A MIDWESTERN LAW FIRM

MEDICOLEGAL MONITOR

A REVIEW OF MEDICAL LIABILITY AND HEALTHCARE ISSUES

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A Word From the Practice Group Chair

This edition of our newsletter alludes to the creeping expansion of consumerism in Illinois medical malpractice law which has put doctors and hospitals in a position where how they relate to the public may significantly impact their professional liability exposure. As healthcare providers wake up to this new paradigm, there probably will be significant friction between medical marketers and medical providers. The simple truth is the more you stoke the public's expectations, the more the law seems to expect of you.

In her article on the *Yarbrough* decision, Renee Monfort of our Urbana office points out that the more pride you show in affiliated practice partners, the more exposure you will have for their mistakes. In the hospital sepsis protocol article provided by Scott Salemi and Mike Denning of our Rockford office, you see an example of how hospitals will be compelled by Illinois law to establish standards of care for your own facility. This gives rise to the possibility that you might just set the bar too high for yourself and suffer the consequences. You also need to be careful to properly staff the committee drafting your sepsis protocol so that the final product represents a medical consensus rather than a political settlement.

Although this and perhaps some other editions of our newsletter seem to portend doom, our firm still wins the vast majority of jury cases it tries. We have trial lawyers who have been trying cases for decades without a single loss. Trouble is never quite so bad when you know where to take it.

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Like Elvis, Has Apparent Agency Left the Building?

By Renee L. Monfort - *rmonfort@heylroyster.com*

Hospitals Beware:

A hospital can be held vicariously liable under the doctrine of apparent agency for the acts of employees of an unrelated, independent clinic which is not a party to the litigation, if the plaintiff can establish the elements of apparent agency. Until now, virtually all apparent agency cases involved conduct of healthcare providers working within some physical part of a contiguous hospital complex. The limited exceptions include the case of *Malanowski v. Jabamoni,* 293 Ill. App. 3d 720 (1st Dist. 1997), where Loyola University of Chicago was held vicariously liable for treatment provided by an independent contractor at Loyola University Mulcahy Outpatient Center, an outpatient center owned and operated by Loyola. In *Yarbrough v. Northwestern Memorial Hospital*, 2016 IL App (1st) 141585, the First District Appellate Court extended the reach of apparent agency well beyond "the four corners of the building."

The Law of Apparent Agency:

In reaching its decision the appellate court, citing *Gilbert v. Sycamore Municipal Hospital,* 156 Ill. 2d 511 (1993), recounted the factors a plaintiff must establish to hold a hospital liable under the doctrine of apparent authority for acts of an independent contractor:

1. the hospital, or its agent, acted in a manner that would lead a reasonable person to conclude that the individual who was alleged to be negligent was an employee or agent of the hospital;

(continued on next page)

2. where the acts of the agent create the appearance of authority, the plaintiff must also prove that the hospital had knowledge of and acquiesced in them; and
3. the plaintiff acted in reliance upon the conduct of the hospital or its agent, consistent with ordinary care and prudence.

Yarbrough, 2016 IL App (1st) 141585, ¶ 33, (citing *Gilbert*, 156 Ill. 2d at 525).

The first two elements, which are frequently grouped together, have been referred to as the "holding out" factor. The focus in this regard is on whether the patient knew or should have known the healthcare provider was an independent contractor. A hospital cannot be vicariously liable if a patient knows or should know that the healthcare provider is an independent contractor. Liability will only attach to the hospital where the jury finds that the treating healthcare provider is the apparent agent of the hospital.

Apparent Agency Beyond the "Four Walls" of a Hospital:

Northwestern Memorial Hospital (Northwestern) contended that the doctrine of apparent agency did not apply because the conduct at issue did not occur at the hospital, but instead occurred at an unrelated, independent clinic (Erie Family Health Center) which was a separate corporate entity. The court summarily dismissed this argument citing the *Malanowski* court which reasoned that there was "nothing in the *Gilbert* opinion which would bar a plaintiff, who could otherwise satisfy the elements for a claim based on apparent agency, from recovering against a hospital merely because the negligent conduct of the physician did not occur in the emergency room or some other area within the four walls of the hospital." *Malanowski,* 293 Ill. App. 3d at 727. The court emphasized that the key determination under *Gilbert* is whether the plaintiff can demonstrate that the hospital's conduct led the plaintiff to rely upon the hospital for treatment, rather than on a particular physician. *Yarbrough,* 2016 IL App (1st) 141585, ¶ 40.

Apparent Agency When the Apparent Agent is Not a Defendant:

There is no requirement that the apparent agent be named as a defendant. In *Yarbrough* neither Erie nor the individual healthcare providers at Erie were named as defendants. The court held that their absence as defendants in the lawsuit did not bar recovery against the hospital under a theory of apparent agency. Accordingly, the court held that a hospital may be held liable under the doctrine of apparent agency for the acts of employees of an independent clinic, when neither the employees nor the independent clinic are a party to the litigation, if the plaintiff can establish the elements of apparent authority as set forth in *Gilbert*. The court specifically held that courts may apply *Gilbert* outside of the "four walls" of the hospital and a plaintiff is not required to name the individual healthcare provider or the employer as a defendant in order to hold the principal/hospital vicariously liable. *Id.* ¶ 45.

Apparent Agency and the *Yarbrough* Facts:

Under the unique facts before the court in *Yarbrough*, the court noted that the plaintiffs had raised a question of fact regarding the "holding out" and reliance elements under *Gilbert* and their apparent authority claim contained issues of fact subject to a jury's determination.

With respect to "holding out" the court heavily relied upon the following facts:

- The hospital held itself out as a "full-service hospital;"
- The hospital promoted itself as a community-oriented hospital that collaborated with neighborhood centers, including Erie, to make healthcare available to those in need;
- The hospital publicized its relationship with Erie on its website, annual reports, community service reports, and other press releases;
- The hospital promoted that 11.2% of babies delivered at the hospital in 2006 received prenatal care at Erie;

- 100% of prenatal patients at Erie delivered at the hospital;
- The hospital's website provided a link to Erie's website and represented that Erie was one of "Our Health Partners" and promoted their formal and long-standing affiliations with Erie;
- Two hospital representatives sat on Erie's board;
- Erie was founded "as a project of volunteer physicians from Northwestern Memorial and Erie Neighborhood" House; and
- The hospital continuously contributed financially to Erie, provided information technology assistance to Erie and did not charge Erie patients for care given at the hospital.

Id. ¶ 52.

Significantly, the relationship between the hospital and Erie involved an affiliation agreement wherein the hospital was the primary site for acute and specialized hospital care. The affiliation agreement also called for a the hospital representative to sit on Erie's Board of Directors, the creation of a community advisory committee and appointment of Erie's executive director to the committee. The agreement also provided for joint marketing efforts related to the affiliations. *Id.* ¶¶ 52-53.

With respect to Erie's actions which would constitute "holding out," Yarbrough testified that Erie's staff informed her that if she were treated at Erie she would be likely to receive additional testing at Northwestern and ultimately deliver at Northwestern. They also provided her with information about delivering at Northwestern. No one told Yarbrough the healthcare providers at Erie were Northwestern employees; she testified that no one informed her that they were not part of Northwestern. In addition, Erie's website referred to Northwestern as its "partner" and there were other references to Erie partnering with Northwestern. The website also stated that Erie physicians had faculty status at Northwestern University Feinberg School of Medicine.

The court noted that whether Yarbrough actually observed these indicia of "holding out" on the websites of Northwestern and Erie and in the written materials was not determinative. Whether a patient actually observes a hospital's advertisements is not relevant to the objective inquiry into the "holding out" factor under *Gilbert*. *Id.* ¶ 56. The third element of apparent authority, reasonable reliance, is established where the plaintiff acts in reliance upon the conduct of the hospital or its agent consistent with ordinary care and prudence. *Id.* ¶ 58 (citing *Gilbert*). The court noted that the critical issue is whether the plaintiff was seeking care from the hospital itself or looking to the hospital merely as a place for her personal physician to provide care.

Yarbrough did not have a prior relationship with any healthcare provider at Erie. Yarbrough testified that she went to Erie because it was a local clinic offering free pregnancy testing. It was her impression that Erie and Northwestern were the same entity and that Erie and Northwestern were working together. Yarbrough testified that her decision for treatment was influenced by the fact that she would deliver at Northwestern if she received prenatal care at Erie. Her impression was that Northwestern was "a very good hospital, very big, very well-known in the city." *Id*. ¶ 60.

Based upon the foregoing, the court found that Yarbrough's testimony raised an issue of material fact regarding whether there was reasonable reliance.

Beware the Expansion of Apparent Agency:

The *Yarbrough* decision arose from an interlocutory appeal. As a consequence, the case was remanded to the trial court for further proceedings consistent with the court's holding.

Clearly, there is a "Whole Lotta Shakin' Goin' On" in the world of apparent agency as evidenced by the fact that we have addressed a new apparent agency case in each edition of the *Medicolegal Monitor* in 2016. From a defense perspective, there is reason to be "All Shook Up."

This case serves as a warning to all hospitals, especially regional hospitals which affiliate with small, rural, independent

healthcare facilities and independent contractors in an effort to provide support to those facilities and make quality care more accessible to the general public. Be careful what your website says and what your affiliation is because "apparently" no good deed will go unpunished!

Renee Monfort's civil litigation practice focuses on the defense of healthcare providers and other professionals in professional liability litigation. In addition to representing clients in healthcare related litigation, she also provides general counsel to individual health care professionals, multi-specialty clinics and hospitals on a wide range of administrative, policy and risk management matters. The scope of her practice also includes representation of clients in administrative proceedings before the Illinois Department of Financial and Professional Regulation and the Illinois Human Rights Commission.

Hospital Sepsis Protocols

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On August 18, 2016, the Illinois Hospital Licensing Act (210 ILCS 85/6.23a) was amended to require hospitals to adopt, implement, and periodically update sepsis screening protocols. These protocols should be carefully considered, with contribution from multiple specialists and stakeholders. With recent developments in the definition and assessment of sepsis, and the potential for the use of sepsis protocols against hospitals and physicians in medical malpractice litigation, the preparation of these protocols should be done with great care.

The Act requires hospital sepsis screening protocols to be "based on generally accepted standards of care." Such language is certain to be used in lawsuits by plaintiffs claiming that the hospital's protocols reflect the standard of care and demand rigid adherence. They will suggest any deviation from the written protocols constitute professional negligence, i.e., deviation from the standard of care.

The Act requires that hospital sepsis protocols include such components as:

1. a process for the screening and early recognition of patients with sepsis, severe sepsis, or septic shock;
2. a process to identify and document individuals appropriate for treatment through sepsis protocols, including explicit criteria defining those patients who should be excluded from the protocols, such as patients with certain clinical conditions or who have elected palliative care;
3. guidelines for hemodynamic support with explicit physiologic and treatment goals, methodology for invasive or non-invasive hemodynamic monitoring, and timeframe goals;
4. for infants and children, guidelines for fluid resuscitation consistent with current, evidence-based guidelines for severe sepsis and septic shock with defined therapeutic goals for children;
5. identification of the infectious source and delivery of early broad spectrum antibiotics with timely re-evaluation to adjust to narrow spectrum antibiotics targeted to identified infectious sources; and
6. criteria for use, based on accepted evidence of vasoactive agents.

When drafting sepsis protocols the hospital should carefully consider recent recommended advancements in sepsis definitions and assessment criteria. Earlier this year, a multinational, multidisciplinary task force completed an 18-month study and proposed new definitions and clinical criteria for sepsis and septic shock. These recommendations include the abandonment of the Systemic Inflammatory Response Syndrome (SIRS) paradigm, and elimination of

the classification of "severe sepsis." On February 23, 2016, the Journal of the American Medical Association published "The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3)," JAMA 2016: 315(8): 801-810, Singer M, et al. This was the first revision of sepsis definitions and clinical criteria attempted since the 2001 (Sepsis-2) and 1991 (Sepsis-1) iterations.

This recent article proposes a new definition of sepsis: evidence of infection plus life-threatening organ dysfunction, clinically characterized by an acute change of 2 points or greater in the Sequential Organ Failure Assessment - SOFA score. The article recommends new clinical criteria for septic shock (sepsis with fluid-unresponsive hypotension, serum lactate level greater than 2 mmol/L, and the need for vasopressors to maintain mean arterial pressure of 65 mm HG or greater). This shift from a SIRS to a SOFA-paradigm includes introduction of a new bedside index called Quick SOFA (qSOFA), to be used for the identification of patients outside critical care units who are likely to develop complications of sepsis. qSofa assesses respiratory rate (22/min or greater), altered mentation, and systolic blood pressure (100 mm Hg or greater) for the immediate screening of those suspected septic.

In its article, the task force acknowledged the challenges in re-defining sepsis and septic shock, the first being that sepsis is a broad term applied to an incompletely understood process. "There are, as yet, no simple and unambiguous clinical criteria or biological, imaging or laboratory features that uniquely identify a septic patient." *Id.*

Some questioning the task force recommendations suggest that calculating a SOFA score in sufficient time to make clinical decisions might not be realistic in some environments, and that the adoption of such protocols for assessment has the potential to drive excessive laboratory testing.

Illinois hospitals are now required by law to have sepsis protocols that reflect generally accepted standards of care. As the stakes are significant, both in regard to the use of the protocols in the treatment of patients and in possible litigation, the creation of such protocols should be a collaborative and thoughtful exercise. The hospital should consider contributions from all administrative, academic, and clinical disciplines, including critical care and infectious disease physicians as well as surgeons. The hospital should also establish a mechanism to ensure that the sepsis protocols are periodically updated and that they reflect the most recent advancements in this serious and difficult area of medicine.

Scott Salemi concentrates his practice in the defense of complex civil litigation, with an emphasis on medical malpractice and civil rights cases. Scott is an accomplished trial lawyer with nearly fifty jury trials to his credit. He has tried substantial civil cases to verdict throughout Illinois in both state and federal court. Prior to joining Heyl Royster, Scott served as Senior Assistant State's Attorney in Rockford, Illinois, and later as an Assistant Illinois Attorney General, assigned to a statewide trial assistance division. Scott has been selected as a Leading Lawyer in Illinois by the Law Bulleting Publishing Company in both Medical Malpractice Defense Law and Personal Injury Defense Law: General in 2014 and 2015.

Michael Denning concentrates his practice on medical malpractice and nursing home litigation. In addition to defending physicians and long term care facilities in malpractice litigation and personal injury claims, Mike also handles a myriad of administrative issues for long term care facilities, including involuntary discharge proceedings, licensure issues, fraud and abuse claims, and other litigation. He has represented physicians as well as Fortune 500 companies, local businesses, professionals and insurance companies in a variety of cases. Mike is a Martindale-Hubbell AV rated lawyer who currently chairs the firm's Long Term Care/Nursing Home practice group.

Firm Obtains Two Med Mal Defense Verdicts in One Week

We are pleased to report that during one week in August, attorneys from our Rockford and Peoria offices obtained defense verdicts in contested medical malpractice claims.

Doug Pomatto and Mike Denning of the firm's Rockford office tried a case in which the firm defended a family practice physician in a wrongful death lawsuit that was brought by the widow and four children of a 45 year-old non-smoker. The lawsuit claimed that the family practice physician failed to diagnose the patient/decedent's lung cancer. Based on the patient's clinical presentation, pulmonary function test, and response to asthma medications, the defendant physician diagnosed the patient/decedent with asthma in January of 2009. In January of 2010, the patient went to the Mayo Clinic on self-referral and was diagnosed with stage IV lung cancer with metastasis to the brain. He underwent chemotherapy and radiation but ultimately passed away in 2015 as a result of lung cancer. Plaintiff sought recovery for survival damages, loss of consortium and wrongful death, and at the end of a more than two-week trial, plaintiffs asked for an itemized verdict of approximately $10.2 million. The jury deliberated for less than two hours before returning a verdict for the defense.

Dave Sinn and Tyler Pratt of the firm's Peoria office defended a gastroenterologist at jury trial in a case in which a 58 year-old female suffered a perforation of the esophagus 20 minutes after being dilated by the defendant gastroenterologist. The plaintiff alleged that the defendant gastroenterologist chose too big of a dilator to dilate her peptic stricture. The plaintiff subsequently underwent a thoracotomy to repair her esophagus and then slipped into a coma for two months. The total of plaintiff's paid medical bills was $350,000. The plaintiff's demand prior to trial was $650,000. At the end of the five-day trial, the plaintiff's attorney asked the jury for "whatever is reasonable," and the jury returned a defense verdict after 45 minutes of deliberation.

Supreme Court Agrees to Hear Statute of Repose Case

The Illinois Supreme Court granted leave to appeal *Lawler v. The Univ. of Chicago Medical Center*, No. 120745, 1st Dist, a case in which the First District Appellate Court allowed the relation back doctrine to apply to the statute of repose to allow the plaintiff to add a wrongful death claim. As reported by the ISBA, "This case presents question as to whether medical malpractice statute of repose (735 ILCS 5/13-212(A)) barred application of relation back doctrine (735 ILCS 5/2-616(b)) for purposes of adding Wrongful Death Act claim to existing (and timely-filed) medical malpractice claim. While trial court found that relation back doctrine did not apply, and thus plaintiff's wrongful death action was essentially new claim that was filed beyond statute of repose, the Appellate Court, in reversing trial court, found that relation back doctrine did apply, so as to allow plaintiff to add wrongful death action, where: (1) plaintiff's decedent had filed timely medical malpractice action; and (2) plaintiff's wrongful death claim arose from same transaction as described in decedent's original complaint. The Court further noted that the relation back doctrine had previously been applied to medical malpractice cases, where medical providers received adequate notice of same operative facts leading to claimed malpractice in the original complaint."

Heyl Royster serves clients in every county in Illinois. We have offices in six major population centers in Illinois - Peoria, Chicago, Edwardsville, Rockford, Springfield, and Urbana - which allows us to appear in any Illinois state or federal court quickly, effectively, and cost-efficiently for our clients. Our offices collaborate with each other and with our clients to achieve client goals. Our statewide practice has earned Heyl Royster a reputation for innovation, excellence, and professionalism and brings our clients a specialized knowledge of the courts and adversaries we face.

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