[Saint Louis University Law Journal](https://scholarship.law.slu.edu/lj)

Volume 68
Number 1 *Fall 2023*

Article 4

2023

“With Friends Like These . . . .” Doctors and Nurses Criticizing Co-Employed Colleagues. Are These Criticisms Admissible as Vicarious Opposing Party’s Statements?

Marc D. Ginsberg
University of Illinois-Chicago School of Law, mgins@uic.edu

Follow this and additional works at: https://scholarship.law.slu.edu/lj

Part of the Law Commons

Recommended Citation

Marc D. Ginsberg, *“With Friends Like These . . . .” Doctors and Nurses Criticizing Co-Employed Colleagues. Are These Criticisms Admissible as Vicarious Opposing Party’s Statements?*, 68 St. Louis U. L.J. (2023).
Available at: https://scholarship.law.slu.edu/lj/vol68/iss1/4

This Article is brought to you for free and open access by Scholarship Commons. It has been accepted for inclusion in Saint Louis University Law Journal by an authorized editor of Scholarship Commons. For more information, please contact Susie Lee.

"WITH FRIENDS LIKE THESE . . . ."[†] DOCTORS AND NURSES CRITICIZING CO-EMPLOYED COLLEAGUES. ARE THESE CRITICISMS ADMISSIBLE AS VICARIOUS OPPOSING PARTY'S STATEMENTS?

MARC D. GINSBERG*

> "Expressing one's own opinion about diagnosis and treatment and acknowledging disagreement with other physicians, if necessary for patient care, can be accomplished without castigating or insulting another provider to the patient."[1]

ABSTRACT

Healthcare provider incivility includes non-collegial conduct such as physicians criticizing co-employed physicians when speaking with patients. This conduct is, obviously, disruptive, and does not help to establish productive, collegial, employee relationships.

Additionally, this incivility may have evidentiary consequences in medical/hospital negligence litigation. If the healthcare providers are employed by a hospital or other healthcare organization, the criticisms of co-employed colleagues which are communicated to patients may be admissible against the employer in medical/hospital negligence litigation as vicarious opposing party's statements. This paper explores this evidentiary curiosity.

[†] With friends like these who needs enemies. The Yale Book of Quotations attributes this statement to comedian Joey Adams. https://en.wiktionary.org/wiki/with_friends_like_these_who_needs_enemies [https://perma.cc/AB86-S8RJ].

* Professor of Law, University of Illinois-Chicago School of Law. The author thanks his wife, Janice, for her inspiration and support, thanks his son Brian, a brilliant appellate lawyer, for his inspiration, and his grandson Dave (Dooley), for his inspiration. The author also thanks Robert Leander, his current research assistant, for his research, citation checking, and proofreading.

1. Susan H. McDaniel et al., *Physicians Criticizing Physicians to Patients*, 28 J. GEN. INTERNAL MED. 1405, 1409 (2013).

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

TABLE OF CONTENTS

I. INTRODUCTORY HYPOTHETICAL 25

II. PHYSICIANS AS DISRUPTIVE OR COLLEGIAL CRITICIZERS 25

III. HOSPITAL VICARIOUS LIABILITY 27

IV. AN OPPOSING PARTY'S STATEMENT 30

V. THE NEED TO ESTABLISH AN AGENCY RELATIONSHIP 31

VI. THE OHIO EXPERIENCE 32

A. PONTIUS V. RIVERSIDE RADIOLOGY & INTERVENTIONAL ASSOCIATES 33

B. BROMALL V. SELECT SPECIALTY, HOSPITAL 35

VII. THE CASE OF THE UNIDENTIFIED DECLARANT 39

A. AUMAND V. DARTMOUTH HITCHCOCK MEDICAL CENTER 39

B. DONATUCCI V. ATLANTICARE HEALTH SERVICES 40

VIII. FACTS OR GOSSIP? 41

IX. A VICARIOUS OPPOSING PARTY'S STATEMENT BY ADOPTION? 42

X. COMMENTS ON THE LAW 44

XI. COMMENT ON MEDICAL EDUCATION 45

XII. CONCLUSION 45

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

I. INTRODUCTORY HYPOTHETICAL

P, patient, is admitted to hospital, H, for treatment. P is treated by three physicians, A, B and C, all of whom are hospital employees. P's hospital chart is accessible to A, B and C. During P's hospital admission, A speaks with P and criticizes the medical care provided by C.

P, unhappy with the treatment results, files a medical negligence claim against H. What, if any, are the evidentiary consequences of the aforementioned facts?

II. PHYSICIANS AS DISRUPTIVE OR COLLEGIAL CRITICIZERS

The disruptive physician has been addressed in medical and legal scholarship.[2] Certainly, disruptive physician conduct includes conflicts with and criticism of physicians, including criticisms communicated to patients. It seems clear that disruptive conduct of this sort is repetitive, likely habitual. In this regard, it has been urged that:

> A single episode of disruptive behavior does not render a physician a disruptive physician. . . . The disruptive behavior label should not be applied to the physician who has an occasional bad day or an occasional reaction that is out of character for that individual. Instead, the disruptive label should refer to a pattern of seriously inappropriate behavior that is deep-seated and habitual.[3]

The American Medical Association has recognized and commented on disruptive physicians in its Code of Medical Ethics Opinions, Ethics Opinion 9.4.4 of which provides, in relevant part:

Code of Medical Ethics Opinion 9.4.4

> The importance of respect among all health professionals as a means of ensuring good patient care is foundational to ethics. Physicians have a responsibility to address situations in which individual physicians behave disruptively, that is, speak or act in ways that may negatively affect patient care, including conduct that interferes with the individual's ability to work with other members of the health care team, or for others to work with the physician.
>
> Disruptive behavior is different from criticism offered in good faith with the aim of improving patient care and from collective action on the part of physicians. Physicians must not submit false or malicious reports of disruptive behavior.[4]

---

2. *See, e.g.*, Norman T. Reynolds, *Disruptive Physician Behavior: Use and Misuse of the Label*, 98 J. MED. REGUL. 8 (2012); McDaniel, *supra* note 1; Samuel D. Hodge Jr., *What Can be Done About a Disruptive Physician? A Legal Analysis*, 40 PACE L. REV. 126 (2019); Samuel D. Hodge Jr., *A Disruptive Physician is Bad Medicine Under any Circumstance*, 66 PRAC. LAW. 19 (2020).

3. Reynolds, *supra* note 2, at 9-10.

4. *Physicians with Disruptive Behavior*, AMA CODE MED. ETHICS OP. § 9.4.4 (2017), https://code-medical-ethics.ama-assn.org/sites/default/files/2022-08/9.4.4.pdf [https://perma.cc/C6SJ-AZTF].

However, not all physicians who criticize their colleagues to patients are "disruptive." Some may be involved in "collegial criticism." This has been defined as:

> [C]omments or communication by one health care provider about another professional's care made to the patient, to other health care professionals, or placed in the medical chart, as well as communication made at depositions or trials regarding a colleague's course of action. These comments may even trigger a lawsuit.[5]

Nurses, as well as physicians, may exhibit disruptive or non-collegial conduct.[6] This conduct may manifest as incivility, "low-intensity rude or disrespectful behaviors with an ambiguous intent to harm others,"[7] or as bullying, "an intentional and intense form of workplace mistreatment that targets particular individuals and not others."[8] Aggressive conduct of this type has been characterized as nurse-to-nurse "lateral violence,"[9] which includes "non-verbal innuendo, verbal affront, undermining activities, withholding information, sabotage, infighting, scape-goating, backstabbing, failure to respect privacy, and broken confidences."[10] While this nursing behavior typically occurs between or among nurses, a physician could be the target of the criticism.[11]

For evidentiary and liability purposes, the distinction between disruptive behavior and collegial criticism is probably not meaningful. The reason for this will be apparent when this paper addresses the evidentiary consequences of physicians' (and nurses') criticisms of colleagues which are communicated to patients.

5. Amy B. Angert, *Collegial Criticism and the Courtroom*, OPHTHALMIC MUT. INS. CO. (Nov-Dec. 1994), https://www.omic.com/collegial-criticism-and-the-courtroom/ [https://perma.cc/959C-S456].

6. *See* Alan H. Rosenstein & Michelle O'Daniel, *A Survey of the Impact of Disruptive Behaviors and Communication Defects on Patient Safety*, 34 JOINT. COMM'N J. ON QUALITY & PATIENT SAFETY 464, 464 (2008); Catherine C. Razzi & Ann L. Bianchi, *Incivility in Nursing: Implementing a Quality Improvement Program Utilizing Cognitive Rehearsal Training*, 54 NURSING F. 526, 527 (2019); Whitney Wright & Naresh Khatri, *Bullying Among Nursing Staff: Relationship with Psychological/Behavioral Responses of Nurses and Medical Errors*, 40 HEALTH CARE MGMT. REV. 139, 140 (2015); Jennifer L. Embree & Ann H. White, *Concept Analysis: Nurse-to-Nurse Lateral Violence*, 45 NURSING F. 166, 166 (2010); Katherine Granstra, *Nurse Against Nurse: Horizontal Bullying in the Nursing Profession*, 60 J. HEALTHCARE MGMT. 249, 250 (2015).

7. Wright & Khatri, *supra* note 6, at 140.

8. *Id*.

9. Embree & White, *supra* note 6, at 166.

10. *Id*. at 167.

11. Richard Sheff, *Vignette 4: Physician-to-Nurse Communication*, 7 ETHICS JAMA 551, 552 (2005).

III. HOSPITAL VICARIOUS LIABILITY

Consideration of hospital vicarious liability for the negligence of hospital employed physicians requires a departure from classic tort law/agency law analysis. Typically, the focus is on respondeat superior, the liability of a master-type principal for the negligent acts of a servant-type agent, committed within the course and scope of employment.[12] "[R]espondeat superior traditionally has been limited in application to employees or other agents and based on the employer's (principal's) right to control the work . . . ."[13] Therefore, it is fair to suggest that the traditional respondeat superior analysis would involve employees not involved in work requiring a high degree of skill or judgment,[14] such as the work of a physician. This issue has been addressed in legal scholarship,[15] noting that "courts are continuing to struggle with the right of control concept and its bearing upon respondeat superior"[16] in the hospital setting. The terms of a physician's contract of employment with a hospital and how the physician is compensated by the hospital are likely significant factors in the right of control equation.[17]

Although the application of respondeat superior to hospital liability for employed physicians may be uncertain and difficult, its consideration has become increasingly important. Medical literature has reported a substantial rise in the hospital-physician employment relationship.[18] There are mutual benefits resulting from this relationship. "Physician employment typically is one of many strategies to gain market share by increasing admissions, diagnostic testing and outpatient services."[19] Hospitals hire "primary care physicians to capture

12. *See* Robert L. Wills, *Joinder of Master and Servant*, 23 OHIO ST. L.J. 488, 488 (1962); Christine W. Young, *Respondeat Superior: A Clarification and Broadening of the Current Scope of Employment Test*, 30 SANTA CLARA L. REV. 599, 600 (1990).

13. Diane M. Janulis & Alan D. Hornstein, *Damned if You Do, Damned if You Don't: Hospitals' Liability for Physicians' Malpractice*, 64 NEB. L. REV. 689, 695 (1985).

14. *See* WILLIAM L. PROSSER, LAW OF TORTS, § 70, at 460-61 (4th ed. 1971) (discussing the traditional master-servant relationship).

15. *See* Roy K. Lisko, *Hospital Liability under Theories of Respondeat Superior and Corporate Negligence*, 47 UMKC L. REV. 171, 171 (1978).

16. *Id*. at 174.

17. *Id.* at 176.

18. *See, e.g.*, Robert Kocher & Nikhil R. Sahni, *Hospitals' Race to Employ Physicians — The Logic Behind a Money-Losing Proposition*, 364 NEW ENG. J. MED. 1790 (2011); Rachel Gifford et al., *Two Sides to Every Coin: Assessing the Effects of Moving Physicians to Employment Contracts*, 292 SOC. SCIENCE. & MED. 1 (2022); Leigh Walton et al., *Hospitals Employing Physicians: A Practical Guide to Buying Physician Practices and Compensating Employed Doctors*, 22 HEALTH LAW. 1 (2009); Ann S. O'Malley et al., *Rising Hospital Employment of Physicians: Better Quality, Higher Costs?*, 136 CTR. FOR STUDYING HEALTH SYS. CHANGE 1 (2011); Shlomo Noy & Ran Lachman, *Physician-Hospital Conflict Among Salaried Physicians*, 18 HEALTH CARE MGMT. REV. 60 (1993).

19. O'Malley et al., *supra* note 18, at 1.

referrals for their employed specialists."[20] Physicians benefit from hospital employment in multiple respects:

- Primary care physicians who practice independently "face challenges . . . because flat reimbursement rates and growing overhead costs are more of a challenge for their practices, which typically cannot generate significant revenue through procedures and ancillary services."[21]
- Hospital employed physicians can avoid the cost of professional medical liability insurance coverage.[22]
- Hospital employed physicians can avoid the costs of "technology and evidence-based medicine, including implementation of expensive and time-consuming electronic health records."[23]
- Hospital employed physicians may experience better quality of life than independent physicians.[24]

Can hospitals exercise sufficient control over employed physicians to satisfy the requirements of respondeat superior? It has been reported that control is exercised by "placing physicians on salary, imposing exclusive hospital affiliation, and providing physicians with managerial jobs."[25] "Options for physician compensation vary widely from a straight salary model to salaries plus a productivity component, to even more complex forms of revenue-sharing spread among a group or department."[26] Furthermore, hospitals will exercise control over employed physicians by scheduling their working hours—likely a complicated matter.[27]

Nursing scholarship reports that "[n]ursing professionals make up the largest group of health care providers in the United States."[28] As of 1990, it was reported that "two thirds of employed nurses practice in hospital settings."[29] As of 2021, the U.S. Bureau of Labor Statistics reported that registered nurses comprised more than thirty percent of general medical and surgical hospital employees.[30]

20. *Id*. at 2.

21. *Id*.

22. *Id.*; *see also* Walton et al., *supra* note 18, at 4-5.

23. Walton et al., *supra* note 18, at 7.

24. O'Malley et al., *supra* note 18, at 2.

25. Noy & Lachman, *supra* note 18, at 60.

26. Walton et al., *supra* note 18, at 21.

27. *See* Melanie Erhard et al., *State of the Art in Physician Scheduling*, 265 EUR. J. OPERATIONAL RSCH. 1, 1 (2018).

28. Wright & Khatri, *supra* note 6, at 140.

29. Linda H. Aiken, *Charting the Future of Hospital Nursing*, 22 IMAGE: J. NURSING SCHOLARSHIP 72, 72 (1990).

30. *Occupational Employment and Wages*, U.S. BUREAU LAB. STAT. (May 2021), https://www.bls.gov/oes/2021/may/oes291141.htm [https://perma.cc/B74F-MU38].

Of course, hospital employed nurses are agents of their employers. Hospitals exercise control over employed nurses through employment tasks.[31]

Before addressing the evidentiary issue, which is the focus of this paper,[32] the applicability of respondeat superior liability to hospitals for the negligence of employed physicians must be resolved. Sixty-five years ago, in *Bing v. Thunig*,[33] Judge Fuld, writing for the Court of Appeals of New York, addressed this issue and stated:

> The doctrine of *respondeat superior* is grounded on firm principles of law and justice. Liability is the rule, immunity the exception.

> [Hospitals] regularly employ on a salary basis a large staff of physicians, nurses and internes, as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such services, if necessary, by legal action. Certainly, the person who avails himself of "hospital facilities" expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility.
>
> Hospitals should, in short, shoulder the responsibilities borne by everyone else. There is no reason to continue their exemption from the universal rule of *respondeat superior*. The test should be, . . . as it is for every other employer, was the person who committed the negligent injury-producing act one of its employees and, if he was, was he acting within the scope of his employment.[34]

Hospital vicarious liability for medical negligence committed by employed physicians exists, but only after a careful review of the specific hospital-physician relationship.[35] With that understanding, this paper turns its focus to vicarious opposing parties' statements. Thereafter, this paper will focus on case law discussing vicarious liability of hospitals and other health care providers which directly employ physicians and nurses.

31. *See* Barbara R. Norrish & Thomas G. Rundall, *Hospital Restructuring and the Work of Registered Nurses*, 79 MILBANK Q. 55, 56 (2001).

32. FED. R. EVID. 801(d)(2).

33. 143 N.E.2d 3, 8 (1957).

34. *Id.* at 8.

35. *Compare* Mduba v. Benedictine Hosp., 52 A.D.2d 450, 452-53 (N.Y. App. Div. 1976) (finding the physician was "not an independent contractor but an employee of defendant hospital" where the physician's contract required that he directed and supervised the emergency room pursuant to "the rules and regulations of the defendant hospital's governing board" and that he "was controlled by the defendant hospital as to the means or manner of achieving this result"), *with* Lilly v. Fieldstone, 876 F.2d 857, 859-60 (10th Cir. 1989) (holding that a civilian physician, who was a urology consultant for the U.S. Army, was an independent contractor, not a U.S. government employee, where he "billed the Army separately at his standard specialty fee rates . . . , maintained a private off-base office, and had exclusive control over his patients and records").

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

IV. AN OPPOSING PARTY'S STATEMENT

Since hospitals (and other health care organizations) can be vicariously liable for medical negligence committed by their employed physicians and nurses pursuant to respondeat superior, it is important to examine whether an employed physician's or nurse's statements criticizing other hospital employed physicians constitute opposing party's statements. If so, the critical statements may provide the foundation of the hospital's vicarious liability.[36]

An opposing party's statement, historically referred to as an admission of a party opponent,[37] really need not be civilly or criminally inculpatory. They "are simply words or actions of the opposing party inconsistent with that party's position at trial, relevant to the substantive issues in the case, and offered against that party."[38] Insofar "[a]s applied to personal statements by a party, . . . [e]ssentially, anything a party says or does is admissible if offered [in evidence] by the party's opponent."[39]

Federal Rule of Evidence 801(d)(2) defines statements that are not hearsay to include the following:

> (2) *An Opposing Party's Statement*. The statement is offered against an opposing party and:
>
> * * * *
>
> (D) was made by the party's agent or employee on a matter within the scope of that relationship and while it existed;
>
> * * * *
>
> The statement must be considered but does not by itself establish . . . the existence or scope of the relationship under (D) . . . .[40]

State jurisdictions may have analogous rules,[41] or rules that classify an opposing party's statement as a hearsay exception.[42]

This rule "authorizes the admission of a statement by a party's agent or servant concerning a matter within the scope of the agency or employment where the statement is offered against the party-principal or the party-employer."[43] Significantly, "the statement of the agent or employee need only be made 'on a

---

36. Diane Cafferata & Carl Spilly, *Supercharging your Case with Party-Opponent Admissions*, DAILY J. (Apr. 15, 2020), https://www.quinnemanuel.com/media/hg4olak4/qeus-dj-4-15-20.pdf [https://perma.cc/N9GX-JAS3].

37. *See* KENNETH S. BROUN ET AL., MCCORMICK ON EVIDENCE 573 *et seq.* (7th ed. 2014).

38. *Id*. at 574.

39. ROGER C. PARK ET AL., EVIDENCE LAW 533 (4th ed. 2018).

40. FED. R. EVID. 801(d)(2).

41. *See, e.g.*, ILL. R. EVID. 801(d)(2); IND. R. EVID. 801(d)(2); OHIO R. EVID. 801(D)(2).

42. *See* Lichtenberger v. Geisinger Cmty. Med. Ctr., No. 142 MDA 2018, 2019 WL 1400101, at *5 (Pa. Super. Ct. Mar. 27, 2019) (referring to Pa. R.E. 803(25)(D)).

43. GLEN WEISSENBERGER & JAMES J. DUANE, FEDERAL RULES OF EVIDENCE: RULES, LEGISLATION HISTORY, COMMENTARY AND AUTHORITY § 801.20, at 555-56 (7th ed. 2011).

matter' within the scope of the agency or employment,"[44] and "no express or implied speaking authority need be established."[45] This is of particular importance when considering an employed physician's or nurse's criticisms of an employer hospital, healthcare provider, or co-employed physician.

As a preliminary matter, it is noteworthy that, unlike hearsay exceptions, opposing party's statements, as non-hearsay statements pursuant to FRE 801(d)(2), need not be "trustworthy."[46] That said, it has been urged that:

> [M]ost statements admitted under this provision are likely to be trustworthy for reasons that help account for its breadth: First, someone who speaks about his duties during the course of his agency or employment is likely to speak carefully and not loosely, since what he says may put employment at risk . . . . Second, a speaker describing such matters is likely to be well informed.[47]

It is also important to mention that there is not a large volume of reported decisions concerning vicarious opposing party's statements by physician declarants. Therefore, this paper will also include analyses of cases involving nurse declarants.

V. THE NEED TO ESTABLISH AN AGENCY RELATIONSHIP

Two recent cases demonstrate that courts will look closely for evidence of an agency relationship between a physician and hospital as a predicate for potential vicarious liability. In *Burnett v. United States*, a medical negligence claim arose from a surgical procedure performed at a facility affiliated with the University of Cincinnati.[48] Multiple physicians, the University of Cincinnati Medical Center, and the University of Cincinnati Health were named as defendants, the latter two allegedly via vicarious liability.[49]

The hospital affiliated physicians named as defendants had privileges to practice medicine.[50] The District Court quite clearly stated that "[i]f a hospital is to be held vicariously liable for the malpractice of a physician practicing therein, merely granting privileges to the physician is not enough to create a direct agency relationship between the hospital and the physician."[51] A grant of staff privileges is not tantamount to employment.[52] Therefore, the vicarious liability claims failed under a theory of ostensible agency.[53]

44. *Id.*
45. *Id.*
46. CHRISTOPHER B. MUELLER ET AL., EVIDENCE § 8.32, at 861-62 (6th ed. 2018).
47. *Id*.
48. No. 19-CV-43, 2020 WL 6702127, at *1 (S.D. Ohio Nov. 13, 2020).
49. *Id.* at *1.
50. *Id.*
51. *Id.* at *2.
52. *See* BARRY FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 790 (8th ed. 2018).
53. *Burnett*, 2020 WL 6702127, at *3.

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

In *Lichtenberger v. Geisinger Community Medical Center*, the Superior Court of Pennsylvania considered an appeal from a jury verdict in favor of the defendants—a physician, physician assistants, and the hospital.[54] The negligence claim arose from a coronary artery bypass graft procedure, including "the harvesting of the greater saphenous vein in [the patient's] left leg so that it could be used to facilitate bypassing the blockages discovered in his coronary artery."[55] Complications from the vein harvesting procedure led to the lawsuit.[56]

The vicarious opposing party's statement arose on appeal as the trial court disallowed testimony from the appellant and his neighbor regarding a statement made to them by Dr. Stahl, a non-party physician.[57] Dr. Stahl allegedly stated that "Dr. Stahl's colleague had nicked appellant's nerve."[58] The appellate issue was whether Dr. Stahl's statement was admissible as an opposing party's statement, a hearsay exception under the Pennsylvania rules of Evidence.[59]

At trial, Dr. Singh, the defendant-operating cardiac surgeon, testified as followed when asked to identify Dr. Stahl: "Dr. Stahl at that time was one of my colleagues and partners."[60] Dr. Singh also testified that at the defendant hospital, Dr. Stahl was "'in charge' with respect to determining individuals' roles in surgery."[61] Despite this testimony, the Superior Court held that the patient-appellant failed to establish the necessary foundation to reveal an agency relationship between Dr. Stahl and the defendant-hospital.[62] Therefore, Dr. Stahl's statement to the patient and his neighbor, allegedly criticizing Dr. Stahl's colleague, Dr. Singh, was not admissible against the defendant-hospital as a vicarious opposing party's statement.[63]

VI. THE OHIO EXPERIENCE

The Court of Appeals of Ohio recently published two opinions concerning vicarious opposing parties' statements in healthcare.[64]

54. 2019 WL 1400101, at *1.
55. *Id.* at *1.
56. *Id.*
57. *Id.* at *4.
58. *Id.*
59. *Id.* at *2.
60. *Id.* at *4.
61. *Id.*
62. *Id.* at *6.
63. *Id.* at *5.
64. Pontius v. Riverside Radiology & Interventional Assocs., 49 N.E.3d 353 (Ohio Ct. App. 2016); Bromall v. Select Specialty, Hosp., 193 N.E.3d 609 (Ohio Ct. App. 2022).

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

A. *Pontius v. Riverside Radiology & Interventional Associates*[65]

In *Pontius,* the medical issue was whether "a computerized tomography ('CT') scan analyzed by appellees the day before the decedent's death showed blood clots in his inferior vena cava."[66] The medical negligence action claimed that a radiologist employed by defendant Riverside Radiology failed to appreciate this finding.[67]

The patient, with "a history of deep vein thrombosis ('DVT')[68] and pulmonary embolism ('PE')),"[69] was treated at the Riverside Hospital emergency room. Significantly, the patient "had medically installed in his body a filter to catch blood clots before they could enter the heart and lungs."[70]

A Riverside Radiology employed radiologist, Dr. Zadvinskis, interpreted a CT scan of the patient's abdomen and pelvis and reported that "other than the presence of the filter, the scan images were essentially normal."[71] Another physician, who reviewed these findings with Dr. Zadvinskis, provided these results to the patient and his wife.[72] The patient was "prescribed an antibiotic for a possible urinary tract infection and pain pills"[73] and was sent home. The next day, "the decedent collapsed in the shower at home and died of what an autopsy later revealed was a pulmonary embolism."[74]

Those are the medical facts. The evidentiary "facts" next discussed, if true, are stranger than fiction.

Following the decedent's demise, the mother of the decedent was introduced by a golf pro to Dr. Schultz, another "radiologist employed by Riverside Radiology [who] had the ability to view the decedent's CT scans."[75] Dr. Schultz reviewed the CT scans and later told the golf pro "that the CT scans had indeed showed clots built up behind the vena cava and on the side of the filter."[76] Dr.

65. *Pontius*, 49 N.E.3d at 353.

66. *Id.* at 354. For medical scholarship discussing inferior vena cava thromboses and related imaging studies, see Lauren B. Kaufman et al., *Inferior Vena Cava Filling Defects on CT and MRI*, 185 AM. J. ROENTGENOLOGY 717 (2005); B.J. McAree et al., *Inferior Vena Cava Thrombosis: A Review of Current Practice*, 18 VASCULAR MED. 32 (2013) (Eng.).

67. *Pontius*, 49 N.E.3d at 355.

68. *Id.* at 354. For a deeper understanding of what deep vein thrombosis entails, see Eran. E. Weinmann & Edwin. W. Salzman, *Deep-Vein Thrombosis,* 331 NEW ENG. J. MED. 1630 (1994); Paul A. Kyrle & Sabine Eichinger, *Deep Vein Thrombosis*, 365 LANCET 1163 (2005) (Eng.).

69. *Pontius*, 49 N.E.3d at 354. For medical scholarship discussing pulmonary embolism, see Clive Kearon, *Diagnosis of Pulmonary Embolism*, 168 CAN. MED. ASS'N J. 183 (2003); Jeffrey L. Carson et al., *The Clinical Course of Pulmonary Embolism*, 326 NEW ENG. J. MED. 1240 (1992).

70. *Pontius*, 49 N.E.3d at 354.

71. *Id*.

72. *Id*.

73. *Id*.

74. *Id.* at 354-55.

75. *Id.* at 355.

76. *Id*.

Schultz "met with two other doctors at Riverside Radiology,"[77] telling them "that the original review of the CT scans had missed the clot."[78] Dr. Schultz told the golf pro that the interpreting radiologist "blew it" and "that [the decedent] should be here today."[79] The golf pro "relayed [that] information to the decedent's wife."[80] Another physician, Dr. Carlucci, testified during discovery that "he was a witness to a conversation in which Dr. Schultz explained that he had looked at the CT scans taken of the decedent, and in his opinion, there was a clot evident on the scan images."[81]

The Court of Appeals opinion detailed relevant professional information about Dr. Schultz. He was an employee of Riverside Radiology, with a part-time status when the decedent died.[82] He was board certified in radiology, licensed to practice medicine and "[h]is job duties included interpreting . . . CT scans and also to peer-review the work of other radiologists to ensure quality."[83] Interestingly, Dr. Schultz' deposition testimony denied that, after reviewing the CT scans, he saw any unusual findings, and denied that he told the golf pro that he identified clots on the CT scans.[84]

At trial, the evidentiary issue was whether the golf pro and Dr. Carlucci could take the witness stand and testify to the statements made to them by the declarant, Dr. Schultz, which were critical of Dr. Zadvinskis and Riverside Radiology.[85] This issue was the subject of a motion in limine filed by Dr. Zadvinskis and Riverside Radiology, and the motion was granted.[86] The case went to trial and the jury returned a defense verdict.[87] On appeal, the issue was whether Dr. Schultz's statements which criticized his employer should be admissible as vicarious opposing party's statements pursuant to Ohio Rule of Evidence 801(D)(2)(d).[88] More specifically, under the evidentiary rule, did Dr. Schultz's statements criticizing his employer reflect "the authority to take action concerning the subject matter of statements?"[89] The law did not require that Dr. Schultz needed to have "authority to make damaging statements."[90]

The Court of Appeals concluded that, based on Dr. Schultz's professional qualifications and job duties, including the duty "to peer-review the work of

77. *Id*.
78. *Id*.
79. *Id.*
80. *Id.*
81. *Id.*
82. *Id.*
83. *Id.* at 355-56.
84. *Id.* at 356.
85. *Id*.
86. *Id.*
87. *Id.*
88. *Id.* at 357.
89. *Id.* at 358.
90. *Id.*

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

other radiologists to ensure quality,"[91] Dr. Schultz' statements did concern matters within the scope of his employment and, therefore, constituted vicarious opposing party's statements admissible against his employer.[92] The trial court's exclusion of these statements criticizing his employer was an abuse of discretion,[93] not harmless error, requiring a new trial.[94]

B. *Bromall v. Select Specialty, Hospital*[95]

In *Bromall*, the Court of Appeals considered a defense verdict in favor of Akron Nephrology Associates, Americare Kidney Institute and Dr. Al-Yafi, defendants in a medical negligence claim.[96] The claim concerned a patient admitted to Akron General Health Systems with, among other medical conditions, a diagnosis of chronic kidney disease.[97] While at the hospital, the patient was diagnosed with additional serious conditions.[98]

During this hospitalization, the patient "was started on hemodialysis following the implantation of a tunneled-dialysis catheter"[99] to address the patient's "deteriorating kidney function."[100] Tunneled dialysis catheters are commonly used in patients with end-stage renal disease.[101] Anchoring the catheter can involve the use of sutures,[102] as were used with this patient.[103]

Dr. Raina, an Akron Nephrology employed physician, "determined that the dialysis was improving [the patient's] condition" but that a discharge to outpatient care would be premature.[104] Instead, the patient was transferred to Select Specialty Hospital, a rehabilitation facility, at which Akron Nephrology "would continue to manage [the patient's] dialysis treatments and renal care."[105]

---

91. *Id.*
92. *Id.*
93. *Id.* at 361.
94. *Id.* at 362.
95. *Bromall*, 193 N.E.3d at 609.
96. *Id.* at 612.
97. *Id.*; *see* Kamyar Kalantar-Zadeh et al., *Chronic Kidney Disease*, 398 LANCET 786, 786-87 (2021) (Eng.) ("Chronic kidney disease is a progressive condition characterized by structural and functional changes to the kidney due to various causes. . . . Signs and symptoms of kidney failure result from progressive uraemia, anaemia, volume overload, electrolyte abnormalities, mineral and bone disorders, and acidaemia, and inevitably lead to death if left untreated.").
98. *Bromall*, 193 N.E.3d at 612-13.
99. *Id.* at 613.
100. *Id.*
101. *See* Mallika L. Mendu et al., *Non-Tunneled Versus Tunneled Dialysis Catheters for Acute Kidney Injury Requiring Renal Replacement Therapy: A Prospective Cohort Study*, 18 BIOMED CENT. NEPHROLOGY 351 (2017).
102. Anil K. Agarwal et al., *Avoiding Problems in Tunneled Dialysis Catheter Placement*, 32 SEMINARS DIALYSIS, 535, 539 (2019).
103. *Bromall*, 193 N.E.3d at 613.
104. *Id.*
105. *Id.*

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

At the rehabilitation facility, the patient was seen by various physicians, including nephrologists Dr. Raina and Dr. Al-Yafi, "an employee of Americare Kidney."[106] "Americare Kidney was in the process of acquiring Akron Nephrology, [and] Dr. Al-Yafi was treating Akron Nephrology patients and assisting other Akron Nephrology doctors during the merger."[107]

Without discussing the details of the patient's ensuing treatment managed by Dr. Al-Yafi, the Court of Appeals noted that "Dr. Al-Yafi did not employ 'urgent management' treatments," the patient "was found unresponsive," and died.[108] "The attending physician certified on [the patient's] death certificate that [the patient] died as a result of cardiopulmonary arrest secondary to end stage renal disease."[109]

Pre-trial discovery included deposition testimony by the decedent's sister, who was "a former medical assistant in the outpatient office of Akron Nephrology,"[110] and deposition testimony by other Akron Nephrology medical assistants.[111] They testified that Dr. Raina made the following statements to them which were quite critical of Dr. Al-Yafi:

- "[T]his is all Amr's [Dr. Al-Yafi] fault, this is all Amr's fault."[112]
- "This is all on Amr. This is all Amr's fault."[113]
- "It's all his fault. He killed [Kaschner]'s brother. He killed [Kaschner]'s brother."[114]
- "He should have been on dialysis. I had been giving him dialysis and Dr. Al-Yafi . . . did not dialyze him, . . . and that's what killed her brother."[115]
- "Amr killed him."[116]

In Dr. Raina's deposition testimony, he "adamantly denied making any statements to Akron Nephrology employees suggesting that Dr. Al-Yafi was responsible for [the patient's] death."[117]

Prior to trial, plaintiff and defendants filed motions in limine regarding Dr. Raina's statements criticizing Dr. Al-Yafi.[118] Plaintiff "asserted that because Dr.

106. *Id.*
107. *Id.*
108. *Id.*
109. *Id.* at 614.
110. *Id.*
111. *Id.*
112. *Id.*
113. *Id.*
114. *Id.*
115. *Id.*
116. *Id.* at 615.
117. *Id.*
118. *Id.*

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

Raina's statements were made within the course and scope of his partnership with Akron Nephrology, the statements were not hearsay because they constituted admissions of a party opponent under Evid. R. 801(D)(2)."[119] The trial court denied plaintiff's motion.[120]

The Court of Appeals characterized the "pivotal inquiry for admission" of Dr. Raina's statements as an opposing party's statements "is whether the statement was made by an agent or employee of the party opponent, during the existence of the relationship, concerning a matter within the scope of the employment or agency."[121] There was no doubt that Dr. Raina was employed by Akron Nephrology at the time of his statements.[122] Therefore, "[t]he only remaining question [was] . . . whether Dr. Raina's statements 'concern[ed] a matter within the scope of the agency or employment.'"[123]

In refining this question, the Court of Appeals noted that "the agency relationship need not encompass authority to make damaging statements but requires only the authority to take action concerning the subject matter of the statements."[124] Then, complicating the inquiry, the Court of Appeals stated that "[a]dmissions of liability against an employer, including statements of opinion regarding liability, are not within an employee's scope of employment and are therefore inadmissible"[125] as opposing party's statements; "[h]owever, factual assertions made by an employee within his or her knowledge and scope of employment are admissible."[126] What if Dr. Raina's statements were self-inculpatory? Under the rationale advanced by the Ohio Court of Appeals, would those statements constitute vicarious opposing party's statements?

Next, the Court of Appeals, at length, addressed and distinguished *Pontius*,[127] although it is arguable that the effort to distinguish *Pontius* was misplaced. The Court of Appeals clearly recognized significant facts about Dr. Raina:

119. *Id.*
120. *Id.*
121. *Id.* (citations omitted).
122. *Id.*
123. *Id.* at 620.
124. *Id.* (citations omitted).
125. *Id.* at 621 (citations omitted).
126. *Id.* (citations omitted).
127. *Id.* at 621-23.

- "[I]s a nephrology specialist";[128]
- "[W]as authorized to monitor and facilitate medical care to Akron Nephrology patients,"[129] including the deceased;
- "[W]as familiar with [the patient's] diagnosis";[130]
- "[F]acilitated [the patient's] referral to SSHA";[131]
- "[W]as personally involved, albeit briefly, in the management of [the patient's] renal care";[132]
- His "care included the facilitation of dialysis and the monitoring of [the patient's] potassium and creatine levels";[133] and
- His "disputed statements were made at [his] place of employment and concerned the care provided by another doctor who was treating patients on behalf of Akron Nephrology."[134]

Despite these facts, the Court of Appeals concluded that "Dr. Raina's statements concerning the care provided by Dr. Al-Yafi were not 'factual assertions' premised on his personal review of [the patient's] medical records following the accidental removal of [the patient's] catheter on March 29, 2016."[135] The Court of Appeals emphasized that Dr. Raina did not have knowledge of certain treatment details, including "blood-work data in the days leading to [the patient's] death or the [various] factors that Dr. Al-Yafi weighed" in connection with his treatment decisions.[136] Accordingly, the Court of Appeals characterized Dr. Raina's critical opinions as "unsubstantiated opinions . . . not based on objective facts gathered by Dr. Raina in the course of his employment."[137]

The Court of Appeals also noted that in *Pontius*, Dr. Schultz, the declarant, did have peer-review authority for Riverside Radiology,[138] and that Dr. Raina had no such authority.[139] However, it should be noted that in *Pontius*, Dr. Schultz, despite his peer-review authority, "denied doing an official review of the work in decedent's case."[140] Nevertheless, the Court of Appeals held that "Dr. Raina did not have the authority to take action concerning the subject matter

128. *Id.* at 622.
129. *Id.*
130. *Id.*
131. *Id.*
132. *Id.*
133. *Id.*
134. *Id.* at 622-23.
135. *Id.* at 623.
136. *Id.*
137. *Id.*
138. *Id.*
139. *Id.*
140. *Pontius*, 49 N.E.3d at 356.

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

of his alleged statements.”[141] Dr. Raina’s statements did not qualify as vicarious admissions admissible against his employer.[142]

The dissenting opinion, having considered that Dr. Raina’s actual involvement with the patient’s care fit well within his employment for Akron Nephrology, concluded that he “had authority to facilitate care for Akron Nephrology patients, and . . . this authority [was] sufficient to establish Dr. Raina’s statements were made in the scope of his employment.”[143] Frankly, the dissent is compelling. “[F]irsthand knowledge is not required for vicarious admissions of corporate employees . . . .”[144] Even if Dr. Raina’s criticisms of Dr. Al-Yafi were vindictive, as suggested by the majority’s characterization of their professional relationship,[145] they were not uninformed. It is fair to suggest that the Court of Appeals went to great lengths to distinguish *Pontius* and find that Dr. Raina’s statements did not qualify as opposing party’s statements.

VII. THE CASE OF THE UNIDENTIFIED DECLARANT

A. Aumand v. Dartmouth Hitchcock Medical Center[146]

Aumand is another case concerning pre-trial evidentiary rulings on motions in limine.[147] This negligence action against Dartmouth Hitchcock Medical Center alleged “negligent medical care . . . during [a] hospitalization there, leading to an infection, the amputation of parts of [the patient’s] hand, and ultimately her death.”[148] The patient’s deteriorating medical condition allegedly resulted from difficulties with the placement and complications of a left-hand catheter, used for the administration of glucose.[149]

The hospital’s motion in limine raised an interesting evidentiary objection. It focused on plaintiffs’ efforts to introduce a statement to the patient’s son by, presumably, a male employee of the hospital.[150] The patient’s son inquired of the declarant, “whom he met in the corridor near the nurse’s station, whether [the male employee] had seen or touched [the patient’s] hand.”[151] The patient’s son, at deposition, testified that this person responded, “it was injection of D-50

141. *Bromall*, 193 N.E.3d at 623.
142. *Id.*
143. *Id.* at 627. (Kilbane, J., dissenting).
144. BROUN ET AL., *supra* note 37, at 581.
145. *Bromall*, 193 N.E.3d at 623.
146. Aumand, v. Dartmouth Hitchcock Med. Ctr., 611 F. Supp. 2d 78 (D.N.H. 2009).
147. *Id.* at 82.
148. *Id.*
149. *Id.* at 82-83.
150. *Id.* at 93.
151. *Id.*

into the tissue of her hand. Someone had made a mistake. He had never seen anything like it."[152]

Significantly, during this testimony, the patient's son "could not recall anything about the man's appearance, such as his hair color, clothing, the characteristics of his voice, or what he was holding or doing at the time."[153] The patient's son "just thought he was a nurse, or a physician's assistant or something because he was the one I met."[154]

Did the unidentified declarant's statement to the patient's son qualify as a vicarious opposing party's statement, admissible against the defendant hospital? The trial court aptly noted that "[t]he proponent of a statement as an admission by an agent within the scope of his employment bears the burden of showing both the existence and scope of the relationship."[155] Pursuant to FRE 801(d)(2)(D) "[t]hese predicates may be shown by circumstantial evidence, so long as the evidence is more than simply the statement itself."[156]

The trial court, perhaps surprisingly, held that adequate circumstantial evidence existed to satisfy the requirements of FRE 801(d)(2)(D).[157] The unidentified declarant was "near the nurse's station."[158] In response to the question asked by the patient's son, the declarant revealed "specific knowledge" about the injured hand, that an injection was given, that he had seen the hand, and had "never seen anything like it."[159] From this, the trial court deduced that the declarant was a hospital employee, noting that the inability to identify the declarant is not a disqualifying factor.[160] The declarant's statements to patient's son were admissible against the defendant hospital as vicarious opposing party's statements.[161]

B. Donatucci v. AtlantiCare Health Services[162]

Donatucci is a premises liability case involving a physician declarant employed by the defendant.[163] Here, the plaintiff, "after picking up medication from a medical facility owned by defendants[,] . . . tripped on a broken portion of sidewalk while walking back to his car."[164] He suffered serious orthopedic

152. *Id.*
153. *Id.*
154. *Id.*
155. *Id.*
156. *Id.*
157. *Id.* at 93-94.
158. *Id.* at 94.
159. *Id.*
160. *Id.*
161. *Id.*
162. Donatucci v. Atlanticare Health Servs., No. A-1894-19, 2021 WL 1017411 (N.J. Super. Ct. App. Div. Mar. 17, 2021).
163. *Id.* at *1.
164. *Id*.

injuries.[165] Thereafter, "a female AtlantiCare employee" came to plaintiff's aid, purportedly telling the plaintiff and his daughter "that this was not the first time a visitor had fallen on the facility's uneven sidewalk."[166] During pre-trial discovery, plaintiff testified that this person may have been a physician "whose name began with a 'J,' though he was unsure."[167] He did not know if the declarant was Dr. Jill Rodgers.[168] A security guard testified that, inside the facility, "he observed plaintiff and Dr. Rodgers have a conversation, but did not hear any discussion of trees, uneven sidewalk, or prior complaints."[169]

On appeal from summary judgment in favor of the defendants, the Superior Court referred to New Jersey Rule of Evidence 803(b)(4),[170] a hearsay exception for a statement by a party opponent's agent, similar in language to the non-hearsay opposing party's statement contained in the Federal Rules of Evidence. The Superior Court noted that "the proponent [of the statement] must sufficiently identify the speaker."[171] Even though plaintiff could not specifically identify Dr. Rodgers as the declarant, plaintiff did so circumstantially through his testimony and through the testimony of the security guard regarding the requirement that "a doctor, in all non-emergent situations, [] assess visitors who fall on defendants' premises."[172] The Superior Court further noted that this "places Dr. Rodgers' alleged statements squarely within the scope of her employment."[173] Therefore, Dr. Rodgers' alleged statements were admissible against the defendant and the grant of summary judgment was reversed.[174]

These declarant identification cases are significant. Declarant identification is necessary but may occur circumstantially.

VIII. FACTS OR GOSSIP?

Brookover v. Mary Hitchcock Memorial Hospital[175]

In *Brookover*, a hospital negligence claim arising from the patient's post-operative fall in a hospital room resulting in a broken hip and defendant's waiver of an objection to the employment status of the declarant nurse resulted in the Court of Appeals focusing on the declarant's personal knowledge of key

165. *Id.*
166. *Id.*
167. *Id.*
168. *Id.*
169. *Id.* at *2.
170. *Id.* at *4.
171. *Id.*
172. *Id.*
173. *Id.*
174. *Id.*
175. Brookover v. Mary Hitchcock Mem'l Hosp., 893 F.2d 411 (1st Cir. 1990).

events.[176] The patient had a history of a serious seizure disorder and was hospitalized for a neurosurgical procedure to improve the disorder.[177]

The evidentiary issue concerned conversations that the patient's father had with nurses after the fall in the hospital room.[178] "The nurses told [the patient's father] that [the patient] should have been restrained to prevent him from getting out of bed."[179] The Court of Appeals spent considerable time in its opinion discussing that a FRE 801(d)(2)(D) declarant need not have personal knowledge of an event which is the subject of declarant's statement.[180] The Court of Appeals distinguished the nurses statements from "gossip,"[181] noting that:

> Although they were not present when [he] fell, they knew that he had fallen and injured himself and that he had not been physically restrained in bed. Defendant does not dispute these facts. No-one would be more knowledgeable about bed restraints than a hospital nurse, except possibly a doctor. So although the nurses did not have personal knowledge of all the circumstances surrounding the fall, the information they did have, albeit based on hearsay, was accurate and by virtue of their training and experience they were qualified to comment on whether or not bed restraints should have been used.[182]

Presumably, the surrounding circumstances (*i.e.*, the hospital setting) provided the additional evidence required to establish the existence or scope of the declarant's relationship pursuant to FRE 801(d)(2)(D).[183]

IX. A VICARIOUS OPPOSING PARTY'S STATEMENT BY ADOPTION?

In *Dalbey v. Heartland Regional Medical Center*,[184] the Missouri Court of Appeals reviewed a medical negligence case in which the jury returned a defense verdict.[185] The patient's claim centered on two emergency room visits, less than a month apart.[186] The first visit related to potential neurological issues, yet the patient was diagnosed "with gastritis versus peptic ulcer disease."[187] The second ER visit involved the same physician who attended to plaintiff at the initial ER

176. *Id.* at 413, 415.

177. *Id.* at 412-13 (noting the patient was treated by the performance of a corpus callosotomy); *see* Ali A. Asadi-Pooya et al., *Corpus Callosotomy*, 13 EPILEPSY & BEHAV. 271, 271 (2008) (defining corpus callosotomy as "a palliative treatment for intractable seizures").

178. *Brookover*, 893 F.2d at 413.

179. *Id.*

180. *Id.* at 415-18.

181. *Id.* at 418.

182. *Id.* at 417-18.

183. *Id.* at 412, 415.

184. 621 S.W.3d 36 (Mo. Ct. App. 2021).

185. *Id.* at 39.

186. *Id.* at 39-41.

187. *Id*. at 40.

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

visit.[188] In the ER, the patient "began experiencing an active seizure,"[189] and the ER physician (defendant) "ordered a non-contrast CT scan"[190] of the head, "the diagnostic tool of choice to exclude acute intracranial pathology . . . ."[191] The CT scan revealed intracerebral hemorrhaging and the patient was ultimately transported to the University of Kansas Medical Center for further treatment.[192] That treatment "revealed . . . an aneurysm in his right pericollosal [sic] artery, which had ruptured,"[193] intraparenchymal hemorrhage,[194] and subarachnoid bleeding.[195] The medical negligence claim that followed alleged that the defendant ER physician failed "to order a CT scan of [plaintiff's] head when [he] first visited Heartland's emergency room on November 6, 2011."[196] The claim alleged that the defendant medical center was vicariously liable for the ER physician's negligence.[197]

The evidentiary issue presented in this case related to conversations that occurred less than a month later between plaintiff's family members and the defendant-physician and other medical center personnel regarding the two ER visits.[198] The physician and other personnel "spontaneously denied there was any connection between [plaintiff's] symptoms on November 6 and the rupture of his brain aneurysm."[199] The trial court excluded the family's testimony in this regard.[200]

Apparently, plaintiff sought to admit the aforementioned comments of the defendant-physician and other medical center personnel as admissions of a party opponent.[201] Unlike the opposing party's statement governed by Federal Rule of

188. *Id.* at 40-41.

189. *Id.* at 41.

190. *Id.*

191. A. L. Callen et al., *Predictive Value of Noncontrast Head CT with Negative Findings in the Emergency Department Setting*, 41 AM. J. NEURORADIOLOGY. 213, 213 (2020).

192. *Dalbey*, 621 S.W.3d at 41.

193. *Id.*; *see* Xiaodong Zhai et al., *Risk Factors for Pericallosal Artery Aneurysm Rupture Based on Morphological Computer-Assisted Semiautomated Measurement and Hemodynamic Analysis*, 15 FRONTIERS NEUROSCIENCE 1, 2 (2021) (explaining that a pericallosal artery aneurysm rupture leads "to subarachnoid hemorrhage . . . , a devastating condition with a high mortality rate of 30-40%").

194. *Dalbey*, 621 S.W.3d at 41; *see* Bradley A. Gross et al., *Cerebral Intraparenchymal Hemorrhage: A Review*, 321 JAMA 1295, 1295 (2019) (reviewing intraparenchymal hemorrhage).

195. *Dalbey*, 621 S.W.3d at 41; *see* Robert G. Kowalski et al., *Initial Misdiagnosis and Outcome after Subarachnoid Hemorrhage*, 291 JAMA 866 (2004) (reviewing subarachnoid bleeding).

196. *Dalbey*, 621 S.W.3d at 42.

197. *Id.*

198. *Id.*

199. *Id.*

200. *Id.* at 45.

201. *Id.* at 46.

Evidence 801(d)(2),[202] under Missouri law, admissions of a party opponent must "consciously or voluntarily acknowledge[] the existence of certain facts unfavorable to, or inconsistent with, the position taken by the party at trial and relevant and favorable to the cause of the opposing party who offers the statement."[203] Since the statements made about the two ER admissions were consistent (*i.e.*, the two ER visits were unrelated), the statements did not qualify as admissions of a party opponent.[204]

Interestingly, neither the plaintiff, nor the Court of Appeals, raised the issue of testimony by the plaintiff's brother regarding the following statement he made to the defendant physician: "I told him that I didn't see how it didn't [have a relationship to the earlier emergency room visit]. It had to have because he came in here with headaches. And you told him that he had a stomach ulcer, pretty much."[205] The defendant physician did not respond to this statement.[206]

Could the defendant physician's non-response to the statement made to him by the plaintiff's brother constitute an opposing party's statement by adoption? Missouri law recognizes the adoptive admission as a hearsay exception.[207] If the defendant-physician would have understood the statement made to him and would reasonably be expected to respond, his non-response might have constituted an adoptive admission, and thus, a vicarious adoptive admission, providing a basis for potential vicarious liability of the defendant medical center.

X. COMMENTS ON THE LAW

As the aforementioned cases reveal, vicarious opposing party's statements made by employed physicians (or other employed health care professionals) are potentially significant as evidentiary matters in medical/hospital negligence litigation. Although, as Professor Morgan aptly noted many years ago, "it is important to distinguish between authority to do an act and authority to talk about it,"[208] that specific authority need not be granted to the declarant. The declarant-employee need only speak "on a matter within the scope of that [agency or employment]."[209] This liberal application to vicarious opposing party's statements may very well encourage courts to admit in evidence

202. WEISSENBERGER & DUANE, *supra* note 43, at 550 (explaining that under F.R.E. 801(d)(2) "any statement by a party is admissible providing it is offered against the party at trial").

203. *Dalbey*, 621 S.W.3d at 46.

204. *Id.*

205. *Id.* at 45.

206. *Id.*

207. *See* Hemphill v. Pollina, 400 S.W.3d 409, 414 (Mo. Ct. App. 2013); Whitley v. Whitley, 778 S.W.2d 233, 237 (Mo. Ct. App. 1989); *but see* FED. R. EVID. 801(d)(2) (defining adoptive opposing party's statements as non-hearsay, not hearsay exceptions).

208. Edmund M. Morgan, *The Rationale of Vicarious Admissions*, 42 HARV. L. REV. 461, 464 (1929).

209. FED. R. EVID. 801(d)(2)(D).

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

criticisms of care voiced by employed physicians and nurses, and, perhaps, other allied health professionals.

Another topic worthy of comment is "control," or lack of it, exercised by a hospital/health care organization over an employed physician. Despite scheduling, committee work, a salary, and employment contracts, which may be imposed on an employed physician, hospitals and health care organizations cannot actually control how a physician practices medicine. Obviously, the practice of medicine requires skill and judgement, distinguishing it from the classic master-servant relationship and respondeat superior. Nevertheless, courts that have recognized a physician's vicarious opposing party's statements do not focus on control of the physician.

XI. COMMENT ON MEDICAL EDUCATION

Years ago, my faculty colleague, Professor Amy Campbell, published a paper titled "*Teaching Law in Medical Schools: First, Reflect*."[210] With respect to providing legal education in medical school, she recommended, among other goals, as follows:

"Enhance medical student's ability to minimize malpractice exposure through legal understanding plus greater awareness of a host of other proactive measures (e.g., enhanced communication, power of apology)."[211] Of course, this is an excellent recommendation. Medical malpractice exposure is an occupational hazard.[212] Health care professionals in training should learn about tort law and other topics relating to medical liability. This paper suggests that health care professionals-in-training receive some education on the law of evidence, as well. The disruptive physician or nurse, and the well-meaning physician or nurse, who criticize colleagues may, unwittingly, provide ammunition for vicarious tort liability of their employers.

XII. CONCLUSION

Prosser teaches that "[t]he idea of vicarious liability was common enough in primitive law."[213] Certainly, it has been with us since then. Statements of employees, made within the scope of their employment, may be imputed to their employers pursuant to the evidentiary concept of the opposing party's statement.[214] The opposing party's statement made by an employee health care provider, criticizing the care rendered by a co-employed colleague, may provide the basis of a negligence claim against the employer-health care provider. Due

210. Amy T. Campbell, *Teaching Law in Medical Schools: First, Reflect*, 40 J. L., MED. & ETHICS 301 (2012).

211. *Id.* at 307.

212. Frank J. Knapp, *Malpractice Litigation*, 31 INS. COUNS. J. 55, 55 (1964).

213. PROSSER, *supra* note 14, at 458.

214. FED. R. EVID. 801(d)(2).

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

to its importance, this topic should be highlighted in the training of health care professionals.