Disputes between Hospitals, Physicians, and Insurance Carriers in Medical Malpractice Cases

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The evolution of medical malpractice litigation has been dramatic over the course of the last thirty-five years. There was a time when most individual physicians had plenty of coverage (usually One Million Dollars at a time when million-dollar verdicts were rare), the predominant law of the land was joint and several liability which thereby augmented everyone's total available coverage for damages, and the liability of hospitals and corporate practices was frequently minimal, secondary, and independent of the claims against the defendant physicians. Over time, verdicts have skyrocketed, often outstripping the available coverage of physicians. Joint and several liability has been eroded, in some jurisdictions the amount of coverage bought by individual physicians has fallen as low as $250,000.00, and many physicians have gone bare. As the individual physicians became a less attractive target to the plaintiffs' attorneys, there was a move to expand theories of vicarious liability to try to make hospitals and corporate entities responsible for physicians who were previously accepted as independent contractors for which liability did not attach. Theories of apparent agency, joint venture, and non-delegable duties started to become routine in medical malpractice litigation.

At the same time, healthcare was changing. Advancements in medicine created new specialties like neonatology, critical care, and hospitalist, all of which practiced solely within a hospital setting in group practices that usually had a contract with the hospital. This created more and more contractual relationships between hospitals and physicians with the contracts having indemnity group provisions running between the physicians and the hospital to augment theories of common law indemnity. These contractual relationships were superimposed on the theories of vicarious liability, contractual duties, and tort duties, all of which did not necessarily track one another thereby creating tensions between the physicians and their hospital hosts.

At the same time, the practice of medicine outside of the hospital setting was also evolving and changing. Due to insurance reimbursement changes physicians started grouping themselves into "super practices," opening ambulatory care centers, and entering into contractual relationships with their own groups and outside entities that further complicated the spider web of contracts and tort duty at play.

Insurance was also evolving and developing. The insurance market responded to the changes in healthcare by creating group policies, wasting policies, and excess policies all of which would have different triggers for coverage that did not always coincide with legal triggers for exposure. Furthermore, some carriers started specializing in physician coverage, while others provided only hospital coverage, and some healthcare providers started creating their own large self-insured retentions with excess policies thereby creating yet another dynamic.

All of these changes have created a complex forest of legal issues that can create tensions between defendants in a medical negligence lawsuit. These problems test not just our legal acumen

as we try to sort out these competing doctrines that developed in piecemeal fashion and are frequently inconsistent, but perhaps also diplomatic skills as we try to navigate important existing business relationships that may be at odds with the agendas of other involved or interested parties in the litigation.

The initial question, of course, is trying to determine who is liable for whom? That has become a much more complex question than the days when physicians and hospitals and other corporate entities were in independent silos. For the most part, physicians were seen as practicing independently of the hospitals and only using hospitals as a place to get nursing and ancillary care for their patients. Hospitals were seen as acting independently of physicians for whom they were not responsible, with their primary purpose being to provide support services to physicians. The law recognized physicians as independent contractors for whom hospitals were not liable.

However, more and more, hospitals are directly employing physicians as employees, making them liable for their actions under a straight respondent superior analysis. In addition, more physicians participate in group practices that have contracts with hospitals to provide services. Even though these contracts generally note the physicians to be "independent contractors," the doctrine of apparent agency has developed to make hospitals liable for these contracted physicians. In some jurisdictions, the doctrine of non-delegable duty has been used to try to make hospitals responsible for any physician practicing within its walls.

The situation where a hospital directly employs a physician does not need any explanation. The doctrine of apparent agency is recognized in most states. Although there is supposed to be an element of reliance upon the representation of the hospital about the physicians to trigger the doctrine, this has been generally left to be a jury question and juries are very quick to find physicians who are contracted with the hospital, who practice exclusively at the hospital, to be agents of the hospital. These physicians include emergency room physicians, pathologists, radiologists, intensive care physicians, and of course, hospitalists. It is very hard to argue that a hospital is not responsible for a hospitalist!

The complication that comes with a case against a contracted physician is that most of these contracts contain indemnity provisions. Sometimes the indemnity clause runs solely from the physicians to the hospital; but more commonly mutual clauses appear in these contracts making the hospital responsible if it is one of its direct employees that is primarily responsible for injuring a patient. Most of the clauses also contain provisions for attorneys' fees. The doctrine of common law indemnity is not very effective in these circumstances because the plaintiffs usually allege active negligence on the part of all healthcare providers, and if there is a finding of any negligence on the part of the party seeking indemnity, common law indemnity fails.

Superimposed on this labyrinth of tort liability and contractual liability is the question of insurance. The theory of extra-contractual liability for an insurer acting in bad faith with regard to one of its insureds is commonplace throughout the United States. This places the burden on the insurer to evaluate the case and take actions to resolve the case in order to protect the interests of the insured. However, the traditional evaluation by a carrier about the exposure of the insured focuses on the exposure created by the lawsuit filed by a patient against the insured**.** It does not necessarily include the exposure that the physician may have from a subsequent indemnity claim

if the plaintiffs settled with the physician, but continue to seek damages for the physicians' actions through a vicarious liability theory such as apparent agency. Most states recognize that even though the physician settles as the active tortfeasor, the passive tortfeasor who is subjected solely through a vicarious liability theory, is still liable. Thus, an insurer of a physician may feel compelled to resolve the case within policy limits on behalf of the physician, but not worry about a potential indemnity claim coming from the passive tortfeasor at a later date. Alternatively, the insurer of the hospital may be interested in resolving the claim within its limits for the vicarious liability of a physician who might be taking comfort in the fact that there is a deep pocket above his insurance layer that can resolve exposure. The carrier for the passive tortfeasor, the hospital, has no duty to protect the interests of the physician for whom it is vicariously liable.

Attorneys have to be aware of this complex labyrinth of tort theories, contractual relationships and insurance dynamics, in order to properly advise their clients, whether an individual or corporate entity, about the right course of action. Frequently, being proactive in reaching out to the co-defendants and negotiating a mutually satisfactory compromise is feasible and most advisable.

There are so many potential scenarios that they cannot all be covered or even foreseen in a single article. However, some of the more common issues for consideration are the following:

If you represent a physician and the client is interested in resolving a claim, and a hospital is vicariously liable for the physician's actions, settlement discussions need to include the possibility of trying to eliminate the hospital's vicarious liability for your physician's actions. In some jurisdictions, you may be able to argue to the plaintiff's lawyer that unless the vicarious liability is resolved your physician is subject to an indemnity claim and therefore you cannot settle the case until that issue is resolved. However, other jurisdictions see the resolution of a vicarious claim as a secondary concern that does not prevent an insurer from having a duty to settle the case in order to prevent a bad faith claim. Under those circumstances, it is imperative to at least attempt resolution of the vicarious claims prior to settling the case. As always, trying to involve the hospital in a complete resolution of the entire case is most advisable.

Next, there is a circumstance in which the hospital or the hospital's insurer wants to settle the case, but the active tortfeasor, the physician, wants to continue to defend the case. Under those circumstances, a physician needs to know that the potential comfort in having a deep pocket beyond his insurance coverage to satisfy the damages to the plaintiff may quickly disappear.

This brings into play the scenario whereby the individual physician and the hospital want to settle the case, but the carrier for the physician does not want to. Under those circumstances, the hospital may want to take aggressive action to demand that the physician and the carrier contribute to the settlement of the case. This situation could be further complicated by the fact that the Plaintiff's attorney can drop the individual defendant and try to hold the hospital vicariously liable for the physician's actions. This brings up the unusual circumstance for a medical malpractice case in which the hospital may want to tender the defense to the individual physician. The problem with this approach is that there are usually independent allegations of negligence against the hospital that make a complete tender of a defense impractical. Unless the pleadings are such that the only liability for the hospital is the actions of the physicians, this option

may be impossible to implement. However, where the sole allegations of negligence are vicarious, the hospital can take a very aggressive position and tender the defense of the case to the physician.

The Law

The law on the various legal doctrines at issue vary from state to state. There are also subtleties to take into consideration in the form of how jury instructions are phrased that affect their applicability and chances for success. Generally, however, we believe that the basic principles of the doctrines are as follows:

Of course, the doctrine of *respondeat superior* applies in the healthcare setting. *Groeller v. Evergreen Healthcare Center LLC*, 2015 IL App (1st) 140932, 31 N.E.3d 869 (Ill. App. Ct. 1st Dist. 2015); *Wells v. Louisiana Dept. of Public Safety and Corrections*, 72 So. 3d 910 (La. Ct. App. 2d Cir. 2011). Therefore, a hospital or any other corporate entity that employs individual healthcare providers such as physicians, mid-level practitioners, nurses, etc., are liable for their actions. Similarly, the general legal principle that an entity is not liable for the actions of an independent contractor also applies. However, there are two exceptions, first, when the employer of the independent contractor exerts too much control over the alleged independent contractor, then the employer will be liable for that independent contractor. A physician that simply has hospital privileges is generally considered an independent contractor; however, physicians that practice within the hospital under the auspices and control of the hospital may not be independent contractors depending on the amount of control. It is generally a jury question.

A more common doctrine used in the medical field is the doctrine of apparent agency. *Williams v. Tissier*, 445 Ill. Dec. 33, 165 N.E.3d 885 (App. Ct. 5th Dist. 2019), appeal denied, 437 Ill. Dec. 619, 144 N.E.3d 1209 (Ill. 2020). This is also known in some jurisdictions as agency by estoppel. *Almanzar v. Fleiss*, 59 Misc. 3d 350, 73 N.Y.S.3d 866 (Sup 2018). Under this legal theory, a hospital is liable for an independent contractor if the hospital acted in a manner that would give a reasonable person the impression that the physician or healthcare provider was an employee or agent of the hospital; and the patient reasonably relied on those representations in seeking care at that hospital. *Williams v. Tissier, supra.* The question of apparent or ostensible agency is generally one for the jury. *Robbins v. Hess*, 659 So. 2d 424 (Fla. 1st DCA).

Another theory of liability on the part of a hospital is the doctrine of non-delegable duty. Florida is the most active state in using non-delegable duty as a means to have liability attach to a hospital for the acts of physicians practicing within its walls even though they are not employees. The doctrine first appeared in a concurring opinion in *Roessler v. Novak*, 858 So. 2d 1158, 1165 – 66 (Fla. 2nd DCA 2003). There, Chief Judge Altenbernd wrote: "Given modern marketing approaches in which hospitals aggressively advertise the quality and safety of the services provided within their hospitals, it is quite arguable that hospitals should have a non-delegable duty to provide adequate radiology departments, pathology laboratories, emergency rooms, and other professional services necessary to the ordinary and usual functioning of a hospital."

The court in *Pope v. Winter Park Healthcare Group, Ltd.*, 939 So. 2d 185 (Fla. 5th DCA 2006) considered the application of non-delegable duty in the hospital setting, but concluded that

the only source of the non-delegable duty had to be an express contract, and adopted the concept from contract law.

The only Florida court to adopt the doctrine without limitation is *Wax v. Tenet Health System Hospitals,* 955 So. 2d 1 (Fla. 4th DCA 2006). The court found bases to support the use of the theory by statute and regulation, ruling: "We conclude that because the statute and regulation impose this duty for non-negligent anesthesia services on all surgical hospitals, it is important enough that as between the hospital and its patient it should be deemed non-delegable without the patient's express consent." *Id.* at 8.

Two other Florida courts have rejected the use of non-delegable duty as a means of holding a hospital liable for the acts of its credentialed physicians. *Tarpon Springs Hospital Foundation, Inc. v. Reth,* 40 So. 3d 823 (Fla. 2nd DCA 2010) (certifying conflict with *Wax*); and *Tabraue v. Doctors Hospital, Inc.*, 272 So. 3d 468 (Fla. 3rd DCA 2019) (also certifying conflict with *Wax*). The Florida Supreme Court has yet to resolve this conflict.

The law indemnity can arise in two forms. The first is common law indemnity. Under common law indemnity, the pleadings have to show that the alleged corporate entity that is being sued for the vicarious liability of another is being sued solely for that reason. *Welch v. Complete Care Corp.*, 818 So. 2d 645 (Fla. 2nd DCA 2002). Any independent act of negligence that is alleged in addition to the vicarious liability theory destroys the opportunity for common law indemnity. If the pleadings are clear that there is only an allegation of vicarious liability, then the hospital may tender the defense to the alleged active tortfeasor and ask for full indemnity not just of the liability component, but for the cost of defense as well.

Presently, a much more common way for indemnity to become an issue is for the contracts running between hospitals and physician groups. Current contracts have provisions that assert that a physician and a hospital will each be responsible for their own negligence and indemnify the other if they suffer harm from their negligence. Sometimes, however, the contracts are a one-way street where the hospital, using its leverage, insist the physicians have to indemnify the hospital for their negligence, but not necessarily the other way around. *Ollerich v. Rotering*, 419 N.W. 2d 548 (S.D. 1988).

Conclusion

In the end, the defense of claims in the healthcare arena is a quagmire of competing interests that exist in a set of laws that bind the participants together while at the same time putting them at odds. When medical-legal litigation was in its infancy, the challenge to the legal professional was to become familiar with medicine. Now, that part seems to be the easy part. A lawyer in this field has to be an excellent legal technician, knowledgeable in a variety of different areas of law, in addition to being well versed in medicine. In addition, a lawyer cannot simply play the role of the zealous advocate, blind to all concerns except his client's victory. The lawyer has to understand the various business interests at hand and use their diplomatic skills in trying to reach mutual compromise for the greater good. It is not an easy task.