the restrictions imposed by Rule 702, Rules of Evidence, enacted in 1996.

One odd case is *Harris v. Miller*, 335 N.C. 379, 438 S.E.2d 731 (1994) in which the court drew upon the "borrowed servant" doctrine to impute the negligence of a nurse anesthetist to the surgeon. The nurse, a CRNA, was an employee of the hospital, but the

hospital's Anesthesia Manual (the hospital did not have a staff anesthesiologist) provided that the CRNA worked under the "responsibility and supervision" of the surgeon. The surgeon was shown to know the principles of anesthesia administration and in fact, on one occasion during the surgery, had directed the nurse to stop all anesthesia and give the patient 100% oxygen. The evidence supported an inference that the surgeon enjoyed authoritative control over the CRNA and was, during the surgery, "his temporary master."

A nurse may become vicariously liable for the negligence of a physician if the nurse obeys a physician's order that is "so obviously negligent as to lead any reasonable person to anticipate that substantial injury would result to the patient by the execution of the order." *Byrd v. Marion Gen. Hospital*, 202 N.C. 337, 162 S.E.2d 739 (1932) in which plaintiff was to be placed in a "sweat cabinet" for treatment of a seizure. Plaintiff was badly burned because she wasn't properly wrapped in toweling. The physician was present at the time the treatment was administered and directed the nurse to keep the patient in the "sweat cabinet" for thirty minutes. There was nothing to alert the nurse that the failure to use more Turkish towels to wrap the patient would result in the burns, so she escaped liability at the expense of the doctor.

The *Byrd* case illustrates two important aspects of nursing in the first half of the twentieth century. First, the nurse who disobeyed a physician's order was excused only if the order was so negligent that an ordinary person would realize its danger. Second, the quality of nursing education at that time varied so widely that it was probably in the patient's best interest to restrict the nurse's judgment regarding physician's orders. Since often, despite being a "trained nurse," the individual may have had very little formal training on which to base a judgment of an order, a "reasonably prudent person" standard may have been appropriate. Even today, nurses are not responsible for diagnosis and prescription of medications and certain therapies, except under the supervision of a physician, as with a nurse practitioner, so *Byrd* still represents sound policy.

In a more recent case, *Paris v. Kreitz*, 75 N.C. App. 365, 331 S.E.2d 234, disc. review denied, 315 N.C. 185, 337 S.E.2d 858 (1985), the court again considered a nurse's duty to obey a physician's orders. The nurse in question had carried out the orders of a

physician or a physician assistant. The allegation was that the nurse should have known plaintiff required treatment by a trained physician and was negligent in not obtaining treatment for him. Relying on *Byrd*, the court stated that “[w]hile a nurse may disobey the instructions of a physician where those instructions are obviously wrong and will result in harm to the patient, the duty to disobey does not extend to situations where there is a difference of medical opinion.” Because the nurse’s evaluation was in agreement with that of the physician assistant, “[a]ny disagreement or contrary recommendation she may have had as to the treatment prescribed would have necessarily been premised on a separate diagnosis which she was not qualified to render.” The negligence of the physician and the physician assistant were questions of fact, it was not so obvious as to require the nurse to disobey instructions.

The question arises, what standard would apply to a nurse’s decision to disobey a physician’s order? Certainly, the quality of nursing education has improved since *Byrd* and the practice of nursing is regulated by the state. Patients and physicians reasonably expect a nurse to use his/her education and experience in judging the soundness of the physician’s orders (well, maybe not the physician). In neither *Byrd* nor *Paris* did the nurse make a reasoned judgment to disobey an order based on observations of the patient. I think the argument still can be made that the professional nurse has a duty, and a right, to use his/her judgment in carrying out physician’s orders, even where those orders are not patently negligent.