

Chapter 36

Liability of Health Care Entities for Negligent Care

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Corporate liability for negligent care and treatment on the part of health care providers was historically limited so that the corporation was responsible only for its employees, acting within the scope of their duties; for the hazardous conditions of its physical plant; and for the equipment it provided. The hospital was considered a facility where physicians, usually contracted privately by patients before their arrival, could practice medicine restricted only by the state regulatory boards. It was the physician rather than the hospital who was licensed to practice medicine. Under these circumstances the physician was considered an independent contractor from whom the patient could seek compensation in case of injury caused by professional negligence.

When the health care provider was a direct employee of the hospital, however, the hospital also could be held liable for injuries to the patient under the doctrine of respondeat superior. In this regard the hospital was treated similarly to other corporate entities whose employees offered services to the public. Where the employee acted within the scope of his or her duties, the employer was held responsible for the outcome. In earlier times some hospitals were run as charitable institutions (eleemosynary), and as such either they were held immune from liability or their damages as a result of liability were greatly reduced on the theory that the charitable contributions were not intended to be used by the donors as compensation for fault. Later, as health care institutions became insured and began accepting other sources of income, the rationale for these exemptions or restrictions dissolved. Other institutions, such as government-run hospitals, escaped liability under the sovereign immunity doctrine. No lawsuit could be brought against the state unless the state gave its permission. With growing recognition of the unfairness of the exemption, local, state, and federal legislation allowed claims to be brought for the negligent acts of its employees, albeit with numerous and varied restrictions, conditions, and caps on selected damages.

In the modern era the law is no longer simply concerned with the corporate responsibility of hospitals. It also must deal with the rapidly emerging variants, mutations, and affiliations of corporate health care, including managed care organizations (MCOs), permutations of all of these types based on their internal organizations, and the increasingly popular professional associations (PAs) or professional corporations (PCs), under which one or more physicians can own and be employed by a self-owned third party.

Hospitals traditionally enjoyed exemption from liability because they have evolved from charitable institutions into sophisticated corporations operating primarily on a fee-for-service basis, while assuming the role of a comprehensive health center with responsibility for arranging and coordinating the total health care of its patients. This has established duties to its patients, including the duty to use reasonable care in:

- The maintenance of safe and adequate facilities and equipment.
- The selection and retention of competent physicians.
- The oversight of clinical performance of health practitioners within its walls.
- The formulation, adoption, and enforcement of adequate rules and policies to ensure quality care for the patients.

Statements and citations mentioning "the hospital" as the corporate entity usually apply to the newer forms of health care organizations and even if they are not perfectly applicable, should at least be considered as a potential bellwether of developments.

Hence the responsibility of the health care institution for proper selection, retention, and supervision of professionals on its staff has assumed more corporate hazards. No longer can the hospital simply delegate to a volunteer staff committee the responsibility to examine a staff applicant's credentials and prior performance before granting clinical privileges. Nor can the physician on staff be allowed to practice without reasonable and prudent continuous

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supervision or review of performance. Under the modern doctrine of corporate negligence a health care organization may share responsibility with the negligent physician for the consequences of his or her acts or omissions.

LEGAL BASIS FOR THE HOSPITAL'S DUTY TO PATIENTS

The scope of a hospital's independent duty of care to its patients has expanded, and now imposes on the hospital the responsibility for monitoring and supervising the quality of medical care of its independent medical staff. The negligence of its health care personnel may be imputed to the hospital under doctrines such as respondeat superior and ostensible agency, making the hospital jointly liable with the negligent staffer.

The corporate liability doctrine requires a hospital to properly credential and monitor its staff physicians for clinical privileges as part of the implied contract between the patient and the hospital.¹ The hospital may even have a duty to intervene to prevent a negligent staff physician from endangering hospitalized patients.

Traditionally a hospital's liability for negligent acts of members of its medical staff depended on the legal relationship between the hospital and the physician. At one end of the legal continuum was the salaried physician who was a hospital employee. Under the doctrine of respondeat superior the hospital would be jointly liable for the physician's negligence.^{2,3} At the other end of the continuum was the independent staff physician who admitted patients under his or her care to the hospital. In the past the hospital was seldom liable for an independent staff physician's negligence, even if the negligent actions occurred within the hospital.^{4,5}

Whether a physician is considered an "employee" may depend less on the written contract between the institution and the physician than on actions and appearances. Thus, if the hospital provides supplies, equipment, uniforms, meals, parking spaces, billing services, and ancillary personnel, a physician who claims to be an independent contractor may be held to be a de facto employee, particularly if the physician does not maintain an office elsewhere. The conditions set by the Internal Revenue Service may have significance here and should be considered.⁶ If a patient seeks treatment directly from the hospital rather than from the physician who negligently caused the injury, or if the hospital does not allow the patient to choose a physician to provide a therapeutic service, that physician may be viewed as an employee and the doctrine of respondeat superior may apply, even if the treating physician is considered an independent contractor for other purposes. If a hospital represents to the patient that a physician is a hospital employee but the doctor actually is an independent contractor, a court may still hold the hospital vicariously liable for the physician's acts under a theory of liability referred to as *ostensible* or *apparent* agency. A plaintiff relying on an ostensible agency theory need show only that he or she looked to the hospital for

treatment and that the assigned attending physician negligently injured the patient in the provision of the treatment sought.

To hold a hospital liable on a corporate liability theory, a plaintiff must show that the hospital knew or should have known that the physician whose negligence caused the plaintiff's injury was providing substandard care.

Previously a hospital's liability for the negligence of a hospital-based physician, such as an anesthesiologist or pathologist, was referred to the contractual arrangements between the physician and the hospital in determining whether the physician was more like an "employee" or an "independent contractor," ordinarily a question of fact for the jury to decide.⁷⁻⁹ Under the ostensible agency doctrine the contract issue is moot. The theory of apparent agency is applicable where a hospital holds out a physician as its agent or employee, and a patient accepts treatment from that physician in the reasonable belief that it is being rendered on behalf of the hospital.¹⁰⁻¹²

Case Law

Pederson v. Dumouchel recognized the need for a hospital to adhere to its own rules and regulations designed to control and regulate a staff physician's conduct.¹³ In this case an injured child was examined by a physician who diagnosed a fractured mandible. A dentist was called in to perform oral surgery, and the physician left the hospital. The operation was performed without a physician in the operating room. The child sustained intraoperative cerebral anoxia and permanent brain damage. The hospital was liable because it had not enforced its own rules, which required that no surgery be performed without a physician present.

The case most often cited as extending and expanding hospital responsibility to include a direct duty to patients, however, is *Darling v. Charleston Memorial Hospital*.¹⁴ In this case a general practitioner who had not treated a leg fracture in several years cast a patient's fractured tibia. As a result of negligence, the leg had to be amputated. The hospital was liable for failing to require the physician to obtain a consultation. *Darling* came to engender the seminal concept that a patient is entitled to expect that the hospital will reasonably monitor and oversee the treatment provided by physicians practicing within its structure.

Fiorentino v. Wenger held that a hospital may be liable if it allows a physician to provide services to its patients when those in charge of granting clinical privileges know, or should know through reasonable inquiry, that the physician is likely to commit malpractice.¹⁵ This knowledge may consist of notice that the physician's staff privileges were rescinded at another hospital because the physician had conducted improper and radical surgery.

Mduba v. Benedictine Hospital held that a nonsalaried physician, despite his contract to the hospital to operate the emergency room, was an employee of the hospital.¹⁶ The rationale was that the physician's fees were based on rates guaranteed by the hospital and that the physician was subject to the rules and regulations of the hospital's governing board.

Corleto v. Shore Memorial Hospital noted that the hospital was ultimately responsible for the care of its patients, and therefore it had a duty to act when it had reason to know that malpractice would probably occur. Therefore, a hospital could be liable for permitting a known incompetent physician to perform an operation and failing to prevent him from treating a patient after his incompetence became obvious to the hospital.¹⁷

Corporate Liability

Under the corporate negligence theory a hospital may be liable for negligently failing to establish adequate procedures to ensure the safety of patients, where the hospital knew or should have known that the physician who caused injury to the patient was not qualified to practice in the hospital but nevertheless granted or renewed the physician's hospital privileges. Earlier, some courts limited the hospital's duty to supervise staff physicians to situations involving only employee physicians or to situations of gross negligence by the hospital. Apparently these courts were concerned that the imposition of a broad duty of hospitals to supervise care would impair independent physicians' discretion in purely medical decisions. Other jurisdictions have imposed a duty on hospitals to use reasonable care in the selection of staff physicians if detectable information exists about a physician's incompetence or lack of qualifications. Such notice can be inferred from records related to denying or restricting privileges at other hospitals or the existence of prior malpractice claims against the physician. If there is no notice of a physician's incompetence and no apparent reason to rescind or deny privileges, a hospital may escape liability. A physician's membership on the medical staff does not by itself create corporate liability for the hospital or health care organization.

NONDELEGABLE DUTY

Under the theory of corporate negligence the hospital may be held responsible for the acts and omissions of its apparent (ostensible) agents under certain circumstances, even when they were thought to be nonemployees or independent contractors. This theory recognizes that the hospital has a nondelegable duty to provide reasonable and safe health care to its patients and that direct liability can arise for negligent care. In addition, liability for employees may arise out of the doctrine of vicarious liability, in which a person may be held responsible for the actions of others whom he or she has the right to control.

Jackson v. Power is a landmark decision that enunciated that a hospital had a nondelegable duty for the acts of a nonemployee, independent contractor emergency department physician.¹⁸ In this case, a man who fell from a cliff was airlifted to a hospital where he was examined by an independent contractor physician. Severe internal injuries allegedly went untreated as a result of the physician's negligence. The court discussed whether a patient transported to the hospital without their specific request for a designated physician established that such a physician was an

ostensible agent of the hospital, or whether such a patient should have known the treating physician was not an employee of the hospital. Although the court said that this determination was a question for the jury, the court held that a general acute care hospital has a *nondelegable* duty to provide nonnegligent physician care in its emergency department. As an acute care facility the state mandated the hospital to provide a physician in the emergency department at all times. The hospital had received Joint Commission on Accreditation of Hospitals (JCAH) accreditation, which imposed standards for operation of the emergency department. The hospital bylaws had rules and regulations governing emergency department performance. In these statutes, standards, and rules, the court found that the hospital had to provide physician care in its emergency department. Seeking guidance in determining the questions of whether that duty could be delegated, the court turned to a case involving the principles governing safety of passengers on common carriers in which it was held that the principal carrier would not be allowed to avoid liability by engaging in separate subcontracts to provide food, perform maintenance, or even supply crews.¹⁹ Seeing similarities in the responsibility of hospitals in supplying various services to patients, the court held that the duty to provide physicians and nonnegligent care for patients in its emergency department was nondelegable. Such a duty does not extend, however, to situations in which a patient is negligently treated in the emergency department by a physician of the patient's own choice.

Insinga v. LaBella held that a hospital has a duty to select and retain competent physicians who, even though they are independent practitioners, would be providing hospital care in the exercise of their clinical staff privileges. The hospital's responsibility for the physician's acts, however, does not extend to acts outside the hospital.²⁰ This concept probably is not applicable where hospitals enter into direct associations with the physician or purchase the staff physician's private practice and continue to refer patients to him or her. Under those limited circumstances there may be an inducement of the patient to visit the physician's "private" office because of the referral or the endorsement of the care by the hospital.

STANDARDS TO MEASURE HOSPITAL CONDUCT

Many courts have distinguished the facts involved in determining a hospital's standard of care from those of *Darling*, thereby blunting the impact of that case on the hospital's requisite standard of care. Some courts have refused to extend *Darling's* holding that a hospital is liable for malpractice by an independently retained physician, unless it had reason to anticipate that the act of malpractice would take place. *Lundahl v. Rockford Memorial Hospital* distinguished the facts of *Darling* on the grounds that the physician in *Lundahl* had been an employee of the hospital and assigned to the emergency department.²¹ In this case, a boy was examined by a physician employed by the hospital, and then referred to a staff orthopedist who was not a

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hospital employee. After the orthopedist replaced a mole-skin traction strip with a floating splint, a blood clot formed, eventually requiring an amputation. The plaintiff claimed that the hospital had a duty to review the *medical* care being given to him by the orthopedist. The court ruled that the decision to treat a patient in a particular manner was a medical question to be made solely by the treating physician, not by the hospital.

Other courts have held that the only way a hospital could be liable for negligent clinical performance by a member of its staff would be if the plaintiff proved that the hospital had been negligent in its original selection of an unskilled physician.²² *Pogue v. Hospital Authority of DeKalb County*, however, involved a partnership under contract to staff an emergency department.²³ Although the contract required that the services performed would be “subject to surveillance by the medical staff of the hospital,” and be in keeping with “good medical practice,” the contract also specifically provided that the partners were “independent contractors.” The hospital was not liable for negligence of a member of the partnership because it had no right to direct specific medical techniques employed by emergency physicians. It was not liable when the physician’s negligence related to a matter of professional judgment as long as the hospital did not have the right to control the physician’s diagnosis and treatment of the patient.

Even though *Vanaman v. Milford Memorial Hospital* had facts similar to *Darling*, a court came to an opposite conclusion.²⁴ A mother brought her child to the emergency department with a fractured leg. Her own physician could not be located, therefore she asked to see the on-call physician, who set the leg, applied the cast, and provided follow-up treatment in his office. The on-call physician, not the hospital, billed for his services. When permanent disability of the leg resulted, the parents sued both the physician and the hospital. In finding that the hospital was not liable, the court said that the medical staff was an organized body with qualifications and privileges approved by the governing board of the hospital for patient care. The court held that the hospital had functioned only as a referral service and had not practiced medicine itself. This viewpoint has become outdated.

Most courts, however, have recognized and reaffirmed the concept of liability enunciated in *Darling*. In *Ohligschlager v. Proctor Community Hospital* a patient experienced severe pain and swelling in her arm near an intravenous infusion insertion site.²⁵ The patient informed a nurse’s aide of the pain, but the aide did nothing. Skin necrosis, requiring skin grafting, resulted from infiltration of the intravenous medication, which the physician had ordered in an incorrect concentration. The patient charged that the hospital’s negligence was the proximate cause of her injuries. The court said that there was sufficient evidence to require submission to the jury of the issues of whether the hospital had failed to heed the patient’s complaints and whether it failed to properly supervise the injection ordered by the physician. Citing *Darling*, the court said that the hospital was under the duty to “conform to the legal standard of reasonable conduct in the light of the apparent risk.”

Ensuring Medical Staff Competence

Tucson Medical Center v. Misevch restated the duty of the hospital, acting through appropriate committees, to ensure the competence of members of its medical staff.²⁶ The hospital was responsible to a patient if failure to properly supervise an incompetent physician results in the patient being injured. In this case the plaintiff contended that a physician staff member was negligent in administering anesthesia during surgery, and as a result the patient had cardiac arrest and died. The key contention against the hospital was that the anesthesiologist was under the influence of alcohol during the operation and that the hospital was negligent in retaining him on its medical staff. The court pointed out that a hospital owes a duty to its patients to ensure the competence of its medical staff by supervision of the physicians on its staff. The court stated that a hospital and its governing body may be held liable for injuries resulting from negligent supervision of members of its medical staff. The court reasoned that a hospital assumed certain responsibilities for the care of its patients and thus was required to meet the standards of responsibility commensurate with that trust.

A hospital would be negligent if its medical staff were negligently supervised by its members or failed to recommend action by the hospital’s governing body before a patient’s injury. When a hospital’s negligence is predicated on an omission to act, the hospital will not be held responsible unless it had reason to know that it should have acted to fulfill its duty to the patient. Therefore, knowledge (actual or constructive) is an essential factor in determining whether the hospital exercised reasonable care under the circumstances. The court quoted JCAH, which stated that “the medical staff is responsible to the governing body of the hospital for the quality of hospital patient care. It therefore evaluates the qualifications of applicants and members to hold staff privileges and recommends curtailment and exclusion when necessary.”

A hospital may be liable for not becoming aware of medical staff members’ incompetence if the hospital, through due diligence, could have acquired such knowledge and acted so as to prevent the plaintiff’s injury but failed to do so. *Gonzales v. Nork* held that a hospital had a duty to its patients to protect them from the malpractice of an independently retained member of its staff if the hospital knew, had reason to know, or should have known that the surgeon’s negligent acts were likely to occur.²⁷ In this case a private physician member of the medical staff admitted to performing unnecessary and negligent spinal surgery on a 27-year-old hospital patient who had suffered from back pain after being injured in an automobile accident. Three years after this operation the hospital administrator heard a rumor that the surgeon’s malpractice insurance had been canceled. Because the hospital required staff physicians to have such insurance, it investigated and found that the rumor was true. The hospital promptly placed the surgeon in a monitoring program under which he was forbidden to operate without another qualified surgeon present. During the trial, the surgeon admitted to performing at least 26

other unnecessary operations over 9 years. The court indicated that the hospital's liability was based on its duty to protect its patients from malpractice by members of its medical staff. Although the hospital had no knowledge of the surgeon's propensity to commit malpractice, it was negligent because it had failed to investigate an earlier malpractice case in which the surgeon had been sued. The court concluded that mere compliance with the prevailing JCAH standards did not discharge the hospital from its duty to its patients because those standards furnished no effective means of detecting a fraudulent physician. The court also concluded that the hospital's peer review of the quality of patient care was random, casual, subjective, and uncritical and therefore at the time of the patient's surgery the hospital had no actual knowledge of the surgeon's fraud and incompetence. The court held that the hospital governing board was corporately responsible for the conduct of its medical staff because it had a duty to protect its patients from malpractice by members of its medical staff.

Hospital Standard of Care

The standard of care that the hospital must meet to discharge this duty was detailed and illustrated in *Johnson v. Misericordia Community Hospital*, a case involving the credentialing of a physician member of the medical staff.²⁸ In this case a patient contended that the hospital was negligent in appointing the surgeon to the medical staff and in granting him surgical privileges. Testimony established the surgeon's negligence and that the surgeon misrepresented the truth on his application and authorized the hospital to verify all information given. The hospital's administrative records were devoid of any procedures used in the appointment of the surgeon to the medical staff organization. The court concluded that these procedures would have uncovered that at two hospitals the surgeon's privileges were revoked; at another hospital he was denied privileges; he was neither board certified nor board eligible; and that 10 malpractice suits had been filed against him. The court held that the hospital had a duty to exercise reasonable care to grant clinical privileges only to competent physicians and surgeons. It concluded that had the hospital exercised ordinary care in the staff selection process, it would not have appointed the surgeon to its medical staff, and thus the patient would not have been negligently injured. In enunciating that a hospital owes a duty of care of its patients to refrain from any act that will cause foreseeable harm or an unreasonable risk of danger, the court interwove the concept of institutional responsibility with foreseeability.

Granting Privileges

Although a hospital is not the insurer of competence of its medical staff, it will be charged with evaluating the knowledge that would have been acquired had it exercised ordinary care in investigating its medical staff applicants.

In addition to judicial recognition of the direct duty of a hospital to exercise reasonable care in selecting and

retaining staff physicians, some courts have enunciated a duty to *supervise* the health care provided by physician staff members. The hospital's duty to promulgate regulations to oversee the clinical performance of physicians was enunciated in *Bost v. Riley*, which adopted the concept of corporate negligence for failure to supervise medical treatment.²⁹ The plaintiff contended that inadequate physician progress notes were evidence of negligent care that resulted in the patient's death. The court held that hospitals have a duty to make a reasonable effort to monitor and oversee the treatment prescribed and administered by physicians practicing in the hospital. Therefore, the hospital may have breached its duty to the patient by failing to enforce its own internal rule requiring the keeping of accurate progress notes.

Supervision of Performance

Other legal decisions have refused to extend or expand a hospital's duty to supervise medical treatment. In *Cox v. Haworth* the patient was hospitalized so that his privately retained physician could perform a myelogram.³⁰ During the course of treatment, the patient sustained permanent injury to the spinal cord. The patient alleged that the hospital was negligent in not obtaining informed consent before the medical procedure was performed. No negligence by the hospital personnel during performance of the myelogram was alleged. The court refused to interpret the doctrine of corporate liability as imposing a duty on a hospital to inform and advise the patient of the nature of medical procedures that are to be privately performed.

The limitations placed on the expansion of the doctrine of corporate liability probably represent judicial recognition that hospitals are not well equipped to supervise patient care actively and concurrently. The personal nature of the physician-patient relationship requires that the physician exercise necessary discretion in the diagnosis and treatment of the patient's condition. Moreover, it would be impractical for the hospital to *personally* supervise the quality of medical care rendered by each medical staff member.

Oversight of Quality

Overseeing the quality of physician performance is a different matter. A hospital's *review* of medical staff clinical performance is not a concurrent duty but one involving a retrospective process performed through delegated medical staff committees (such as quality assurance, risk management, and credentials). To project future performance, the committees use a historical data base describing the physician's training, experience, and prior performance. Some courts have conditioned a hospital's duty to ensure the competence of its staff on the hospital's knowledge (actual or constructive) and awareness of a physician's incompetent acts. This approach adopts the agency law principle that a corporation is bound by the knowledge acquired by, or by the notice given to, its agents or officers, who are within the scope of its authority in reference to matters to which its authority extends.

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Fridena v. Evans held that a negligent physician was an officer of the hospital who held a medical administrative position as chief of the medical staff.³¹ This relationship became the linchpin for imputing knowledge of the physician's incompetence to the hospital. Holding that the hospital had "actual" notice of the physician's incompetence, the court concluded that the hospital had been negligent in failing to supervise the physician's performance.

Elam v. College Park Hospital provides insight into the law's reluctance to create the unusually difficult task of supervising physicians as a responsibility of hospital staffs.³² The court indicated that the hospital had a duty of "continuing evaluation" of the staff physicians' clinical performance, apparently a less onerous and more achievable modification of the requirement that a hospital supervise the *actual* medical care. Such a requirement did not necessarily require concurrent supervision and on-line intervention.

Pickle v. Curns expresses additional modifications of the hospital's duty to supervise physicians.³³ The court rejected the contention that a hospital has a duty to ensure that physicians practicing on its premises never commit negligent acts. Instead, the court formulated the hospital's duty as one to prevent injuries resulting from negligence of its staff physicians when it knew, or should have known, that the physician would perform a negligent act.

The trend evinced by these cases is to impose a duty on the hospital to supervise clinical performance only when the hospital has been put on notice by past negligent acts. Thus, it does not impose on hospitals a duty to concurrently supervise the administration of medical care but rather to monitor a physician's provision of medical services through patient care assessment committees.

Policy and Procedures

In addition to responsibilities to patients regarding medical staff conduct, hospitals must have developed adequate policies to protect the welfare of patients receiving care in their institutions and must establish an organizational structure to carry out those policies.

Polischeck v. United States illustrated a violation of this duty. A hospital was held liable for failing to have a patient with a severe headache examined or her chart reviewed by a physician prior to discharge from an emergency department.³⁴ The hospital permitted emergency department patients to be admitted and discharged by physician assistants, who under state law were not considered qualified to make such determinations.

Ravenis v. Detroit General Hospital imposed direct liability on the hospital for failing to have appropriate standards of care related to handling tissues to be transplanted from donor cadavers.³⁵ Several patients were injured as a result of contaminated cornea transplants because the hospital had no policy that required the performance of necessary tests on the donor or the donor tissue.

In *Andrews v. Burke*, the plaintiff contended that an incomplete physician's note of a failed resuscitation effort made the hospital corporately negligent per se because it

violated hospital regulations adopted by governing boards regarding hospital record-keeping rules.³⁶ The state regulatory code required the adoption of minimum standards and regulations to govern the operation of hospitals, and the state administration code directed hospitals to establish governing bodies to govern such regulations. The court rejected the contention that a physician staff member's violation of hospital regulations amounted to negligence per se. The plaintiff argued that the physician failed to comply with the hospital record-keeping rules. The court noted that privately adopted standards are generally admissible to establish the standard of care when relevant and reliable, but they do not have the force of law. The court rejected the contention that the hospital had been corporately negligent because the plaintiff did not assert that the defendant physician was incompetent, or identify any negligent act that the hospital should have prevented in properly exercising its corporate responsibility. Therefore, the physician's failure to comply with hospital record-keeping rules did not establish that the hospital's failure to enforce this rule contributed to the patient's death.

MEDICAL STAFF SELECTION, MONITORING, AND SUPERVISION

Courts have recognized the hospital's duty to select, monitor, and supervise independent contractor members of the medical staff. Although a hospital's overall monitoring system is closely examined when a hospital is named in a suit, the hospital is not considered to be guarantor of the adequacy of medical care rendered in its facility. Isolated negligent acts of an otherwise competent independent contractor physician generally are not evidence of negligence on the part of the hospital.

Selection

The hospital is responsible for obtaining reasonably available information on prospective staff members regarding their credentials and any prior negligent conduct. In *Joiner v. Mitchell County Hospital Authority* a patient complaining of chest pain was examined at the hospital by an independent contractor member of the medical staff.³⁷ The physician advised the patient that the condition was not serious and sent the patient home. Shortly after he returned home, the patient's condition worsened and he died. The patient's estate sued the hospital directly for its negligence in permitting an allegedly known incompetent physician to continue to serve on its medical staff. The court rejected the hospital's contention that it was relieved of liability by delegating its authority to screen medical staff applicants to the members of the existing staff, reasoning that the medical staff simply acted as an agent for the hospital in screening applicants. The court held that because the hospital knew or because, based on information in the hospital's possession, it was apparent that the

physician was incompetent, the hospital did not act with reasonable care in permitting the physician to remain a member of the staff.

A hospital also may incur liability if it has implemented a data system for evaluating the qualifications of its staff members but has failed to use this system to restrict the clinical privileges of a physician who has demonstrated incompetence. *Purcell v. Zimbelman* ruled that the hospital had “notice” of the surgeon’s incompetence, based on evidence that prior similar operations performed by the surgeon had resulted in lawsuits against him and other hospitals.³⁸ Significantly the court concluded that the failure of the hospital surgical department, which had reviewed the surgeon’s various mishaps in the operating room, to take any corrective action against the surgeon did not relieve the hospital of its duty to protect the patient.

Monitoring

If a hospital has not implemented review procedures to properly credential and appraise staff physicians’ clinical performance, plaintiffs must demonstrate that review procedures would have placed the hospital on notice. *Reynolds v. Memnonite Hospital* involved a negligence lawsuit against a hospital for damages caused by allegedly unnecessary surgery.³⁹ The plaintiff claimed that the hospital failed to comply with certification and review procedures. The court said, however, that such failure, even if the surgery was unnecessary, was insufficient to prove that the hospital was directly negligent. The hospital had no notice of any flaw in the qualifications or background of the surgeon or of any circumstances existing before the plaintiff’s surgery that would have caused the hospital to limit or revoke the surgeon’s privilege to operate. The court pointed out that a hospital is not an insurer of a patient’s safety; therefore because nothing in the record indicated that an evaluation of the surgeon’s capabilities would have disclosed standard practices, the hospital was not negligent.

Supervision

In *Braden v. St. Francis Hospital* the plaintiff alleged that an unnecessary amputation was performed by a staff surgeon, that the hospital had a duty to exercise proper supervision to prevent unnecessary and wrongful surgery, and that it breached this duty.⁴⁰ The court pointed out that statistics themselves do not indicate a proclivity on the part of the staff surgeon to perform unnecessary amputations because multiple surgeries do not necessarily support a reasonable inference that any one procedure, including the procedure in this case, was unnecessary or negligently performed. The plaintiff offered statistics showing that the staff surgeon had performed significantly more amputations than the average number of amputations performed by other surgeons on the hospital staff. The plaintiff also referred to the hospital’s bylaws, which documented an elaborate administrative structure of supervision and monitoring to ensure quality care. The court held that a hospital does not generally expose itself to liability for negligence unless it knows

or should know of a physician’s propensity to commit negligent acts.

EXPANDING HOSPITAL LEGAL DUTIES

Kirk v. Michael Reese Hospital expanded a hospital’s liability beyond its patients to individuals affected by the actions of patients.⁴¹ In this case the hospital discharged a patient on medication that should not be combined with alcohol, especially if the patient intended to drive. The patient consumed alcohol and injured a pedestrian, who sued both the patient and the hospital. The court ruled that the hospital had an obligation to that pedestrian, an individual who had not been admitted or treated in the hospital.

Physician Offices

In general, hospitals do not have a duty to ensure that its staff physicians render medical care competently outside the hospital setting. *Pedroza v. Bryant* held that a hospital is not liable for injuries resulting from malpractice committed in the private office of a nonemployee physician before the patient was admitted to the hospital.⁴² The plaintiff charged that the hospital was negligent in not ensuring that its staff physician, the patient’s private physician, was competent. Noting that the physician’s negligent acts had occurred entirely outside the hospital, the court stated that for the plaintiff to prevail, the court would have to extend the hospital’s corporate duty of care to patients treated by staff members in their private offices, where the hospital is not involved. The court declined to do so, pointing out that negligence committed by staff physicians outside the hospital is relevant *only* if the hospital has actual or constructive notice of it and negligently fails to take action. A hospital is not an inspector or insurer of the private office practices of its staff members. Within the hospital, the hospital’s delineation of staff privileges may reasonably affect staff members.

Notification Requirement

The doctrine of corporate liability may encompass a duty for the hospital to inform a patient when it is aware of a deviation from the standard of care that has caused an injury. When a hospital knows that a deviation from the standard of care has caused an injury, the failure to inform the patient or the patient’s survivors may constitute fraudulent concealment. *Kruegar v. St. Joseph’s Hospital* held that whether fraudulent concealment was present was a question of fact for the jury to determine.⁴³ In this case the plaintiff was advised by her husband’s physicians that he had died of heart failure during an operation. Three years later, it was anonymously disclosed to his spouse that intraoperative malfunction of respiratory equipment had contributed to the cause of death. The patient’s estate sued, alleging that the hospital had a duty to inform her of this fact and was therefore precluded from asserting the statute

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of limitations as a defense. The court noted that fraud can exist even when no false statement is made. The suppression of a material fact, which a party is bound in good faith to disclose, is equivalent to a false representation.

Failure to Warn of Disease

A hospital must be sensitive to emerging areas of liability for failure to warn, particularly in areas involving the adverse side effects of radiation therapy and possibility of contact with communicable diseases. Case law principles governing a hospital's duty to warn in these instances are still developing. *Knier v. Albany Medical Center Hospital* dealt with the hospital's duty to warn the general public that one of its employees had come in contact with a patient who had scabies, a communicable disease.⁴⁴ A nurse's family sued the hospital for failing to warn them that the nurse had been exposed to a contagious disease. The court ruled that the hospital did not have an obligation to warn her family, friends, or the public at large that she had been exposed to scabies.

Far more dangerous than scabies is the threat of AIDS. The hospital's duty to warn patients that a surgeon was HIV-positive was explored when the hospital restricted the surgeon's privileges until he provided proof of informed consent from his patients. The duty of confidentiality to the surgeon as patient was pitted against the duty of the hospital to protect other patients from "risk of harm." Although the restriction and temporary suspension of surgical privileges may not violate state law against discrimination,⁴⁵ further developments are needed before a health care corporation may take such action without exposure to liability. AIDS, considered to be a handicap in many states, is protected by special laws of confidentiality in others, and is a reportable disease (although not with disclosure of the patient's name) everywhere. How these competing issues will play out remains to be seen.⁴⁶

Thompson v. Nason Hospital imposed an additional responsibility on hospitals to control independent medical staff members.⁴⁷ This case involved emergency department treatment of a trauma patient by a private staff physician who was not a member of the department, nor "on call" to the department. When negligent treatment of intracerebral hemorrhage caused the patient permanent dysfunction, the patient sued both the physician and the hospital, claiming that the physician was an ostensible agent of the hospital, and therefore the hospital had a responsibility to ensure that care given in the emergency department was not negligent.

The court pointed out that a hospital has a corporate responsibility to a patient to supervise hospital care, even medical services rendered by physicians whose only relationship with the hospital is as a member of the medical staff. The court also pointed out that hospitals have changed as the structure of the health care system has changed. The practice of medicine is now being carried out by hospitals that have many full-time physician employees. Present-day hospitals now undertake to treat the patient through their physicians and nurses, rather than

simply to procure them to act upon their own responsibility. Their manner of operation demonstrates that hospitals do far more than furnish facilities for treatment. People who avail themselves of hospital facilities expect that the hospital will attempt to cure them, not that employees will act on their own responsibility.

This case raises the question of whether hospitals can refuse to grant clinical privileges to physicians without due process on the grounds that hospitals must protect themselves from corporate liability. This development is likely to create tension with antitrust issues that would further expose a hospital to liability.

An important predicate, in determining whether a hospital was negligent, is the demonstration that the hospital knew of an ongoing aberration in the clinical care of its patients. A hospital fulfills this duty by recognizing the established responsibility of hospital employees (such as nurses and technicians) to notify the hospital of unusual orders, treatments, or decisions observed in the course of a patient's care. Failure to give such notice would be a liability burden just as the negligence itself is such a burden.

MANAGED CARE ORGANIZATIONS

An MCO is designed to facilitate the financial management of health care while delivering services to its enrolled members. The most common type is the HMO, which in turn may consist of groups of physicians under contract to an employer or an insurer, independent practice networks, staff model organizations with direct employment of physicians, and open-ended networks that allow enrollees to seek services from within and from outside the organization. Regardless of the variant, MCOs share a common goal to provide health care services at reduced costs through consumer competition.

Cost-containment measures may include direct incentive payments to physicians to decrease patient-initiated use of services, deselection of physician involvement where overuse can be demonstrated, fixed fees for identified procedures, and capitation payment. These cost-containment services may require the physician to restrict or deny some health care measures requested by the patient. Conflicts may arise when the patient feels harm has resulted from the restriction or denial of care, especially when the restrictions are contrary to the treating physician's own medical judgment.

The MCO may face liability for the improper selection and retention of the physicians or other professionals with whom it contracts to provide services to enrollees. This area of liability is similar to that of corporate liability for a hospital's negligence in providing hospital staff privileges. Because the MCO may function as the provider, the payor, and the quality reviewer, it may be exposed to liability for breaches in each of these areas.

Harrell v. Total Health Care, Inc. found that an HMO had failed in its duty to properly select the physician whose care allegedly injured an enrollee because the physician

had a history of malpractice and incompetence.⁴⁸ The Missouri Supreme Court found the HMO free of liability on statutory grounds but did not reject the theory of corporate liability.

McClellan v. Health Maintenance Organization of Pennsylvania refused to apply the doctrine of nondelegable duty to an HMO that did not provide on-site health care services.⁴⁹ Nevertheless, the court apparently recognized the theory of corporate liability for negligent staff selection and retention of HMO physicians.

Because MCOs may be employers, the theory of respondeat superior is applicable to hold the HMO liable for the negligence of its employees and agents acting within the scope of their duties. Therefore, a staff model HMO was held liable for acts of its physicians in *Robbins v. HIP of New Jersey*.⁵⁰ The hallmark of such action is the HMO's right to control the physician's activities. Thus, in *Sloan v. Metropolitan Health Council, Inc.*, the HMO was liable because it exercised control over an allegedly negligent physician.⁵¹ In *Schleier v. Kaiser Foundation Health Plan of Mid-Atlantic States*, the HMO was held liable for the acts of a physician who was a consultant rather than an employee because the HMO had "controlled" the physician through its medical director.⁵²

Mitts v. HIP of Greater New York, however, found physicians to be independent contractors because the HMO did not directly treat patients; therefore negligence was not imputed.⁵³ A similar conclusion was reached in *Chase v. Independent Practice Association* in which an HMO contracted with an IPA and had no direct control over medical decisions. In this case the court refused to apply respondeat superior.⁵⁴

Ostensible Agency

Under the theory of apparent or ostensible agency, HMOs have been held liable for negligent acts of affiliated physicians who were not directly employed by the HMO. Judicial considerations include: whether the HMO "held out" the physician as an agent; whether the patient looked to the HMO rather than the designated physician for care; whether the physician was chosen from lists supplied by the HMO; and whether the HMO restricted the patient's choice of physician.⁵⁵ However, HMOs were not held liable where the HMO exercised no professional control over the physician, or where the state law prohibits the HMO from practicing medicine.^{56,57} If an HMO physician specifically promised a given result and the patient relied on that promise, the HMO could be held liable for breach of contract when the result was not forthcoming from the treatment.⁵⁸

Cost-Containment Measures

In *Wickline v. State of California* a patient was prematurely discharged from a hospital because of a utilization review decision to deny additional hospitalization, resulting in the amputation of her leg.⁵⁹ She sued the state Medicaid program for its interference with her physician's judgment

to keep her hospitalized. Although holding that only the physician could be held responsible for the patient's premature discharge, the court allowed that the program could be held liable if a defect in the MCO's cost-containment measures caused harm. In *Wilson v. Blue Cross of So. California* the utilization review organization of a private insurer refused extension of a patient's hospitalization for depression.⁶⁰ The patient committed suicide after discharge. The court said the utilization review organization, the insurer, and the utilization review physician could be held liable. Unlike in *Wickline*, in *Wilson* there was no clear public policy expressed in the statute that required a cost-containment utilization review process. The private insurance provisions requiring cost-containment review and restriction of services were not the products of public policy.

ERISA

Claims of malpractice against an MCO by an enrollee may be preempted under the Employee Retirement Income Security Act of 1974 (ERISA),⁶¹ where a qualified health plan is offered to an employee as part of a benefit package. The preempted malpractice claims usually are those resulting from defective design or implementation of cost-containment or claims-handling systems, or those resulting from vicarious or direct liability for negligence by a health care provider. At present there does not seem to be a sense of urgency by courts to preempt medical malpractice claims against MCO providers (*DeGenova v. Ansel*).⁶² However, the issue may become more prominent with further federal involvement in health care and attempts to correct so-called malpractice crises.⁶³

DIRECT LIABILITY OF MANAGED CARE ORGANIZATIONS

MCOs may be subject to direct liability for corporate negligence, such as in cases for negligent selection and retention of incompetent physicians who are held out to subscribers on its list of specialists.⁶⁴ The theory applied is similar to that of corporate liability of the hospital.⁶⁵

As courts continue to view MCOs as "health care providers," particularly in delivery models where care is dispensed instead of merely financed, direct liability for negligent supervision and control of MCO physicians will probably increase. A coherent and consistent standard of care for MCOs may be difficult and as yet remains unclear.⁶⁶ The federal government's efforts to reform health care nationwide may attempt to set practice parameters that some courts may interpret as "standards."

Vicarious Liability

Courts have found health plans vicariously liable for the actions of physicians they hold out as their own. *Lancaster v. Kaiser Foundation Health Plan* took the next step and found that institutional negligence should be applied

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to HMOs that do *not* hold out physicians as their own.⁶⁷ The Illinois Supreme Court has been influential in establishing direct corporate liability for hospital staff and vicarious liability for independent contractor physicians, and has extended liability for corporate negligence to MCOs.

In *Jones v. Chicago HMO Ltd. of Illinois*, an enrollee of an IPA model HMO was assigned a physician because public assistance enrollees were not allowed to choose their own physicians.⁶⁸ The physician negligently failed to diagnose bacterial meningitis in the enrollee's daughter. As a result, the daughter became permanently disabled. An ensuing lawsuit charged the HMO with institutional negligence for assigning a primary care physician who was serving an overloaded patient population, and for negligently adopting procedures that required enrollees to call first for an appointment before visiting the physician's office or obtaining emergency care.

Because the HMO was an IPA model that both assigned physicians to enrollees and supervised the care provided to them, the ERISA preemption was not mentioned by the court. The court stressed that institutional negligence was just an extension of traditional tort law where institutions take on responsibilities that include the possibility of injuring people through tortious conduct. This conclusion was driven by recognition that MCOs are heavily involved in patient care decisions that go beyond the provision of insurance services.

Proof of Institutional Negligence

The plaintiff did not need expert testimony on allegations of negligently assigning more enrollees to the PCP than he was capable of serving, and adopting procedures requiring the enrollee to call first for an appointment before visiting the PCP's office, because other evidence established the appropriate standard of care and the defendant indicated that there should be a primary care physician for every 3500 patients, and in its contract with the state to provide services promised to have a PCP for every 2000 patients. Since the defendant's medical director testified that patient load could influence the standard of care, and since the defendant's own records and other testimony indicated that the PCP might be assigned to more than 4500 patients, the court found that this raised an issue for the jury and summary judgment was inappropriate.

CONTRACT AND WARRANTY THEORIES

Dissatisfied enrollees may seek relief in the courts via legal theories other than negligence, including breach of contract or warranty or misrepresentation by the MCO. *Williams v. Health America* and *Boyd v. Albert Einstein Medical Center* provide examples, albeit unsuccessful at the time, of these theories.^{69,70} The more the MCO becomes a "provider" of health care for its enrollees, the more it can be expected that a court will find contractual or fiduciary relationships between it and the enrollee.

PROFESSIONAL SERVICE CORPORATIONS

Professional service corporations, variously known as a PC or PA, are products of state legislatures. Specific regulations, restrictions, limitations, and liabilities for these corporations and their shareholders, agents, and employees should therefore be researched in the applicable state statutes.

In most states, professionals, such as physicians and lawyers, may incorporate for the sole purpose of rendering specific professional services, provided that the shareholders are duly licensed to render the same service.⁷¹ Motivation for incorporation by professionals includes tax benefits, pension plans, group ownership of property or contracts, and reduction of liability exposure. Although the corporation cannot legally provide professional medical services, it can be owned by the licensed professionals and contract with others as a provider of health care services, own and convey property, employ persons (who need not be licensed) for managerial purposes, employ licensed professionals who need not be shareholders, sue, and be sued.

Under these professional service corporation arrangements the individual professionals are not necessarily shielded from liability for their own acts, but the corporation may assume liability for the professional acts of its employees, including the individual licensed professional, up to a specific amount of its property.⁷²

The PA may purchase professional liability insurance to cover all of its professional employees and others acting within the scope of their duties, and each licensed professional may purchase individual liability coverage. Strict attention should be paid to these variables by all seeking to purchase coverage for the corporation, its shareholders, or both and for the employees, as well as by all those to whom professional employment is offered. The terms may vary significantly from state to state.

Conversely the liability of individual shareholders for the "nonmalpractice" liability of the professional corporation has been held in some jurisdictions to be limited to an extent similar to that of shareholders of nonprofessional corporations. For example, the assets of the individual shareholders should be exempt for ordinary business debts or nonprofessional contracts entered into solely in the name of the corporation. Compare *We're Associates Co. v. Cohen et al.*, where individual shareholders of a professional corporation of attorneys were not held responsible for the corporation's default on its lease, with *South High Dev. Ltd. v. Weiner et al.*, where the bar rules made the individual lawyers guarantors for the acts of their professional corporation when professional duties were concerned.^{73,74}

In the sale or lease of a piece of expensive medical equipment, the prudent vendor may require that the individual professionals as shareholders cosign with the corporation itself. Notification of the professional corporation at the time of notice to a shareholder in a malpractice action is customary or required in many states, but failure to do so is not necessarily fatal because the intent of the state legislature allowing professional corporations was not to provide an escape mechanism for the errant individual.

CONCLUSION

The role of the health care corporations who provide patient care has significantly changed. No longer is the hospital simply a physician's workplace that merely furnishes room, board, operating rooms, sophisticated equipment, nurses, attendants, and other personnel. Today, health care corporations play a role in the treatment of the patient as a health care center that is ultimately responsible for the health care provided within its walls. The public expectation is that the hospital will act to ensure the overall quality of care rendered. The doctrine of corporate liability is an attempt to pragmatically focus the law on the modern relationships between legal doctrine and socioeconomic reality. The courts are moving away from an overly strict application of traditional but archaic doctrinal rules in recognition of these changing relationships among the hospital, health care corporation, patients, subscribers or enrollees, and physicians.

A common thread running through those legal cases that have applied the corporate negligence theory is the court's role in identifying and analyzing the organizational structure of the hospital. This approach recognizes that hospitals have assumed the dual role of delivering services and monitoring the physicians they appoint to their staff. The duty, however, does not automatically render the hospital liable for all malpractice committed by physicians if the hospital has been reasonable in its procedures and has carefully selected and monitored its medical staff. The movement to assign responsibility for all types of professional malpractice, including acts of independently practicing physicians, to the hospital corporation itself has developed slowly, considering that it has been the most common form of legal responsibility in most aspects of "enterprise liability" in American law during the past century.

Endnotes

1. *Insinga v. LaBella*, 543 So. 2d 209 (1989) (Fla.).
2. *Bing v. Thunig*, 143 N.E. 2d 3 (1957) (N.Y.).
3. *Sepaugh v. Methodist Hospital*, 202 S.W. 2d 985 (1946) (Tenn.).
4. *Byrd v. Marion General Hospital*, 162 S.E. 738 (1932) (N.C.).
5. *Moon v. Mercy Hospital*, 373 P. 2d 944 (1962) (Colo.).
6. 1992-22 I.R.B. 59.
7. *Carroll v. Richardson*, 110 S.E. 2d 193 (1959) (Va.).
8. *Seneris v. Haas*, 291 P. 2d 915 (1957) (Cal.).
9. *Brown v. Moore*, 247 F. 2d 711 (1957) (Pa.).
10. *Cuker v. Hillsborough County Hospital Authority*, 605 So. 2d 998 (1992) (Fla.).
11. *Orlando Regional Medical Center v. Chmielewski*, 573 So. 2d 876 (1990) (Fla.).
12. *Arthur v. St. Peter's Hospital*, 405 A. 2d 443 (1979) (N.J.).
13. *Pederson v. Dumouchel*, 431 P. 2d 973 (1967) (Wash.).
14. *Darling v. Charleston Memorial Hospital*, 211 N.E. 2d 253 (1965) (Ill.).
15. *Fiorentino v. Wenger*, 227 N.E. 2d 296 (1967) (N.Y.).
16. *Mduba v. Benedictine Hospital*, 384 N.Y.S. 2d 527 (1976) (N.Y.).
17. *Corleto v. Shore Memorial Hospital*, 350 A. 2d 534 (1975) (N.J.).
18. *Jackson v. Power*, 743 P. 2d 1376 (1987) (Ala.).
19. *Alaska Airlines v. Sweat*, 568 P. 2d 916 (1977) (Ala.).
20. *Supra* note 1.
21. *Lundahl v. Rockford Memorial Hospital*, 235 N.E. 2d 671 (1968) (Ill.).
22. *Clary v. The Hospital Authority of the City of Marietta*, 126 S.E. 2d 470 (1962) (Ga.).
23. *Pogue v. Hospital Authority of DeKalb County*, 170 S.E. 2d 53 (1969) (Ga.).
24. *Vanaman v. Milford Memorial Hospital*, 262 A. 2d 263 (1970) (Del.).
25. *Ohligschlager v. Proctor Community Hospital*, 303 N.E. 2d 392 (1973) (Ill.).
26. *Tucson Medical Center v. Misevch*, 545 P. 2d 958 (1976) (Ariz.).
27. *Gonzales v. Nork*, No. 228566 (Cal. Sup. Ct., Sacramento Co.) (1974) (Cal.).
28. *Johnson v. Misericordia Community Hospital*, 301 N.W. 2d 156 (1980) (Wis.).
29. *Bost v. Riley*, 262 S.E. 2d 391 (1980) (N.C.).
30. *Cox v. Haworth*, 283 S.E. 392 (1981) (N.C.).
31. *Fridena v. Evans*, 622 P. 2d 463 (1981) (Ariz.).
32. *Elam v. College Park Hospital*, 183 Cal. Rptr. 156 (1982) (Cal.).
33. *Pickle v. Curns*, 435 N.E. 2d 877 (1982) (Ill.).
34. *Polischeck v. United States*, 535 F. Supp. 1261 (1982) (Pa.).
35. *Ravenis v. Detroit General Hospital*, 234 N.W. 2d 411 (1976) (Mich.).
36. *Andrews v. Burke*, 779 P. 2d 740 (1989) (Wash.).
37. *Joiner v. Mitchell County Hospital Authority*, 189 S.E. 2d 412 (1972) (Ga.).
38. *Purcell v. Zimbelman*, 500 P. 2d 335 (1972) (Ariz.).
39. *Reynolds v. Mennonite Hospital*, 522 N.E. 2d 827 (1988) (Ill.).
40. *Braden v. St. Francis Hospital*, 714 P. 2d 505 (1985) (Colo.).
41. *Kirk v. Michael Reese Hospital*, 513 N.E. 2d 387 (1987) (Ill.).
42. *Pedroza v. Bryant*, 677 P. 2d 166 (1984) (Wash.).
43. *Kruegar v. St. Joseph's Hospital*, 305 N.W. 2d 18 (1981) (N.D.).
44. *Knier v. Albany Medical Center Hospital*, 500 N.Y.S. 2d 490 (1986) (N.Y.).
45. *Estate of William Behringer, M.D. v. The Medical Center at Princeton, et al.*, 592 A. 2d 1251 (1991) (N.J.).
46. G.A. Reed & S.W. Malone, *Acquired Immunodeficiency Syndrome*, Ch. 13 in *Healthcare Facilities Law* (A.M. Dellinger ed., Little Brown and Company, Boston, 1991).
47. *Thompson v. Nason Hospital*, 591 A. 2d 703 (1991) (Pa.).
48. *Harrell v. Total Health Care, Inc.*, 781 S.W. 2d 58 (1989) (Mo.).
49. *McClellan v. Health Maintenance Organization of Pennsylvania*, 604 A. 2d 1053 (1992) (Pa.).
50. *Robbins v. HIP of New Jersey*, 625 A. 2d 45 (1993) (N.J.).
51. *Sloan v. Metropolitan Health Council, Inc.*, 516 N.E. 2d 1104 (1987) (Ind.).
52. *Schleier v. Kaiser Foundation Health Plan of Mid-Atlantic States*, 876 F. 2d 174 (1989) D.C.
53. *Mitts v. HIP of Greater New York*, 478 N.Y.S. 2d 910 (1984) (N.Y.).
54. *Chase v. Independent Practice Association*, 583 N.E. 2d 251 (1991) (Mass.).
55. *See Boyd v. Albert Einstein Medical Center*, 547 A. 2d 1229 (1988) (Pa.); *Dunn v. Praiss*, 606 A. 2d 862 (1992) (N.J.); *Decker v. Saini*, 88-361768 NH (1991) (Mich.).
56. *Raglin v. HMO Illinois, Inc.*, 595 N.E. 2d 153 (1992) (Ill.).
57. *Williams v. Good Health Plus, Inc.*, 743 S.W. 373 (1987) (Tex.).

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58. *Depenbrok v. Kaiser Foundation Health Plan, Inc.*, 144 Cal. Rptr. 724 (1978) (Cal.).
59. *Wickline v. State of California*, 239 Cal. Rptr. 810 (1986) (Cal.).
60. *Wilson v. Blue Cross of So. California*, 271 Cal. Rptr. 876 (1990) (Cal.).
61. 29 U.S.C.A. §1001-1461.
62. *DeGenova v. Ansel*, 555 A. 2d 147 (1988) (Pa.).
63. W.A. Chittenden III, *Malpractice Liability and Managed Health Care: History and Prognosis*, Tort & Ins. L. J. 451-496 (Spring 1991).
64. See *Darling v. Charleston Community Hospital*, 211 N.E. 2d 253 (1965) (Ill.); *Purcell v. Zembelman*, 500 P. 2d 335 (1992) (Ariz.); *Corleto v. Shore Memorial Hospital*, 350 A. 2d 534 (1975) (N.J.); *Elam v. College Park Hospital*, 183 Cal. Rptr. 156 (1982) (Cal.); *Blanton v. Moses Cone Memorial Hospital*, 354 S.E. 2d 455 (1987) (N.C.).
65. *Harrell v. Total Health Care Inc.*, *supra* note 48.
66. See D. Kinney & M. Wilder, *Medical Standard Setting in the Current Malpractice Environment: Problems and Possibilities*, 22 U.C. Davis L. Rev. 421 (1989).
67. *Lancaster v. Kaiser Foundation Health Plan*, 958 F. Supp. 1137 (1997) (Va.).
68. *Jones v. Chicago HMO Ltd. of Illinois*, 730 N.E. 2d 1119 (2000) (Ill.).
69. *Williams v. Health America*, 535 N.E. 2d 717 (1987) (Ohio).
70. *Boyd v. Albert Einstein Medical Center*, *supra* note 55.
71. Ch. 621 Florida Stat. (1991).
72. Ch. 621.07 Florida Stat. (1991).
73. *We're Associates Co. v. Cohen et al.*, 480 N.E. 2d 357 (1985) (N.Y.).
74. *South High Dev. Ltd. v. Weiner et al.*, 445 N.E. 2d 1106 (1983) (Ohio).