

ISSUES IN TODAY'S MEDICAL MALPRACTICE LITIGATION EMPLOYEES, AGENTS, AND MORE – CLAIMS OF HOSPITAL LIABILITY FOR PHYSICIAN CONDUCT

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Liability for Employed Physicians

Traditionally, physicians have not been employees of the hospital; rather, they actually have been independent contractors with staff privileges giving them the ability to treat patients at that given facility. Thus, traditional medical malpractice cases have involved claims against a physician for the decisions he or she made relative to the care provided and then against the hospital for care provided by the hospital's employees, i.e., the nursing staff. Recent trends have plaintiffs not only seeking to impose liability against the individual physicians for their own actions but also seeking to impose liability against the hospital for the actions of that physician, especially in cases where the plaintiff cannot arguably support a separate claim against the nursing staff.

The Alabama Medical Liability Act governs all claims for injury or damages against healthcare providers. This includes those claims related to the hiring, training and supervision of individual healthcare providers. *See Ala. Code* § 6-5-551 (1975). Accordingly, hospitals, clinics, medical practices, etc. are all healthcare providers under the Alabama Medical Liability Act; and, therefore, they are considered to be healthcare providers which can be found liable to a plaintiff under a theory of corporate negligence.

Cases involving these issues find the plaintiff alleging that the physician is either a direct or an apparent agent of the hospital. Again, the relationship is far more clear in the issue of care provided by employed nursing staff. However, it becomes more complicated when the issue of agency as to a particular physician is scrutinized.

At the heart of the issue is the right of control. Control over the physician – as the alleged agent – unrelated to the activities giving rise to a particular claim by plaintiff is not a relevant component to an analysis as to the agency issue. Alabama law requires that an alleged principal be able to control the specific conduct of agent. However, Alabama law does not allow a hospital to control a physician's practice of medicine in the care that is provided to patients.

Statistics show in recent years a growing number

of physicians who are directly employed by hospitals. Physicians appear to have become more willing over the last several years to forgo a degree of independence for the stability of a salary-based employment with a corporate entity like a hospital. There are benefits to this arrangement which serve arguably both hospital and physician.

An employed physician seemingly has more complete access to the entire system of healthcare provided at a hospital, including quite simply the business of providing patient care in a hospital setting. This includes matters such as the flow of care, familiarity with the departments which provide the different aspects and levels of care, the chain of command, etc.

Arguably, an employment relationship provides complete access by the physician to the medical record. An employed physician may have more familiarity with patient records, especially with the electronic medical records (EMR). If a physician has more complete access to a medical record, he or she may be able to more efficiently provide and to have access to information about a particular patient's care.

This direct employment relationship appears to give more power to a hospital over a physician as well as more ability to control his or her actions and decisions. Examples of that include more potential control over a physician's patient referrals to specialists. It might also include encouragement for the physician to err on the side of admitting a patient to the hospital rather than not. There could be also be encouragement to refer a patient for a diagnostic procedure if that service is offered at that hospital. If a physician is employed by a hospital, there is an implied argument that physician is limited in how some of those decisions might be made. A savvy plaintiff's attorney might try to show that this relationship and arguably right of control governs, or affects the decisions that are ultimately made by the physicians who treated a particular patient, thus allowing for a "corporate" claim in addition to one solely based on *respondeat superior*.

Even in light of the issues above, Alabama law is clear

that a hospital can employ a physician but cannot control the way that he or she provides medical care. This is specifically set out in *Alabama Administrative Code* Chapter 540-X-9-.06 which states that a physician “must exercise independent judgment in matters related to the practice of medicine, and that physician’s or osteopath’s actions with respect to the practice of medicine shall not be subject to the control of an individual not licensed to practice medicine.” A physician’s ability to diagnose and treat a patient for a medical condition cannot be controlled by a corporate hospital facility that cannot practice medicine itself.

The Administrative Code goes further to state in Chapter 540-X-9-.07(1) that a physician “may not neglect that patient nor fail for any reason to prescribe the full care that patient requires in accord with the standards of acceptable medical practice. Further, it is the Board’s position that it is unethical and unprofessional for a physician to allow financial incentives or contractual ties of any kind to adversely affect his or her medical judgment or practice care.” The Code further provides that patient trust is fundamental to this relationship, and it requires “that there be no conflict of interest between the patient and physician or third-parties.” Chapter 540-X-9-.07(4)(b).

In defending an employing hospital, it is important that hospital witnesses understand that employment of a physician does not equal control over professional activities. Likewise, an employed physician must remember that his or her role is one of physician and not one of hospital administration. While the hospital may be held vicariously liable for an employed physician’s acts or omissions, it is important to maintain the professional distinction to avoid creation of a separate, direct claim against the hospital.

Other Traditional Concepts of Liability

Again, presuming that juries will more likely return a verdict against a hospital than a local physician, or in search of a “deep pocket,” attorneys representing injured patients have sought to hold hospitals vicariously liable for the actions of independent physicians and affiliated providers such as nurse anesthetists and nurse practitioners in addition to employed providers. In the case of independent providers, liability is often sought alleging that the providers are the direct or apparent agents of the hospital. As alluded to above, the general test for direct agency is retention of the right to control

the method and manner in which the purported agent practices. Alabama courts have addressed various factors which may be suggestive of the retained right to control. Even absent this relationship, vicarious liability is frequently sought by alleging that the physician or other provider is the “apparent” or “ostensible” agent of the hospital. Otherwise known as agency by estoppel, this theory of liability is premised upon a belief by the patient that medical services are being rendered by one having authority to act on behalf of the hospital.

Another theory seeking hospital liability is the doctrine of corporate negligence. First, this claim differs from the above as it is premised upon the actions of the hospital as opposed to the physician or provider alleged to be the agent of the hospital. Generally, these claims involve alleged failure to appropriately select or credential physicians, to appropriately supervise staff physicians, or to establish rules and procedures. Many states have adopted this theory of liability which, naturally, is dependent upon an underlying finding of negligence on the part of the physician or advanced practice nurse.

A number of states have also applied a non-delegable duty doctrine. This theory of liability is generally predicated upon the notion that certain duties are so important to the public that responsibility may not be shifted to another. Application of this concept requires liability on the part of a hospital as the facility may not avoid liability by delegation of the responsibility or activity to an independent contractor. Such duties are frequently codified in state statutes or regulations.

Reliance Upon Regulatory Provisions In Attempting to Establish a Non-Delegable Duty or Agency

In seeking to establish hospital liability, some plaintiff attorneys have sought to expand the concept of a non-delegable duty through application of provisions included in the Medicare “Conditions for Participation for Hospitals.” (482.1 et. seq. of Title 42 of the Code of Federal Regulations). Specifically, these regulations require that “[t]he hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution.” 42 C.F.R. § 482.12. As regards the medical staff, the governing body is obligated to determine which candidates are eligible for appointment, appoint medical staff members, confirm that the medical staff has bylaws, as well as approval of those bylaws, and to “[e]nsure that the medical staff is

accountable to the governing body for quality of care provided to patients.” 42 C.F.R. § 482.12(a)(1)-(5). Regarding contracted services, the “governing body must be responsible for the services furnished in the hospital whether or not they are furnished under contracts.” 42 C.F.R. § 482.12(e). In doing so, the “governing body must ensure that the services performed under a contract are provided in a safe and effective manner.” 42 C.F.R. § 482.12(e)(1).

Plaintiffs may argue that the above regulations provide that the ultimate responsibility for medical care in a hospital is the obligation of the governing body no matter if the care was provided by a staff physician or independent contractor. However, these regulatory provisions fail to include any language providing a private right of action to a patient. The section defining the scope of the provision provides that “the provisions of this part serve as the basis of survey activities and for the purpose of determining whether a hospital qualifies for a provider agreement under Medicare and Medicaid.” 42 C.F.R. 482.1(b). In other words, these regulations are merely intended to set out guidelines for whether a hospital may, or may not, participate in Medicare or Medicaid. In doing so, the regulations confirm the minimum requirements for hospitals to participate in these programs. *Id.* They do not create non-delegable duties owed by hospitals to a patient to ensure non-negligent care. As one commentator has concluded, “[a] non-delegable duty claim under 42 C.F.R. 482.1 is simply not supported by existing law.” See Edward J. Carbone, “Hospitals and the Non-Delegable Duty of Care,” *Trial Advocate Quarterly* (Winter, 2009).

Courts from a number of jurisdictions have found that these regulations do not create a non-delegable duty or a private cause of action. For example, in *Sepulveda v. Stiff*, 2006 WL 3314530 (E.D. Va. 2006), the plaintiff brought a medical malpractice claim against the hospital asserting that the facility owed him a non-delegable duty pursuant to 42 C.F.R. § 482. Specifically, the plaintiff asserted that the regulations providing the requirements for participation created a “contractually non-delegable duty,” thereby rendering the hospital liable to the plaintiff. In rejecting the plaintiff’s argument, the *Sepulveda* Court found that the plaintiff was attempting “to circumvent the long-established rule in Virginia that vicarious liability cannot be attributed to independent contractors, except in special circumstances.” *Sepulveda*, 2006

WL 3314530, *7. Further, the court determined that neither the explicit text of the Act, nor its implications, created a private right of action for medical liability plaintiffs. Rather, the regulations “are merely intended to set out the guidelines for determining whether a hospital may participate in Medicaid or Medicare; indeed, that is its stated purpose.” *Id.* at *8.

Similarly, in *Burns v. St. Edward Mercy Medical Center*, 2005 WL 5582062 (Ark. Cir. 2005), the plaintiffs in a medical malpractice action claimed that, pursuant to these federal regulations, the defendant hospital owed a “duty to ensure” that its contracted services were conducted properly. The court concluded, however, that the regulations “were not intended to preempt or supplant state law in the medical malpractice arena.” *Burns*, 2005 WL 5582062. The court further noted the defendant’s persuasive argument that application of the regulations as suggested by the plaintiff would have, in effect, made the hospital the insurer for the acts and omissions of the physician. Such a claim was also rejected in *Blackmon v. Tenet Healthsystem Spalding, Inc.*, 653 S.E.2d 333, 340 (Ga. 2007), *reversed on other grounds*, 667 S.E.2d 348 (Ga. 2008). In doing so, the court stated:

Blackmon argues that in its summary judgment order, the trial court erroneously refuses to recognize as a basis for liability the Medicare regulations, which require that hospitals, to be eligible to participate in Medicare, comply with the following: [T]he governing body [of the hospital] must be responsible for services furnished in the hospital whether or not they are furnished under contracts The governing body must ensure that the services performed under a contract are provided in a safe and effective manner.” 42 C.F.R. § 482.12(e). Blackmon, however, misreads this regulation. It does not purport to impose state tort liability on hospitals for the negligence of their independent contractor; rather, it simply outlines with which the hospitals must comply to receive Medicare. This state tort case is not about whether Tenet’s hospital is complying with all necessary regulations so as to be eligible for Medicare reimbursement; rather, it is about whether under the detailed strictures of Georgia law concerning agency and the particular facts of this case, the hospital is liable for the actions of Dr. Webb. The

two issues are wholly different and do not intersect for the purposes of determining liability in this case.

Blackmon, 653 S.E.2d 340.

The *Blackmon* Court, in analyzing the “Conditions for Participation,” addressed the second purported legal use of these provisions. As indicated above, plaintiffs have argued that these federal regulations create a non-delegable duty. However, a second argument is, while legally illogical, the existence of the non-delegable duty makes a physician or other provider the agent of the hospital. In other words, plaintiffs may argue that the responsibility placed upon the governing board carries with it the authority to “control” so as to create a direct agency relationship between the hospital and medical staff members and independent contractors. This argument was rejected in *Blackmon* and in *Dunn v. Atlantic Surgical Associates, LLC*, 2007 WL 1784093 (Del. Super. 2007) wherein the court addressed the issue as follows:

The plaintiffs additionally claim that by admitting that they participate in the Medicare Program, Bayhealth Medical Center acknowledges their responsibility and control over the defendant doctors pursuant to 42 C.F.R. § 482.12(e), which states that “the governing body must be responsible for services furnished in the hospital, whether or not they are furnished under contract.” Mere participation by a hospital in the federally mandated Medicare Program is insufficient to show the control necessary to establish an actual agency relationship. To accept the inverse proposition, that participation by a Hospital in the Medicare Program establishes the control necessary to create an actual agency relationship, would require a finding that every independent contractor practicing in that Hospital is a servant/agent of that Hospital. The Court is unwilling to so find.

Dunn, 2007 WL 1784093, *2.

In August of 2016, the Florida Court of Appeal, Second District, likewise rejected such a claim. *Godwin v. University of South Florida Board of Trustees*, 2016 Fla. App. LEXIS 12729. Specifically, the Court stated:

The rule [42 C.F.R. § 482.12(e)] does not create liability for the hospital due to the negligence of any independent contractor. Instead, the rule and the discussion and responses to public comments explain that the services that a contractor furnishes to a hospital will be part of the quality assurance evaluation for the hospital’s continued participation in the Medicare program. The rule does not purport to diminish or preempt state laws dealing with the traditional common law theories of principal/agent and independent contractors.

Godwin, 2016 LEXIS 12729, *16-17.

Finally, in rejecting the notion of a non-delegable duty in general, one court found neither the federal regulations nor accreditation provisions from the then named Joint Commission on the Accreditation of Health Care Organizations supported such a legal duty. In *Dunn v. Chen*, 2010 WL 5610866. (Sup. Ct. Conn. 2010), the court rejected such a claim granting a motion to strike the vicarious liability allegation of the patient.

Similarly, plaintiffs have argued that Alabama regulations create such a non-delegable duty. For example, *Alabama Administrative Code* Chapter 420-5-7-.04(1) provides that hospitals “shall have an effective governing authority that is legally responsible for the conduct of the hospital as an institution.” Likewise, *Alabama Administrative Code* Chapter 420-5-7-.04(5) provides:

Contracted Services. The governing authority shall be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing authority shall ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to maintain compliance with the requirements of these rules.

- The governing authority shall ensure that the services performed under a contractor are provided in a safe and effective manner.

These regulations are substantively identical to the federal regulations described above. As such, the same rationale should be applicable.

Moreover, medical malpractice actions in Alabama are

governed by the Alabama Medical Liability Act. Such provides for one action against healthcare providers for alleged breached of the standard of care. *Ala. Code* § 6-5-551 (1975). While the Alabama Legislature has authorized the State Board of Health to issue rules and regulations, the Board “shall not have the power to promulgate any regulation in conflict with law . . .” *Ala. Code* § 22-21-28 (1975). Thus, hospitals and similar providers have an argument the assertion that such regulations create a non-delegable duty is tantamount to the creation of a new, prohibited cause of action against those providers. Viewed otherwise, the Board does not have authority to, in essence, create a cause of action distinct from the AMLA

On February 10, 2017, the Supreme Court of Alabama released an important opinion addressing the above issues. In *Bain v. Colbert Cnty.* Northwest Ala. Healthcare Auth., 2017 Ala. LEXIS 9, the Supreme Court of Alabama addressed a claim that the hospital should be held vicariously liable for the alleged acts and omissions of an emergency room physician. In rejecting plaintiff’s claim, the Court found that the state and federal regulations referenced above did not create a non-delegable duty on hospitals “to provide emergency medical physician services that fall within the applicable standard of care”. *Id.**51.

Importantly, the Bain Court also addressed plaintiff’s claim that the emergency room physician was the apparent agent of the hospital. In rebuffing this claim, the Court, focused on the rarely addressed element of reliance in connection with a claim of apparent authority. In doing so, the Court further found that the plaintiff’s burden of proof is not met by failure of the principal (in this case a hospital) to give notice of the status of independent contractors. Bain is must reading for attorneys representing hospitals. .

Practical Considerations

In addressing such claims, aside from the above legal analysis, several practical issues come into play. First, when faced with such an allegation one should determine whether or not the allegedly injured patient was a Medicare or Medicaid recipient. Arguably, in no case would such a duty or relationship come into play if the patient was not a Medicare/Medicaid patient. Also, many hospitals utilize consent forms in which the patient acknowledges that physicians and other similar providers are not the employees or agents of the hospital.

While such have an obvious effect on an allegation of apparent agency, the hospital may also argue that the form presents a consent for the hospital to delegate the involved service. Finally, hospital witnesses should be made aware of these provisions before depositions so that they have a full understanding of the nature and purpose of the regulations.

Alleged Role of The Joint Commission

Claims of the existence of a duty or principal and agent relationship have also been premised upon requirements of The Joint Commission. Standards promulgated by TJC contain language and obligations similar to the Medicare “Conditions for Participation.” The governing body requirements, and its relationship to the medical staff, are similarly addressed. For example, the Hospital Accreditation Standards provide that “[t]he hospital’s governing body has the ultimate authority and responsibility for the oversight and delivery of health care rendered by licensed independent practitioners....” (2014 *HAS*, January). Yet weakening the argument that a non-delegable duty is created is that The Joint Commission is a “completely private entity.” *See e.g. Slavcoff v. Harrisburg Polyclinic Hospital*, 375 F. Supp. 999, 1004 (M.D. Penn. 1974). Participation in Joint Commission accreditation is voluntary. Likewise, a voluntary standard should not establish a legal duty. *See, e.g. Florida Fuels, Inc. v. Citgo Petroleum Corp.*, 6 F.3d 330 (5th Cir. 1993) (“nonetheless, although custom may be considered as evidence bearing on the question of negligence once a duty is found to exist, custom itself does not create the duty.”); *De Kwiatkowski v. Bear, Stearnes & Co., Inc.*, 306 F.3d 1293 (2nd Cir. 2002) (“As a policy matter, it makes no sense to discourage the adoption of higher standards than the law requires by treating them as predicates for liability. Courts therefore have sensibly declined to infer legal duties from internal ‘house rules’ or industry norms that advocate greater vigilance than otherwise required by the law”). Nevertheless, attorneys defending hospitals must be aware that such standards may be used as evidence of the standard of care or the reasonableness of efforts to meet legal duties. *See, e.g. Pederson v. Dumouchel*, 431 P.2d 973, 979 (Wash. 1967); *Pedroza v. Bryant*, 677 P.2d 166 (Wash. 1984).

Additional Practical Thoughts

Again, practical advice needs to be provided to hospital employees who are to be submitted for deposition and

who may be questioned about the relationship of the hospital and physicians as well as other providers. Just as these witnesses must know the nature and purpose of the “Conditions for Participation,” they need to remember that accreditation standards are voluntary and provide, for example, that the medical staff is an independent, self-governing body which may be distinguished from the governing body, as the medical staff is made up of licensed practitioners. An argument can be made that the medical staff necessarily has the authority over physician services as non-licensed administrators and are in no position to “police” physician care.

The role of the medical staff must also be addressed with potential witnesses so as to avoid unintended acknowledgement of control. Counsel for the plaintiff may use either, or both, the federal regulations or Joint Commission standards to try to establish the authority of the governing body combined with the medical staff bylaws fair hearing procedure in an effort to seek an admission that the hospital may punish or remove a physician who fails to comply with hospital procedures or meet care requirements, therefore evidencing “control.” Careful review of the bylaws is required to allow the witness to definitively show the medical staff’s exclusive position in assessing the clinical care provided by other licensed providers. Indeed, one may maintain that seeking to effectively provide medical care via a non-delegable duty making it responsible for physician actions is the same as asking the hospital to practice medicine. In other words, a hospital cannot have authority to require that a physician undertake a particular course of care or treatment since a hospital and its non-physician employees may not practice medicine. *Ala. Code* § 34-24-51 (1975).

I’m Hired to Diligently Defend My Healthcare Provider Client – Why Would I Admit Liability?

Admitting Liability in a Medical Malpractice Case

Does admitting liability in a medical malpractice case help or hurt a defendant in front of a jury? Under the Alabama Medical Liability Act, the Plaintiff must prove that there has been a breach of the standard of care by the involved healthcare provider or providers. Furthermore, the alleged breach of the standard of care by the healthcare provider must be the proximate cause of the injury. Plaintiff is required to prove that the alleged acts or omissions probably, not possibly, caused the injury. *Williams v.*

Springhill Memorial Hospital, 646 So. 2d 1373 (Ala. 1994). With such a high burden, why would a healthcare provider want to admit liability? One reason may be that liability is so obvious that not admitting liability would cause a jury to become angry about wasting time instead of just determining damages. From a litigator’s standpoint, this can be a daunting task because there is no exhilaration in obtaining a defense verdict but, instead, the issue is simply how bad will you be beaten.

Generally, when a healthcare provider admits liability, he or she is admitting only that he or she caused the accident, but not necessarily that the accident caused the injuries being claimed by the plaintiff. Plaintiffs would still bear the burden of proving that all injuries they claim were caused by the accident. This is where the healthcare provider gains an advantage. In many cases the plaintiff is so focused on the liability portion that causation is not given its due attention. Is the plaintiff claiming that every ailment is the result of the negligence of the health care provider? This may be termed the “ingrown toenail syndrome.” Take for example, a medication error case. The physician ordered 30 mg “qd” (once daily) and instead it was dispensed at “qid” (four times daily) resulting in a near fatal overdose. The patient files suit claiming permanent damages from the overdose including the ingrown toenail he has been suffering from for years. Such may result in a loss of that most important trial component – credibility.

It is the healthcare provider who goes to trial on an admitted liability case who gains credibility with the jury. There are cases where there is no dispute about the medical negligence, but there is simply a dispute about the amount of damages. The honesty a defendant shows in admitting liability can persuade jurors to believe that the plaintiff forced a trial due to an overinflated damages claim and simple greed. After all, isn’t the healthcare provider being reasonable when it admits that it was at fault? Why would it be unreasonable when it came to causation or damages? Even in a case where the healthcare provider has no choice but to admit liability, a jury will probably still give it credit for doing so. On the other hand, a defendant that denies liability when such is clear can anger a jury enough to award more damages than a plaintiff hoped for. A defendant that admits liability not only diffuses that risk, but also paints itself as being reasonable and fair. Again, if a jury thinks that the healthcare provider is reasonable and fair, it may blame the plaintiff for forcing a trial.

Discovery is still important in a damages-only case. Just like the plaintiff may “forget” that causation is still an element to prove, the healthcare provider attorney has to redefine what a win means and not go down the path of “why bother” and fail to engage in discovery. Do the medical records show that the patient would not follow the physician’s advice in mitigating his/her damages? A jury may award damages for past medical expenses but refuse to award damages for pain and suffering because the plaintiff has done nothing to alleviate those symptoms. How is the plaintiff’s demeanor at trial? During direct examination does she become emotional when describing her ordeal and what she has caused to suffer as the result of the healthcare provider’s mistake? But during cross examination does her demeanor change? Does she become aloof, refuse eye contact, etc. even when defense counsel is asking fair and reasonable questions? A jury will pick up on those nuances and as long as the health care provider maintained its credibility in trying to do the right thing, the provider will be “rewarded.” In other words, diligent preparation is still required even when the defense lawyer feels he or she is “giving up.”

Admitting liability is hard. It goes against everything one is taught as a litigator. But this truism that we heard from our parents applies; tell me the truth now and face the consequences, or not and face far worse consequences later. Admit liability when it is the right call and a jury will “reward” you for your candor.

Even Worse – Why Would I Prove My Client Does It Differently Now?

Subsequent Remedial Measures

The general rule excluding evidence of subsequent remedial measures is that evidence of repairs or alternations made, or precautions taken, by an individual and/or corporation after an injury or/and an accident are not admissible as tending to show the antecedent negligence or culpable conduct. Specifically, Rule 407 of the Alabama Rules of Evidence provides:

When, after an event, measures are taken which, if taken previously, would have made the event less like to occur, evidence of the subsequent measures is not admissible to prove negligence or culpable conduct in connection with the event....

This rule does not require the exclusion of evidence of subsequent measures when offered for another purpose, such as proving ownership, control, or feasibility of

precautionary measures, if controverted, or impeached. However, one may want to prove subsequent remedial measures to show changes have been made to prevent the event from happening again, i.e. you’ve learned your lesson. Courts have found evidence showing that if the subsequent remedial change made the condition safer, then such subsequent change could not be used to prove that the condition was unsafe before. See example, *Peoples v. CSX Transp.*, 681 So. 2d 1388 (Ala. 1996). In *Peoples*, plaintiff attempted to admit photographs taken after an accident at a railroad crossing. Plaintiff contended that the photos showed maintenance of the vegetation and the paint markings at the crossing. The defendant contended the photos showed the changes made at the crossing and the photos did not depict the scene as it was at the time of the accident. The trial court excluded the photos and this decision was upheld on appeal.

Three distinct public policy grounds support the subsequent remedial measure rule. The first is that subsequent remedial measures are irrelevant to proving negligence, culpable conduct or product defect. The second is a social policy consideration encouraging individuals, companies, and other entities to take remedial measures to prevent further injuries. Admitting such evidence in court will dissuade parties from making the improvements in the first place if those changes will later be used against them. For healthcare providers, one would not be encouraged to make advances in medicine if such advances could be used to demonstrate negligence later in civil litigation. See *Ex parte Krothapalli*, 762 So. 2d 836, 839 (Ala. 2000).

However, what if the medical care provider wants to show that a subsequent remedial measure has been taken? Can a medical care provider defendant show to the jury that changes have been made or is “what’s good for the goose is good for the gander?” As indicated above there are exceptions to Rule 407 of not allowing evidence of subsequent remedial measures. The Alabama Supreme Court has “established a three factor test for the admissibility of evidence of subsequent remedial measures offered for ‘another purpose’”: ... (1) whether the ‘other purposes’ are material; ... (2) whether they are relevant...; and (3) whether the probative value of the evidence is substantially outweighed by its prejudicial effect....” *Phar-Mor, Inc. v. Goff*, 594 So.2d 1213 (Ala. 1992) quoting *Holland v. First National Bank of Brewton*, 519 So.2d 460,462 (Ala. 1987).

In certain instances, a subsequent remedial measure

would be relevant and material, such as if the Plaintiff has requested punitive damages. The jury's basis for awarding punitive damages and the amount of punitive damage award includes: "... to protect the public by deterring or discouraging the defendant and others from doing the same or similar wrongs in the future." See Alabama Pattern Jury Instructions Civ. 3rd 11.03. *Green Oil Co. v. Hornsby*, 539 So. 2d 218 (Ala. 1989) confirms that one factor in a punitive award is deterrence of future similar conduct. How is one able to show that this future conduct will not occur again if they cannot show what changes have been made? Excluding evidence of later changes would be prejudicial to the party defendant which made such changes.

The fact that a healthcare provider has already taken affirmative steps by changing its policies is clearly relevant to the "deterrence" element of the plaintiff's claim for punitive damages. For example, consider a claim made against a healthcare provider that a specimen was mislabeled and the specimen was mixed up with another patient's specimen yet the provider had no protocol for managing such specimen. As a result, the patient's specimen was misdiagnosed. Shouldn't the provider be allowed to show the jury that a protocol has been put in place following this incident so that this alleged event doesn't occur again and the jury may consider not awarding punitive damages? There would be no reason to deter future conduct because the hospital has made a change and, therefore, at least one of the considerations when deliberating punitive damages can be taken out of the equation. The Alabama Supreme Court has consistently held that in a punitive damage case where the defendant changed its conduct, such evidence may be admissible. In *Macon County Comm'n v. Sanders*, 555 So. 2d 1054 (Ala. 1990), the Court noted that "subsequent remedial measures" are not admissible to show negligence, but the defendant's subsequent conduct was admissible on the claim of wanton conduct. The Supreme Court stated:

Plaintiff was not offering the evidence to show Defendants' prior negligence, but rather, to show that the Defendants did not intend to improve the safety of the road and thus that their conduct was wanton.

554 So. 2d 1058.

Even in a case involving a claim for compensatory and

punitive damages, the healthcare provider may certainly want to take this step of showing that the conduct which allegedly caused the injury has been changed. Again, not to show that there was negligence but to show that the conduct was not intentional or wanton. Obviously such proof generally goes hand-in-hand with admitting liability or that an error was made. In post-judgment *Hammond/Green Oil* hearings, the Alabama Supreme Court has found that a company's lack of intention to improve the safety or has failed to take remedial steps to prevent similar injuries is relevant with regard to punitive damages. See *Shiv-Ram, Inc. v. McCaleb*, 892 So. 2d 299, 318 citing *Macon County Comm'n v. Sanders*, 555 So. 2d 1054, 1057-58 (Ala. 1990). Furthermore, when arguing that subsequent remedial measures should be allowed, one can argue that Rule 407 of the Alabama Rules of Evidence does not apply since the rule only prohibits the evidence from being used to "prove negligence, culpable conduct, a defect in a product, a defense in its product design, or a need for a warning or instruction." Here, evidence of a subsequent remedial measure is being offered for "another purpose," i.e. to show that punitive damages would not be applicable.

Where is My Paper Medical Record?

Electronic Medical Record and Emergent Issues

Federal requirements that healthcare providers maintain an electronic medical record of care provided to a patient have led to ramifications that exceed just the sheer cost of the implementation of same. The mechanics alone of the physical transformation of a medical chart from a piece of paper upon which someone uses a pen to record patient care to a computer that employs drop down boxes, electronic tabs, auto-populate, and such commands as cut, paste, delete, and save have been, and will likely continue to be, fraught with pitfalls and learning curves. With the advent of the EMR, several issues have evolved which present a struggle for the lawyer defending the healthcare provider and the EMR, and an effective tool for plaintiff's counsel in pursuing a claim for medical negligence.

First, the amount of information which is stored electronically can be vastly different and more complex than the old days of an indexed manila folder which was home to hard copies of nurses' notes, physicians' orders, lab results and the like. So what happens when a provider hits print on a patient's medical chart? Is

all the information relative to the care provided to that patient printed in one single document? Can your client select certain information which is printed if the medical chart is produced in hard copy form? Has some information – but not all – already been provided to the patient or his or her attorney if requested? Does the EMR default to print automatically all information contained in the system or do certain parameters have to be set by the requestor? Does the system mandate that a healthcare provider (nurse or physician) who is entering information relative to care in the form of a note close it out in order to affix it with an electronic signature? If that provider does not close that note if so mandated by the system, does the sheer production of the chart into a paper form change any dates of care provided to the date it was actually printed? These are questions that defense counsel must now address in addition to the issues of liability, causation, and damages.

When an EMR is printed for review and hard copy, it is generally printed in a different format than seen on the actual computer screen and seen by individual providers on a daily basis. It is also important to understand who exactly printed the EMR for review by defense counsel or production to a patient and/or that patient's attorney. A growing trend finds corporate health care providers contracting with third parties for production of the EMR in response to a HIPAA request for that information. Therefore, it may well be that an employee of a third party vendor actually reproduced the medical chart rather than an employee of that provider. That makes it even more difficult to determine what exactly was selected for inclusion in the EMR and whether the entire medical record has been reproduced.

Furthermore, if a nurse who is reviewing a printout of the EMR reflecting care he or she provided to a patient, the printed record might not contain in that form all information available to that particular nurse when the care was originally provided. The way it appears on the screen may be different as well as the prompts that are given to the provider when information is being put into the system as to that patient. It is important to address such when interviewing nurses and hospital staff and certainly when providing them for a deposition or other testimony.

This issue of the actual appearance of the information ties into the use of templates in a record which can reflect matters such as daily or hourly nursing assessments, patient conditions, symptoms, etc. It is common for

templates in a hospital record reflecting this information to repopulate when a new or different nurse assumes care for a patient. Issues can also come into play, for example, when a patient's condition changes over the course of a shift but the information copied over from the previous shift has not been revised to reflect those changes.

Another potential pitfall with respect to the EMR involves failure of the EMR to accurately reflect and confirm a patient's informed consent to a particular treatment or procedure, including acknowledgement of risks and benefits which were explained prior to that consent being given. Failure to obtain informed consent is a common claim against healthcare providers. Inherent in defending that claim is the ability to show that the patient acknowledged the risks and benefits of the subject treatment or procedure and gave informed consent for same. Thus, it is imperative to the defense of the claims that the EMR reflect that conversation actually occurred.

The use of the EMR has often led to the deconstruction of the chronology of care that existed with a physical medical chart. Prior to the use of electronic records, a hard copy of a medical chart typically would provide an instructive and beneficial chronology of the course of treatment provided to a particular patient. Not only was this a benefit to someone reviewing care well after the fact, as in the case of a subsequent healthcare provider or in a lawsuit, but it was also instructive in the situation of providing continuity of care to a patient while that care was ongoing. The EMR, by its very design, has virtually eliminated that concept as now the record is divided into distinct segments based on activity or discipline.

Audit Trails

The primary purposes of the electronic medical record, as established by HIPAA and HITECH, are to reflect not only the care that was provided to a particular patient, but also who accessed the record and when. Before the advent of EMR, issues concerning the medical record often involved late entries, questions about whose handwriting was on the actual record if unsigned, whether something has been physically removed from the chart, etc. Today, in this world of electronic reality, several of those questions have been eliminated or diminished; however, new problems and pitfalls have arisen in their places.

One such area involves the audit trail. The audit trail

of the EMR is designed to incorporate another layer of the who, the when and the where, into the global medical record. In so doing, it becomes an invisible yet integral component of that care. The audit trail can also present challenges in defending medical malpractice actions. An audit trail can reveal the “behind the scenes” aspects of the care including a digital footprint of anyone who accessed the record at any time – before, during and after. This digital footprint can reveal any authorized user (albeit healthcare provider or either administrative staff) who views, alters, or even deletes any data reflecting care provided to the patient. Such could reveal access to the record resulting in loss or corruption of pertinent data as to the care, whether it was done inadvertently or intentionally. Most notably, depending on the system, the audit trail may show that the records have been revised - - something that one cannot determine from only looking at the final version of the record. Individuals who review a particular EMR, especially after the fact, and the activities done within the patient chart can be utilized by Plaintiff’s counsel to support his or her claims against the healthcare provider, including potential claims of spoliation of evidence.

Many plaintiff attorneys now routinely request the audit trail and other metadata. The question of whether such is part of the “medical record” is unresolved. A healthcare provider defendant may be able to object to production if there is no specific claim in the complaint relating to the accuracy of the record or alleging improper access to the record under *Ala. Code* § 6-5-551 (1975). Likewise, a practical argument may be made that this hidden record is not used in making medical or nursing decision or providing medical or nursing care.

Another concern was alluded to above; that being, the printed record often does not appear the same as when accessed “live” on a computer screen. This presents a real dilemma. Witnesses may, for example, not recall what was asked by drop-down boxes or prompts in responding to a specific aspect of a patient’s condition in one way or another. Presumably, the plaintiff’s attorney could even argue that the record is not complete. Either of these issues may cause counsel to consider opening “Pandora’s box” in either permitting the witness to view the live electronic system or, on the other hand, result in a request from plaintiff’s counsel to do so. Of course, the potential for surprises in such a process is limitless. For this reason, defense counsel now must also often engage the client’s in-house technical staff for assistance,

and depositions of such personnel are becoming more and more common.

How Do I Prepare a Healthcare Provider For Deposition Now?

There have always been many challenges associated with preparing healthcare providers for deposition. Today, in addition to the matters addressed above, two issues are of particular concern. The first is the continued use of “Reptile Theory” tactics by plaintiff counsel, and the second involves a perceived mistrust of institutions which even affects the impression of employees of hospitals, nursing homes, and the like.

Reptile Theory

Regarding the former, the purpose of this discussion is not to address the supposed “scientific” background for the “Reptile Theory” but, instead, to present practical examples of the types of questions associated with that strategy and simple responses. The “Reptile Theory” was introduced in David Ball and Don C. Keenan, *Reptile: The 2009 Manual of the Plaintiff’s Revolution*. The theory generally seeks to focus on fears and concerns broader than the issues in the case, presumably causing jurors to respond to a threat to their own safety. Ann T. Greeley, Ph.D., *Snakes and Lizards and Crocodiles (Oh My!): A Primer on the Reptile Theory of Trial Strategy*. In undertaking this process, the plaintiff attorney attempts to focus on the behavior of the defendant particularly demonstrating that there were safety rules which were available or in place to prevent danger of the type at issue, yet those rules were violated. Greeley; John R. Crawford and Benjamin A. Johnson. “*Strategies for Responding to Reptile Theory Questions*,” *For the Defense* (December 2015).

The “Reptile” process generally involves an effort to obtain key admissions in depositions, to condition the jury to the themes during voir dire, and to set the stage for application of the themes in opening statement. The themes, particularly as sought through deposition questioning, include an assertion that safety is always the defendant’s top priority and that any level of danger is never appropriate. Greeley, p. 9. Accordingly, reducing risk is also a top priority. These assertions are concluded with the question or statement seeking affirmation that if someone violated a safety rule that person or company would be responsible for the accident or incident. Greeley, p. 10.

Generally, the attorney seeks admissions from the witness regarding broad statements about safety and safety rules which then prevent the witness from escaping those points in case-specific questions. Below is a series of questions presented to a nurse in a recent medical malpractice case in Alabama demonstrating the preliminary, broad safety statements:

- (1) Tell me if you agree with the following statement. In your opinion is a hospital or its staff ever allowed to needlessly endanger a patient?
- (2) Should a hospital and its staff ever refuse a patient's request for help walking?
- (3) Would you agree that patient safety is the most important thing at a hospital?
- (4) So pretty much everything that a hospital nurse does should be ruled by safety?
- (5) And at a minimum, a hospital and its staff should at least follow its own safety rules and procedures?
- (6) This is because violating a patient's safety rule might end up hurting or killing somebody, right?
- (7) So it's fair to say that a nurse shouldn't make choices that put patients at unnecessary risk?
- (8) Because extra risk means more danger, right?
- (9) You tell me if you agree with this - - I put my life in your hands. In return, you agree to take care of me and keep me safe. Now is that a fair deal?
- (10) Do you think most patients expect that? Do you think patients deserve that?
- (11) So you would agree with me that it's basically a patient's right to be taken care of kept safe?

(The case name, witness name, and objections have been omitted for confidentiality and brevity.) Of course, medical cases are ripe for such an approach as potential "safety rules" abound. These may include hospital or nursing home policies and procedures, medical treatises and texts, standards promulgated by The Joint Commission and other industry groups, federal regulations, and resources such as the *Physician's Desk Reference*. Advice regarding responses to questions seeking to apply such "rules" will follow.

The "Reptile Theory," while purportedly having a scientific basis, for purposes of witness questioning,

involves two tried-and-true techniques. The first is, as alluded to above, the progressive application of general rules to a specific situation. Another example of this progression is as follows:

- (1) If a patient's status changes, the safest thing to do is call the physician immediately?
- (2) Documentation in the chart must be thorough; otherwise, a patient could be put in danger, right?
- (3) When a test or labs are ordered, you would agree with me that you should review the results immediately, because any delay would put the patient at risk?
- (4) Nurse Jones, you would agree with me that when a troponin level is elevated, the patient is in imminent danger, correct?

Bill Kanasky, Jr., Ph.D. and Ryan A. Malphurs, Ph.D., *Derailing the Reptile Safety Rule Attack: A Neurocognitive Analysis and Solution*, p. 6. Once the witness has agreed to the paramount nature of safety, including here timely contact with the physician, he or she may struggle to escape the assertion that a lab valve was not timely reported to the physician.

The other familiar form of witness questioning is to "shame" the witness into feeling obligated to provide a certain response. Examples of these questions include:

- (1) Failing to call a physician at 4:00 p.m. was a safety violation?
- (2) It exposed my client to unnecessary risk and harm, right? If you would have called a physician it would have prevented by client's stroke, right?
- (3) Nurse Jones, failing to call a physician immediately at 4:00 p.m. was a deviation of the standard of care, wasn't it?

Kanasky and Malphurs, p. 9. Often, the witness feels compelled to say he or she "knew better" than to act as occurred.

The most important rule in responding to "Reptile" questions is to "never say 'yes'." Crawford and Johnson, p. 71. General safety rules of this type fail to consider the specific circumstances of the case and, more importantly, fail to consider the complexity of medical matters. While witnesses may certainly testify that safety is important and that they strive to prevent injury to patients, the

rather simple example of a surgery shows that medicine does not present a black-and-white home for the use of “safety” rules. It should only take a matter of moments to list the number of risks, and even dangers, associated with many, if not most, medical procedures undertaken in an effort to cure. Indeed, a discussion of this analysis is key to building the witness’ confidence in disagreeing with the “safety rule” statements which are posing as questions. The key is to avoid the cascade of affirmative responses whereby the witness becomes “boxed in” when finally asked about the care at issue. In doing so, the witness may certainly disagree with the premise of the initial, broader questions.

Recognizing that “Reptile” progression of questioning generally moves from general to more specific safety questions, witnesses must be prepared to respond to those initial questions asserting that a particular course of care would be the safest course or would be the course least likely to place the patient in danger. Often, the following are true and accurate responses:

- (1) It depends on the patient’s specific circumstances.
- (2) It depends on the full picture.
- (3) Not necessarily, as every situation is different.
- (4) That is not always true.
- (5) I would not agree with the way you stated that.
- (6) That is not how I was trained.

Kanasky and Malphurs, p. 12. Again, this approach is not new, and it is not inappropriate, particularly given the mandates of the Alabama Medical Liability Act prohibiting discovery regarding other acts and omissions thereby confirming that it is the care at issue which should be the subject of discovery.

Returning to the notion that the “Reptile” attorney seeks damaging admissions during discovery depositions, a corollary to the “never say ‘yes’” rule is that the witness may say “yes, but.” For generations, defense lawyers have been mentored or taught that witness preparation includes instructions such as “answer only the question asked” and “do not volunteer.” However, “saying too little can leave false impressions, impair credibility, or otherwise harm the case as much as saying too much, sometimes even more so.” Kenneth R. Berman, “Reinventing Witness Preparation,” *Litigation* (Summer 2015), p. 27. (Indeed, Berman’s article provides an excellent discussion

of general witness preparation). The “yes, but” ancillary rule allows the witness to tell the full story without being limited by the attorney’s question thereby preventing the witness from being misunderstood or facts from being left out of the description.

Another concern in the medical field is the potential that the general “safety rule” replaces either the concept of “reasonableness” or even the medical or nursing standard of care. *See, e.g.* Crawford and Johnson, p. 72. Defense counsel must carefully prepare witnesses in medical malpractice actions to focus on the legal standard applied in a medical liability action; that being, the medical or nursing standard of care.

Finally, regarding the “Reptile” topic, it may be suggested that witnesses not answer “damages” questions. Crawford and Johnson, p. 72. Responsibility for injury or damage is a legal matter, and the involved lawyers will argue those issues to the jury.

Institutional Mistrust

Another current trend in witness preparation involves a general thought that many jurors are mistrusting of institutions. Such a concern may go hand-in-hand with the “Reptile Theory” where plaintiff attorneys seek to play upon these biases. In preparing healthcare providers for deposition, it is important to consider those issues significant to patients. In a twist of the “Reptile Theory,” one may consider that jurors might assess healthcare providers by considering whether the jurors would themselves welcome the care of the testifying witness. A 2006 article addressed the behavior of healthcare providers considered as “ideal.” Neeli M. Bendapudi, Ph.D., et al., “Patients’ Perspectives on Ideal Physician Behavior,” *Mayo Clin. Proc.* (March 2006). The traits identified included:

- (1) Confidence;
- (2) Empathy;
- (3) Humanity;
- (4) Personal Concern;
- (5) Forthrightness;
- (6) Respect; and,
- (7) Thoroughness.

Benapudi, p. 340. While one may easily recognize these qualities as a patient, they can also be exhibited

by a testifying witness. For example, the most important factor in establishing witness confidence is preparation and practice. This includes sample questioning which is often videotaped for witness review and critique. Intimate knowledge of the medical record is key to establishing this confidence as well. Empathy, humanity, and personal concern are important to the most basic of trial issues—credibility. A patient and professional witness will largely demonstrate these qualities though, yet again, preparation and practice are essential to invoking these qualities, especially in the “Reptile” realm where the questioning often involves attempts to unnerve or humiliate witnesses. Greeley, p. 8, 9. By way of example, the above questions posed in the noted Alabama deposition example came immediately after the witness was asked her name.

Forthrightness is demonstrated by the witness who honestly acknowledges facts which are true, even if recognized as harmful. In appearing respectful, in addition to being patient and professional, the witness should listen carefully and not interrupt when responding to the lawyer’s questions. He or she must stay “above” the questioning attorney’s tone or demeanor. Thoroughness is demonstrated largely by the ability to clearly describe the medical or nursing issues involved providing detail and even enlightening the questioner. While the witness must be cautioned that the plaintiff attorney will likely never agree with him or her, the ability to educate the ultimate audience – the jury – is vital.

Conclusion

Defending healthcare providers has always been a demanding task. However, at this time, issues such as medical liability and causation are only part of the story. Ongoing efforts to hold others responsible for the alleged acts and omissions of physicians require knowledge and application of the laws and regulations plaintiffs attempt to rely upon. Novel or unconventional approaches such as admitting liability and proving the client’s own subsequent remedial measures may be the best approach in cases of clear liability. Finally, today’s involvement of electronic medical records obligate defense counsel

to become familiar with these systems and, more importantly, assure that clients and witnesses are fully familiar with exported versions of these materials.



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