Establishing Agency in Medical Malpractice Cases: Part II: The Law

By MARK McGRATH

While the basic principles of agency are straightforward under North Carolina law, their application by the North Carolina courts in medical malpractice cases has been anything but simple. Anyone attempting to establish an agency relationship between health care providers in a malpractice case should familiarize herself with this body of case law before filing suit. Failing to do so can lead to fatal flaws in pleading and missed opportunities in the discovery process.

In medical malpractice cases, agency issues typically arise when plaintiffs attempt to establish an agency relationship between hospitals and the physicians and other persons who render healthcare services within the hospital. Like so much of North Carolina tort law, the cases are decidedly onerous from the perspective of the injured claimant.

In the recent case of Diggs v. Novant Health, Inc., ___ N.C. App. ___, 628 S.E.2d 851 (2006), plaintiff attempted to establish an agency relationship between the hospital where the plaintiff was treated, and the in-house anesthesia group that provided anesthesia services to the patient. The court first addressed whether there was an actual agency relationship between the hospital and the outside physician group. In keeping with general precepts of agency, the court assessed the degree of control exerted by the hospital over the anesthesia group. The linchpin of this exercise was a review of the services contract between the hospital and the physician group.

In holding that the plaintiff had failed to establish an agency relationship, the court noted the following contractual factors as being determinative:

1. The contract stated that the hospital did not control the manner in which the anesthesia group rendered its professional services. The court seized upon language indicating that the hospital "shall neither have nor exercise any control or direction over the methods by which [the anesthesia group] or any Physician shall perform it or his work and functions; the sole interest and responsibility of [hospital] are to assure that the services covered by this Agreement shall be performed and rendered in a competent, efficient and satisfactory manner."

2. The physicians were not prohibited from practicing outside the hospital.

3. The anesthesia group and the hospital billed patients separately for their respective services.

4. The anesthesia group was responsible for meeting its own hiring needs.

5. The anesthesia group was responsible for scheduling.

The court held that the following contractual provisions did not constitute the kind of control that is required to forge an agency relationship.

1. The hospital's contractual right to require that anesthesiologists become members of the medical staff and comply with rules and regulations governing medical staff membership.

2. The contractual right to approve and credential all CRNAs.

3. The contractual right to require the anesthesia group to remove physicians from their payroll for specified grounds.

The court reasoned that these provisions did not evidence control, but merely the hospital's duty to ensure that all medical personnel permitted to provide services to patients were qualified to do so.

Taken as a whole, the court held, the contract did not authorize the hospital to control the manner in which the group provided anesthesia services. Because there was no control exerted by the hospital, there could be no agency relationship.

In Diggs, the plaintiff also attempted to argue that there was an apparent agency relationship between the hospital and the physician group. The court began its analysis of this issue by holding that the holding of privileges at a hospital is not sufficient, standing alone, to render a physician the agent of the hospital. The court went on to articulate a three-part test to be applied in medical malpractice cases involving allegations of apparent agency.

First, plaintiff must establish that hospital held itself out as providing medical services of its own.

Second, plaintiff must demonstrate that she was looking to the hospital rather than the individual medical providers to perform those services.

Finally, the patient must establish that she accepted the services at issue in the reasonable belief that the services were being rendered by the hospital or by its employees.

In holding that the plaintiff had come forward with sufficient evidence to send the apparent agency issue to a jury, the court identified the following evidence as being determinative:

1. The hospital had its own department of anesthesiology and medical director, indicating to public that the hospital itself provided anesthesia services.

2. The hospital contracted with an outside physician group to provide anesthesia services on an exclusive basis.

3. Physicians employed by the anesthesia group served as the hospital's chief of anesthesiology and anesthesia medical director.

4. Hospital patients had no choice as to who would provide anesthesia services for their operations.

5. An affidavit from the patient indicating unawareness that anesthesia personnel were not employees of the hospital.

6. A consent form signed by patient which did not indicate that anesthesia providers were employed by an entity other than the hospital.

So far, it would appear that the court was rather indulgent of the plaintiff's argument. Not so quickly, Grasshopper. The court went on to hold that hospital's can escape liability under an apparent agency theory by providing "meaningful notice" to the patient that given services will be rendered not by the hospital, but by a third-party contractor. In Diggs, the court held that the following language in a consent form did not provide such notice, thereby allowing the apparent agency issue to survive summary judgment: "I authorize the administration of such anesthetics as may be necessary or advisable by the anesthetist [or] anesthesiologist responsible for this service and I request the administration of such anesthetics…. I have had sufficient opportunity to discuss my condition and treatment with my physician and his or her associates and all of my questions have been answered to my satisfaction."

In short, the Diggs court offers the prospect of success to plaintiffs, then dashes those hopes with an exception that swallows the rule. I think one can make the safe assumption that legal teams are busy revising consent forms as we speak, and that forms failing to identify outside contractors will soon be rarer than hen's teeth.

Rules of the Road: Establishing Actual Agency

Given existing case law in our state, establishing a relationship of actual agency is extraordinarily difficult in malpractice cases. For those fearless few who venture down this path, the first step in the process is to request the contract between the hospital and the putative agent. Glean from it all language tending to indicate that the hospital exerted sufficient control over the contractor to render it vicariously liable for the torts of the contractor.

Temper your optimism before undertaking this exercise. Virtually all such contracts will specifically provide that the hospital lacks the right to supervise, direct or control the services rendered by the contractor. The contract will also likely provide that the relationship between the parties is one of owner and independent contract, not employer and employee, or principal and agent.

Rules of the Road: Establishing Apparent Agency

As with claims of actual agency, the starting point will be requesting relevant documents from the hospital. In particular, be sure to scrutinize the admission documents and consent forms to determine whether the hospital has disclosed to the patient that services will be provided by outside contractors. If so, you might well be out of luck.

If the hospital did not make such a disclosure, the remainder of the claim could be established by testimony from the patient establishing the appearance of agency created by the hospital. Using the rendering of anesthesia services by way of example, the issue is whether the hospital created an appearance that it provided the services at issue. Sources for this evidence could include the following:

1. Information from the hospital's web site, marketing and advertising materials. For example, does the site tout the hospitals' anesthesia services or capabilities?

2. Materials indicating that the hospital had a "department" of anesthesiology.

3. Evidence indicating that anesthesia personnel wore badges bearing the name of the hospital and not the anesthesia group.

4. Anesthesia department regulations, bylaws, policies and procedures. Do members of the group serve as the facility's department of anesthesiology? Is the anesthesia program directed by the outside contractor in the name of the hospital's anesthesia department?

5. Testimony from the patient that she believed that the hospital was providing such services, and that she was not aware that an outside contractor would be treating her during her hospitalization.

6. Testimony from the patient that she would have chosen other providers or otherwise have reacted differently if she had known that anesthesia services would be rendered by an outside group with whom she had no familiarity.

7. Evidence that members of the outside group staff the hospital's department of anesthesiology.

8. Evidence indicating that the anesthesia group was the exclusive provider of anesthesia services at the hospital and serve in quasi-administrative positions such as director of anesthesia services.

9. Evidence indicating that the patient was provided no opportunity to select anesthesia personnel of her own choosing.

The Doctrine of Non-Delegability

While it is not technically an agency theory, the doctrine of non-delegability is so nearly related that it would be misleading not to give it voice in an article addressing agency issues. The theory of non-delegability provides that some forms of medical care and treatment are so central to a patient's hospitalization that responsibility for performing these services cannot be contractually delegated to outside contractors.

The theory received its fullest articulation in the Florida case of Shands Teaching Hospital and Clinic, Inc. v. Juliana, 863 So.2d 343, rev. denied, 865 So.2d 481 (2003). In Shands, plaintiff attempted to establish that the defendant hospital could not escape liability for the negligence of a perfusionist who rendered services to the patient during open heart surgery. The hospital argued that the perfusionist was the employee of an outside contractor, and that this fully insulated the hospital from liability for his negligence.

The plaintiff contended that the duty to provide perfusionist services within the hospital could not be delegated to an independent contractor, and that the hospital was, therefore, liable for the perfusionist's negligence. The Shands court held that, because the agreement between the patient and hospital provided that the hospital would provide "hospital care" and "medical treatment," the hospital could not escape liability for the negligence of the perfusionist because these services were exactly the kind of care and treatment that the hospital agreed to provide to the patient. As a result, the responsibility for performing these services could not be delegated to a third-party contractor.

Aside from Shands, there is support for the doctrine of non-delegability in the federal Medicare conditions of participation. Among these conditions of participation are provisions codified in 42 CFR Sect. 482.12(e). This section establishes as a condition of participation that a hospital's "governing body must be responsible for services rendered in the hospital whether or no they are furnished under contracts….The governing body must ensure that the services performed under a contract are provided in a safe and effective manner." The legislative history for this regulation evidences a clear intent to hold hospitals responsible for services rendered inside their walls, regardless of contractual provisions designed to deflect liability.

"[This section is] 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 arrangements, 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 relationship between the hospital and the contractor is irrelevant…." 51 Fed. Reg. 116, p. 22015 (1986).

Remarkably, despite this clarity of language, the North Carolina Court of Appeals has held in an unpublished opinion that the federal Medicare regulations do not create an agency relationship or create theories of liability, but merely establish conditions that must be satisfied before hospitals can receive Medicare reimbursement. See Wrenn v. Maria Parham Hospital, COA97-1043, June 16, 1998 (unpublished opinion).

So what is to be done? Hospitals routinely take positions in malpractice cases that fly in the face of these regulatory provisions, and disavow any responsibility for the contractors who provide services within their facilities. Do patients have any recourse for this flouting of applicable regulations? In my experience, federal agencies, including the Department of Health and Human Services and the Office of the Inspector General, have no interest whatsoever in enforcing these regulations.

One intriguing option is the filing of qui tam actions against hospitals who certify compliance with the Medicare regulations in their annual reports, but then take positions in malpractice cases (e.g., denying any responsibility for the actions of outside contractors) that repudiate those regulations. This rejection of the conditions of participation, including 42 CFR Sect. 482.12(e), could be viewed as being actionable under the False Claims Act. To my knowledge, no plaintiff has yet made this argument, and no court has addressed its validity. In the nursing home context, however, FCA claims have been asserted against facilities for certifying compliance with federal conditions of participation, while at the same time failing to abide by OBRA regulations.

Alternatives to Agency

Keep in mind that relying upon agency is typically a theory of last resort. There are other alternative theories of liability that can be directed against hospitals in malpractice cases, including negligent supervision of outside contractors, negligent training of contractors, negligent credentialing, the borrowed servant doctrine, negligent entrustment of equipment to contractors, liability for torts of hospital employees (e.g., nurses) and hospital's direct liability for failure to promulgate appropriate policies, procedures, guidelines and protocols.

The Reading List

The foregoing merely provides an analytical framework. The cases applying agency principles in malpractice cases are rife with nuance and idiosyncrasy, and attorneys who venture to establish agency in malpractice cases would be well advised to spend some time in the library before filing anything. While not exhaustive, the following cases (in addition to those referenced above) should be on the mandatory reading list.

1. Hylton v. Koontz, 138 N.C. App. 629, 532 S.E.2d 252, rev. denied, 353 N.C. 264, 546 S.E.2d 98 (2000).

2. Rouse v. Pitt County Memorial Hospital, 343 N.C. 186, 470 S.E.2d 44 (1996).

3. Sweatt v. Wong, 145 N.C. App. 33, 549 S.E.2d 222 (2001).

4. Hoffman v. Moore Regional Hospital, Inc., 114 N.C. App. 248, 441 S.E.2d 567, rev. denied, 336 N.C. 605, 447 S.E.2d 391 (1994).

5. Harris v. Miller, 103 N.C. App. 312, 407 S.E.2d 556 (1991).

6. Harris v. Miller, 335 N.C. 379; 438 S.E.2d 731 (1994).

7. Smock v. Brantley, 76 N.C. App. 73, 331 S.E.2d 714 (1985), rev. denied, 315 N.C. 590, 341 S.E.2d 30 (1986).

8. Noell v. Kosanin, 119 N.C. App. 191, 457 S.E.2d 742 (1995).

9. Willoughby v. Wilkins, 65 N.C. App. 626, 310 S.E.2d 90 (1983), rev. denied, 310 N.C. 631, 315 S.E.2d 698 (1984).