



Recent Trends and Defense Strategies

By Erika L. Amarante

As plaintiffs continue to search for the “deep pocket” in negligence claims, direct liability claims against hospital will inevitably continue to grow and expand.



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Corporate Liability for Hospitals





Historically, hospitals have been named as defendants in medical malpractice lawsuits predominantly based on claims of respondeat superior, whether (1) employment/actual agency, (2) apparent agency/ostensible agency, or

(3) non-delegable duty. These vicarious liability claims generally do not assert that the hospital—as an institution—did anything to contribute to the plaintiff’s alleged injuries. Instead, vicarious liability claims seek to hold the hospital liable based solely upon the conduct of individual health care providers.

As hospitals have grown and expanded, and charitable immunity laws have eroded, the types of claims that hospitals face in litigation have multiplied. Today, in addition to defending derivative claims based upon agency theories, as mentioned above, hospitals are increasingly faced with claims of direct liability. Under a broad theory of “corporate negligence,” courts have held that hospitals owe duties *directly* to their patients, and can be found liable for a breach of those duties, even when an individual health care provider was not negligent. The duties of a hospital can take many forms, and extend to functions such as hiring, staffing, credentialing, maintaining safe equipment and facilities, and issuing and enforcing policies.

State law governs the viability and scope of direct liability claims against hospitals, and different states recognize different types of claims. Some state courts have adopted “corporate negligence” that is limited to negligent hiring and credentialing. Other states have adopted a more broad interpretation of corporate negligence that extends beyond credentialing and establishes additional duties. A 50-state survey is beyond the scope of this article. Instead, this article will provide a broad overview of direct liability claims, defense strategies, and recent trends, with a special focus on negligent credentialing claims.

The Development of Direct Liability Claims Against Hospitals

The origins of direct liability claims against hospitals can be traced to the Illinois Supreme Court’s decision in *Darling v. Charleston Community Memorial Hospital*,

33 Ill. 2d 326 (1965). In *Darling*, an 18-year-old college football player presented to the hospital with a broken leg. Two weeks later, his leg was amputated due to gangrene. He sued the hospital and the physician, arguing that the failure to recognize the deterioration of the leg’s condition was negligent. The plaintiff settled with the physician before trial and proceeded against the hospital only. The jury found for the plaintiff, and awarded damages. The Illinois Supreme Court affirmed the verdict, rejecting the hospital’s argument that it could not be liable for allegedly negligent medical care because a corporation does not engage in the practice of medicine:

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

Darling, 33 Ill. 2d at 332 (citations omitted). The court then concluded that there was ample evidence to support the jury’s conclusion that the hospital “[f]ailed to have a sufficient number of trained nurses for bedside care of all patients at all times capable of recognizing the progressive gangrenous condition of the plaintiff’s right leg,” and “[f]ailed to require consultation with or examination by members of the hospital surgical staff skilled in such treatment.” *Id.* at 333. *Darling* is an important—and frequently cited—decision, particularly because it acknowledges the most common sources of a hospital’s direct duties to patients: regulations and statutes, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards, and the hospital’s own bylaws and policies.



Indeed, failing to implement or follow a written policy is frequently cited as evidence in direct liability claims against hospitals. In *Barkes v. River Park Hospital*, 328 S.W.3d 829 (Tenn. 2010), the Supreme Court of Tennessee reinstated a jury verdict against a hospital, based in part upon a failure to follow the hospital's own policy. There, when the plaintiff's decedent went to

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the emergency room with arm pain, a nurse practitioner diagnosed him with a sprain. Two hours after discharge, he collapsed at home and died from a myocardial infarction. At trial, the jury found that the nurse practitioner was not negligent, but held the hospital liable for failing to follow its internal policy requiring all emergency room patients to be seen by a physician. The trial court overturned the verdict as internally inconsistent and because it believed that Tennessee law did not recognize direct liability claims against hospitals. On appeal, the Tennessee Supreme Court reversed and reinstated the verdict, holding that "a hospital can be negligent for failing to enforce its policies and procedures in patient care absent a finding that other health care providers were also negligent." *Id.* at 835. According to the court, the evidence supported a conclusion that "the resulting injury to [decedent] resulted from an institutional failure that was, in essence, managerial and administrative in nature." *Id.* But see *Petriello v. Kalman*, 215 Conn. 377, 386 (1990) (finding the violation of hospital policy admissible but not dispositive; "hospital rules, regulations and policies do not themselves establish the standard of care").

Thompson v. Nason Hospital

One seminal case involving direct liability is *Thompson v. Nason Hospital*, 527 Pa. 330

(1991), in which the Pennsylvania Supreme Court adopted "as a theory of hospital liability the doctrine of corporate negligence or corporate liability under which the hospital is liable if it fails to uphold the proper standard of care owed its patient." *Id.* at 341. The plaintiff was hospitalized after a car accident and suffered an intracerebral hematoma during her hospitalization, allegedly due to warfarin and other medications. She sued two physicians and the hospital, alleging specifically that the hospital failed to follow its rules relative to consultations and failed to monitor her conditions during treatment. The trial court granted the hospital's motion for summary judgment, but the appellate court reversed. The Pennsylvania Supreme Court affirmed, adopting the rule of corporate negligence under Pennsylvania law, and remanding to the trial court for resolution of the material fact questions regarding whether the hospital was negligent in supervising the quality of medical care provided.

In recognizing the cause of action for corporate negligence, the *Thompson* court explained that a hospital's duties to patients can be classified into four general areas: (1) a duty to use reasonable care in the maintenance of safe and adequate facilities and equipment; (2) a duty to select and retain only competent physicians; (3) a duty to oversee all persons who practice medicine within its walls performing patient care; and (4) a duty to formulate, adopt, and enforce adequate rules and policies to ensure quality care for the patients. *Id.* at 339. The third category is the most controversial, since it appears to place a duty upon a hospital to supervise and oversee all the medical care that occurs within its four walls. This is a very broad and expansive duty that could verge on imposing strict liability on hospitals. See Mitchell J. Nathanson, *Hospital Corporate Negligence: Enforcing the Hospital's Role of Administrator*, 28 Tort & Ins. L.J. 575, 590-94 (Spring 1993).

After describing the categories of a hospital's duty, the court then provided a roadmap for defending direct liability claims:

It is important to note that for a hospital to be charged with negligence, it is necessary to show that the hospital had actual or constructive knowledge of the defect or procedures which created the

harm.... Furthermore, the hospital's negligence must have been a substantial factor in bringing about the harm to the injured party.

Id. at 341 (citations omitted). Justice Flaherty dissented, calling the majority's new theory of liability "a monumental and ill-advised change in the law" that "reflects a deep pocket theory of liability, placing financial burdens upon hospitals for the actions of persons who are not even their employees." *Id.* at 343. In Justice Flaherty's view, this monumental change was unnecessary because "[t]raditional theories of liability, such as respondeat superior, have long proven to be perfectly adequate for establishing corporate responsibility for torts." *Id.* at 343-44.

State Rejection of Corporate Negligence Theory

At least two states have declined to recognize a cause of action for "corporate negligence" against hospitals. In *Gafner v. Down East Community Hospital*, 735 A.2d 969 (Me. 1999), a shoulder dystocia case, the plaintiffs asserted that the hospital was directly liable for failing to have in place a written policy mandating that obstetricians consult with a specialist in high-risk births. In rejecting the claim, the court noted that neither the legislature nor the common law has placed "a duty on the part of a hospital to adopt rules and policies controlling the actions of independent physicians practicing within its walls." *Id.* at 976. The court then declined to impose that duty on hospitals: "Creating a duty that would place external controls upon the medical judgments and actions of physicians should not be undertaken without a thorough and thoughtful analysis." *Id.* at 979. Recognizing that hospitals are already heavily regulated, the court deferred to the legislature to "address the policy considerations and determine whether imposing such a duty constitutes wise public policy." *Id.*

More recently, Minnesota courts have rejected a cause of action for direct hospital negligence. For example, in *Bothun v. Martin LM, LLC*, 2013 WL 1943019 (Minn. Ct. App. May 13, 2013), the court held that Minnesota has not recognized a cause of action for corporate negligence by hospitals, other than a limited claim for negligent creden-

tialing, as recognized in *Larson v. Wasemiller*, 738 N.W.2d 300 (Minn. 2007). Thus, the *Bothun* court affirmed the grant of summary judgment to the defendant rehabilitative care center on direct corporate liability claims that were not based on credentialing. Similarly, in *Damgaard v. Avera Health*, 2015 WL 3561336 (D. Minn. June 3, 2015), the district court cited *Bothun* and granted a hospital's motion for summary judgment on direct negligence claims related to the alleged failure to "adequately instruct, train or supervise employees" and the alleged failure to "establish, follow or enforce policies and protocols relevant to the delivery of babies, such as the failure to develop policies regarding the administration of Pitocin." *Id.* at *3.

Negligent Credentialing

Negligent credentialing is the most widely accepted form of direct liability claim against a hospital. More than 30 states have adopted this theory of direct liability. See, e.g., *Brookins v. Mote*, 292 P.3d 347, 361 & n.6 (Mont. 2012) (citing cases from other jurisdictions and adopting theory under Montana law). The "widespread acceptance" of this cause of action flows from the fact that "negligent credentialing is simply the application of broad common law principles of negligence, and is a natural extension of torts such as negligent hiring." *Id.*

Nonetheless, several states have declined to recognize the tort. See, e.g., *Paulino v. QHG of Springdale, Inc.*, 386 S.W.3d 462, 469 (Ark. 2012) (declining to adopt common law cause of action for negligent credentialing); *McVay v. Rich*, 874 P.2d 641 (Kan. 1994) (concluding that state statutes bar negligent credentialing claim). Others states, such as Texas, have significantly limited the scope of a negligent credentialing claim. See, e.g., *St. Luke's Episcopal Hosp. v. Agbor*, 952 S.W.2d 503 (Tex. 1997) (requiring evidence of malice required to state a cause of action against hospital for credentialing activities). State legislatures have also taken action. In 2011, the Utah legislature enacted Section 78B-3-425 of the Utah Code, stating: "It is the policy of this state that the question of negligent credentialing, as applied to health care providers in malpractice suits, is not recognized as a cause of action." This stat-

ute was a direct response to the Utah Supreme Court decision in *Archuleta v. St. Mark's Hosp.*, 238 P.3d 1044 (Utah 2010), which recognized negligent credentialing as a cause of action for the first time. In Ohio, R.C. Section 2305.251 provides a presumption that a hospital was not negligent in its credentialing activities if the hospital is accredited by certain organizations (such as the Joint Commission on Accreditation of Healthcare Organizations). R.C. §2305.251(B)(1). The statutory presumption may be rebutted by evidence that, among other things, the hospital "failed to comply with all material credentialing and review requirements of the accrediting organization," R.C. §2305.251(B)(2)(b); or that the hospital "through its medical staff executive committee or its governing body, and sufficiently in advance to take appropriate action, knew that a previously competent individual had developed a pattern of incompetence or otherwise inappropriate behavior," R.C. §2305.251(B)(2)(c).

Three Elements of Proof

In the states where the cause of action is recognized, plaintiffs generally must establish three basic elements to prove a negligent credentialing claim. The first element is that a hospital failed to meet the standard of reasonable care in the selection of a particular physician. "Reasonable care" means that degree of care, skill, and judgment usually exercised by the average hospital. Expert testimony is usually required to prove the applicable standard of care and that it was violated. Plaintiffs may also rely upon a hospital's licensing regulations, accreditation standards, and bylaws to prove this element. The second element is that a physician breached the applicable standard of care when treating the patient. The third element is that a hospital's negligent granting of credentials was a proximate cause of a plaintiff's injuries. See generally *Frigo v. Silver Cross Hosp. and Med. Ctr.*, 876 N.E.2d 697, 723 (Ill. App. 2007) (describing the three proof elements).

Based upon the second and third elements, it is clear that "[i]f the physician is not negligent, there is no negligent credentialing claim against the hospital." *Hiroms v. Scheffey*, 76 S.W.3d 486 (Tex. App. 2002)

(affirming summary judgment for a hospital on a negligent credentialing claim where the jury found that the physician was not negligent). Hospital counsel therefore may find themselves defending the physician's conduct as a first line of defense, particularly if the physician is not involved in the case and defending his or her own care (either because he or she was not

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sued, previously settled with the plaintiff, or filed for bankruptcy protection). See *Schelling v. Humphrey*, 916 N.E.2d 1029 (Ohio 2009) (where the physician filed for bankruptcy and was dismissed from the case, the hospital must defend the physician's care as part of its defense to negligent credentialing).

While physician negligence is a condition precedent to prove causation, the focus of a negligent credentialing claim is not on the care provided by a particular physician, but rather the *process* that a hospital uses to review the physician's qualifications. The credentialing process is not meant to be a guarantee that a physician will never make a mistake. A hospital is not strictly liable to ensure all medical decisions by the physicians to whom it provides credentials. Instead, the question is whether a hospital was—or should have been—on notice of potential negligence. Thus, in *Johnson v. Misericordia Community Hosp.*, 301 N.W.2d 156 (Wisc. 1981), the defendant hospital was liable for negligent credentialing because it granted privileges to a physician who had made significant misstatements and omissions in his credentialing application, and the hospital staff failed to contact the physician's references and discover the misrepresentations. In contrast, *Rodrigues v. Miriam Hospital*, 623 A.2d 456, 463–64 (R.I. 1993), affirmed a directed verdict for the hospital defendant on a negligent credentialing claim because



there was no evidence that the hospital had constructive knowledge of the physician's reluctance or inability to perform tracheostomies. Similarly, *Essig v. Advocate Bro-Menn Medical Center*, 33 N.E3d 288 (Fla. App. May 29, 2015), affirmed the grant of summary judgment to the defendant hospital on a negligent credentialing claim because the plaintiffs "have offered no

hospital in the credentialing process. *Id.* at 310. However, the court explained that plaintiffs can still obtain information "otherwise available from original sources." *Id.* Thus, even without knowing what the hospital *actually* knew during its credentialing process, plaintiffs have the opportunity to establish what the hospital "should have known" about the physician's qualifications and competence. Similarly, in *Romero v. KPH Consolidation, Inc.*, 166 S.W.3d 212, 215 (Tex. 2005), the Texas Supreme Court noted that "a plaintiff must prove that a hospital acted maliciously without access to evidence of what happened, or did not happen, in the credentialing process." See also *Cawthorn v. Catholic Health Initiatives Iowa Corp.*, 806 N.W.2d 282 (Iowa 2011) (holding that a credentialing file is absolutely privileged and cannot be used to support a negligent credentialing claim, even if already disclosed). While it may be more difficult for a hospital to defend its credentialing decisions without relying upon a credentialing file; the burden falls more heavily upon a plaintiff who has the burden of proof and can only meet it with evidence of what a hospital "should" have known. Moreover, as another peer review related defense, the federal Health Care Quality Improvement Act (HCQIA), 42 U.S.C. §11111 *et seq.*, provides hospitals with immunity for credentialing decisions under certain circumstances.

Second, counsel should also consider bifurcating the trial of the claims against the physician from the trial of negligent credentialing claims, because the physician's negligence is a necessary element to pursue the credentialing claim. In *Schelling*, 916 N.E.2d at 1036, the Ohio Supreme Court ruled in favor of bifurcating the determination of whether the physician committed medical malpractice from the negligent credentialing claim against the hospital, reasoning as follows:

The bifurcation of a negligent-credentialing claim and the underlying medical-malpractice claim avoids the problems of jury confusion or prejudice that may result from admitting evidence of prior acts of malpractice in a combined trial on both claims. Evidence of prior acts of malpractice by the doctor may be relevant to a negligent-credentialing claim,... but presents

the risk of unfair prejudice in determining whether the doctor committed malpractice...

Bifurcation also allows a negligent-credentialing claim against a hospital to be dismissed if the plaintiff does not prevail on the malpractice claim against the doctor. If the fact-finder determines that negligence of the doctor was not the proximate cause of the plaintiff's injury, then a hospital's grant of staff privileges to a doctor is not the cause of the plaintiff's injury...

Id. at 1036 (citations omitted). Decisions to bifurcate are governed by state law and generally left to the discretion of the trial court. However, there is ample authority in several states for bifurcating negligent credentialing claims from the underlying claims of physician malpractice. See, e.g., *Patterson v. Marshall*, 2009 WL 2341448, at *1 (Ky. Ct. App. July 31, 2009) (affirming the trial court decision to bifurcate); *Jalowitz v. Physicians Ins. Co. of Wisc., Inc.*, 691 N.W.2d 926 (Wis. App. 2004) (same); *Stottlemeyer v. Ghramm*, 597 S.E.2d 191, 194 (Va. 2004) (same); *Prissel v. Physicians Ins. Co.*, 2003 WL 22998133 (Wis. Ct. App. 2003) (same); *Beavis v. Campbell County Mem. Hosp.*, 20 P.3d 508, 510 (Wyo. 2001) (same); *Neeble v. Sepulveda*, 1998 WL 11710, at *6 Tex. Ct. App. 1998) (same); *Davis v. Immediate Medical Services, Inc.*, 1995 WL 809478 (Ohio Ct. App. Dec. 12, 1995) (same). The benefit to bifurcating is that potentially prejudicial information about a physician's claims history and/or qualifications is not admissible in the first part of the trial because it is not relevant to the issue of whether the physician was negligent when treating the plaintiff.

The Special Case of an Allegedly Impaired Physician

Negligent credentialing cases often assert that a hospital is liable because it knew or should have known about a physician's alleged impairment due to substance abuse. See, e.g., *Holliday v. Waccamaw Community Hospital*, 2015 WL 7760805 (S.C. 2015) (recognizing negligent credentialing claims based on physician's drug problem and subsequent reappointment to medical staff); *Romero v. KPH Consolidation, Inc.*, 166 S.W.3d 212, 221 (Tex. 2005) (recognizing that "a physician engaged in

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evidence pertaining to [the physician's] history, peer-review assessments, or any other such information that [the hospital] allegedly had—or should have had—which would have put them on notice of [the physician's] allegedly negligent treatment of patients." Accordingly, that a physician may have deviated from the standard of care does not mean that he or she should not have been credentialed; a hospital must simply use "reasonable care" in reaching its credentialing decision.

Defense Counsel Strategies

When defending a hospital against a negligent credentialing claim, counsel should consider both peer review protections and bifurcation. First, it is essential to assert a peer review privilege over a hospital's credentialing file. Many state statutes specify that peer review activities—including the proceedings and decisions of a credentialing committee—are confidential and not subject to disclosure even in litigation. For example, in *Larson v. Wasemiller*, 738 N.W.2d 300 (Minn. 2007), the Minnesota Supreme Court recognized a cause of action for negligent credentialing, but also held that the peer review statute precluded the hospital from disclosing the contents of its credentialing file. The court recognized that the confidentiality of credentialing files creates a burden for plaintiffs, who therefore have no way of discovering the exact information that was used by the

drug abuse presents an extreme risk to patients,” yet overturning verdict against hospital for negligent credentialing absent evidence that hospital acted with malice). Because of the stigma of addiction and the need to encourage physicians to seek the treatment that they need, many states have established physician health programs to allow physicians to obtain treatment confidentially. See generally Federation of State Physician Health Programs, <http://www.fsphp.org>. Whether and when a hospital should intervene by suspending or revoking a physician’s privileges is a complicated question, especially when a physician is actively seeking treatment. See Sarah Has-ton, *Impaired Physicians and the Scope of Informed Consent: Balancing Patient Safety with Physician Privacy*, 41 Fla. St. U. L. Rev. 1125, 1142 (Summer 2014) (advocating for corporate liability because “if a hospital chooses to grant privileges to a physician who has suffered from alcoholism, drug abuse, or mental illness in the past, the hospital bears the risk of such impairments resurfacing” but also stating that “a hospital should be free to grant privileges to a physician currently undergoing treatment for alcoholism, drug abuse or mental illness; however it should be presumed that the hospital underwent investigative measures to ensure that this physician is able to safely practice medicine.”). The extent of the “investigative measures” that a hospital would undertake to decide if a physician can practice without harming patients while the physician undergoes substance abuse treatment is uncertain, but hospitals that credential physicians who have sought treatment run the risk of having to defend those credentialing decisions in court.

Plaintiffs asserting negligent credentialing claims based on physician substance abuse often confront causation issues. That a physician received substance abuse treatment at some point in his or her life does not mean that he or she should lose his or her license forever or never have privileges again. Such a harsh rule would fly in the face of public policy favoring rehabilitation. Thus, in *Domingo v. Doe*, 985 F. Supp. 1241 (D. Haw. 1997), the district court granted a hospital’s motion for summary judgment on a negligent credentialing claim when there was no evidence that the physician had used drugs or alcohol in more than 10

years. There was no “evidence which suggests that Dr. Doe’s prior substance abuse was a factor in the performance of [plaintiff’s] surgery.” *Id.* at 1246. The Court of Appeals of Texas reached a similar result in *McGrath v. Baylor University Medical Center*, 2000 WL 1222039 (Tex. App. Aug. 29, 2000), affirming a grant of summary judgment for the defendant hospital when “the alleged drug use occurred some ten years before the recredentialing decision at issue in this case.” *Id.* at *7. The court rejected the plaintiff’s tenuous causation theory that appropriate action by the hospital in 1982, when the physician’s substance abuse was discovered, would have prevented the physician from treating the plaintiff in 1993: “Baylor’s conduct in 1982 is too remotely connected to the procedure utilized in 1993 to constitute legal causation.” *Id.* at *10. See also *Taylor v. Cabell Huntington Hospital*, 538 S.E.2d 719 (W. Va. 2000) (affirming the trial court’s evidentiary ruling excluding evidence of nurse’s prior substance abuse as irrelevant to the malpractice claim at issue).

Bifurcating a negligent credentialing claim from the underlying medical negligence claim can be even more important in cases alleging physician misconduct or substance abuse. For example, in *Davis v. Immediate Medical Services, Inc.*, 1995 WL 809478 (Ohio Ct. App. Dec. 12, 1995), the plaintiff alleged malpractice and negligent credentialing based upon a physician’s history of alcoholism. The trial court bifurcated the claims, tried the medical negligence claim first and excluded any evidence of the physician’s alcoholism and treatment. The jury found the physician not negligent, and the trial court granted the hospital’s summary judgment motion on the negligent credentialing claim. The appellate court affirmed the decision to bifurcate the claims:

As was pointed out by the trial court, the issue of undue prejudice was present when the main thrust of appellant’s claim against appellee Hospital centered on appellee [physician’s] alleged alcohol abuse. Why raise the specter of an appeal issue or undue prejudice or bias if it can be avoided by the bifurcation of the issues?

Id. at *7. Moreover, the types of experts needed to defend hospitals against a neg-

ligent credentialing claim based upon impairment illustrate the benefit of bifurcation. For example, defending against a claim that a surgeon was negligent requires testimony from a similar surgeon about the applicable standard of care for the surgery at issue. Defending a hospital’s decision to credential that surgeon in light of the surgeon’s alleged substance abuse requires a whole different slate of experts, including hospital administrators, substance abuse specialists, and possibly toxicologists. It would be both inefficient and highly prejudicial to the defense to inundate the jury with all of this information if the evidence shows that the surgeon did not deviate from the standard of care after all.

Conclusion

As plaintiffs continue to search for the “deep pockets” in negligence claims, direct liability claims against hospitals will inevitably continue to grow and expand. Unfortunately, the scope of a hospital’s direct duties to patients is amorphous, and governed by the law of 50 different states. See David H. Rutchik, *The Emerging Trend of Corporate Liability: Courts’ Uneven Treatment of Hospital Standards Leaves Hospitals Uncertain and Exposed*, 47 Vand. L. Rev. 535 (March 1994). When faced with direct liability claims, hospital attorneys and defense counsel should consult the statutes and case law in their own jurisdictions to formulate an appropriate defense under state law.

In most states, the argument remains that a hospital should not become an insurer of all medical care that occurs within its walls. Holding hospitals liable for “supervising” all the medical care provided by independent physicians goes too far. However, hospitals arguably do have a duty, at a minimum, to follow the applicable JCAHO standards, and to follow their own bylaws and policies. To be fair, direct liability claims against hospitals should be limited to administrative duties such as hiring, credentialing, complying with JCAHO standards, and enforcing policies, but not the actual medical care itself. See generally Mitchell J. Nathanson, *Hospital Corporate Negligence: Enforcing the Hospital’s Role of Administrator*, 28 Tort & Ins. L.J. 575 (Spring 1993). 