Health Law: Quality & Liability

Professor Thaddeus M. Pope

Reading Packet for Week 11 (Fall 2018)

Weekly Summary

For many weeks, our focus in this course has been on the liability of individual clinicians (e.g. nurses and physicians for abandonment, battery, informed consent, medical malpractice, and a few other theories). Now, we turn to the liability of entities (e.g. hospitals and managed care organizations). Recall that we already examined the liability of the hospital in the EMTALA context. Now, we look at the liability of the hospital for negligence that results in too-low quality medical care.

Hospital Direct Liability

There are two basic *categories* of liability theories against hospitals: (1) vicarious and (2) direct. Theories of direct liability focus on the way in which the hospital administration has established structures and processes for staffing and running the hospital. There are four direct theories of direct liability: (a) negligent selection, (b) negligent retention, (c) negligent supervision (policies, procedures, equipment), and (d) ordinary negligence.

Hospital Vicarious Liability

Unlike theories of direct liability, theories of vicarious liability do not require the plaintiff to establish any fault on the part of the hospital. It is sufficient that the plaintiff establishes liability on the part of an individual clinician. The hospital may be vicariously liable simply because of its relationship to the individual clinician. There are three vicarious theories: (a) respondeat superior, (b) ostensible agency, and (c) the non-delegable duty doctrine. Note that a plaintiff may be able to assert multiple theories of both direct and vicarious liability against a hospital in a single case.

Managed Care Organization Liability

Good news: Managed care organization liability is very similar to hospital liability. The primary difference is that MCOs do something that hospitals do not: they make coverage decisions (utilization review).

Utilization review might be done negligently (e.g. an MCO may wrongly deny payment for medical care). Therefore, patients have a theory of liability against MCOs that they do not have against hospitals. On the other hand, since most patients have health insurance as a benefit of their employment, when they complain about a coverage denial, they are effectively complaining about not getting "owed employee benefits." Such claims are governed by the federal ERISA statute which preempts analogous state law claims based in tort, contract, or state statutes. We will examine ERISA in the next unit.

Reading

All the following materials are collected into a single PDF document:

- Restatement of Agency § 2.04 (respondeat superior)
- Restatement of Agency § 7.07 (respondeat superior)
- *Thomas v. Oldfield* (Tenn. App. 2008) (hospital ostensible)
- *Pickett v. Olympia Medical* (Cal. App. 2016) (hospital direct/corporate)
- *Renown Health v. Vanderford* (Nev. 2010) (hospital non-delegable)
- *Boyd v. Albert Einstein Medical* (Pa. Super. 1988) (MCO ostensible)
- *Wickline v. California* (Cal. App. 1986) (MCO UR)

Objectives

By the end of this week, you will be able to:

- Analyze and apply civil liability legal principles concerning the provision of medical treatment by institutional providers (primarily hospitals). (5.0)
- Analyze and apply three theories of vicarious liability: respondeat superior, ostensible agency, and the non-delegable duty doctrine. (5.1)
- Analyze and apply four theories of direct liability: (a) negligent selection, (b) negligent retention, (c) negligent supervision (policies, procedures, training, equipment), and (d) ordinary negligence. (5.2)
- Analyze and apply civil liability legal principles concerning the provision of medical treatment by managed care organizations. (6.0)
- Analyze and apply three theories of vicarious liability: respondeat superior, ostensible agency, and the non-delegable duty doctrine. (6.1)
- Analyze and apply four theories of direct liability: (a) negligent selection, (b) negligent retention, (c) negligent supervision (policies, procedures, training, equipment), and (d) ordinary negligence. (6.2)
- Analyze and apply the theory of negligent utilization review. (6.3)

REST 3d AGEN § 2.04
Restatement (Third) Of Agency § 2.04 (2006)

Restatement of the Law — Agency
Restatement (Third) of Agency
Current through April 2010

Chapter 2. Principles Of Attribution
Topic 3. Respondeat Superior

§ 2.04 Respondeat Superior

An employer is subject to liability for torts committed by employees while acting within the scope of their employment.

Comment:
a. Terminology and cross-references. This Restatement does not use the terminology of "master" and "servant." Section 7.07(3) defines "employee" for purposes of this doctrine. Section 7.07(2) states the circumstances under which an employee has acted within the scope of employment. Section 7.08 states the circumstances under which a principal is subject to vicarious liability for a tort committed by an agent, whether or not an employee, when actions taken with apparent authority constituted the tort or enabled the agent to conceal its commission.

b. In general. This Comment is a brief discussion of the operation of respondeat superior and the justifications for it. The doctrine of respondeat superior is fundamental to the operation of the tort system in the United States. The doctrine establishes a principle of employer liability for the costs that work-related torts impose on third parties. Its scope is limited to the employment relationship and to conduct falling within the scope of that relationship because an employer has the right to control how work is done. This right is more detailed than the right of control possessed by all principals, whether or not employers.

Functionally tied though the doctrine is to tort law, it has long been classified as an element of agency doctrine. In early times, a master's servants were treated as part of the household and their relation to the master made their acts his responsibility as the head of the household. Blackstone's Commentaries refer not to agents but to types of servants, "such as *stewards*, *factors*, and *bailiffs*: whom, however, the law considers as servants *pro tempore*, with regard to such of their acts, as affect their master's or employer's property." William Blackstone, 1 Commentaries *427 (1765). In the first treatise on agency published in the United States, William Paley stated, as a principle of agency law, that "[a] master is responsible for the negligence or unskillfulness of a servant acting in the prosecution of his service, though not under his immediate direction." William Paley, A Treatise on the Law of Principal and Agent, Chiefly with Reference to Mercantile Transactions 126 (3d ed. 1840). As the location of work moved outside the household and into mercantile and industrial settings, an employer's responsibility for harm caused by employee activities followed the employer's right to control how work is done.

Viewed as a doctrine within the law of agency, respondeat superior is a basis upon which the legal consequences of one person's acts may be attributed to another person. Most often the doctrine applies to acts that have not been specifically directed by an employer but that are the consequence of inattentiveness or poor judgment on the part of an employee acting within the job description. Most cases applying the doctrine involve negligence resulting in physical injury to a person or to property. But respondeat superior is not the exclusive basis on which an employer may be vicariously liable for torts committed by employees. Many employees have jobs in which they interact with third parties, as do nonemployee agents, by making transactions and statements on the employer's behalf. This activity is transactional and communicative in nature. When it is misused, for example to perpetrate a fraud for the employee's sole benefit, the employer's responsibility is often determined by whether the party injured reasonably believed the employee's activity to be authorized. The fraud is associated with a transaction, in contrast to the negligent physical actions to which respondeat superior is conventionally applied. Many cases apply the doctrine of apparent authority to determine whether an employer is liable for employee torts associated with such transactions and statements. See § 7.08. The application of apparent-authority doctrine, and not respondeat superior, may be a consequence of the generalization that employees work with things but agents deal with people. Many employees and agents, of course, do both, and “things” are often instrumentalities for communicating with others.

Respondeat superior is inapplicable when a principal does not have the right to control the actions of the agent that makes the relationship between principal and agent performing the service one of employment as defined in § 7.07(3). In general, employment contemplates a continuing relationship and a continuing set of duties that the employer and employee owe to each other. Agents who are retained as the need arises and who are not otherwise employees of their principal normally operate their own business enterprises and are not, except in limited respects, integrated into the principal's enterprise so that a task may be completed or a specified objective accomplished. Therefore, respondeat superior does not apply.

Respondeat superior assigns responsibility to an employer for the legal consequences that result from employees' errors of judgment and lapses in attentiveness when the acts or omissions are within the scope of employment. See § 7.07(2). A firm or organization that employs individuals usually structures their work to limit the scope of discretion and individual action, thus limiting the occasions when unreasonable decisions are likely to be made. Impulsive conduct is not typical of firms or organizations. The firm as a principal may always act more rationally and reasonably than would most individuals acting by themselves because different individuals are assigned different tasks, often monitoring and checking each other. Respondeat superior creates an incentive for principals to choose employees and structure work within the organization so as to reduce the incidence of tortious conduct. This incentive may reduce the incidence of tortious conduct more effectively than doctrines that impose liability solely on an individual tortfeasor.

Respondeat superior also reflects the likelihood that an employer will be more likely to satisfy a judgment. Moreover, an employer may insure against liability encompassing the consequences of all employees' actions, whereas individual employees lack the incentive and ability to insure beyond any individual's liability or assets.

Despite the general scope of the doctrine, there are significant exceptions to the applicability of respondeat superior to tortious conduct committed by employees. The doctrine is inapplicable when the question is municipal liability for money damages for most acts of local-government employees in actions brought under 42 U.S.C. § 1983. Additionally, respondeat superior is inapplicable when an employee's tortious conduct does not fall within the scope of employment as stated in § 7.07(2). Finally, when the question is an employer's vicarious liability for punitive damages stemming from the employee's tort, a majority of jurisdictions impose liability on the employer when the employee acted with apparent authority or within the scope of employment, while a sizable minority of jurisdictions require some showing of the employer's direct culpability or, in some circumstances, impose liability when the employee was a manager. See § 7.03, Comment *e*.

REST 3d AGEN § 7.07
Restatement (Third) Of Agency § 7.07 (2006)

Restatement of the Law — Agency
Restatement (Third) of Agency
Current through April 2010

Chapter 7. Torts—Liability Of Agent And Principal
Topic 2. Principal's Liability

§ 7.07 Employee Acting Within Scope Of Employment

(1) An employer is subject to vicarious liability for a tort committed by its employee acting within the scope of employment.
(2) An employee acts within the scope of employment when performing work assigned by the employer or engaging in a course of conduct subject to the employer's control. An employee's act is not within the scope of employment when it occurs within an independent course of conduct not intended by the employee to serve any purpose of the employer.
(3) For purposes of this section,
(a) an employee is an agent whose principal controls or has the right to control the manner and means of the agent's performance of work, and
(b) the fact that work is performed gratuitously does not relieve a principal of liability.

Comment:
a. Scope and cross-references. Subsection (1) repeats the basic doctrine of respondeat superior stated in § 2.04 as a basis on which legal consequences of one person's actions may be attributed to another person. Subsection (2) states when an employee's tortious conduct occurs within the scope of employment for purposes of subjecting the employer to liability. Comment *b* discusses the rationale for the formulation in subsection (2), contrasting it with its counterparts in Restatement Second, Agency § 228 and in cases. Comment *c* discusses employee conduct that constitutes performance of work and is within the scope of employment. Comment *d* discusses other employee conduct that is subject to an employer's control. Comment *e* examines employees' peregrinations, that is, their travel necessitated by or otherwise in connection with their work. Comment *f* discusses the definition of employee in subsection (3).

b. When tortious conduct is within the scope of employment—in general. An employee's conduct, although tortious, may be within the scope of employment as defined in subsection (2). If an employee commits a tort while performing work assigned by the employer or while acting within a course of conduct subject to the employer's control, the employee's conduct is within the scope of employment unless the employee was engaged in an independent course of conduct not intended to further any purpose of the employer. The formulation in subsection (2) reflects the definition of scope of employment applied in most cases and in most jurisdictions. ….

f. Definition of employee. For purposes of respondeat superior, an agent is an employee only when the principal controls or has the right to control the manner and means through which the

agent performs work. The definition has the consequence of distinguishing between employees and agents who are not employees because they retain the right to control how they perform their work. If a person has no right to control an actor and exercises no control over the actor, the actor is not an agent. See § 1.01, Comment *f(1)*.

The fact that an agent performs work gratuitously does not relieve a principal of vicarious liability when the principal controls or has the right to control the manner and means of the agent's performance of work.

A person who causes a third party to believe that an actor is the person's employee may be subject to liability to the third party for harm caused by the actor when the third party justifiably relies on the actor's skill or care and the actor's conduct, if that of an employee, would be within the scope of employment. For the general principle of estoppel, see § 2.05.

Numerous factual indicia are relevant to whether an agent is an employee. These include: the extent of control that the agent and the principal have agreed the principal may exercise over details of the work; whether the agent is engaged in a distinct occupation or business; whether the type of work done by the agent is customarily done under a principal's direction or without supervision; the skill required in the agent's occupation; whether the agent or the principal supplies the tools and other instrumentalities required for the work and the place in which to perform it; the length of time during which the agent is engaged by a principal; whether the agent is paid by the job or by the time worked; whether the agent's work is part of the principal's regular business; whether the principal and the agent believe that they are creating an employment relationship; and whether the principal is or is not in business. Also relevant is the extent of control that the principal has exercised in practice over the details of the agent's work.

In some employment relationships, an employer's right of control may be attenuated. For example, senior corporate officers, like captains of ships, may exercise great discretion in operating the enterprises entrusted to them, just as skilled professionals exercise discretion in performing their work. Nonetheless, all employers retain a right of control, however infrequently exercised. ……

IN THE COURT OF APPEALS OF TENNESSEE
AT NASHVILLE
February 8, 2008 Session

JAMES G. THOMAS, JR., EX REL. KAREN G. THOMAS v. ELIZABETH OLDFIELD, M.D., ET AL.

Appeal from the Circuit Court for Davidson County
No. 05C3207 Walter C. Kurtz, Judge

No. M2007-01693-COA-R3-CV - Filed: June 2, 2008

The issue on appeal in this medical malpractice action is whether the hospital is vicariously liable for the acts or omissions of an emergency room physician. The trial court summarily dismissed all claims against the hospital finding that it was not vicariously liable for the conduct of the emergency room physician because he was neither its actual or apparent agent. We find the trial court correctly granted summary judgment to the hospital on the issue of actual agency because there are no material facts in dispute and the hospital is entitled to summary judgment on the issue of actual agency as a matter of law. We, however, find that material facts are in dispute concerning whether the hospital held itself out to the public as providing medical services; whether the plaintiff looked to the hospital rather than to the individual physician to perform those services; whether the patient accepted those services in the reasonable belief that the services were provided by the hospital or a hospital employee; and, if so, whether the hospital provided meaningful notice to the plaintiff at the time of admission that the emergency room physician was not its agent. Accordingly, we have determined the hospital was not entitled to summary judgment on the issue of apparent agency. Therefore, we remand to the trial court the issue of apparent agency for further proceedings consistent with this opinion.

Tenn. R. App. P. 3 Appeal as of Right; Judgment of the Circuit Court Affirmed in Part and Reversed in Part

FRANK G. CLEMENT, JR., J., delivered the opinion of the court, in which PATRICIA J. COTTRELL, P.J., M.S., and DAVID H. WELLES, SP.J., joined.

William D. Leader, Jr., and John B. Carlson, Nashville, Tennessee, for the appellant, James G. Thomas, Jr., brother and next of kin of Karen G. Thomas, deceased.

C. J. Gideon, Jr., and Margaret Moore, Nashville, Tennessee, for the appellee, Crockett Hospital, LLC.

OPINION

On December 13, 2004, Karen G. Thomas was experiencing severe abdominal pain following surgery performed five days earlier.[1] When Chris Price arrived to take Ms. Thomas to the hospital, he found her bent over in pain and holding her abdomen with her arms. Ms. Thomas directed Mr. Price to "just carry me down here to the hospital so I can get something for the pain." Ms. Thomas was then taken to the emergency room at Crockett Hospital around 5:30 p.m.

While waiting for treatment in the emergency room as she was experiencing great pain, Ms. Thomas signed a lengthy consent form for medical treatment that contained twelve enumerated paragraphs and numerous subparagraphs. Only one of the paragraphs in the Conditions of Admission and Authorization for Medical Treatment Form that Ms. Thomas signed addressed the issue before the court. It reads as follows:

> **9. Legal Relationship Between Hospital and Physician**
> I understand that, unless I am specifically otherwise informed in writing, all physicians furnishing services to me, including the pathologist, anesthesiologist, *emergency room physician*, and the like, are independent contractors and are not employees or agents of the Hospital. . . ." (Emphasis added.)

After signing the form, Ms. Thomas was asked by the triage nurse to rate her pain on a scale of one to ten, with ten being the worst pain she had ever experienced. Ms. Thomas responded that her pain was a ten.

Thereafter, Ms. Thomas saw Dr. Charles Love, M.D., the only physician on duty in the emergency room. Dr. Love ordered blood and urine tests and x-rays. He subsequently diagnosed Ms. Thomas with a urinary tract infection, prescribed her an antibiotic, and told her to follow-up with her primary care physician. Dr. Love discharged Ms. Thomas from the emergency room at 11:20 p.m. that same day.

The next morning, Ms. Thomas was still in pain, her speech was slurred, and she was having difficulty talking. She was taken back to the emergency room at Crockett Hospital where the emergency room physician on-duty, Dr. June McMillan, diagnosed Ms. Thomas' condition as "sepsis." Shortly after arriving at the Crockett Hospital emergency room, Ms. Thomas suffered cardiopulmonary arrest requiring intubation and mechanical ventilation. She was then taken by Air Ambulance to Baptist Hospital in Nashville.

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[1] The plaintiff originally filed a wrongful death action against seventeen healthcare defendants for medical care provided over a period of time at different locations that allegedly led to the death of Karen G. Thomas. However, only the claims against Crockett Hospital, LLC, are at issue in this appeal. Thus, only the facts that pertain to the issues on appeal against Crockett Hospital are addressed here.

Within fifteen minutes of arriving at Baptist Hospital, Ms. Thomas again suffered cardiopulmonary arrest. Unfortunately, resuscitation efforts were unsuccessful. The autopsy listed her cause of death as "complications from diverticular disease."

On October 18, 2005, James G. Thomas, Jr. (the "plaintiff") filed this wrongful death action on behalf of his deceased sister. The plaintiff's complaint alleged that Crockett Hospital, LLC (the "hospital") was vicariously liable for the medical negligence of its emergency room physician, Dr. Charles Love, that the hospital was negligent by failing to properly supervise, train, and monitor Dr. Love, and that the hospital deviated from the recognized minimum standard of acceptable professional practice. On April 11, 2007, Crockett Hospital filed its Motion for Summary Judgment. The only portion of the hospital's Motion for Summary Judgment that was contested was the claim that the hospital was vicariously liable for the conduct of its emergency room physician, Dr. Love, under the theory of actual and apparent agency.

After a full hearing on the merits, the trial court granted summary judgment to the hospital finding the hospital was not vicariously liable for the conduct of Dr. Love, the emergency room physician, because he was neither its actual nor apparent agent. This appeal followed.

STANDARD OF REVIEW

The issues were resolved in the trial court upon summary judgment. Summary judgments do not enjoy a presumption of correctness on appeal. *BellSouth Adver. & Publ'g Co. v. Johnson*, 100 S.W.3d 202, 205 (Tenn. 2003). This court must make a fresh determination that the requirements of Tenn. R. Civ. P. 56 have been satisfied. *Hunter v. Brown*, 955 S.W.2d 49, 50-51 (Tenn. 1997). We consider the evidence in the light most favorable to the non-moving party and resolve all inferences in that party's favor. *Stovall v. Clarke*, 113 S.W.3d 715, 721 (Tenn. 2003); *Godfrey v. Ruiz*, 90 S.W.3d 692, 695 (Tenn. 2002). When reviewing the evidence, we first determine whether factual disputes exist. If a factual dispute exists, we then determine whether the fact is material to the claim or defense upon which the summary judgment is predicated and whether the disputed fact creates a genuine issue for trial. *Byrd v. Hall*, 847 S.W.2d 208, 214 (Tenn. 1993); *Rutherford v. Polar Tank Trailer, Inc.*, 978 S.W.2d 102, 104 (Tenn. Ct. App. 1998).

Summary judgment is appropriate where a party establishes that there is no genuine issue as to any material fact and that a judgment may be rendered as a matter of law. Tenn. R. Civ. P. 56.04; *Stovall*, 113 S.W.3d 721. Moreover, it is proper in virtually all civil cases that can be resolved on the basis of legal issues alone, *Byrd v. Hall*, 847 S.W.2d at 210; *Pendleton v. Mills*, 73 S.W.3d 115, 121 (Tenn. Ct. App. 2001); however, it is not appropriate when genuine disputes regarding material facts exist. Tenn. R. Civ. P. 56.04. The party seeking a summary judgment bears the burden of demonstrating that no genuine disputes of material fact exist and that the party is entitled to judgment as a matter of law. *Godfrey v. Ruiz*, 90 S.W.3d at 695. Summary judgment should be granted at the trial court level when the undisputed facts, and the inferences reasonably drawn from the undisputed facts, support one conclusion, which is the party seeking the summary judgment is entitled to a judgment as a matter of law. *Pero's Steak & Spaghetti House v. Lee*, 90 S.W.3d 614, 620 (Tenn. 2002); *Webber v. State Farm Mut. Auto. Ins. Co.*, 49 S.W.3d 265, 269 (Tenn. 2001). The court must take the strongest legitimate view of the evidence in favor of the non-moving party, allow

all reasonable inferences in favor of that party, discard all countervailing evidence, and, if there is a dispute as to any material fact or if there is any doubt as to the existence of a material fact, summary judgment cannot be granted. *Byrd v. Hall*, 847 S.W.2d at 210; *EVCO Corp. v. Ross*, 528 S.W.2d 20 (Tenn. 1975). To be entitled to summary judgment, the moving party must affirmatively negate an essential element of the non-moving party's claim or establish an affirmative defense that conclusively defeats the non-moving party's claim. *Cherry v. Williams*, 36 S.W.3d 78, 82-83 (Tenn. Ct. App. 2000).

ANALYSIS

The plaintiff presents two issues on appeal. One, whether the trial court erred in granting the hospital summary judgment on the issue of actual agency. Two, whether the trial court erred in granting the hospital summary judgment on the issue of apparent agency.

ACTUAL AGENCY

The trial court summarily dismissed the plaintiff's claim that was based on the contention that Dr. Love was the actual agent of the hospital. We affirm that decision.

In general, the concept of agency includes every relation in which one person acts for or represents another. *White v. Revco Discount Drug Ctrs., Inc.*, 33 S.W.3d 713, 723 (Tenn. 2000) (internal quotation omitted). Whether an agency relationship exists is a question of fact under the circumstances of the particular case and is determined by examination of agreements among the parties or of the parties' actions. *Id.* "The principal's right to control the acts of the agent is a relevant factor when determining the existence of an agency relationship." *Johnson v. LeBonheur Children's Med. Ctr.*, 74 S.W.3d 338, 343 (Tenn. 2002). Similarly, whether an agency relationship exists depends upon the amount of control by the principal over the "means and method" of the work of the agent. *Davis v. University Physicians Found. Inc.*, No. 02A01-9812-CV-00346, 1999 WL 643388, at *4 (Tenn. Ct. App. Aug. 24, 1999).

When an agency relationship exists, the principal may be held vicariously liable for the negligence of his agent. *Johnson*, 74 S.W.3d at 343. However, the general rule is that an employer is not ordinarily liable for the negligence of an independent contractor. *Carr v. Carr*, 726 S.W.2d 932, 933 (Tenn. Ct. App. 1986). The burden of proving an agency relationship is on the person alleging its existence. *Sloan v. Hall*, 673 S.W.2d 548, 551 (Tenn. Ct. App. 1984) (citing *Cobble v. Langford*, 230 S.W.2d 194 (Tenn. 1950); *Testerman v. Home Beneficial Life Ins. Co.*, 524 S.W.2d 664 (Tenn. App. 1974)).

There is no evidence in the record that Dr. Love was an actual agent of the hospital. It is undisputed that Dr. Love was employed by Emergency Coverage Corporation (ECC), ECC provided Dr. Love's malpractice insurance, and ECC determined his schedule while working at the hospital. There is no evidence in the record that the hospital directed Dr. Love's treatment of his patients. To the contrary, hospitals in Tennessee are legally precluded from controlling the means and methods by which physicians render medical care and treatment to hospital patients, *see* Tenn. Code Ann. §§

63-6-204(f)(1)(A) and 68-11-205(b)(1)(A). Moreover, hospitals are specifically precluded from employing emergency physicians. *See* Tenn. Code Ann. §§ 63-6-204(f)(1) and 68-11-205(b)(6).

There being no evidence upon which to find that Dr. Love was an actual agent of the hospital, we affirm the summary dismissal of the plaintiff's claim against the hospital based on the theory of actual agency.

APPARENT AGENCY

The trial court reluctantly granted summary judgment to the hospital on the claim it was vicariously liable for Dr. Love's actions or conduct under the theory of apparent agency due to this court's ruling in *Boren v. Weeks*, No. M2007-00628-COA-R9-CV, 2007 WL 1711666 (Tenn. Ct. App. June 12, 2007). The trial court went on to state that if it did not feel bound by this Court's opinion in *Boren*, it would have determined there was an inference of reliance in the hospital setting that has not been overcome by the hospital in regard to its motion for summary judgment, and therefore, the trial court would have denied the motion on the issue of apparent agency.

Subsequent to the trial court's grant of summary judgment in this matter, the Tennessee Supreme Court adopted the Restatement (Second) of Torts § 429 in its ruling in *Boren v. Weeks*, No. M2007-00628-SC-R11-CV, 2008 WL 1945985, at *6, ___ S.W.3d. ___ (Tenn. May 6, 2008). Under this approach, "[t]o hold a hospital vicariously liable for the negligent or wrongful acts of an independent contractor physician, a plaintiff must show that (1) the hospital held itself out to the public as providing medical services; (2) the plaintiff looked to the hospital rather than to the individual physician to perform those services; and (3) the patient accepted those services in the reasonable belief that the services were provided by the hospital or a hospital employee." *Id.* at *9. Our Supreme Court further noted that a hospital may be able to avoid vicarious liability for the negligence of an independent contractor by providing *meaningful* written notice to the patient that is acknowledged at the time of admission. *Id.* The Court, however, went on to state that in certain cases, as "in the case of a medical emergency, . . . written notice may not suffice if the patient had an inadequate opportunity to make an informed choice." *Id.* (citing *Sword v. NKC Hosps., Inc.*, 714 N.E.2d 142, 152 (Ind. 1999)). Therefore, the Court stated, the issue often becomes what constitutes "'meaningful' notice." *Id.*

In discussing what constitutes "meaningful notice," our Supreme Court looked to the decision of the Georgia Court of Appeals in *Cooper v. Binion*, 598 S.E.2d 6 (Ga. Ct. App. 2004), which stated:

> Generally, posting a conspicuous sign in the admissions area that the emergency room physicians are not hospital employees and having the patient sign an acknowledgment to this effect would preclude a claim of apparent authority. However, since there was testimony that a witness present that day did not recall seeing any such signs in the admissions area, and there was no testimony that either Cooper or his wife saw such, some evidence would indicate that no such sign was posted or if so, it was not conspicuous. The acknowledgment in the admitting form

> was one of thirteen paragraphs in a two-page document signed by Cooper's wife, and nothing indicates that the hospital called attention to the acknowledgment. Under these circumstances and evidence, we cannot hold that the hospital as a matter of law sufficiently notified Cooper that Dr. Binion was not its employee.

598 S.E.2d at 11-12. Using the *Cooper* analysis, the Tennessee Supreme Court reasoned that while the hospital included a disclaimer in the consent form, it was not sufficient, as a matter of law, to provide adequate notice that the physician was not its employee. *Boren*, 2008 WL 1945985, at *10. Further, our Supreme Court found it significant that the acknowledgment in the consent form was in the second half of one paragraph of a three-page form, there was no evidence that the hospital called attention to the disclaimer, and that the hospital staff did not as a matter of practice explain that the physicians were independent contractors rather than employees or agents. *Id.*

As was the case in *Boren*, we are unable to hold that the hospital in this case, as a matter of law, sufficiently notified Ms. Thomas that Dr. Love was not its agent. The Conditions of Admission and Authorization for Medical Treatment form signed by Ms. Thomas contained a clause stating that the emergency room physicians were independent contractors; however, that clause was merely number nine of twelve clauses, it was not set out in any way from the rest of the form language, and it was not separately acknowledged, as was the case in *Boren*. Nothing in this record suggests that this clause was brought to Ms. Thomas' attention. Furthermore, Ms. Thomas was in extreme pain when she was taken to the hospital's emergency room. Based upon these facts, we find there exists a dispute of a material fact, that being whether the disclaimer provided to Ms. Thomas in the emergency room constituted meaningful notice that Dr. Love was not an agent of the hospital. Accordingly, the hospital was not entitled to summary judgment on the issue of apparent agency.

IN CONCLUSION

The judgment of the trial court is affirmed in part and reversed in part and remanded to the trial court for further proceedings consistent with this opinion. Costs of appeal are assessed against Crockett Hospital, LLC.

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FRANK G. CLEMENT, JR., JUDGE

Filed 5/25/16 Pickett v. Olympia Medical Center CA2/2

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION TWO

KIMBERLY PICKETT, Plaintiff and Appellant, v. OLYMPIA MEDICAL CENTER, Defendant and Respondent.	B260878 (Los Angeles County Super. Ct. No. BC529994)

APPEAL from an order of the Superior Court of Los Angeles County. Terry A. Green, Judge. Reversed.

Baum Hedlund Aristei & Goldman, Ronald L.M. Goldman, Bijan Esfandiari, and Nicole K.H. Maldonado, for Plaintiff and Appellant.

Lewis Brisbois Bisgaard & Smith, Jeffry A. Miller, Brittany H. Bartold, Lee M. Thies, and John J. Weber for Defendant and Respondent.

Plaintiff and appellant Kimberly Pickett (Pickett) appeals from the order dismissing her negligence action against defendant and respondent Olympia Medical Center (Olympia) after the trial court sustained, without leave to amend, Olympia's demurrer to Pickett's second amended complaint (SAC). Olympia provided services and facilities for a surgery in which Pickett was allegedly injured.

The SAC states a claim for negligence against Olympia. We therefore reverse the order sustaining the demurrer and dismissing the action against Olympia.

BACKGROUND

In December 2013, Pickett filed her original complaint. She later filed a first amended complaint alleging nine causes of action, one against Olympia. Following a successful demurrer by Olympia, where leave to amend was granted, Pickett filed her SAC.

The SAC alleges generally as follows: Pickett was a director of Medtronic, Inc. (Medtronic) when she sustained neck injuries at a work-related outing.

An MRI revealed disc compression in her cervical spine. A Medtronic co-worker recommended that she consult with Todd H. Lanman, M.D., a neurosurgeon in Beverly Hills. Unbeknownst to Pickett, Lanman was a prominent consultant for Medtronic, which paid him up to $500,000 annually in fees and royalties.

Lanman examined Pickett and recommended cervical spine surgery using a Medtronic product called Infuse. Infuse consists of a bioengineered liquid bone graft (called rhBMP-2) that is intended to substitute for the patient's own bone when performing spinal fusion surgery, a surgical technique in which vertebrae are fused together so that motion no longer occurs between them. The Food and Drug Administration (FDA) has approved the use of Infuse in anterior lumbar fusion surgeries, where the Infuse is implanted in the lumbar spine in combination with a certain type of "cage," a hollow metal cylinder.

The FDA has not approved the use of Infuse in the cervical spine. Rather, in July 2008, the FDA issued a notification to "Healthcare Practitioner[s]" titled "Life-threatening Complications Associated with Recombinant Human Bone Morphogenetic

Protein in Cervical Spine Fusion," noting reports of "life-threatening complications associated with" rhBMP, including Infuse, when used in the cervical spine. The notification stated that the FDA had received at least 38 reports of complications from the use of rhBMP in cervical spine fusion, including swelling of neck and throat tissue, compression of airway or neurological structures in the neck, and difficulty swallowing, breathing, or speaking. The notification further read: "Since the safety and effectiveness of rhBMP for treatment of cervical spine conditions has not been demonstrated, and in light of the serious adverse events described above, FDA recommends that practitioners either use approved alternative treatments or consider enrolling as investigators in approved clinical studies."

Lanman did not disclose to Pickett his financial relationship with Medtronic or the FDA's concerns with the use of Infuse in the cervical spine. On June 25, 2012, Lanman performed Pickett's cervical spine surgery at Olympia. He implanted Infuse into her cervical spine, using a cage that was not approved for use with Infuse.

Following the surgery, Pickett experienced severe nerve pain radiating to her arms. A December 2012 scan revealed that she had developed Infuse-induced ectopic bone overgrowth in her cervical spine, which impinged nerves. Pickett met with various surgeons who told her that Infuse should not have been used in her cervical spine and that she needed revision surgery. Pickett had revision surgery in May 2013; the surgeon chiseled and drilled away some of the ectopic bone growth. Pickett continues to experience agonizing nerve pain, however, and may need further revision surgery.

Pickett's SAC alleges seven causes of action against Medtronic and two against Lanman. It alleges a single cause of action for negligence against Olympia. The SAC states that Olympia was negligent because: it permitted the off-label implantation of Infuse in Pickett's cervical spine despite the FDA's warning; it approved and allowed the off-label use of Infuse without any restrictions; and it participated in the preparation and implanting of the Infuse in Pickett's cervical spine. The SAC alleges that following the FDA's July 2008 notification, many hospitals and medical facilities in California and the United States, including another hospital where Lanman has privileges, implemented

policies and procedures prohibiting the off-label, cervical use of Infuse. The SAC further alleges that Lanman chose to perform Pickett's surgery at Olympia because the other hospital at which he had privileges would either have prohibited the use of Infuse in her cervical spine surgery or would have restricted such use or made it more difficult to use Infuse at its facility, whereas Olympia had no such prohibitions or restrictions. The SAC claims that Olympia was negligent in failing to implement any policies regarding the use of Infuse in the cervical spine and in allowing surgeons to implant Infuse in the cervical spine without first ensuring patients were enrolled in approved clinical trials. Further, Olympia failed to provide Pickett with appropriate consent forms warning of the FDA's concerns regarding Infuse.

Olympia filed a demurrer, arguing that it did not owe a duty to Pickett based on the SAC's allegations. The trial court sustained the demurrer without leave to amend and the action against Olympia was dismissed. Pickett timely appealed.

DISCUSSION

I. Standard of review

We review the ruling sustaining the demurrer de novo, exercising independent judgment as to whether the complaint states a cause of action as a matter of law. (*Desai v. Farmers Ins. Exchange* (1996) 47 Cal.App.4th 1110, 1115 (*Desai*).) We give the complaint a reasonable interpretation, assuming that all properly pleaded material facts are true, but not assuming the truth of contentions, deductions, or conclusions of law. (*Aubry v. Tri-City Hospital Dist.* (1992) 2 Cal.4th 962, 967 (*Aubry*).)

A demurrer tests the legal sufficiency of the complaint. (*Hernandez v. City of Pomona* (1996) 49 Cal.App.4th 1492, 1497.) Accordingly, we are not concerned with the difficulties the plaintiff may have in proving the claims made in the complaint. (*Desai, supra*, 47 Cal.App.4th at p. 1115.) We are also unconcerned with the trial court's reasons for sustaining the demurrer, as it is the ruling, not the rationale, that is reviewable. (*Mendoza v. Town of Ross* (2005) 128 Cal.App.4th 625, 631; *Sackett v. Wyatt* (1973) 32 Cal.App.3d 592, 598, fn. 2.)

"The judgment must be affirmed 'if any one of the several grounds of demurrer is well taken. [Citations.]' [Citation.] However, it is error for a trial court to sustain a demurrer when the plaintiff has stated a cause of action under any possible legal theory. [Citation.] And it is an abuse of discretion to sustain a demurrer without leave to amend if the plaintiff shows there is a reasonable possibility any defect identified by the defendant can be cured by amendment. [Citation.]" (*Aubry, supra*, 2 Cal.4th at pp. 966-967.)

II. Negligence and a hospital's duty of care

The elements of a negligence cause of action are """(a) a *legal duty* to use due care; (b) a *breach* of such legal duty; [and] (c) the breach as the *proximate or legal cause* of the resulting injury."' [Citation.]" (*Ladd v. County of San Mateo* (1996) 12 Cal.4th 913, 917-918.) "The existence and the scope of a duty of care in a given factual situation are issues of law for the court. [Citations.]" (*Walker v. Sonora Regional Medical Center* (2012) 202 Cal.App.4th 948, 958 (*Walker*).)

"[A] hospital has a duty of reasonable care to protect patients from harm [citation]." (*Elam v. College Park Hospital* (1982) 132 Cal.App.3d 332, 340 (*Elam*).) "'The measure of duty of a hospital is to exercise that degree of care, skill and diligence used by hospitals generally in that community.'" (*Wood v. Samaritan Institution, Inc.* (1945) 26 Cal.2d 847, 851 (*Wood*); *Osborn v. Irwin Memorial Blood Bank* (1992) 5 Cal.App.4th 234, 285-286 (*Osborn*).) """The extent and character of the care that a hospital owes its patients depends on the circumstances of each particular case . . . ."' [Citation.]" (*Rice v. California Lutheran Hospital* (1945) 27 Cal.2d 296, 299.)

The scope of a hospital's duty of care to its patients was addressed by our Supreme Court in *Leung v. Verdugo Hills Hospital* (2012) 55 Cal.4th 291 (*Leung*). In that case, a newborn suffered irreversible brain damage soon after birth. The plaintiff newborn's mother repeatedly expressed concerns to the pediatrician and nurses regarding the baby's troubles with breastfeeding, yellowish eyes, chapped lips, and bruises on the head. She was told that the symptoms did not indicate an emergency, and to wait for the next scheduled appointment with the pediatrician. Before the next appointment, the

plaintiff developed kernicterus, resulting in severe brain damage. (*Id.* at p. 299.) In arguing that it was not liable for the plaintiff's injuries, the hospital averred that, because hospitals in general do not practice medicine, as a matter of public policy, its conduct could not be considered a legal cause of the plaintiff's injuries. (*Id.* at p. 309.) The Supreme Court disagreed, noting: """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 internes [*sic*], 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."""" (*Id.* at p. 310, quoting *Mejia v. Community Hospital of San Bernardino* (2002) 99 Cal.App.4th 1448, 1453 (*Mejia*), and *Bing v. Thunig* (1957) 2 N.Y.2d 656.) The *Leung* court concluded: "Although hospitals do not practice medicine in the same sense as physicians, they do provide facilities and services in connection with the practice of medicine, and if they are negligent in doing so they can be held liable." (*Leung, supra,* at p. 310.) The court noted that the hospital had "implicitly recognized" that principle when it requested a jury instruction that stated: "'A hospital must provide procedures, policies, facilities, supplies, and qualified personnel reasonably necessary for the treatment of its patients.'" (*Ibid.*)

Other cases in which courts have addressed a hospital's duty of care include *Meyer v. McNutt Hospital* (1916) 173 Cal. 156, in which a hospital was found to have breached its "duty of protection" to the plaintiff, who was burned while under the hospital's care, most likely by a hot water bottle placed near her bed. (*Id.* at pp.158-159.) In *Elam, supra,* 132 Cal.App.3d 332, the plaintiff alleged that she received negligent podiatric surgery at a hospital, and sought to hold both the surgeon and the hospital liable, arguing that the hospital had negligently failed to ensure that its staff physicians were competent. Finding that the plaintiff identified a cognizable duty of care, the court held that "a hospital is accountable for negligently screening the competency of its

medical staff to insure the adequacy of medical care rendered to patients at its facility." (*Id.* at p. 346.) In *Mejia, supra*, 99 Cal.App.4th 1448, the plaintiff entered an emergency room complaining of a hurt neck, was discharged by the emergency room physician after a radiologist determined that an X-ray showed no serious abnormalities, and awoke paralyzed; it was subsequently determined that her neck was actually broken. The plaintiff brought a lawsuit against various parties, including the hospital, claiming that the radiologist was an ostensible agent of the hospital. In reversing a nonsuit in favor of the hospital, the appellate court found that the issue of whether the radiologist was an ostensible agent could only be determined by the trier of fact. (*Id.* at pp. 1458-1459.)

The principles articulated in the foregoing cases are summarized in CACI No. 514, which defines a hospital's duty to its patients as follows: "A hospital is negligent if it does not use reasonable care toward its patients. A hospital must provide procedures, policies, facilities, supplies, and qualified personnel reasonably necessary for the treatment of its patients." (CACI No. 514; see *Leung, supra*, 55 Cal.4th at p. 310.)

III. The SAC states a claim for negligence

The SAC alleges that the FDA issued a notice advising healthcare practitioners of life-threatening complications associated with the use of Infuse in the cervical spine and recommending against such use unless part of an approved clinical trial. The SAC further alleges that following the issuance of the FDA notice, other hospitals, including another hospital at which Lanman has privileges, implemented policies, procedures, and guidelines restricting the use of Infuse in the cervical spine by surgeons at their facilities. The SAC alleges that Olympia knew or should have known of the FDA notice, that Olympia failed to implement any guidelines, policies, or procedures regarding use of Infuse in the cervical spine, failed to inform Pickett of the FDA notice regarding use of Infuse in the cervical spine, and allowed Lanman to implant Infuse in Pickett's cervical spine without first determining whether she had been enrolled in an approved clinical trial. These allegations are sufficient to establish that Olympia breached a duty of care to Pickett.

Under California law, "a hospital has a duty of reasonable care to protect patients from harm [citation]." (*Elam, supra*, 132 Cal.App.3d at p. 340.) Those duties include providing "policies" and "procedures" that are "reasonably necessary" for the treatment of patients. (CACI No. 514; *Leung, supra*, 55 Cal.4th at p. 310.) The measure of a hospital's duty is the degree of care, skill, and diligence used by other hospitals in similar circumstances. (*Wood, supra*, 26 Cal.2d at p. 851; *Osborn, supra*, 5 Cal.App.4th at pp. 285-286.)

Olympia argues that the FDA notice imposed no duty on it to inform Pickett about the risks of using Infuse in the cervical spine or to implement policies and procedures governing such use and cites *Walker, supra*, 202 Cal.App.4th 948 as support for this argument. That case, however, is distinguishable.

At issue in *Walker* was whether a hospital that performed a cystic fibrosis screening test ordered by the plaintiff's doctor owed a duty to disclose the test results to the plaintiff. The plaintiff's doctor did not inform the plaintiff that she had tested positive for cystic fibrosis, and the plaintiff subsequently gave birth to a child who was diagnosed with cystic fibrosis. The court in *Walker* affirmed the summary judgment entered in the hospital's favor, concluding that to the extent the hospital was providing clinical laboratory services to perform a test ordered by the plaintiff's doctor, it owed a duty to send the laboratory results to the doctor only. The hospital had no affirmative duty to release the laboratory test results directly to the patient. (*Walker, supra*, 202 Cal.App.4th at p. 962.) The court based its decision on limitations imposed by both federal and California law restricting the persons to whom a laboratory may release a patient's test results to licensed medical professionals. The applicable statutes and regulations, the court in *Walker* reasoned, circumscribed the hospital's duty of care to transmit clinical laboratory test results to the physician who ordered the test. (*Id.* at pp. 961-962.) For that same reason, the court in *Walker* rejected the plaintiff's claim that the hospital had a duty to implement policies and procedures to ensure that she would be informed and counseled concerning the test results. (*Id.* at pp. 966-967.) The court further reasoned that imposing such a duty on the hospital might interfere in the physician-patient

relationship and would "create an onerous administrative burden on hospitals providing laboratory services." (*Ibid.*)

Here, unlike *Walker*, no federal or California law circumscribes Olympia's duty regarding the FDA notice. The procedural posture of the two cases also differs. *Walker* involved a motion for summary judgment, whereas the parties in the instant case are only in the pleading stage. Under the standard applicable here, we must assume that all properly pleaded material facts are true, and we do not consider any difficulties the plaintiff may have in proving the allegations made in the complaint. (*Aubry, supra*, 2 Cal.4th at p. 967; *Desai, supra*, 47 Cal.App.4th at p. 1115.)

The SAC alleges that Olympia breached a duty of care owed to Pickett, and that as a result of that breach of duty, Pickett sustained injuries and incurred damages. Pickett has alleged sufficient facts to state a negligence claim against Olympia. The trial court accordingly erred by sustaining the demurrer without leave to amend and dismissing the action against Olympia.

DISPOSITION

The order dismissing the action against Olympia Medical Center is reversed. Pickett is awarded her costs on appeal.

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS.

_____, J.
CHAVEZ

I concur:

_____, J.
ASHMANN-GERST

126 Nev., Advance Opinion 24

IN THE SUPREME COURT OF THE STATE OF NEVADA

RENOWN HEALTH, INC., F/K/A WASHOE MEDICAL CENTER, INC., Appellant,
vs.
BETTY VANDERFORD, INDIVIDUALLY AND AS THE PERSONAL REPRESENTATIVE OF CHRISTOPHER WALL, A MINOR, Respondent.

No. 51755

Appeal from a district court order dismissing a medical malpractice action. Second Judicial District Court, Washoe County; Janet J. Berry, Judge.

Reversed.

Piscevich & Fenner and Margo Piscevich, Reno; Molof & Vohl and Robert C. Vohl, Reno,
for Appellant.

John P. Echeverria, Reno; Durney & Brennan and Peter D. Durney, Reno,
for Respondent.

Bradley Drendel & Jeanney and Bill Bradley, Reno,
for Amicus Curiae Nevada Justice Association.

Lewis & Roca, LLP, and Daniel F. Polsenberg and Jennifer B. Anderson, Las Vegas,
for Amicus Curiae Nevada Hospital Association.

Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC, and D. Lee Roberts, Jr., and Rosemary Missisian, Las Vegas,
for Amicus Curiae Catholic Healthcare West.

10-17117

BEFORE THE COURT EN BANC.

OPINION

By the Court, PARRAGUIRRE, C.J.:

In this appeal, we consider whether hospitals owe an absolute nondelegable duty to provide competent medical care to their emergency room patients through independent contractor doctors. Although the parties settled in this matter, appellant Renown Health, Inc., reserved its right to appeal the district court's interlocutory order granting partial summary judgment based on the imposition of a nondelegable duty. A portion of the settlement remains contingent upon this appeal. We conclude that no such absolute duty exists under Nevada law, nor are we at this time willing to judicially create one. Accordingly, we reverse the district court's grant of partial summary judgment insomuch as the district court concluded that hospitals have such a nondelegable duty. We hold that Renown may be liable for patient injuries under the ostensible agency doctrine that we previously recognized in Schlotfeldt v. Charter Hospital of Las Vegas, 112 Nev. 42, 910 P.2d 271 (1996).[1]

FACTS AND PROCEDURAL HISTORY

This appeal arises from the tragic illness of respondent Betty Vanderford's minor son Christopher Wall. After he complained of headaches, nausea, and fever, Vanderford took Christopher to Renown's emergency room on four different occasions. During the first visit, tests were performed and Christopher was discharged and referred to a

[1]We do not address whether this case supports a finding of ostensible agency because it involves unresolved questions of fact.

specialist. On the second visit, he was given a prescription for an antibiotic and again discharged. On the third visit, Christopher was given a prescription for Vicodin and encouraged to continue taking his antibiotic. Different doctors attended to him on each of these visits.

Vanderford took Christopher to Renown's emergency room for a fourth time after she found him unconscious in the bathroom. At that time, he was diagnosed with basilar meningitis and complications including abscesses. As a result of his illness, Christopher suffered permanent, debilitating injuries, including brain damage.

Vanderford sued Renown in her individual capacity and on behalf of Christopher. The district court granted partial summary judgment for Vanderford, finding that Renown owed Christopher an absolute nondelegable duty such that it was liable for the acts of the emergency room doctors, who were independent contractors.

The district court provided four bases to support its conclusion that hospitals owe an absolute nondelegable duty to their emergency room patients. The district court relied on Nevada statutes, the Joint Committee on the Accreditation of Health Organizations (JCAHO) standards, with which Renown complied, public policy, and common law principles found in sections 428 and 429 of the Restatement (Second) of Torts and cases from Alaska and South Carolina to impose an absolute nondelegable duty as a matter of law. The district court distinguished Oehler v. Humana, Inc., 105 Nev. 348, 775 P.2d 1271 (1989), and Schlotfeldt v. Charter Hospital of Las Vegas, 112 Nev. 42, 910 P.2d 271 (1996), stating that neither case involved an emergency room patient and an independent contractor doctor. Vanderford and Renown agreed on a

settlement, resolving all issues except the duty issue, on which Renown reserved its right to appeal.

DISCUSSION

Renown argues that the district court erred by concluding that it had an absolute nondelegable duty to provide competent medical care to its emergency room patients through its independent contractor doctors because no basis for imposing such a duty exists under Nevada law. Renown therefore argues that the district court erred by granting partial summary judgment in this case. We agree. We also discuss the ostensible agency doctrine as applied to emergency room scenarios like the one in this case.

Standard of review

We review a district court's decision to grant summary judgment and its conclusions regarding questions of law de novo, without deference to the findings of the lower court. Wood v. Safeway, Inc., 121 Nev. 724, 729, 121 P.3d 1026, 1029 (2005); Pressler v. City of Reno, 118 Nev. 506, 509, 50 P.3d 1096, 1098 (2002).

The district court erred in imposing an absolute nondelegable duty on Renown

The district court based its decision to impose an absolute nondelegable duty on Renown on Nevada's statutory scheme, the JCAHO standards, public policy, and the common law. However, we conclude that the district court erred in this determination because there is no basis in Nevada law for imposing such a duty.

Generally, hospitals are not vicariously liable for the acts of independent contractor doctors. Oehler v. Humana, Inc., 105 Nev. 348, 351, 775 P.2d 1271, 1273 (1989); see Restatement (Second) of Torts § 409 (1965). The imposition of an absolute nondelegable duty is an exception to

this general rule. Restatement (Second) of Torts § 409 (1965). An absolute nondelegable duty is essentially a strict liability concept, where, despite delegation of a duty to an independent contractor, the principal remains primarily responsible for improper performance. See Black's Law Dictionary 544 (8th ed. 2004). While we have recognized some exceptions to the general rule that hospitals are not vicariously liable for the acts of independent contractor doctors, see, e.g., Schlotfeldt v. Charter Hosp. of Las Vegas, 112 Nev. 42, 910 P.2d 271 (1996), there is no legal or policy basis for imposing an absolute nondelegable duty on Renown, and we decline to adopt one for the reasons set forth below.

First, Nevada's statutory scheme regulating hospital emergency room care does not provide a basis for imposing an absolute nondelegable duty on hospitals. See NRS Chapter 439B. The provisions create a scheme under which a hospital is a policy-setter and overseer, and the provisions contemplate the delegation of medical care to qualified professionals. See, e.g., NRS 439B.410. Similarly, the Nevada Administrative Code highlights a hospital's administrative and supervisory role, requiring that hospitals set procedure and ensure that policies and provisions conform to national standards. See, e.g., NAC 449.331, 449.349, 449.3622.

Second, the JCAHO standards, with which Renown complied, do not require an absolute nondelegable duty. Instead, these requirements again emphasize a hospital's role as a policy-setter and administrator. JCAHO, Accreditations Manual for Hospitals, Emergency Services, Standards I-V.

Third, we decline to impose an absolute nondelegable duty on hospitals based upon public policy. This court may refuse to decide an

issue if it involves policy questions better left to the Legislature. Nevada Hwy. Patrol v. State, Dep't Mtr. Veh., 107 Nev. 547, 550-51, 815 P.2d 608, 610-11 (1991); see also Niece v. Elmview Group Home, 929 P.2d 420, 428 (Wash. 1997) (noting that the policy decision to expand the scope of an employer's liability for an employee's intentional acts against a person to whom the employer owes a duty of care "should be left to the legislature"). The Legislature has heavily regulated hospitals and would have codified a nondelegable duty to emergency room patients if the Legislature had intended such a duty to be imposed on hospitals.

Finally, the common law relied upon by the district court and Vanderford does not support the imposition of an absolute nondelegable duty. In Jackson v. Power, 743 P.2d 1376 (Alaska 1987), the Alaska Supreme Court imposed a nondelegable duty on hospitals, holding them vicariously liable for a doctor's negligence when a patient visits the emergency room and the hospital assigns a doctor to the patient. Id. at 1385. But subsequently, the Alaska Legislature modified this holding, passing a law that allows hospitals to rebut the nondelegable duty by proving it was unreasonable for the patient to assume that the hospital provided care because the patient had notice of the doctor's independent contractor status. Alaska Stat. § 09.65.096 (2008).[2] Further, in Fletcher v. South Peninsula Hospital, the Alaska Supreme Court refused to extend the nondelegable duty to operating rooms. 71 P.3d 833, 839 (Alaska 2003).

Here, the district court also relied on caselaw from South Carolina. In Simmons v. Tuomey Regional Medical Center (Simmons I),

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[2]This legislative modification of the Jackson holding was recognized in Evans ex rel. Kutch v. State, 56 P.3d 1046, 1067 (Alaska 2002).

498 S.E.2d 408 (S.C. Ct. App. 1998), a case involving hospitals' duties in the emergency room setting, the South Carolina Court of Appeals reversed a district court grant of summary judgment for a hospital, deciding that public reliance and regulations imposed on hospitals "created an absolute duty for hospitals to provide competent medical care in their emergency rooms." Id. at 411. On appeal, the South Carolina Supreme Court modified the absolute nondelegable duty adopted by the court in Simmons I. Simmons v. Tuomey Regional Medical Center (Simmons II), 533 S.E.2d 312, 322 (S.C. 2000). The Simmons II court concluded that most jurisdictions hold hospitals liable for the acts of independent contractor doctors under various theories, and this result remains the same, "whether it is through a theory of apparent agency or nondelegable duty." Id. at 320. The modified approach of Simmons II, called a nonabsolute nondelegable duty, expressly adopted the Restatement (Second) of Torts section 429, which is also "sometimes described as ostensible agency." Simmons II, 533 S.E.2d at 322. Under section 429, the injured patient must show that the hospital held itself out to the public by providing services, that the patient looked to the hospital and not an individual doctor for care, and that a patient in similar circumstances would reasonably have believed that the physician was a hospital employee. Id. When the patient can demonstrate genuine issues of material fact exist as to these factors, "summary judgment is not appropriate." Id. at 323.

In examining the caselaw cited by the district court and by Vanderford to support an absolute nondelegable duty, we conclude that these cases, while labeling their approaches as a nondelegable duty, actually require the same analysis as our ostensible agency approach in Schlotfeldt v. Charter Hospital of Las Vegas, 112 Nev. 42, 910 P.2d 271

(1996). Once a "nondelegable" duty becomes nonabsolute, as described in Simmons II, the duty is no longer truly nondelegable. See Simmons II, 533 S.E. 2d at 322. As noted above, a nondelegable duty is a strict liability concept. Thus, a "nondelegable" duty that is not absolute veers away from the concept of strict liability, and creates a duty that is not actually nondelegable. A nonabsolute nondelegable duty is much closer to the ostensible agency approach and is not truly a nondelegable duty at all. Based on the above, we conclude that the district court erred by imposing an absolute nondelegable duty on Renown. However, we still must address the ostensible agency doctrine as a basis for holding hospitals liable for the acts of their independent contractor emergency room doctors.

Hospitals may be liable for the acts of their independent contractor doctors under the ostensible agency doctrine adopted in Schlotfeldt

Given our prior holding in Schlotfeldt v. Charter Hospital of Las Vegas, where we adopted the ostensible agency doctrine, we conclude that Renown could be held liable under that theory. 112 Nev. 42, 48, 910 P.2d 271, 275 (1996).

In Schlotfeldt, we considered the acts of an independent contractor doctor who attended to a patient at a drug and alcohol treatment center. Id. at 43-44, 910 P.2d at 272. The independent contractor doctor attended to Schlotfeldt at the request of a Charter Hospital psychiatrist who was busy with other patients. Id. Charter did not release Schlotfeldt, despite her requests to return home, because, based on the independent contractor doctor's conclusions, she was a suicide risk and releasing her would be imprudent. Id. at 44, 910 P.2d at 272. The patient sued the treatment center for false imprisonment, and the district court instructed the jury that the treatment center was vicariously liable for the doctor's acts because the treatment center chose

the doctor to examine Schlotfeldt. Id. at 46-47, 910 P.2d 274. Charter opposed such an instruction because the existence of an agency relationship between Charter and the doctor was a question of fact for the jury. Id. at 48, 910 P.2d at 275.

We agreed with Charter. Id. at 49, 910 P.2d at 275. Consequently, we adopted an approach known as ostensible agency, which applies when a patient goes to the hospital and the hospital selects the doctor to treat the patient, such that it is reasonable for the patient to assume the doctor is an agent of the hospital. Id. at 48, 910 P.2d at 275. We identified typical fact questions that arise under ostensible agency, including: (1) whether the patient entrusted herself to the hospital, (2) whether the hospital selected the doctor, (3) whether the patient reasonably believed the doctor was an agent of the hospital, and (4) whether the patient had notice of the doctor's independent contractor status. Id. at 49, 910 P.2d at 275. Whether a patient can demonstrate these factors remains a question for the jury. Id. at 48-49, 910 P.2d at 275.

Here, we see no compelling reason why Schlotfeldt should not apply to substantially similar factual scenarios that involve independent contractor emergency room doctors. Like the patient in Schlotfeldt, Vanderford and Christopher entrusted themselves to Renown by going to its emergency room. They did not choose a doctor for Christopher, but were subject to the choice by Renown, as is the case in most emergency room scenarios. The remaining two questions, focusing on Vanderford's reasonable beliefs and whether Vanderford had notice, are subject to the jury's fact-finding but present a situation quite similar to the treatment center discussed in Schlotfeldt. Public policy supports this decision as well

because under an ostensible agency approach, hospitals may be liable for the malpractice of independent contractor emergency room physicians. This theory allows tort victims recovery by demonstrating facts that are often present in an emergency room setting, while not judicially creating an absolute duty on hospitals that is better left to the Legislature to impose.

Moreover, the typical questions of fact discussed in Schlotfeldt that make up the ostensible agency inquiry are similar to section 429 of the Restatement (Second) of Torts and the nonabsolute nondelegable duty adopted in Simmons II. See Schlotfeldt, 112 Nev. at 49, 910 P.2d at 275. The Simmons II approach presents an approach no different than the ostensible agency doctrine we articulated in Schlotfeldt. Whether it is called a nonabsolute nondelegable duty or ostensible agency, the result remains the same: hospitals may be held liable for the acts of independent contractor emergency room doctors if the hospital selects the doctor and it is reasonable for the patient to assume that the doctor is an agent of the hospital.

CONCLUSION

For the foregoing reasons, we conclude that hospitals do not have an absolute nondelegable duty to provide nonnegligent medical care to emergency room patients through doctors who are independent contractors. However, we extend the ostensible agency doctrine of Schlotfeldt to emergency room scenarios. We therefore conclude that Renown may be held liable for the acts of its independent contractor emergency room doctors under this approach. Because the district court improperly imposed an absolute nondelegable duty on Renown, we reverse the decision of the district court insomuch as it imposed upon Renown a

nondelegable duty to provide competent medical care to its emergency room patients through independent contractor doctors.

Parraguirre, C.J.

We concur:

Hardesty, J.

Douglas, J.

Pickering, J.

C

Superior Court of Pennsylvania.
Wayne K. BOYD, in his own right and as Administrator of the Estate of Chardella Boyd, Deceased, and as Parent and Guardian on Behalf of Darren Boyd, and Patrice Boyd, Minor Children of the Deceased, Appellant,
v.
ALBERT EINSTEIN MEDICAL CENTER, Northern Division, the Health Maintenance Organization of Pennsylvania, David E. Rosenthal, M.D., Perry L. Dornstein, M.D., Erwin Cohen, M.D., Appellees.
Argued June 8, 1988.
Filed Sept. 22, 1988.

Widower of a woman who died while under the care of physicians who participated in a health maintenance organization (HMO) sued the HMO. The Court of Common Pleas, Philadelphia County, Civil Division, No. 4887 July Term 1983, Lehrer, J., granted summary judgment for HMO, and widower appealed. The Superior Court, No. 3133 Philadelphia 1987, Olszewski, J., held that there was an issue of material fact as to whether the participating physicians were the ostensible agents of the HMO.

Reversed and remanded.

McEwen, J., issued a concurring opinion.

West Headnotes

Before McEWEN, OLSZEWSKI and CERCONE, JJ.

OLSZEWSKI, Judge:

This is an appeal from the trial court's order granting summary judgment in favor of defendant/appellee, Health Maintenance Organization of Pennsylvania (hereinafter HMO). Appellant asserts that the trial court erred in granting the motion for summary judgment when there ***611** existed a ques-

tion of material fact as to whether participating physicians are the ostensible agents of HMO. For the reasons stated below, we reverse the grant of summary judgment.

The facts, as averred by the parties in their pleadings and elicited through deposition testimony, reveal that at the time of her death, decedent and her husband were participants in the HMO. HMO is a medical insurance provider that offers an alternative to the traditional Blue Cross/Blue ****1230** Shield insurance plan.[FN1] Decedent's husband became eligible for participation in a group plan provided by HMO through his employer. Upon electing to participate in this plan, decedent and her husband were provided with a directory and benefits brochure which listed the participating physicians. Restricted to selecting a physician from this list, decedent chose Doctor David Rosenthal and Doctor Perry Dornstein as her primary care physicians.

FN1. "A Health Maintenance Organization is an organized system of health care which provides or arranges for a comprehensive array of basic and supplemental health care services. These services are provided on a prepaid basis to voluntarily enrolled members living within a prescribed geographic area. Responsibility for the delivery, quality and payment of health care falls to the managing organization-the HMO." Physicians Office Coordinator Training Manual citing *HMOs An Alternative to Today's Health Care System.* A Towers, Perrin, Forster, and Crosby Background Study, December 1975.

In June of 1982, decedent contacted Doctor David Rosenthal regarding a lump in her breast. Doctor Rosenthal ordered a mammogram to be performed which revealed a suspicious area in the breast. Doctor Rosenthal recommended that decedent undergo a biopsy and referred decedent to Doctor Erwin Cohen for that purpose. Doctor Cohen, a surgeon, is also a participating HMO physician. The referral to a specialist in this case was made in accordance with the terms and conditions of HMO's subscription agreement.[FN2]

FN2. Doctor Rosenthal admitted in his deposition that HMO limited specifically the doctors to whom decedent could have been referred. Deposition, p. 70.

***612** On July 6, 1982, Doctor Cohen performed a biopsy of decedent's breast tissue at Albert Einstein Medical Center. During the procedure, Doctor Cohen perforated decedent's chest wall with the biopsy needle, causing decedent to sustain a left hemothorax. Decedent was hospitalized for treatment of the hemothorax at Albert Einstein Hospital for two days.

In the weeks following this incident decedent complained to her primary care physicians, Doctor David Rosenthal and Doctor Perry Dornstein, of pain in her chest wall, belching, hiccoughs, and fatigue. On August 19, 1982, decedent awoke with pain in the middle of her chest. Decedent's husband contacted her primary care physicians, Doctors Rosenthal and Dornstein, and was advised to take decedent to Albert Einstein hospital where she would be examined by Doctor Rosenthal. Upon arrival at Albert Einstein emergency room, decedent related symptoms of chest wall pain, vomiting, stomach and back discomfort to Doctor Rosenthal. Doctor Rosenthal commenced an examination of decedent, diagnosed Tietz's syndrome,[FN3] and arranged for tests to be performed at his office where decedent underwent x-rays, EKG, and cardiac ioenzyme tests.[FN4] Decedent was then sent home and told to rest.[FN5]

FN3. Tietze's Syndrome is an inflammatory condition affecting the costochondral cartilage. It occurs more commonly in females, generally in the 30 to 50 age range. Deposition of Doctor Rosenthal, p. 48.

FN4. HMO avers that decedent was returned to the doctor's office for testing because it was more comfortable and con-

venient for her. Appellant, however, asserts that the tests were performed in the doctor's office, rather than the hospital, in accordance with the requirements of HMO whose primary interest was in keeping the medical fees within the corporation.

FN5. Appellant contends that Doctor Rosenthal acted negligently in ordering the tests to be performed in his office when decedent exhibited symptoms of cardiac distress. The safer practice, avers appellant, would have been to perform the tests at the hospital where the results would have been more quickly available. Appellant further contends that, despite Doctor Rosenthal's diagnosis of Tietze's Syndrome, the nature of the tests he ordered indicates that he was concerned about the possibility of a heart attack.

During the course of that afternoon, decedent continued to experience chest pain, vomiting and belching. Decedent ***613** related the persistence and worsening of these symptoms by telephone to Doctors Rosenthal and Dornstein, who prescribed, without further examination, Talwin, a pain medication. At 5:30 that afternoon decedent was discovered dead in her bathroom by her husband, having expired as a result of a myocardial infarction.

****1231** Appellant's complaint and new matter aver that HMO advertised that its physicians and medical care providers were competent, and that they had been evaluated for periods of up to six months prior to being selected to participate in the HMO program as a medical provider. The complaint further avers that decedent and appellant relied on these representations in choosing their primary care physicians. The complaint then avers that HMO was negligent in failing to "qualify or oversee its physicians and hospital who acted as its agents, servants, or employees in providing medical care to the decedent nor did HMO of Pa. require its physicians, surgeons and hospitals to provide adequate evidence of skill, training and competence in medicine and it thereby failed to furnish the decedent with competent, qualified medical care as warranted." Paragraph 39, plaintiff's amended complaint. Finally, appellant's new matter avers that HMO furnished to its subscribers documents which identify HMO as the care provider and state that HMO guarantees the quality of care. Plaintiff's new matter, paragraph 18.

Appellant's theory of recovery before the trial court was primarily one of vicarious liability under the ostensible agency theory. *See Capan v. Divine Providence Hospital,* 287 Pa.Super. 364, 430 A.2d 647 (1980). In granting defendant HMO's motion for summary judgment, the trial court found that plaintiff/appellant had failed to establish either of the two factors on which the theory of ostensible agency, as applied to hospitals in *Capan,* is based. On appeal, appellant contends that the evidence indicates that there exists a question of fact regarding whether HMO may be held liable under this theory.

***614** Before embarking on a substantive analysis of appellant's claims, we must delineate our well-settled standard of review in cases involving the granting of summary judgment. Initially we note that our standard of review in such cases is plenary. *Thornburgh v. Lewis,* 504 Pa. 206, 209, 470 A.2d 952, 954 (1983). Summary judgment may be granted:

" 'if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law.' Pa.R.C.P. 1035. In considering a motion for summary judgment, the trial court is bound to follow several firmly established principles. Specifically, the court must examine the entire record in the light most favorable to the non-moving party. The court's sole function is to determine whether there is an issue of fact to be tried and not to decide issues of fact. Finally, the court must resolve all doubts as to the existence of a genuine issue of fact against the party moving for

summary judgment." *See Taylor v. Tukanowicz,* 290 Pa.Super. 581, 586, 435 A.2d 181, 183 (1981); *Schacter v. Albert,* 212 Pa.Super. 58, 62, 239 A.2d 841, 843 (1968).

Perry v. Middle Atlantic Lumbermans Association, 373 Pa.Super. 554, 542 A.2d 81 (1988). Summary judgment should not be entered unless the case is free from doubt. *Weiss v. Keystone Mack Sales, Inc.,* 310 Pa.Super. 425, 456 A.2d 1009 (1983). Further, the moving party has the burden of proving that no genuine issue exists as to a material fact. For that reason the record is examined in a light most favorable to the non-moving party, and in doing so our Court shall accept as true all well-pleaded facts in the non-moving party's pleadings. *Hower v. Witmak Associates,* 371 Pa.Super. 443, 538 A.2d 524 (1988).

Preliminarily, we note that Pennsylvania courts first recognized the theory of ostensible agency in *Capan v. Divine Providence Hospital,* 287 Pa.Super. 364, 430 A.2d 647 (1980).

***615** There, pursuant to instructions by our Supreme Court, we determined that the trial court had erred in failing to instruct the jury on the Restatement (Second) of Torts § 429 (1965). We further pointed out that Section 429 provided an exception to the general rule that an employer is not liable for torts committed by an independent contractor in his employ. ****1232** *Capan,* [*supra,*] at 367, 430 A.2d at 648. Section 429 states:

> 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 by 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.

In adopting the theory of ostensible agency, we noted that several jurisdictions had applied the concept to cases involving hospital liability for the negligence of independent contractor physicians. [*Id.*] at 368, 430 A.2d at 649. We also noted two factors which contributed to the conclusion by other courts that, although a physician holds independent contractor status with respect to the hospital, he may nevertheless be an agent of the hospital with respect to the patient. First, there is a likelihood that patients will look to the institution rather than the individual physician for care due to the changing role of the hospital in today's society. Second, "where the hospital 'holds out' the physician as its employee[,]" a justifiable finding is that there is an ostensible agency relationship between the hospital and the physician. *Id. See also, Simmons v. St. Clair Hospital,* 332 Pa.Super. 444, 481 A.2d 870 (1984). We recognized that a holding out occurs "when the hospital acts or omits to act in some way which leads the patient to a *reasonable* belief he is being treated by the hospital or one of its employees." *Capan,* [*supra,*] at 370, 430 A.2d at 649. (Citation omitted) (Emphasis in original).

***616** *Thompson v. Nason Hospital,* 370 Pa.Super. 115, 535 A.2d 1177 (1988).

We must, therefore, consider appellant's claim in light of Section 429 and decide whether there is an issue of material fact as to participating physicians being the ostensible agents of HMO. In order to make these determinations, we will discuss, initially, the arrangement between HMO and participating doctors and their relationship with HMO members.

The record reflects that, through his employer, appellant became eligible for and ultimately chose to participate in a group plan provided by the Health Maintenance Organization of Pennsylvania (hereinafter HMO).[FN6] As part of its services, HMO provided its members with a brochure explaining, in general outline form only, the main features of the program of benefits. Appellant's brief, appendix E. The brochure also provided a directory of participating primary physicians and declared

that the complete terms and conditions of the plan were set forth in the group master contract. *Id.*

> FN6. In a document entitled "Why offer HMO-PA?", Appellee's brief at 55b, HMO reasoned to employers that HMO "is a total care program which not only insures its subscribers, but provides medical care, guarantees the quality of the care and controls the costs of health care services." The document also claimed that "HMO-PA is more than just another health insurance plan. HMO-PA is an entire health care system. HMO-PA provides the physicians, hospitals and other health professionals needed to maintain good health. HMO-PA assures complete security, when illness or injury arises." Appellee's brief at 58b. Finally, the document provided that HMO-PA "[a]ssumes responsibility for quality and accessibility." Appellee's brief at 61b.

The group master contract provides that HMO "operates a comprehensive prepaid program of health care which provides health care services and benefits to Members in order to protect and promote their health, and preserve and enhance patient dignity." Group master contract, Form HMOPA/GM-6 (5/83) of record [hereinafter group master contract].[FN7] HMO was incorporated in 1975 under the laws ***617** of Pennsylvania and converted from a non-profit to a for-profit corporation in 1981. Training manual of record at 1. HMO is based on the individual practice association ****1233** model (hereinafter IPA), which means that HMO is comprised of participating primary physicians who are engaged in part in private practice in the HMO service area. *Id.* Under the plan, IPA contracts with HMO to provide medical services to HMO members. *Id.* at 1-2. IPA selects its primary and specialist physicians and enters into an agreement with them obligating the physician to perform health services for the subscribers of HMO. Primary physician agreement of record at 1.

> FN7. The introduction to the group master contract also provides that "HMOPA operates on a direct service rather than indemnity basis. The interpretation of the Contract shall be guided by the direct service nature of HMOPA's prepaid program." Group master contract at 1.

"A physician applying for membership in the IPA of the HMO-PA should expect a four to six months review process prior to admission to the organization." Document entitled Membership Process of the IPA of record at 1. When an interested physician calls the IPA, the Provider relations representative reviews the physician's credentials and the reasons for his interest in HMO. The physician then subsequently receives an application packet that requests the applicant's *curriculum vitae*, four letters of recommendation, copies of the state license, and evidence of malpractice insurance. Soon thereafter, the IPA coordinator visits the applicant's practice in order to: (1) observe how the office is run, how the office personnel treat patients, and the ability of the office to absorb a number of new patients; (2) inspect the actual physical plant to ensure that appropriate procedures, space, and necessary medical equipment are available; (3) explain the payment system, the incentive program, and the rights and responsibilities of an IPA physician; and (4) set up a medical director's interview. *Id.* at 1-2.

After interviewing the applicant,[FN8] the medical director makes a recommendation that is forwarded to the membership***618** committee, which thoroughly discusses and determines whether the applicant has met all the criteria for membership. The criteria include: Twenty-four-hour-a-day coverage provided with another IPA member for office and hospital patients, with any exclusions being approved by the executive committee; prior routine hospitalization of patients on his own service at a participating HMO hospital; specific routinely performed procedures including minor surgery and office gynecology; scheduling of appointments at a rate of no more than five patients per hour per doctor; and office records that are legible, reprodu-

cible, and pertinent. *Id.* at 3-4.

> FN8. During the interview, the medical director reviews applicant's understanding of the HMO and IPA, the physician's referral pattern, how he would handle various medical problems, and his medical charts.

The membership committee makes a recommendation to the executive committee, which makes the final decision regarding the applicant. Those accepted into the IPA are called by an IPA coordinator, who schedules an office orientation.

The primary physician's role is defined as the "gatekeeper into the health care delivery system." Document entitled Role of the Primary Physician of record at 1. "An HMO member must consult with his primary physician before going to a specialist and/or the hospital." *Id;* Group master contract at II B. If the primary physician deems it necessary, he arranges a consultation with an HMO participating specialist, which constitutes a second opinion. Role of the Primary Physician at 1. "Basically, with the primary physicians 'screening' the members' illnesses, excessive hospitalization and improper use of specialists can be reduced." *Id.*

Member-patients use a physician directory and choose a conveniently located office of a participating primary physician. HMO members will only receive reimbursement from non-participating providers when the condition requiring treatment was of an immediate nature. Determinations of immediacy are made by the HMO quality assurance committee. In any event, persons desiring emergency non-provider benefits must notify HMO or their primary physician of the emergency within forty-eight hours and must give written ***619** proof of the occurrence within ninety days after service is rendered. Group master contract at 13. Reimbursement for emergency care by a non-participating provider is limited to expenses incurred prior to the time the ****1234** member's condition, "in the opinion of HMOPA, reasonably permitted him or her to travel or be transported to the nearest HMOPA Participating Provider, or to receive follow-up care from a Participating Provider, upon referral by the Member's Participating Primary Physician." *Id.* at 14.

Primary physicians are paid through a mechanism termed "capitation." Capitation is an actuarially determined amount prepaid by HMO to the primary physician for each patient who has chosen his office. Revised attachment AA to primary physician agreement. The dollar amount is based upon a predetermined rate per age group. The primary physicians are paid 80% of the capitation amount and the remaining 20% is pooled by IPA and goes back into a pooled risk-sharing fund as a reserve against specialty referral costs and hospital stays. Each primary care office has its own specialist fund and hospital fund established by allocating a predetermined amount each month for each member who has chosen that primary care office. The surplus from the specialist fund is returned to the primary care office. The hospital fund, however, is governed by a hospital risk/incentive-sharing scheme which anticipates a number of inpatient days per members per year. If the actual hospital utilization is less than anticipated, the HMO and IPA each receive 50% of the savings. IPA must place the savings in the Special IPA risk-sharing account and must use the funds to offset losses resulting from unanticipated physician costs. Attachment B to primary physician agreement. If utilization is greater than anticipated, IPA is responsible for 50% of the loss up to the amount of uncommitted funds in the Special IPA risk sharing account. *Id.*

[1] Appellant asserts that he has raised a question of material fact as to whether the treating physicians were the ostensible agents of HMO. As delineated *supra,* Pennsylvania courts have determined that the two factors relevant ***620** to a finding of ostensible agency are: (1) whether the patient looks to the institution, rather than the individual physician for care, and (2) whether the HMO "holds out" the physician as its employee. Also instructive is the

definition of apparent or ostensible agency in Restatement (Second) of Agency, Section 267, which provides:

> One who represents that another is his servant or other agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such.

Comment (a) to Section 267 is particularly instructive:

> The mere fact that acts are done by one whom the injured party believes to be the defendant's servant is not sufficient to cause the apparent master to be liable; [rather,] ... [t]he rule normally applies where the plaintiff has submitted himself to the care or protection of an apparent servant in response to an invitation from the defendant to enter into such relations with such servant.

[2] HMO asserts that because the theory of ostensible agency has been applied in Pennsylvania only to the relationship between hospitals and independent contractor physicians, the theory is not appropriate in the instant situation. We emphasize, however, that when this Court introduced the concept of ostensible agency to this Commonwealth in *Capan, supra,* we based that decision in large part upon "the changing role of the hospital in society [which] creates a likelihood that patients will look to the institution" for care. *Id.* 287 Pa.Super. at 368, 430 A.2d at 649. Because the role of health care providers has changed in recent years, the *Capan* rationale for applying the theory of ostensible agency to hospitals is certainly applicable in the instant situation.

Therefore, while *Capan* is distinguishable on its facts, it is instructive in our resolution of the instant matter. Moreover, we are guided not so much by facts of *Capan* and its progeny as their delineation of the theory of ostensible ***621** agency as ****1235** contained in Restatement (Second) of Torts and their justification for implementing the theory.

We find that the facts indicate an issue of material fact as to whether the participating physicians were the ostensible agents of HMO. HMO covenanted that it would "[provide] health care services and benefits to Members in order to protect and promote their health...." Group master contract at 1. "HMOPA operates on a direct service rather than an indemnity basis." *Id.* Appellant paid his doctor's fee to HMO, not to the physician of his choice. Then, appellant selected his primary care physicians from the list provided by HMO. Regardless of who recommended appellant's decedent to choose her primary care physician, the fact remains that HMO provides a limited list from which a member must choose a primary physician. Moreover, those primary physicians are screened by HMO and must comply with a list of regulations in order to honor their contract with HMO. *See* discussion and footnote 8, *supra.*

Further, as mandated by HMO, appellant's decedent could not see a specialist without the primary physician's referral. As HMO declares, the primary physician is the "gatekeeper into the health care delivery system." Document entitled Role of the Primary Physician of record at 1. "An HMO member must consult with his primary physician before going to a specialist and/or the hospital." *Id.* Moreover, appellant's decedent had no choice as to which specialist to see. In our opinion, because appellant's decedent was required to follow the mandates of HMO and did not directly seek the attention of the specialist, there is an inference that appellant looked to the institution for care and not solely to the physicians; conversely, that appellant's decedent submitted herself to the care of the participating physicians in response to an invitation from HMO. *See* comment (a), Restatement (Second) Agency § 267.

Summary judgment should be granted only where there is not the slightest doubt as to the absence of a triable issue of fact. *Thompson, supra,* 370 Pa.Super. at 120, 535 A.2d at 1180, citing ***622**

Chandler v. Johns-Manville Corp., 352 Pa.Super. 326, 507 A.2d 1253 (1986); *Long John Silver's, Inc. v. Fiore*, 255 Pa.Super. 183, 386 A.2d 569 (1978). Based on the foregoing, we find that there is an issue of material fact as to whether the participating physicians were the ostensible agents of HMO. We conclude, therefore, that the trial court erred when it granted HMO's motion for summary judgment on the ground that the participating physicians were not the ostensible agents of HMO.

The order granting summary judgment is reversed and the case remanded for proceedings consistent with this opinion. Jurisdiction is relinquished.

McEWEN, J., concurs with opinion.McEWEN, Judge, concurring.
I concur in the result reached by the majority since the author, after a very careful analysis of the issues presented in this appeal, reaches the quite basic principle that issues of material fact may not be resolved by summary judgment.

I write only because it appears to me that the learned trial court improperly resolved by summary judgment the basic factual issue of whether the literature, in which HMO “guaranteed” and “assured” the quality of care provided to its subscribers, had been distributed to appellant or to other subscribers of HMO.

It might also be mentioned that while the court was understandably uncertain as to the theories upon which plaintiff was proceeding [FN1], it appears that the amended complaint of plaintiff does contain factual averments supporting a breach of warranty claim. *See:* ****1236***Alpha Tau Omega Fraternity v. University of Pennsylvania*, 318 Pa.Super. 293, 298, 464 A.2d 1349, 1352 (1983) (“Pennsylvania ***623** is a fact-pleading state.”). *Accord: Smith v. Brown*, 283 Pa.Super. 116, 119, 423 A.2d 743, 745 (1980).

> FN1. The trial court noted in its opinion that “the gravamen of plaintiff's complaint is that HMO of PA guaranteed or warranted the quality of care provided.... Plaintiff's theory of recovery ... is not entirely clear. A reading of the complaint suggests Plaintiff is proceeding upon grounds of corporate liability. However, in his answer to the motion of HMO of PA for summary judgment, plaintiff contends HMO of PA is vicariously liable through ostensible agency.”

Pa.Super.,1988.
Boyd v. Albert Einstein Medical Center
377 Pa.Super. 609, 547 A.2d 1229

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Court of Appeal, Second District, Division 5, California.
Lois J. WICKLINE, Plaintiff and Respondent,
v.
STATE of California, Defendant and Appellant.
No. B010156.

July 30, 1986.

Patient brought action against Medi-Cal following amputation of leg as result of alleged premature discharge from hospital. The Superior Court, Los Angeles County, Barnet M. Cooperman, J., entered judgment on jury verdict in favor of patient, and State appealed. The Court of Appeal, Rowen, J., assigned, held that: (1) patient who is harmed when care which should have been provided is not provided should recover from all responsible for deprivation of care, including, when appropriate, health care payor; (2) third-party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in designs or implementation of cost containment mechanisms; (3) physician who complies without protest with limitations imposed by third-party payor cannot avoid ultimate responsibility for patients care; and (4) Medi-Cal was not liable for discharge decision.

Reversed.

Review granted 231 Cal.Rptr. 560, 727 P.2d 753 dismissed, remanded and ordered published 239 Cal.Rptr. 805, 741 P.2d 613, republication of 228 Cal.Rptr. 661.

West Headnotes

****811** ROWEN, Associate Justice.[FN*]

FN* Assigned by the Chairperson of the Judicial Council.

This is an appeal from a judgment for plaintiff entered after a trial by jury. For the reasons discussed below, we reverse the judgment.

Principally, this matter concerns itself with the legal responsibility that a third party payor, in this case, the State of California, has for harm caused to a patient when a cost containment program is applied in a manner which ***1633** is alleged to have affected the implementation of the treating physician's medical judgment.

The plaintiff, respondent herein, Lois J. Wickline (plaintiff or Wickline) sued defendant, appellant herein, State of California (State or Medi-Cal). The essence of the plaintiff's claim is found in para-

graph 16 of her second amended complaint which alleges: "Between January 6, 1977, and January 21, 1977, Doe I an employee of the State of California, while acting within the scope of employment, negligently discontinued plaintiff's Medi-Cal eligibility, causing plaintiff to be discharged from Van Nuys Community Hospital prematurely and whil [*sic*] in need of continuing hospital care. As a result of said negligent act, plaintiff suffered a complete occlusion of the right infra-renoaorta, necessitating an amputation of plaintiff's right leg."

I

Responding to concerns about the escalating cost of health care, public and private payors have in recent years experimented with a variety of cost containment mechanisms. We deal here with one of those programs: The prospective utilization review process.

At the outset, this court recognizes that this case appears to be the first attempt to tie a health care payor into the medical malpractice causation chain and that it, therefore, deals with issues of profound importance to the health care community and to the general public. For those reasons we have permitted the filing of amicus curiae briefs in support of each of the respective parties in the matter to assure that due consideration is given to the broader issues raised before this court by this case.

Traditionally, quality assurance activities, including utilization review programs, were performed primarily within the hospital setting under the general control of the medical staff. (See, generally, 22 Cal.Admin.Code § 70703; Joint Commission on Accreditation of Hospitals, Accreditation Manual for Hospitals (1985), Utilization Review, pp. 197-198; 42 U.S.C. § 1395x(k); 42 C.F.R. § 405.1035.) The principal focus of such quality assurance review schema was to prevent overutilization due to the recognized financial incentives to both hospitals and physicians to maximize revenue by increasing the amount of service provided and to insure that patients were not unnecessarily exposed to risks as a result of unnecessary surgery and/or hospitalization.

Early cost containment programs utilized the retrospective utilization review process. In that system the third party payor reviewed the patient's chart after the fact to determine whether the treatment provided was medically***1634** necessary. If, in the judgment of the utilization reviewer, it was not, the health care provider's claim for payment was denied.

In the cost containment program in issue in this case, prospective utilization review, authority for the rendering of health care services must be obtained before medical care is rendered. Its purpose is to promote the well recognized public interest in controlling health care costs by reducing unnecessary services while still intending to assure that appropriate medical and hospital services are provided to the patient in need. However, such a cost containment strategy creates new and added pressures on the quality assurance portion of the utilization review mechanism. The stakes, the risks at issue, are much higher when a prospective cost containment review process is utilized than when a retrospective review process is used.

****812** A mistaken conclusion about medical necessity following retrospective review will result in the wrongful withholding of payment. An erroneous decision in a prospective review process, on the other hand, in practical consequences, results in the withholding of necessary care, potentially leading to a patient's permanent disability or death.

II

Though somewhat in dispute, the facts in this case are not particularly complicated. In 1976, Wickline a married woman in her mid-40's,[FN1] with a limited education, was being treated by Dr. Stanley Z. Daniels (Dr. Daniels), a physician engaged in a general family practice, for problems associated

with her back and legs. Failing to respond to the physical therapy type of treatment he prescribed, Dr. Daniels had Wickline admitted to Van Nuys Community Hospital (Van Nuys or Hospital) in October 1976 and brought in another physician, Dr. Gerald E. Polonsky (Dr. Polonsky), a specialist in peripheral vascular surgery, to do a consultation examination. Peripheral vascular surgery concerns itself with surgery on any vessel of the body, exclusive of the heart.

FN1. Date of birth, March 14, 1928.

Dr. Polonsky examined plaintiff and diagnosed her condition as arteriosclerosis obliterans with occlusion of the abdominal aorta, more generally referred to as Leriche's Syndrome. Leriche's Syndrome is a condition caused by the obstruction of the terminal aorta. (Dorland's Illustrative Medical Dictionary (26th Ed.) p. 1293.) The aorta is the main artery of the body, carrying blood from the left ventrical of the heart to arteries in all organs and parts of the body. (*Id.*, p. 97.) In plaintiff's situation, the occlusion occurred just above the point where the aorta divides into two common ***1635** iliac arteries which descend, respectively, into each leg. The occlusion was due to arteriosclerosis. Arteriosclerosis is a thickening of the walls of the arteries. (*Id.*, p. 119.)

According to Dr. Polonsky, the only treatment for Leriche's Syndrome is surgical. In Wickline's case her disease was so far advanced that Dr. Polonsky concluded that it was necessary to remove a part of the plaintiff's artery and insert a synthetic (Teflon) graft in its place.

After agreeing to the operation, Wickline was discharged home to await approval of her doctor's diagnosis and authorization from Medi-Cal for the recommended surgical procedure and attendant acute care hospitalization. It is conceded that at all times in issue in this case, the plaintiff was eligible for medical benefits under California's medical assistance program, the "Medi-Cal Act," which is more commonly referred to as Medi-Cal. (Welf. & Inst. Code, §§ 14000 et seq., 14000.4.)

As required, Dr. Daniels submitted a treatment authorization request to Medi-Cal, sometimes referred to as form "161," "MC-161" or "TAR." In response to Dr. Daniels' request, Medi-Cal authorized the surgical procedure and 10 days of hospitalization for that treatment.

On January 6, 1977, plaintiff was admitted to Van Nuys by Dr. Daniels. On January 7, 1977, Dr. Polonsky performed a surgical procedure in which a part of plaintiff's artery was removed and a synthetic artery was inserted to replace it. Dr. Polonsky characterized that procedure as "a very major surgery."

Later that same day Dr. Polonsky was notified that Wickline was experiencing circulatory problems in her right leg. He concluded that a clot had formed in the graft. As a result, Wickline was taken back into surgery, the incision in her right groin was reopened, the clot removed and the graft was resewn. Wickline's recovery subsequent to the two January 7th operations were characterized as "stormy." She had a lot of pain, some spasm in the vessels in the lower leg and she experienced hallucinating episodes. On January 12, 1977, Wickline was returned to the operating room where Dr. Polonsky performed a lumbar sympathectomy.

****813** A lumbar sympathectomy is a major operation in which a section of the chain of nerves that lie on each side of the spinal column is removed. The procedure causes the blood vessels in the patient's lower extremity to become paralyzed in a wide open position and was done in an attempt to relieve the spasms which Wickline was experiencing in those vessels. ***1636** Spasms stop the outflow of blood from the vessels causing the blood to back up into the graft. Failure to relieve such spasms can cause clotting.

Dr. Polonsky was assisted in all three surgeries by Dr. Leonard Kovner (Dr. Kovner), a board certified specialist in the field of general surgery and the

chief of surgery at Van Nuys. Dr. Daniels was present for the initial graft surgery on January 7, 1977, and for the right lumbar sympathectomy operation on January 12, 1977.

Wickline was scheduled to be discharged on January 16, 1977, which would mean that she would actually leave the hospital sometime before 1 p.m. on January 17, 1977. On or about January 16, 1977, Dr. Polonsky concluded that "it was medically necessary" that plaintiff remain in the hospital for an additional eight days beyond her then scheduled discharge date. Drs. Kovner and Daniels concurred in Dr. Polonsky's opinion.

Dr. Polonsky cited many reasons for his feeling that it was medically necessary for plaintiff to remain in an acute care hospital for an additional eight days, such as the danger of infection and/or clotting. His principal reason, however, was that he felt that he was going to be able to save both of Wickline's legs and wanted her to remain in the hospital where he could observe her and be immediately available, along with the hospital staff, to treat her if an emergency should occur.

In order to secure an extension of Wickline's hospital stay, it was necessary to complete and present to Medi-Cal a form called "Request for Extension of Stay in Hospital," commonly referred to as an "MC-180" or "180." It is the hospital's responsibility to prepare the 180 form. The hospital must secure necessary information about the patient from the responsible physician. It then submits the 180 form to Medi-Cal's representative and obtains appropriate authorization for the hospital stay extension.

The physician's responsibility in the preparation of the 180 form is to furnish (to the hospital's representative) the patient's diagnosis, significant history, clinical status and treatment plan in sufficient detail to permit a reasonable, professional evaluation by Medi-Cal's representative, either the "on-site nurse" or/and the Medi-Cal Consultant, a doctor employed by the State for just such purpose.

The Medi-Cal Consultant's responsibility is to review requests submitted by private physicians on behalf of their patients for hospital treatment they believe necessary and to review requests for extensions of hospital time submitted on behalf of hospitalized patients. The Medi-Cal Consultant is not permitted to approve the request unless the information furnished is ***1637** timely, complete and indicates the medical necessity of the requested treatment.

At Van Nuys, Patricia N. Spears (Spears), an employee of the hospital and a registered nurse, had the responsibility for completing 180 forms. In this case, as requested by Dr. Polonsky, Spears filled out Wickline's 180 form and then presented it to Dr. Daniels, as plaintiff's attending physician, to sign, which he did, in compliance with Dr. Polonsky's recommendation. All of the physicians who testified agreed that the 180 form prepared by Spears was complete, accurate and adequate for all purposes in issue in this matter.

Doris A. Futerman (Futerman), a registered nurse, was, at that time, employed by Medi-Cal as a Health Care Service Nurse, commonly referred to as an "on-site nurse." As such, her primary duties were to contact, daily, a group of hospitals assigned to her to review requests for extensions of hospital stays prepared on behalf of patients in those particular hospitals. Van Nuys was one of the hospitals to which she was assigned.

****814** Futerman had the authority, after reviewing a 180 form, to approve the requested extension of time without calling a Medi-Cal Consultant. She could not, however, either reject the request outright or authorize a lesser number of days then requested. If, for any reason, she felt she could not approve the extension of time in the hospital as requested, she was required to contact a Medi-Cal Consultant and that physician would make the ultimate decision on the request.

Futerman, after reviewing Wickline's 180 form, felt that she could not approve the requested eight-day

extension of acute care hospitalization. While conceding that the information provided might justify some additional time beyond the scheduled discharge date, nothing in Wickline's case, in Futerman's opinion, would have warranted the entire eight additional days requested and, for those reasons, she telephoned the Medi-Cal Consultant. She reached Dr. William S. Glassman (Dr. Glassman), one of the Medi-Cal Consultants on duty at the time in Medi-Cal's Los Angeles office. The Medi-Cal Consultant selection occurred randomly. As was the practice, whichever Medi-Cal Consultant was available at the moment took the next call that came into the office.

Dr. Glassman was board certified in general surgery and had practiced in that field until 1975 when he became employed by the Department of Health of the State of California as a Medi-Cal Consultant I. At the time of trial Dr. Glassman was not employed by the State and attempts to personally serve him with a subpoena to appear as a witness in this case were ***1638** without success. Without objection from the State, Dr. Glassman's testimony was taken at trial by the reading of his deposition in open court.

After speaking with Futerman on the telephone, Dr. Glassman rejected Wickline's treating physician's request for an eight-day hospital extension and, instead, authorized an additional four days of hospital stay beyond the originally scheduled discharge date.

Dr. Glassman testified that since the initial request for extension of hospital stay is made to him by way of a telephone call from the on-site nurse, he does not actually see the 180 form itself until after he has acted on it, when it is forwarded to him for his signature. While there are appropriate places provided on the 180 form to indicate what the on-site nurse's recommendation is and the reason given for disapproval of the requested hospital stay extension by the Medi-Cal Consultant, both of those places were left blank on Wickline's 180 form. Dr. Glassman could not recall why he granted a four-day extension rather than the eight days requested by plaintiff's treating physician.

Neither Futerman nor Dr. Glassman had any specific recollection of the Wickline case. Each testified based upon their ordinary practice and procedure except where requested to state their opinion based on information provided to them at the time their respective testimony was taken as, for example, regarding information appearing on Wickline's 180 form.

After review of Wickline's 180 form, Dr. Glassman testified that the factors that led him to authorize four days, rather than the requested eight days, was that there was no information about the patient's temperature which he, thereupon, assumed was normal; nothing was mentioned about the patient's diet, which he then presumed was not a problem; nor was there any information about Wickline's bowel function, which Dr. Glassman then presumed was functioning satisfactorily. Further, the fact that the 180 form noted that Wickline was able to ambulate with help and that whirlpool treatments were to begin that day caused Dr. Glassman to presume that the patient was progressing satisfactorily and was not seriously or critically ill.

Dr. Glassman testified that he had no recollection of reviewing any documentary information available to him before rejecting the requested eight-day extension and authorizing four days instead. Initial treatment authorization requests, form MC-161, which had to be completed by the plaintiff's physician in order to obtain prior ****815** authorization from Medi-Cal for her initial hospitalization was, according to the State's own witness, Dr. Harry Kaufman (Dr. Kaufman), the chief Medi-Cal Consultant at the Los Angeles field office (and Dr. Glassman's supervisor), always supported by documentation***1639** submitted by the physician before such authorization was granted. Therefore, such material was apparently available to Dr. Glassman for review before he acted.

Further, it is reasonable to conclude from the record

that Dr. Glassman did not consult with a specialist in peripheral vascular surgery before making his decision. Such specialists were employed by Medi-Cal, according to Dr. Kaufman, and were made available to Medi-Cal Consultants to confer with for special information and guidance in areas beyond the Medi-Cal Consultants' own general knowledge, training and experience.

In essence, respondent argues, Dr. Glassman based his decision on signs and symptoms such as temperature, diet and bowel movements, which were basically irrelevant to the plaintiff's circulatory condition for which she was being treated and did not concern himself with those symptoms and signs which an ordinary prudent physician would consider to be pertinent with regard to the type of medical condition presented by Wickline.

Complying with the limited extension of time authorized by Medi-Cal, Wickline was discharged from Van Nuys on January 21, 1977. Drs. Polonsky and Daniels each wrote discharge orders. At the time of her discharge, each of plaintiff's three treating physicians were aware that the Medi-Cal Consultant had approved only four of the requested eight-day hospital stay extension. While all three doctors were aware that they could attempt to obtain a further extension of Wickline's hospital stay by telephoning the Medi-Cal Consultant to request such an extension, none of them did so.

Dr. Polonsky, the senior man on the Wickline matter, and the specialist brought in specifically to treat Wickline's condition, was acknowledged by his associates as the doctor with primary responsibility in making decisions regarding her case. It would appear that both Drs. Daniels and Kovner, observing nothing that looked threatening to the patient, deferred to Dr. Polonsky and allowed Wickline to be discharged at the expiration of the period authorized by Dr. Glassman, the Medi-Cal Consultant.

At trial, Dr. Polonsky testified that in the time that had passed since the first extension request had been communicated to Medi-Cal, on January 16th or 17th, and the time of her scheduled discharge on January 21, 1977, Wickline's condition had neither deteriorated nor become critical. In Dr. Polonsky's opinion no new symptom had presented itself and no additional factors had occurred since the original request was made to have formed the basis for a change in the Medi-Cal Consultant's attitude regarding Wickline's situation. In addition, he stated that at the time of Wickline's discharge it did not appear that her leg was in any danger.

***1640** Dr. Polonsky testified that at the time in issue he felt that Medi-Cal Consultants had the State's interest more in mind than the patient's welfare and that that belief influenced his decision not to request a second extension of Wickline's hospital stay. In addition, he felt that Medi-Cal had the power to tell him, as a treating doctor, when a patient must be discharged from the hospital. Therefore, while still of the subjective, non-communicated, opinion that Wickline was seriously ill and that the danger to her was not over, Dr. Polonsky discharged her from the hospital on January 21, 1977. He testified that had Wickline's condition, in his medical judgment, been critical or in a deteriorating condition on January 21, he would have made some effort to keep her in the hospital beyond that day even if denied authority by Medi-Cal and even if he had to pay her hospital bill himself.

Dr. Daniels testified that he believed it was medically proper to discharge Wickline from the hospital on January 21, 1977. Dr. Kovner testified that while he did not recall whether or not he saw Wickline on January ****816** 21, as he was given credit for doing in a nurse's note in the hospital record, he did see her on January 19, 1977, and from his knowledge of her case he had no objection to her discharge from the hospital. Dr. Kovner stated that if he had seen (on the day of her discharge) “a grossly infected wound, that in anyway looked threatening to the patient,” he would have done whatever was necessary to take measures to continue her hospitalization.

All of the medical witnesses who testified at trial

agreed that Dr. Polonsky was acting within the standards of practice of the medical community in discharging Wickline on January 21, 1977.

Just prior to Wickline's actual discharge from the hospital, which she protested, Dr. Kovner met with her husband and explained to him how he was to administer to his wife's needs at home. That care consisted primarily of antibiotic powder for the groin incision, medication, warm water baths and bed rest.

Wickline testified that in the first few days after she arrived home she started feeling pain in her right leg and the leg started to lose color. In the next few days the pain got worse and the right leg took on a whitish, statue-like marble appearance. Wickline assumed she was experiencing normal recovery symptoms and did not communicate with any of her physicians. Finally, when "the pain got so great and the color started changing from looking like a statue to getting a grayish color," her husband called Dr. Kovner. It was Wickline's memory that this occurred about the third day after her discharge from the hospital and that Dr. Kovner advised Mr. Wickline to give extra pain medicine to the plaintiff.

Thereafter, gradually over the next few days, the plaintiff's leg "kept getting grayer and then it got bluish." The extra medication allegedly prescribed ***1641** by Dr. Kovner over the telephone did not relieve the pain Wickline was experiencing. She testified that "by then the pain was just excruciating, where no pain medicine helped whatsoever." Finally, Wickline instructed her husband to call Dr. Kovner again and this time Dr. Kovner ordered plaintiff back into the hospital. Wickline returned to Van Nuys that same evening, January 30, 1977, nine days after her last discharge therefrom.

Because Dr. Polonsky was not immediately available at the time, Dr. Kovner admitted Wickline into the hospital. She was admitted as an emergency patient and, therefore, did not require preauthorization from Medi-Cal. On examination, after admission, Dr. Kovner found an open wound in the right groin area, a secondary infection in the femoral incision on the right, a mottled foot (areas of white mixed with areas of blue discoloration or pink discoloration) and a right leg that was cooler than the left leg. Wickline was experiencing severe unrelenting pain in the right lower extremity. Dr. Polonsky first examined Wickline on the day following her readmission to the hospital. His observations were similar to Dr. Kovner's. Dr. Polonsky concluded that Wickline had developed clotting in the right leg, that there was no circulation to that leg, and that she had developed an infection at the graft site.

Dr. Polonsky could not estimate when the infection in Wickline's leg first developed after her January 21st discharge from Van Nuys nor did he know when the clotting in that leg first started. Neither could he estimate as to how long the plaintiff's leg had been without circulation.

Because of the presence of the infection in the groin, Dr. Polonsky was unable to remove the clot surgically. To have attempted to do so, in Dr. Polonsky's opinion, would have resulted in spreading the graft's infection throughout the body, through the circulatory system, resulting in repetitive clotting and possible death from septicemia, blood poisoning.

Attempts to save Wickline's leg through the utilization of anticoagulants, antibiotics, strict bed rest, pain medication and warm water whirlpool baths to the lower extremity proved unsuccessful. On February 8, 1977, Dr. Polonsky amputated Wickline's leg below the knee because had he not done so "she would have died." The ****817** condition did not, however, heal after the first operation and on February 17, 1977, the doctors went back and amputated Wickline's leg above the knee.

Had the eight-day extension requested on Wickline's behalf been granted by Medi-Cal, she would have remained in the hospital through the morning hours of January 25, 1977. In Dr. Polonsky's medic-

al opinion, based upon hypothetical questions derived from Wickline's recollection of her course ***1642** subsequent to her discharge from the hospital, had she been at Van Nuys on January 22, 23 or 24, he would have observed her leg change color, would have formed the opinion that she had clotted and would have taken her back into surgery and reopened the graft to remove the clot again, not an uncommon procedure in this type of case. As previously stated, he had performed a similar procedure on the first day of surgery, January 7, 1977. In addition thereto, Dr. Polonsky testified that had Wickline developed an infection while she was in the hospital, it could have been controlled with the vigorous use of antibiotics.

In Dr. Polonsky's opinion, to a reasonable medical certainty, had Wickline remained in the hospital for the eight additional days, as originally requested by him and her other treating doctors, she would not have suffered the loss of her leg.

Dr. Kovner testified that he had no recollection of speaking to Wickline or her husband on the telephone prior to January 30, 1977, the date of her readmission to the hospital, nor was there any notation in his chart of such a conversation, as it was his practice to do. In Dr. Kovner's opinion there was no direct relationship between Wickline's January 21 hospital discharge and the condition of the surgical site at the time she was readmitted to the hospital on January 30, 1977. Further, he testified that plaintiff's January 21st hospital discharge did not cause or contribute to the loss of her leg.

Dr. Daniels testified that he saw plaintiff at his office on January 28, 1977, one week after her discharge from Van Nuys. Dr. Daniels had no actual memory of that office visit but it was recorded in his office chart. He did not note any material or substantial change in Wickline's condition in his office medical chart from the time plaintiff was discharged from the hospital, as it was his general practice to do if such a change had occurred. From that he concluded that the condition of the incision site in the groin was essentially the same as when Wickline left the hospital.

Dr. Polonsky testified that in his medical opinion, the Medi-Cal Consultant's rejection of the requested eight-day extension of acute care hospitalization and his authorization of a four-day extension in its place did not conform to the usual medical standards as they existed in 1977. He stated that, in accordance with those standards, a physician would not be permitted to make decisions regarding the care of a patient without either first seeing the patient, reviewing the patient's chart or discussing the patient's condition with her treating physician or physicians.

III

From the facts thus presented, appellant takes the position that it was not negligent as a matter of law. Appellant contends that the decision to discharge ***1643** was made by each of the plaintiff's three doctors, was based upon the prevailing standards of practice, and was justified by her condition at the time of her discharge. It argues that Medi-Cal had no part in the plaintiff's hospital discharge and therefore was not liable even if the decision to do so was erroneously made by her doctors.

Further, appellant raises the defense of the doctrine of discretionary immunity pursuant to Government Code section 820.2, and, finally, argues that the language of Government Code section 818.4 can reasonably be interpreted to apply to provide the State with absolute immunity in this matter.

IV

Civil Code section 1714, derived from the common law, reads in pertinent part as follows: “Every one is responsible, not ****818** only for the results of his willful acts, but also for an injury occasioned to another by his want of ordinary care or skill in the management of his property or person, except so far as the latter has, willfully or by want of ordinary care, brought the injury upon himself.”

In *Rowland v. Christian* (1968) 69 Cal.2d 108, 70 Cal.Rptr. 97, 443 P.2d 561, the court reexamined the negligence liability rules applicable in this state and came to the conclusion that the principle embodied in this code section, i.e., Civil Code section 1714, serves as the foundation of our negligence law. Rephrased, it establishes the general rule that " 'All persons are required to use ordinary care to prevent others being injured as a result of their conduct.' And, 'in the absence of statutory provision declaring an exception to the fundamental principle enunciated by section 1714 of the Civil Code, no such exception should be made unless clearly supported by public policy.' " (69 Cal.2d at p. 112, 70 Cal.Rptr. 97, 443 P.2d 561.)

The opinion then sets forth broad criteria for determining the applicability of both the principal rule and the exceptions: " 'A departure from this fundamental principle involves the balancing of a number of considerations; the major ones are the foreseeability for harm to the plaintiff, the degree of certainty that the plaintiff suffered injury, the closeness of the connection between the defendant's conduct and the injury suffered, the moral blame attached to the defendant's conduct, the policy of preventing future harm, the extent of the burden to the defendant and consequences to the community of imposing a duty to exercise care with resulting liability for breach, and the availability, cost, and prevalence of insurance for the risk involved.' " (69 Cal.2d at p. 112, 70 Cal.Rptr. 97, 443 P.2d 561.)

***1644** Applying those standards to the facts in issue in this matter causes this court to conclude that appellant's contentions are well taken and that it is absolved from liability in this case as a matter of law.

[1] Negligence is not absolute or to be measured in all cases in accordance with some precise standard, but always relates to some circumstance of time, place and person. (*Fouch v. Werner* (1929) 99 Cal. App. 557, 564, 279 P. 183.)

Dr. Kaufman, the chief Medi-Cal Consultant for the Los Angeles field office, was called to testify on behalf of the defendant. He testified that in January 1977, the criteria, or standard, which governed a Medi-Cal Consultant in acting on a request to consider an extension of time was founded on title 22 of the California Administrative Code. That standard was "the medical necessity" for the length and level of care requested. That, Dr. Kaufman contended, was determined by the Medi-Cal Consultant from the information provided him in the 180 form. The Medi-Cal Consultant's decision required the exercise of medical judgment and, in doing so, the Medi-Cal Consultant would utilize the skill, knowledge, training and experience he had acquired in the medical field.

Dr. Kaufman supported Dr. Glassman's decision. He testified, based upon his examination of the MC-180 form in issue in this matter, that Dr. Glassman's four-day hospital stay extension authorization was ample to meet the plaintiff's medically necessary needs at that point in time. Further, in Dr. Kaufman's opinion, there was no need for Dr. Glassman to seek information beyond that which was contained in Wickline's 180 form.

Dr. Kaufman testified that it was the practice in the Los Angeles Medi-Cal office for Medi-Cal Consultants not to review other information that might be available, such as the TAR 160 form (request for authorization for initial hospitalization), unless called by the patient's physician and requested to do so and, instead, to rely only on the information contained in the MC-180 form. Dr. Kaufman also stated that Medi-Cal Consultants did not initiate telephone calls to patient's treating doctors because of the volume of work they already had in meeting their prescribed responsibilities. Dr. Kaufman testified that any facts relating to the patient's care and treatment that was not shown on the 180 form was of no significance.

****819** As to the principal issue before this court, i.e., who bears responsibility for allowing a patient to be discharged from the hospital, her treating physicians or the health care payor, each side's medical expert witnesses agreed that, in accordance

with the standards of medical practice as it existed in January 1977, it was for the patient's treating physician to decide ***1645** the course of treatment that was medically necessary to treat the ailment. It was also that physician's responsibility to determine whether or not acute care hospitalization was required and for how long. Finally, it was agreed that the patient's physician is in a better position than the Medi-Cal Consultant to determine the number of days medically necessary for any required hospital care. The decision to discharge is, therefore, the responsibility of the patient's own treating doctor.

Dr. Kaufman testified that if, on January 21, the date of the plaintiff's discharge from Van Nuys, any one of her three treating doctors had decided that in his medical judgment it was necessary to keep Wickline in the hospital for a longer period of time, they, or any of them, should have filed another request for extension of stay in the hospital, that Medi-Cal would expect those physicians to make such a request if they felt it was indicated, and upon receipt of such a request further consideration of an additional extension of hospital time would have been given.

Title 22 of the California Administrative Code section 51110, provided, in pertinent part, at the relevant time in issue here, that: “The determination of need for acute care shall be made in accordance with the usual standards of medical practice in the community.”

[2][3][4] The patient who requires treatment and who is harmed when care which should have been provided is not provided should recover for the injuries suffered from all those responsible for the deprivation of such care, including, when appropriate, health care payors. Third party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms as, for example, when appeals made on a patient's behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overridden. However, the physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care. He cannot point to the health care payor as the liability scapegoat when the consequences of his own determinative medical decisions go sour.

There is little doubt that Dr. Polonsky was intimidated by the Medi-Cal program but he was not paralyzed by Dr. Glassman's response nor rendered powerless to act appropriately if other action was required under the circumstances. If, in his medical judgment, it was in his patient's best interest that she remain in the acute care hospital setting for an additional four days beyond the extended time period originally authorized by Medi-Cal, Dr. Polansky should have made some effort to keep Wickline ***1646** there. He himself acknowledged that responsibility to his patient. It was his medical judgment, however, that Wickline could be discharged when she was. All the plaintiff's treating physicians concurred and all the doctors who testified at trial, for either plaintiff or defendant, agreed that Dr. Polonsky's medical decision to discharge Wickline met the standard of care applicable at the time. Medi-Cal was not a party to that medical decision and therefore cannot be held to share in the harm resulting if such decision was negligently made.

[5] In addition thereto, while Medi-Cal played a part in the scenario before us in that it was the resource for the funds to pay for the treatment sought, and its input regarding the nature and length of hospital care to be provided was of paramount importance, Medi-Cal did not override the medical judgment of Wickline's treating physicians at the time of her discharge. It was given no opportunity to do so. Therefore, there can be no viable cause of action ****820** against it for the consequences of that discharge decision.

The California Legislature's intent, in enacting the Medi-Cal Act, was to provide “mainstream” medical care to the indigent. (*California Medical Assn. v.*

Brian (1973) 30 Cal.App.3d 637, 642, 106 Cal.Rptr. 553.) The Legislature had expressly declared that Medi-Cal recipients should be able "whenever possible and feasible ..., to the extent practical, ... to secure health care in the same manner employed by the public generally, and without discrimination or segregation based purely on their economic disability." (Welf. & Inst. Code, § 14000.)

Welfare and Institutions Code section 14132 provided, in pertinent part, as follows: "The following is the schedule of benefits under this chapter: [¶] (b) In-patient hospital services, ... are covered subject to utilization controls." Welfare and Institutions Code section 14133, provided, in pertinent part: "Utilization controls that may be applied to the services set forth in section 14132 which are subject to utilization controls shall be limited to: [¶] (a) Prior authorization, which is approval by a department [of health] consultant, of a specified service in advance of the rendering of that service based upon a determination of medical necessity."

Title 22 of the California Administrative Code set forth the pertinent regulations applicable to the State's Medi-Cal program. Section 51327 thereof, dealt with inpatient hospitalization for other than emergency services and stated, in pertinent part, as follows:

"(a)(2) Nonemergency hospitalization is covered only if prior authorization is obtained from the Medi-Cal Consultant before the hospital admission is effected. The Medi-Cal Consultant's authorization shall be for a specified number of days of hospital care. Continued necessary hospitalization beyond the specified number of days shall be covered after approval by the Medi-Cal Consultant has been ***1647** obtained by the hospital on or before the last day of the previously approved period of hospitalization." (Cal.Admin.Reg. 75, No. 43, pp. 1276.2.1-1276.2.2.)

In the case before us, the Medi-Cal Consultant's decision, vis-a-vis the request to extend Wickline's hospital stay, was in accord with then existing statutory law.

V

This court appreciates that what is at issue here is the effect of cost containment programs upon the professional judgment of physicians to prescribe hospital treatment for patients requiring the same. While we recognize, realistically, that cost consciousness has become a permanent feature of the health care system, it is essential that cost limitation programs not be permitted to corrupt medical judgment. We have concluded, from the facts in issue here, that in this case it did not.

For the reasons expressed herein, this court finds that appellant is not liable for respondent's injuries as a matter of law. That makes unnecessary any discussion of the other contentions of the parties.

The judgment is reversed.

FEINERMAN, P.J., and HASTINGS, J., concur.

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