LITIGATION
COMMENTARY
& REVIEW

EJOURNAL INFORMATION, NEWS & EVENTS

Cathleen Rebar & M. Penchansky-July 2011

Possible Ways of Offsetting Liability for Acute Care Facilities in Medical Malpractice Cases in Pennsylvania

Cathleen Kelly Rebar & Marc L. Penchansky

Cite as 4 *Litigation Commentary & Rev. 82 (June/July 2011)*

HUTCHINGS
COURT REPORTERS
World-Class Service Since 1953

If you have been involved in the defense of a medical malpractice case, you know that generally any medical provider who was involved in the care of a patient is named as a defendant, including any hospitals at which the Plaintiff may have received treatment. Of all the parties, the hospital has the hardest job defending the case, as it is potentially on the hook for virtually all negligence which occurs within its four walls because of the principle of vicarious liability, which includes the standard notions of agency and also the broader theory of ostensible agency. As an actual employer, a hospital would be liable for any acts of negligence committed by its actual agents in the course and scope of the agency agreement. However, a hospital is generally not liable for torts committed by an independent contractor in its employ. *See Capan v. Divine Providence Hosp.*, 287 Pa. Super. 364, 367, 430 A.2d 647, 648 (1980) (quoting *McDonough v. US Steel Corp.*, 228 Pa. Super. 268, 324 (1974)). Pennsylvania courts have recognized an exception to this general rule where there is evidence that the physician is the ostensible or apparent agent of the hospital. *See Capan*, 287 Pa. Super. at 452, 430 A.2d at 648. In short, a physician who is an independent contractor can be considered an ostensible agent of a hospital if (1) the patient looks to the hospital for care; and (2) the hospital holds the doctor out as its employee. *See Simmons v. St. Claire Hosp.*, 332 Pa. Super. 444, 452, 481 A.2d 870, 874 (1984).

In the first instance, ostensible agency is most easily found in the emergency room setting, because the patient goes to the emergency room for treatment by the hospital and not for care by a specific physician. *See Stipp v. Kim*, 874 F. Supp. 663, 665 (E.D. Pa. 1995). However, ostensible agency has been extended to other physicians practicing within the hospital. *See Goldberg ex rel. Goldberg v. Isdaner*, 780 A.2d 654, 660 (Pa. Super. 2001). In the second instance, ostensible agency can also be found where "the hospital acts or omits to act in some way which leads the patient to reasonably believe they are being treated by the hospital or one of its employees." *Capan*, 287 Pa. Super. at 370, 430 A.2d at 649; *see Yacoub v. Lehigh Valley Medical Associates P.C.*, 805 A.2d 579, 591 (Pa. Super., 2002); *Parker v. Freilich*, 803 A.2d 738, 747 (Pa. Super., 2002). The General Assembly codified this doctrine in the Medical Care Availability and Reduction in Error (MCARE) Act.[1] 40 P.S. §1303.516.

Because the hospital risks potential liability for any medical provider that the Plaintiff reasonably believes was an agent of the hospital, it is important that the hospital evaluate closely all possible means of offsetting its potential liability. This article provides an overview of some avenues a hospital may want to explore to reduce its exposure for the negligence of others. Those avenues include: joining as a defendant all agents and/or alleged ostensible agents as defendants; joining as a defendant anyone who could be viewed an actual employer of the alleged negligent actor; and reviewing closely all contractual agreements which permitted the alleged negligent physician's practice at the hospital for defense and indemnity clauses and/or additional insured status.

Vicarious liability permits recovery from a principal/employer for the negligence of its agent/employee to prevent an injured plaintiff from being uncompensated. *See Milton S. Hershey Medical Center*, 573 Pa. 74, 85, 821 A.2d 1205, 1212 (2003). Significantly, the insurance of the vicariously liable principle will not be exposed where the primarily liable physician has sufficient coverage to satisfy the loss. *Id.* at 573 Pa. at 80-81; 821 A.2d at 1209-1210. It is not required that the Plaintiff name the primarily liable physician as a defendant in order to recover from the vicariously liable principle/hospital. *See Mamalis v. Atlas Van Lines, Inc.*, 364 Pa. Super. 360, 365, 528 A. 2d 198, 200 (1987) ("[T]he law gives the right of election, the party may sue either master or servant . . .").

If the primarily liable physician is not a defendant, the vicariously liable hospital will be responsible to satisfy the entire verdict stemming from the negligence of that physician. To combat this, a hospital can permissibly join the alleged negligent physician within 60 days of service of the Complaint. *See* Pa.R.C.P. 2253(a)(1). After 60 days, a hospital can join the alleged negligent physician only with leave of Court or with the agreement of the parties and court approval. *See* Pa.R.C.P. 2253(a)(2). It is almost always the case that the alleged negligent physician has a minimum of $500,000 in insurance coverage plus an additional $500,000 of MCARE coverage that would be available to satisfy an adverse verdict before any hospital funds would be contributed. 2011 MCARE Assessment Manual at p. 4 (2011).[2] By not joining the alleged negligent physician as a defendant, the hospital is sacrificing that $1,000,000 that would precede its obligated contribution to a verdict.

Of course, the hospital would have indemnity rights following an adverse verdict, but there are many factors that complicate a hospital's ability to seek indemnity. Importantly, MCARE coverage is not available to satisfy a subsequent indemnity action. *See Bender v. Pennsylvania Ins. Dep.*, 893 A.2d 161, 162 - 164 (Pa.Cmwlth., 2006).[3] Accordingly, at a minimum, the hospital would be depriving itself of the physician's available $500,000 from MCARE, if it did not join the physician in the same case in which the hospital was a defendant.

Where there are multiple alleged primarily liable physician agents it is important to request special jury verdict interrogatories which require the jury to specifically indicate whether each actor was negligent, whether each actor was an agent, and also to apportion percentages of fault to these actors regardless of whether they have been named as defendants. Without these findings the hospital will have no way of demonstrating in a subsequent indemnity case the amount of liability it bore as a result of each specific actor's negligence.[4] Additionally, unless the hospital provides the alleged negligent physician with definite, direct and certain notice of its intention to seek indemnity from him in the event of an adverse outcome as well as an

opportunity to defend himself in the underlying case, it is likely the hospital will need to prove the physician's liability in a subsequent trial in the indemnity action. *See Orth v. Consumers' Gas Co.*, 280 Pa. 118, 121-122, 124 A. 296, 297 (Pa. 1924). This could possibly create an inconsistent outcome. Specifically, a jury hearing the indemnity action could conclude that the physician, upon whose negligence the original jury found the hospital liable, was in fact not negligent. In other words, the hospital would not recover its loss.

Another avenue that should be explored by the hospital to potentially offset its responsibility to satisfy a jury verdict or settlement is to look for other possible principles/masters/employers of the alleged negligent actor. If the alleged negligence occurred during a surgery setting and the alleged negligent actor is a nurse, the hospital can pursue a "captain of the ship" theory of liability arguing that a surgeon overseeing the surgery was in control of the nurse at the time of the alleged negligence and therefore he was the nurse's master at the time and not the hospital. *See Tiburzio-Kelly v. Montgomery*, 452 Pa. Super. 158, 187, 681 A.2d 757, 772 (1996), *abrogated by statute on other grounds*, 23 Pa.C.S. §1901(a).

Additionally, there can be dual masters for any given agent. For example, if a physician is actually employed with a physician group and that physician group receives payment for the physician's services at that hospital, the hospital can argue that the physician group is the physician's actual principle and/or master and not the hospital. Or, if not the exclusive principle/master to the physician, the physician group could be a dual master. In that case, both the hospital and the actual employer could be equally responsible to satisfy a verdict for the physician's negligence. *See Pratt v. Stein*, 298 Pa. Super. 92, 142-147, 444 A.2d 674, 700 – 703 (1982). Dual masters could also be found where a physician is controlling the care provided by nurses and/or resident physicians. The key aspect of finding either a physician group or physician as a dual master of the primarily liable actor is to establish that the group or the physician had the right to control the work that was being performed that gave rise to the alleged negligence. *See id.*

Further, if the primarily liable physician was providing services at the hospital pursuant to a contract between the hospital and the physician's actual employer/physician group, the hospital can argue that the employer of the physician/physician group is the actual agent and the physician is a subagent. According to the Restatement (Second) of Agency § 5, a subagent is "a person appointed by an agent empowered to do so, to perform functions undertaken by the agent for the principal, but for whose conduct the agent agrees with the principal to be primarily responsible."[5] As explained in Comment F to § 5 of the Restatement (Second) of Agency, "[a] subservant committing a tort in the scope of employment subjects both his employer and the latter's master to liability, his employer having a right of indemnity against him and a duty of indemnity in favor of the master of both of them." This language encompasses the concept that the hospital is third in line in terms of triggering its coverage since its obligation would not be triggered until the coverage of the subagent physician and the coverage of the actual employer/physician group were first exhausted. Joinder of the actual employer/physician group as well as the alleged negligent physician should be explored.

All contractual relationships existing between the hospital and any entity which permitted the services at issue to occur within the hospital's four walls should be reviewed carefully for any and all provisions which could require another to either insure, defend and/or indemnify the hospital for the alleged negligence. For example, if the physician is an employee of a group which contracted with the hospital to provide certain services and those services are at issue the agreement could specifically assign responsibility for the loss to the physician group via a specific indemnity clause. If the indemnity provision expresses in clear and unequivocal terms that the group will indemnify the hospital for all claims of negligence of the group's employees, the hospital could have a basis to request the group to not only indemnify it in the event of an adverse verdict, but also to assume the hospital's defense against the allegations. If the group refuses, the hospital would assert its rights through a contractual indemnity claim and if successful could recover all of its defense costs for the underlying action.[6] *See Boiler Engineering & Supply Co. v. General Controls, Inc.*, 443 Pa. 44, 47, 277 A.2d 812, 814 (1971).

Also, many agreements between the hospital and physician groups not only require the group to obtain insurance to cover negligence claims arising out of its services but also require the group to name the hospital as an additional insured on its insurance policy. The hospital's status as an additional insured would provide the hospital coverage for the claim regardless of whether the primarily liable physician or the group were named as defendants in the Plaintiff's action. Because many of these policies are claims made rather than occurrence based, it is imperative that the hospital obtain a copy of the actual policy and comply strictly with all notice provisions to the carrier. Notice is generally required within a short time frame from notice to the hospital of the lawsuit. Failure to provide timely and appropriate notice could waive the hospital's rights to this coverage. *See Ace American Ins. Co. v. Underwriters at Lloyds and Companies*, 939 A.2d 935 (Pa. Super., 2007), *aff'd*, 601 Pa. 95, 971 A.2d 1121 (2009). Generally, an insurance company must show prejudice when a claimant does not meet the policy's notice requirements. *Brakeman v. Potomac Insurance Co.*, 472 Pa. 66, 76-77, 371 A.2d 193, 198 (1977). However, an insurer need not show prejudice to deny coverage for a claims made policy. *See Ace American*, 939 A.2d at 941.

Since most liability attorneys do not perform coverage analysis, it would be wise to recommend to the client to engage coverage counsel, as the policy will likely contain many provisions that the carrier for the physician group will attempt to assert to place its coverage behind that of the hospital's primary policy. Even if the insurance for the group is required to only cover a portion of the loss, at least you will have succeeded in assisting your client to offset some its loss.

In sum, since hospitals are often left to defend medical malpractice actions based on the actions of many individuals caring for patients in its facilities, the hospital should seek to encompass all possible means of offsetting its potential liability.

Cathleen Kelly Rebar is a partner at Nelson Levine de Luca & Horst. In January 2010, Ms. Kelly Rebar was elected Magisterial District Judge of Collegeville, Trappe, Lower Providence, and parts of Upper Providence where she won both sides of the primary by a four to one margin. Ms. Kelly Rebar is a member of the Premises Liability Committee and the Products Liability Committee on the Council of Litigation Management (CLM). Ms. Kelly Rebar is licensed to practice in all State Courts of Pennsylvania and New Jersey. She is also licensed in the U.S. District Court Eastern District of Pennsylvania, the U.S. District Court for the Northern District of Florida, the Court of Appeals for the Third Circuit, the United States District Court for the District of New Jersey and the United States Supreme Court.

Marc L. Penchansky is an associate at McCumber Daniels and practices in the firm's Philadelphia area office where he concentrates on appellate matters and the defense of the firm's clients. Mr. Penchansky is admitted to practice in

---

[1] This act states, in pertinent part:

Vicarious liability.--A hospital may be held vicariously liable for the acts of another health care provider through principles of ostensible agency only if the evidence shows that:

(1) a reasonably prudent person in the patient's position would be justified in the belief that the care in question was being rendered by the hospital or its agents; or

(2) the care in question was advertised or otherwise represented to the patient as care being

rendered by the hospital or its agents.

40 P.S. §1303.516(a)

[2] The 2011 Assessment Manual is accessible through the website of the Commonwealth of Pennsylvania.

[3] The *Bender* Case concerns a subsequent indemnification action commenced on an extended claim, *i.e.*, a claim filed more than four years after the tort or breach of contract occurred but within the statute of limitations. 40 P.S. § 1303.715(a). The section of MCARE concerning claims pursued less than four years from the alleged culpable act is sufficiently similar to assume that the judiciary will find that MCARE coverage would not be available in a subsequent indemnity action. 40 P.S. § 1303.712(a). Specifically, a subsequent indemnification action is not considered a medical malpractice claim to which MCARE is authorized to cover. 40 P.S. § 1303.103 (defining medical professional liability claim). It is important to note that the *Bender* Court remarked that MCARE was "inadequate legislation" because it required such a result. *Bender*, at 164.

[4] The Court may refuse to permit such interrogatories and there is no case law indicating that such interrogatories are required. However, failing to include such interrogatories guarantees that the hospital will be required to prove every element of liability in a subsequent action. In essence, a full re-trial would have to occur, which could have an inconsistent outcome. The tenets of judicial economy and the principles of indemnity do not support such a result.

[5] The Pennsylvania Supreme Court has adopted several sections of the Restatement of Agency including Section 5. *See*, *Lerman v. Rudolph*, 413 Pa. 555, 558, 198 A.2d 532, 533 (1964); *McKnight v. Peoples-Pittsburgh Trust Co.*, 360 Pa. 290, 293, 61 A.2d 820, 822 (1948); *see also*, *Richardson v. John F. Kennedy Mem'l Hosp.*, 838 F. Supp. 979, 985 n. 7 (1993).

[6] There are specific requirements for notice to the contractual indemnitor before defense fees will be awarded.

© Copyright 2010. All rights reserved.

^ back to top