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Torts: *Anderson v. Eichner*--Although Faculty Physicians, Resident Physicians, and Interns Face Private Tort Liability for Medical Malpractice, the State Is Immune

Christa L. Britton

Torts: *Anderson v. Eichner* — Although Faculty Physicians, Resident Physicians, and Interns Face Private Tort Liability for Medical Malpractice, the State Is Immune

Introduction

As it existed at common law, the doctrine of sovereign immunity shielded a governmental entity from liability for the tortious acts of its employees. In 1907, Oklahoma adopted the doctrine of sovereign immunity. The doctrine was judicially modified several times until the Oklahoma legislature codified its sovereign immunity policies in 1984 through the adoption of the Governmental Tort Claims Act (GTCA).[1] The GTCA affords immunity to the state, its political subdivisions, and to their employees for torts committed within the scope of employment.[2]

The recent Oklahoma Supreme Court case, *Anderson v. Eichner*,[3] examined the GTCA in relation to faculty physicians, resident physicians, and interns. The court held that these physicians are not acting within the scope of their employment while practicing medicine or providing treatment to patients.[4] Thus, if these physicians commit a tortious act while practicing medicine, the state is immune from liability, and the physicians are subject to private tort liability.[5] However, while engaged in teaching activities or while participating in a graduate medical program, these physicians are immune from liability, and the state is liable for their actions.[6]

Most states have abrogated or at least modified the common law doctrine of sovereign immunity. However, several jurisdictions have upheld immunity for faculty physicians, resident physicians, and interns. In contrast to Oklahoma's Governmental Tort Claims Act, the Federal Tort Claims Act provides immunity for physicians acting within the scope of their employment, even though the physician was practicing medicine or engaged in the treatment of patients.

Several implications result from the Oklahoma Supreme Court's decision in *Anderson*. First, plaintiffs may not be adequately compensated because a resident physician's and intern's tort liability is limited to $100,000 under the GTCA.[7] Thus, a plaintiff may attempt to find a deeper pocket to bear the liability. Second, in Oklahoma, state hospitals are immune from liability for the tortious acts of their

1. *See* Political Subdivision Tort Claims Act, ch. 203, 1978 Okla. Sess. Laws 431 (codified as amended at 51 OKLA. STAT. §§ 151-172 (1991 & Supp. 1995)).
2. *See* 51 OKLA. STAT. § 152.1(A) (1991).
3. 890 P.2d 1329 (Okla. 1994).
4. *See id.* at 1341.
5. *See id.*
6. *See id.*
7. *See* 51 OKLA. STAT. § 154(D) (Supp. 1995).

faculty physicians, resident physicians, and interns engaged in the practice of medicine.[8] Thus, a faculty physician remains as the only vicarious defendant when a plaintiff sues a resident physician or intern, and no statutory limit to recovery exists under the GTCA to limit his potential liability. Therefore, the faculty physician's insurer is placed in more jeopardy than a private physician's. Third, because resident physicians and interns engaged in the practice of medicine face tort liability, an appropriate standard of care should be developed for resident physicians because they are physicians in training. Resident physicians should not be held to the same standard of care as a licensed physician. Holding resident physicians to the same standard of care as a licensed physician would be unfair and financially burdensome.

Part I of this note will discuss the historical development of the doctrine of sovereign immunity in American common law as well as the development of the doctrine in Oklahoma law. Part II focuses on the Oklahoma Supreme Court's decision in *Anderson*. Part III will examine the Federal Tort Claims Act's treatment of federally employed physicians. Part IV will discuss the implications of the *Anderson* case. Finally, Part V will analyze *Anderson* in light of a subsequent Oklahoma Supreme Court opinion in *Strubhart v. Perry Memorial Hospital Trust Authority*.[9]

I. Doctrine of Sovereign Immunity

A. Historical Development in English and American Common Law

The doctrine of sovereign immunity shields a governmental entity from the tortious acts of its employees.[10] The United States borrowed its sovereign immunity principles from English common law.[11] English tradition stated that "the King could do no wrong."[12] In other words, the King was incapable of wrongdoing.[13] This legal maxim represented the idea that no court in England could obtain jurisdiction over the King unless he consented to the action.[14] This idea was firmly rooted in English common law when the colonies gained their independence from England.[15]

The newly independent United States modified English sovereign immunity principles and determined that the government is "immune from any suit to which it has not [yet] consented."[16] Subsequently, the doctrine was applied to state

8. *See Anderson*, 890 P.2d at 1337.

9. 903 P.2d 263 (Okla. 1995).

10. *See* Bruce G. Hart, Jr., *Medical Malpractice Protection Under the Federal Tort Claims Act: Protecting Both Physicians and Claimants*, 58 FORDHAM L. REV. 1107, 1107 (1990).

11. *See* George J. Meyer, *Sovereign Immunity for Tort Actions in Oklahoma: The Governmental Tort Claims Act*, 20 TULSA L.J. 561, 561 (1985).

12. *Id.* at 562.

13. *See generally* Edwin M. Borchard, *Government Liability in Tort*, 34 YALE L.J. 1, 3-5 (1924).

14. *See id.* at 4.

15. *See* Hart, *supra* note 10, at 1107 n.1.

16. *Id.*; *see also* Feres v. United States, 340 U.S. 135, 139 (1950).

governments. The foundation for the doctrine as illustrated by Justice Holmes is that "there can be no legal right against the authority that makes the law on which the right depends."[17] That is, the sovereign creates legal rights but is not required to abide by those rights.[18]

B. Sovereign Immunity in Oklahoma

The doctrine of sovereign immunity first appeared in Oklahoma law in 1907 in *James v. Trustees of Wellston Township*.[19] In *James*, the Oklahoma Supreme Court held that, absent a specific statute imposing liability, the township and the state are immune from liability.[20] Oklahoma employed the governmental-proprietary-function inquiry in assessing tort liability as to all levels of government.[21] Under the governmental-proprietary-function inquiry, a governmental entity retained sovereign immunity for tortious conduct performed in its governmental capacity; however, the governmental entity was subject to tort liability for conduct performed in its proprietary capacity.[22]

Until the Oklahoma Supreme Court's 1983 decision in *Vanderpool v. State*,[23] the state enjoyed almost complete immunity from tort liability with few exceptions.[24] In light of the expanded role of government in modern society, the *Vanderpool* court modified the common law doctrine of sovereign immunity.[25] The *Vanderpool* court declared that the governmental-proprietary-function inquiry should no longer be determinative in assessing tort liability.[26]

Instead, the *Vanderpool* court announced a new standard for determining the state's liability in tort actions. The court held that a state or local governmental entity is liable for the tortious acts of that entity's employees acting within the scope of employment, in the same manner as a private individual.[27] The *Vanderpool* court noted that its decision did not impact "any act of the Legislature in the area of governmental immunity whether presently in effect or hereafter passed."[28] In

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17. Kawananakoa v. Polybank, 205 U.S. 349, 353 (1907).

18. *See* James P. Cooney III & Robert J. Eidnier, *Sovereign Immunity for State Hospital Employees After* James v. Jane, 67 VA. L. REV. 393, 397 (1981).

19. 90 P. 100 (Okla. 1907).

20. *See id.* at 106.

21. *See* Vanderpool v. State, 672 P.2d 1153, 1156 (Okla. 1983).

22. *See* Meyer, *supra* note 11, at 568; *see also* Hershel v. University Hosp. Found., 610 P.2d 237 (Okla. 1980); Terry v. Edgin, 598 P.2d 228 (Okla. 1979); Oklahoma City v. Hill, 50 P. 242 (Okla. 1897).

23. 672 P.2d 1153 (Okla. 1983).

24. *See id.* at 1153; *see also* Meyer, *supra* note 11, at 569. The exceptions included:

> 1. the tortious activity in which the state was involved was being conducted in a proprietary, as opposed to governmental capacity; or 2. the state had purchased liability insurance, in which case implied consent to waive its immunity was assumed, up to the amount of the policy; or 3. the plaintiff had obtained a 'constitutionally complete' consent from the legislature to bring his tort cause of action against the state in its courts.

Id.

25. *See Vanderpool*, 672 P.2d at 1156.

26. *See id.*

27. *See id.* at 1156-57.

28. *Id.* at 1157.

further deference to the legislature, the court expressly stated that except for the case at bar, its opinion would not become effective until October 1, 1985.[29] The court set the effective date of the opinion two years in the future to provide the legislature enough time to consider the issue of sovereign immunity.[30]

In 1984, in response to the *Vanderpool* decision, the Oklahoma legislature codified its sovereign immunity policies through the enactment of the GTCA.[31] In the GTCA, the Oklahoma legislature adopted the doctrine of sovereign immunity.[32] In *Turner v. Board of County Commissioners*,[33] the Oklahoma Court of Appeals held that the GTCA is the exclusive remedy against a governmental entity within the state.[34] The *Turner* court specifically abrogated any previously existing common law or statutory right of recovery for torts falling within the GTCA's purview.[35]

Under the GTCA, the state, its political subdivisions, and all their employees are immune from tort liability for acts committed within the scope of their employment.[36] The GTCA defines "scope of employment" as "performance by an employee acting in good faith within the duties of his office or employment or of tasks lawfully assigned by a competent authority . . . ."[37]

With respect to faculty physicians, resident physicians, and interns, the following are employees of the state who fall within the scope of the GTCA:

> (1) physicians acting in an administrative capacity,
>
> (2) resident physicians and resident interns participating in a graduate medical education program of the University of Oklahoma Health Sciences Center . . . , and
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> (3) faculty members and staff of the University of Oklahoma Health Sciences Center . . . , while engaged in teaching duties.
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> Physician faculty members and staff of the University of Oklahoma Health Sciences Center . . . not acting in an administrative capacity or engaged in teaching duties are not employees or agents of the state. However, in no event shall the state be held liable for the tortious conduct of any physician, resident physician, or intern while practicing medicine or providing medical treatment to patients.[38]

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29. *See id.* at 1153. This opinion was rendered on July 26, 1983.

30. *See id.* at 1157.

31. *See* Political Subdivision Tort Claims Act, ch. 203, 431 Okla. Sess. Laws 1978 (codified as amended at 51 OKLA. STAT. §§ 151-172 (1991 & Supp. 1995)).

32. *See* 51 OKLA. STAT. § 152.1(A) (1991).

33. 858 P.2d 1283 (Okla. Ct. App. 1993).

34. *See id.* at 1289.

35. *See id.*

36. *See* 51 OKLA. STAT. § 152.1(A) (1991). This immunity applies irrespective of whether the state, its political subdivisions or its employees are performing proprietary or governmental functions. *See id.*

37. 51 OKLA. STAT. § 152(9) (Supp. 1995).

38. *Id.* § 152(5)(b).

Moreover, the GTCA provides in pertinent part that "the State or a political subdivision shall be liable for loss resulting from its torts or the torts of its employees acting within the scope of their employment . . . only where the state or political subdivision, if a private person or entity, would be liable for money damages under the laws of this State."[39] Recently, in *Anderson v. Eichner*,[40] the Oklahoma Supreme Court clarified the issue of when faculty physicians, resident physicians, and interns are "employees" of the state "acting within the scope of their employment" under the GTCA. The court then determined when faculty physicians, resident physicians, and interns are not provided immunity from tort liability under the GTCA.

II. Anderson v. Eichner

A. Facts

In *Anderson*, the Oklahoma Supreme Court consolidated two separate actions for disposition in a single opinion. The court joined these two actions to determine a single issue of first impression in Oklahoma: Whether the Governmental Tort Claims Act shields faculty physicians, resident physicians, and interns acting within the scope of their employment as state employees from tort liability in medical malpractice suits?

In the first action, the Anderson claim, a patient died from complications arising from a surgical attempt to place a central venous line (CVL) into the patient's jugular vein.[41] During the surgery, the patient's lung and subclavian vessel were punctured resulting in intrapulmonary and pleural hemorrhage.

Defendants in the Anderson claim included a resident intern, a resident physician, and a faculty physician at the University of Oklahoma Health Sciences Center (OUHSC).[42] The resident intern and resident physician were participating in a graduate medical education program at the OUHSC when they rendered medical treatment to the patient. The faculty physician supervised and instructed the resident intern and resident physician regarding the patient's treatment.

The representative of the patient's estate and next of kin brought a wrongful death action for medical malpractice against defendant-physicians. Defendant-physicians moved for summary judgment in the trial court. The trial court granted summary judgment holding that defendant-physicians are immune from suit under the GTCA because defendant-physicians were engaged in teaching duties or participating at the OUHSC as students.

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39. *Id.* § 153(A). A state or political subdivision is "subject to the limitations and exceptions specified in this act . . . ." *Id.*

40. 890 P.2d 1329 (Okla. 1994).

41. The CVL was needed to inject chemotherapeutic and antibiotic regiments into the patient. The patient was being treated for leukemia. The patient's existing CVL began leaking and this surgery was performed to replace it with a new CVL on his opposite side. *See id.* at 1333 n.2.

42. Plaintiffs also sued Oklahoma Memorial Hospital and the State of Oklahoma Teaching Hospital. Plaintiffs' claims against these two entities were pending in trial court when this decision was rendered. *See id.* at 1333 n.3.

In the second action, the Bhat claim, the patient died from complications arising from an elective valvuloplasty to correct a narrowing of her heart's mitral valve. During this procedure, the patient's heart was perforated, causing pericardial bleeding which interfered with her heart's functions. This procedure was performed by two faculty physicians and two resident physicians.

The patient's next of kin brought a medical malpractice action against defendants, the individual physicians.[43] Defendant-physicians moved for summary judgment. The trial court granted summary judgment, holding that defendant-physicians were immune from tort liability while engaged in teaching duties or while participating in a graduate medical education program at the OUHSC.[44]

B. Holding

The Oklahoma Supreme Court in *Anderson* held that although the state is shielded from liability, the GTCA does not extend immunity from tort liability to faculty physicians, resident physicians, and interns engaged in the activities of practicing medicine or providing treatment to patients.[45] The *Anderson* court noted, however, that faculty physicians engaged in teaching or administrative duties, as well as resident physicians and interns participating in a graduate medical education program, are immune from liability.[46]

C. Reasoning

The *Anderson* court reasoned that the question of the physicians' immunity from private tort liability turned on the construction of the GTCA.[47] The Oklahoma Supreme Court abrogated the doctrine of sovereign immunity in *Vanderpool v. State*.[48] In *Vanderpool*, the court held that in the absence of a statute, the state, political subdivisions, and their employees are liable in tort the same as a private individual or corporation.[49] In response to *Vanderpool*, the Oklahoma legislature enacted the GTCA in 1984.[50] In section 152.1(B) of the GTCA, the state's immunity is waived "only to the extent and in the manner provided in" the GTCA.[51] Under section 152.1(A) of the GTCA, the state, its political subdivisions, and all their employees are immune from private tort liability while acting within the scope of their employment.[52] Section 153 of the GTCA extends governmental

43. Plaintiff also sued the State of Oklahoma Department of Human Services, Oklahoma Memorial Hospital and the College of Medicine Private Practice Plan. Plaintiff's claims against these three entities were pending in district court when this decision was rendered. *See id.* at 1334 n.8.

44. *See id.* at 1334. That is, physicians were state employees acting within the scope of their employment under the GTCA. *See* 51 OKLA. STAT. § 152(5) (Supp. 1995).

45. *See Anderson*, 890 P.2d at 1341.

46. *See id.*

47. *See id.* at 1335.

48. *See id.*; Vanderpool v. State, 672 P.2d 1153, 1156-57 (Okla. 1983).

49. *Anderson*, 890 P.2d at 1335-36.

50. *See id.* at 1336.

51. *Id.*

52. *See id.*

liability to all torts for which a private person or entity would be liable subject to specific "limitations and exceptions."[53]

In determining whether the physicians were immune from liability pursuant to the GTCA, the *Anderson* court analyzed the definitional portion of the GTCA, specifically section 152(5), in which an "employee" within the scope of the GTCA is defined.[54] The language of section 152(5) distinguishes between two categories of physicians: (a) teachers or students and (b) practitioners of medicine.[55] However, in *Anderson*, the physicians were engaged in activities that included teaching or participating in an educational program and practicing medicine.[56] These activities do not fit exactly within section 152(5)'s definitional scheme.[57]

Thus, the *Anderson* court sought to determine the legislative intent behind the GTCA. The *Anderson* court opined that the legislature intended physicians to be outside the scope of their employment while engaged in the practice of medicine, even though at the same time they may be involved as a teacher or student.[58] The *Anderson* court noted that these physicians are protected by respondeat superior liability for their acts that do not involve treating patients.[59] Thus, pursuant to section 153(A) of the GTCA, the state is not liable for the physicians' acts while treating patients because "[t]he state . . . shall not be liable . . . for any act or omission of an employee acting outside the scope of his employment."[60]

However, defendant-physicians urged that section 152(5) may limit the state's liability but does not waive the physicians' individual immunity from private tort liability.[61] The *Anderson* court reasoned that the GTCA must be analyzed in its entirety and must be interpreted to be reasonable and consistent as a whole.[62] The *Anderson* court rejected defendant-physicians argument after a review of other sections of the GTCA. The *Anderson* court first discussed section 156(G) of the GTCA, which requires that claims and suits against resident physicians or interns must be made in accordance with title 12 (civil procedure) and title 76 (tort) of the Oklahoma Statutes.[63] In addition, section 163 subjects resident physicians to private

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53. *Id.* Section 153 provides:

> A. The state or a political subdivision shall be liable for loss resulting from its torts or the torts of its employees acting within the scope of their employment subject to the limitations and exceptions specified in this act and only where the state or political subdivision, if a private person or entity, would be liable for money damages under the laws of this state. The state or a political subdivision shall not be liable under the provisions of this act for any act or omission of an employee acting outside the scope of his employment.

51 OKLA. STAT. § 153 (1991).

54. *See Anderson*, 890 P.2d at 1336; *see also supra* text accompanying note 38.

55. *See supra* text accompanying note 38.

56. *See Anderson*, 890 P.2d at 1337.

57. *See id.*

58. *See id.*

59. *See id.*

60. 51 OKLA. STAT. § 153(A) (1991).

61. *See Anderson*, 890 P.2d at 1337.

62. *See id.* at 1338.

63. *See id.* Section 156(G) provides: "Claims and suits against resident physicians or interns shall

tort liability despite their employee status.[64] Section 154(D) limits resident physicians' and interns' liability to $100,000.[65] The court reasoned that the legislature included these provisions in the GTCA to protect student physicians in the event they are sued for medical malpractice.[66] The *Anderson* court concluded that because the legislature protected student physicians by enacting these provisions, the legislature intended to subject faculty and student physicians practicing medicine to individual tort liability.[67]

Therefore, the *Anderson* court concluded that even though defendant-physicians may have been acting as teachers or students when the tortious conduct occurred, they were also engaged in practicing medicine.[68] When a patient is brought to a clinical setting and the emphasis shifts to the treatment of illness, the physician is outside the scope of protection provided by the GTCA.[69]

D. Dissenting Opinion in Anderson

In *Anderson*, similar to the majority opinion, the dissent focused their argument on the interpretation of "employee" under the GTCA.[70] The majority differentiated between physicians as teachers and students versus physicians practicing medicine or treating patients. In contrast, the dissent opined that for the purpose of imposing liability, the distinction should lie between a physician treating a "state patient" versus a physician treating a "private patient."[71] The dissent argued that because the actions of the physicians in *Anderson* would not have been performed but for their status as faculty physicians and students participating in an educational program at the OUHSC, their acts must be considered those of state employees under the GTCA.[72]

In other words, the state hires faculty physicians for the purpose of training young physicians.[73] It is necessary for part of that training to take place in a clinical setting where patients are treated.[74] The *Anderson* dissent noted that "[t]eaching, training and treatment go hand-in-hand and all are integral components of the medical educational process."[75] The State of Oklahoma requires the faculty physicians it employs to perform all these functions.[76] The dissent reasoned that whether a faculty physician is teaching students, performing surgery, or treating the

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be made in accordance with the provisions of Titles 12 and 76 of the Oklahoma Statutes." 51 OKLA. STAT. § 156(G) (Supp. 1995).

64. *See Anderson*, 890 P.2d at 1338.
65. *See id.*
66. *See id.* at 1339.
67. *See id.*
68. *See id.* at 1341.
69. *See id.*
70. *See id.* (Watt, J., dissenting).
71. *See id.* at 1339 (Watt, J., dissenting).
72. *See id.* at 1341-42 (Watt, J., dissenting).
73. *See id.* (Watt, J., dissenting).
74. *See id.* at 1342 (Watt, J., dissenting).
75. *Id.* (Watt, J., dissenting).
76. *See id.* (Watt, J., dissenting).

state's patients, the physician remains a teacher.[77] The state pays this physician to perform these tasks, and the physician would not do these tasks but for his state salary.[78] Therefore, the dissent concluded that those activities should not be considered "practicing medicine or providing medical treatment to patients" pursuant to section 152(5).[79]

However, a faculty physician at a teaching hospital who is treating a private patient usually receives compensation directly from the patient.[80] The physician does not receive payment from the state, as in the case of a state patient.[81] Irrespective of his affiliation with the state, a faculty physician's treatment of private patients is "practicing medicine or providing treatment to patients" within section 152(5).[82] Even though a faculty physician may be engaged in teaching activities while treating a private patient, his reason for initially treating the patient was that the patient retained him, not that he was employed as a teacher by the state.[83]

In addition, this analysis of a faculty physician is applicable to resident physicians and interns participating in an educational program.[84] The state requires residents and interns to treat state patients as part of their scholastic responsibilities.[85] Residents and interns only engage in treating these patients because the state employs them to do so.[86] Thus, the residents' and interns' activities while treating the state's patients should be considered a portion of their educational process and not the practice of medicine pursuant to section 152(5).[87]

Therefore, the dissent in *Anderson* agreed with the trial courts that granted summary judgment to defendant-physicians.[88] The physicians in *Anderson* were engaged in either teaching or participating in an educational program as well as practicing medicine; however, they would not have done so but for their status as state employees.[89] Thus, pursuant to section 152(5), the physicians should be shielded from private tort liability.[90]

In response to the dissent's argument, the majority in *Anderson* argued that the plain language of the GTCA does not support the dissent's contentions. The majority argued that if the legislature had intended to distinguish between medical treatment rendered to a "state patient" and that given to a "private patient," it could have explicitly done so.[91]

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77. *See id.* (Watt, J., dissenting).
78. *See id.* (Watt, J., dissenting).
79. *See id.* (Watt, J., dissenting).
80. *See id.* (Watt, J., dissenting).
81. *See id.* (Watt, J., dissenting).
82. *See id.* (Watt, J., dissenting).
83. *See id.* (Watt, J., dissenting).
84. *See id.* (Watt, J., dissenting).
85. *See id.* (Watt, J., dissenting).
86. *See id.* (Watt, J., dissenting).
87. *See id.* (Watt, J., dissenting).
88. *See id.* (Watt, J., dissenting).
89. *See id.* (Watt, J., dissenting).
90. *See id.* (Watt, J., dissenting).
91. *See id.* at 1339.

The majority seems correct in that a plain reading of section 152(5) of the GTCA suggests that if the legislature intended to differentiate between medical treatment of "state" and "private" patients, it could have done so expressly. However, the dissent suggests a better alternative to the determination of liability under the GTCA as it currently exists for five reasons. First, the dissenting opinion recognizes the legitimate public interest of protecting faculty physicians, resident physicians, and interns engaged in the treatment of "state patients" and of ensuring that these physicians are properly trained. The state needs these physicians to treat its patients, and these physicians need the state to provide a training facility.

Second, these physicians are paid a salary by the state for treating "state patients"; thus, they should be considered state employees. However, physicians should be subject to tort liability for the negligent treatment of "private patients" because they receive compensation from the patient. Third, as one of their job functions, the state requires faculty physicians to not only teach young physicians but also to train them to practice medicine. Similarly, resident physicians and interns treat state patients as part of their academic responsibilities. Fourth, retaining immunity from private tort liability for physicians will attract qualified persons into governmental service. Finally, the dissent strikes a compromise between providing complete immunity from liability to physicians and providing them no protection under the GTCA.

III. The Federal Tort Claims Act's Treatment of Federally Employed Physicians

The Federal Tort Claims Act (FTCA) provides a limited waiver of the federal government's sovereign immunity.[92] The FTCA subjects the federal government to liability for the negligent acts of its employees but not its independent contractors.[93] If a physician is an independent contractor, the plaintiff's remedy is to sue the physician individually rather than to sue the United States.[94] If a court determines that a physician is a federal employee in a medical malpractice suit, the United States is substituted as the defendant for the physician.[95] Thus, the government bears the costs of litigation and liability.[96]

In addition, a physician is immune from private tort liability if deemed a federal employee.[97] However, whether the physician is a federal employee or an independent contractor, a judgment of medical malpractice will be placed in the physician's file in the National Practitioner Data Bank.[98] The physician is therefore subject to some degree of professional accountability, even though the physician bears no

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92. *See* 28 U.S.C. §§ 1346, 2671-2680 (1994).

93. *See id.* §§ 1345(b), 2671.

94. *See* Thomas K. Kruppstadt, *Determining Whether a Physician Is a United States Employee or an Independent Contractor in a Medical Malpractice Action Under the Federal Tort Claims Act*, 47 BAYLOR L. REV. 223, 224 (1995).

95. *See* 28 U.S.C. § 2679(d)(1) (1994).

96. *See id.* § 2679(c), (d)(1).

97. *See* Kruppstadt, *supra* note 94, at 225.

98. *See id.* Hospitals are required to request a search of the National Practitioner Data Bank whenever they offer a doctor hospital privileges. *See* 42 U.S.C. § 11131 (1994).

monetary responsibility.[99] In 1988, Congress amended the FTCA, adopting the Federal Employees Liability Reform and Tort Compensation Act in which a suit against the government under the FTCA was deemed the exclusive tort remedy for plaintiffs injured by government employees acting within the scope of their employment.[100]

A plaintiff will generally prefer to assert that a physician is a federal employee for several reasons. First, if the physician is a federal employee and the United States is substituted as the defendant, then the plaintiff has found a deep pocket for the payment of damages.[101] In other words, a plaintiff is not limited by the physician's assets and malpractice insurance limits.[102] Second and interrelated, a plaintiff is more likely to collect on a judgment rendered against the United States than from a private physician.[103]

These reasons justify retaining immunity from private tort liability for physicians employed by the state while treating "state patients" and subjecting the state to liability for these physicians' acts without regard to whether they were acting as a teacher, student, or a practitioner of medicine. Further, a plaintiff may find it easier to collect from the state than from a private physician, and the state is better able to bear the cost. In addition, the state has an interest in ensuring quality medical care. A stable and efficient medical service system will sustain a healthy population, therefore decreasing the demand on social welfare agencies.[104]

IV. Implications of Anderson v. Eichner

Resident physicians are physicians in transition.[105] These physicians have graduated from medical school and have learned the basic skills to practice medicine; however, they still have much to learn.[106] In addition, although most physicians receive their M.D. degree at the end of medical school, the majority of states require at least one year of clinical training.[107]

A significant problem with the *Anderson* court's decision to subject resident physicians and interns engaged in practicing medicine to private tort liability is that residents and interns have little liability insurance and few assets.[108] Under Oklahoma's GTCA, a resident physician's and intern's tort liability is limited to

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99. *See* Kruppstadt, *supra* note 94, at 225.

100. Federal Employees Liability Reform and Tort Compensation Act of 1988, Pub. L. No. 100-694, § 5, 102 Stat. 4563, 4564 (codified as amended at 28 U.S.C. § 2679(b)(1) (1994)); H.R. REP. NO. 100-700, at 2 (1988), *reprinted in* 1988 U.S.C.C.A.N. 5945, 5945-46.

101. *See* Kruppstadt, *supra* note 94, at 225.

102. *See id.*

103. *See id.*

104. *See* Terri Skladany, *Physician Immunity Under the Massachusetts Tort Claims Act: A Test Without Direction*, 10 W. NEW ENG. L. REV. 5, 35 (1988).

105. *See* Stewart R. Reuter, M.D., J.D., *Professional Liability in Postgraduate Medical Education: Who Is Liable for Resident Negligence?*, 15 J. LEGAL. MED. 485, 485 (1994).

106. *See id.*

107. *See id.*

108. *See id.* at 488.

$100,000.[109] However, this limit may fail to satisfy the tort principle of compensation in serious medical malpractice cases.[110] In other words, because recovery is statutorily limited, those plaintiffs who would otherwise obtain a judgment in excess of $100,000 are not adequately compensated.[111] As a result, a plaintiff may seek a deeper pocket to bear the liability.[112]

Thus, a plaintiff may attempt to recover vicariously from faculty physicians or the hospital. In most instances, a medical school is affiliated with a public hospital as in the *Anderson* case.[113] Medical schools need a public hospital's medical facilities to educate their medical students, and public hospitals need the faculty of medical schools to educate and train their residents.[114] Without these educational programs, public hospitals would have a difficult time finding sufficient physicians to treat their patients.[115]

Pursuant to Oklahoma's GTCA, the *Anderson* court concluded that the state is immune from liability for the tortious acts of its resident physicians, faculty physicians, and interns engaged in the practice of medicine.[116] Therefore, a faculty physician is left as the only available vicarious defendant when a plaintiff sues a resident or an intern.[117] Under Oklahoma's GTCA, no statutory limit to recovery exists to limit a faculty physician's liability. Because under certain theories of liability a private hospital may be liable for the acts of its staff physicians, this effectively places the faculty physician's insurer in greater jeopardy than a private practice physician's insurer.[118] In addition, this may increase the faculty physician's practice of defensive medicine and convey an improper message to resident physicians and medical students.[119] This practice will likely result in an increase in medical malpractice insurance.

Determining the appropriate standard of care for resident physicians in malpractice suits is another important consideration. Residents have few assets from which they can compensate injured patients. Thus, most injured patients seek recovery through the legal doctrine of respondeat superior, which is premised on the theory that the master should answer for the torts of the servant. However, the servant must be negligent before the master is liable for his actions.

If the standard is too high, then faculty physicians and medical schools will be held vicariously liable, for which the resident physician should be held accountable.[120] If the standard is too low, the plaintiff will not be adequately compensat-

109. *See* 51 OKLA. STAT. § 154(D) (Supp. 1995).
110. *See* Skladany, *supra* note 104, at 25.
111. *See id.*
112. *See* Reuter, *supra* note 105, at 488.
113. *See id.* at 487.
114. *See id.*
115. *See id.*
116. *See Anderson*, 890 P.2d at 1337.
117. *See* Reuter, *supra* note 105, at 514.
118. *See id.*
119. *See id.*
120. *See id.* at 489.

ed.[121] The crucial questions are: Should residents be held to the standard of care of a specialist even though they are not completely trained? Should they be held to the standards of a general practitioner even though they may have specialty training well in excess of a generalist?[122]

Resident physicians are in residency for three to seven years. During this period, their responsibilities, training, and experience improve. Most courts have held first-year residents to a general practitioner's standard of care.[123] However, most courts have not addressed the issue of the standard of care to which residents should be held after their first year. The majority who have examined the issue impose a specialist's standard of care.[124]

However, residents should be held to a progressively higher standard of care as their knowledge, experience, and training advance.[125] First-year residents should be held to a generalist's standard, and residents in their final year should be held to a specialist's standard of care.[126] Residents in the middle of their training should be held to a standard in between a generalist and a specialist.[127] Placing too great a standard of care on resident physicians will result in holding hospitals and faculty physicians unjustly accountable. However, imposing too low a standard of care may leave plaintiffs without adequate compensation for their injuries.

V. Understanding Anderson in Light of Strubhart v. Perry Memorial Hospital Trust Authority[128]

The Oklahoma Supreme Court rendered its decision in *Anderson* several months prior to its decision in *Strubhart.* In *Anderson,* the court noted that resident physicians, faculty physicians, and interns remain within the purview of respondeat superior liability for their activities that do not involve practicing medicine.[129] The *Anderson* court opined that the language of section 152 of Oklahoma's GTCA, providing that the state is not liable for medical malpractice, indicates that the legislature attempted to maintain the same protection that is afforded private hospitals in similar situations.[130] Under the doctrine of respondeat superior, an employer is generally held liable for those acts of an employee that fall within the

121. *See id.*

122. *See id.* at 488.

123. *See id.* at 490; *see also, e.g.,* Bahr v. Harper-Grace Hosp., 497 N.W.2d 526, 528 (Mich. Ct. App. 1993).

124. *See* Reuter, *supra* note 105, at 490; *see also, e.g.,* Harrigan v. United States, 408 F. Supp. 177, 185 (E.D. Pa. 1976); Valentine v. Kaiser Found. Hosps., 15 Cal. Rptr. 26, 33 (Ct. App. 1961); Parmelee v. Kline, 579 So. 2d 1008, 1016-17 (La. Ct. App. 1991); Felice v. Valley Lab, Inc., 520 So. 2d 920, 928 (La. Ct. App. 1987); Jenkins v. Clark, 454 N.E.2d 541, 551 (Ohio Ct. App. 1982); Pratt v. Stein, 444 A.2d 674, 708 (Pa. Super. Ct. 1982).

125. *See* Reuter, *supra* note 105, at 492.

126. *See id.*

127. *See id.*

128. 903 P.2d 263 (Okla. 1995).

129. *See Anderson,* 890 P.2d at 1337.

130. *See id.* at 1337 n.24.

employer's authority.[131] However, the *Anderson* court noted that in most jurisdictions, the theory of respondeat superior is not extended to subject a hospital to liability for the tortious acts of a staff physician because the physician is usually considered an independent contractor operating on his own behalf.[132] Thus, private hospitals are generally free from liability for the tortious acts of their staff physicians.

However, as a result of *Strubhart*, private hospitals are now subject to increased liability for the negligent acts of their physicians. The court's decision in *Strubhart* extended a private hospital's potential liability beyond respondeat superior by adopting the doctrine of independent hospital corporate negligence.[133] The court imposed an independent and direct duty of ordinary care upon hospitals to ensure that an incompetent physician has not been granted staff privileges.[134] This duty requires the hospital to take some reasonable steps to ensure that action is taken to protect patients.[135]

The Oklahoma Supreme Court has never answered the question of whether under the current version of the GTCA the doctrine of independent hospital corporate negligence applies to state hospitals as well as to private hospitals. However, in *Nelson v. Pollay*,[136] the Oklahoma Supreme Court did address this issue under the 1985 version of the GTCA.[137] In *Nelson*, a patient brought a medical malpractice action against a state-owned hospital and faculty physician, alleging negligent medical treatment. The *Nelson* court held that the standards of liability which govern private hospitals extend to a state hospital that is liable under the 1985 version of the GTCA in tort for a negligence of nonemployee physicians who provided health care services at the hospital.

Thus, the *Nelson* court noted that under *Strubhart*, a private hospital owes an independent duty directly to its patients to exercise ordinary care in extending and supervising medical staff privileges of physicians.[138] The *Nelson* court opined that although faculty physicians practicing medicine are not state employees, "their 'nonemployee' status does not relieve a state hospital of its responsibility properly to credential medical-staff physicians."[139]

Although the *Nelson* court rendered its decision based on the 1985 version of the GTCA, its analysis is likely applicable to the current version of the GTCA. If so, state hospitals and Oklahoma teaching hospitals (collectively, the State Hospitals) may be held liable for the negligent supervision and extension of staff privileges to physicians who commit tortious acts while practicing medicine, even though the State Hospitals are not liable under the doctrine of respondeat superior for the

131. *See id.*
132. *See id.*
133. *See Strubhart*, 903 P.2d at 266.
134. *See id.*
135. *See id.* at 273.
136. 916 P.2d 1369 (Okla. 1996).
137. *See id.* at 1376.
138. *See id.* (citing *Strubhart*, 903 P.2d at 274-76).
139. *Id.* at 1375 n.30.

physician's tortious acts. However, the State Hospitals have a persuasive argument that the following language, which was not included in the 1985 version of the GTCA, indicates a contrary intent of the legislature: "[I]n no event shall the state be held liable for the tortious conduct of any physician, resident physician or intern while practicing medicine or providing medical treatment to patients."[140]

When the Oklahoma Supreme Court finally determines the issue, the court should hold the State Hospitals accountable for failing to properly credential medical staff physicians. The State Hospitals should not be shielded from tort liability because the justifications for imposing the doctrine of independent corporate negligence are equally applicable to state and private hospitals.

The primary justification for adopting the corporate liability doctrine is to increase a hospital's liability based on the modern hospital's changing role.[141] Today, hospitals are large, profit-making corporations, which offer extensive medical services within a corporate framework.[142] A patient "expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility."[143] Patients believe the physicians are caring for them on the hospital's behalf.[144] Therefore, the public's increased reliance on hospitals justifies adoption of corporate liability.[145] It is inequitable for private hospitals, faculty physicians, resident physicians, and interns to face increasing liability while state hospitals hide under the cloak of sovereign immunity.

Conclusion

The recent Oklahoma Supreme Court decision in *Anderson v. Eichner*[146] determined that faculty physicians, resident physicians, and interns practicing medicine are not immune from private tort liability.[147] The dissenting opinion in *Anderson* presents a persuasive argument that faculty physicians, resident physicians, and interns should be immune from liability while treating "state" patients because these physicians are compensated by the state and would not treat these patients but for their status as employees of the state.[148] In addition, the State of Oklahoma requires the faculty physicians it employs to perform the functions of teaching, training, and treatment.[149] The faculty physician remains a teacher, even

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140. 51 OKLA. STAT. § 152(5)(b)(3) (Supp. 1995).

141. *See* Darling v. Charleston Community Memorial Hosp., 211 N.E.2d 253, 257 (Ill. 1965); Pedroza v. Bryant, 677 P.2d 166, 169 (Wash. 1984); Johnson v. Misericordia Community Hosp., 301 N.W.2d 156, 164 (Wis. 1981).

142. *See* David H. Rutchik, *The Emerging Trend of Corporate Liability: Courts' Uneven Treatment of Hospital Standards Leaves Hospitals Uncertain and Exposed*, 47 VAND. L. REV. 535, 538 (1994).

143. *Darling*, 211 N.E.2d at 257 (quoting Bing v. Thunig, 143 N.E.2d 3, 8 (N.Y. 1957)).

144. *See Johnson*, 301 N.W.2d at 164.

145. *See Pedroza*, 677 P.2d at 169.

146. 890 P.2d 1329 (Okla. 1994).

147. *See id.* at 1341.

148. *See Anderson*, 890 P.2d at 1342 (Watt, J., dissenting).

149. *See id.* (Watt, J., dissenting).

though he is performing surgery or treating the state's patients.[150] Thus, these physicians treating state patients should be deemed employees of the state and therefore immune from liability. This analysis is equally applicable to resident interns participating in an educational program. Resident physicians and interns treat state patients as part of their scholastic responsibilities. Thus, resident physicians and interns should also be immune from liability for the treatment of state patients. In contrast, these physicians should not receive protection from liability for their treatment of "private" patients because the physician generally is compensated by the patient.[151]

Finally, it is unfair to subject private hospitals and not state hospitals to increased liability for their staff physicians through the adoption of the doctrine of independent hospital corporate liability. The justifications for imposing the doctrine of corporate liability are applicable to state and private hospitals. *Strubhart* should be extended to subject state hospitals to this doctrine. Thus, state hospitals as well as private hospitals should be held accountable for negligent supervision and extension of staff privileges to faculty physicians, resident physicians, and interns, even though these physicians may also be practicing medicine.

Christa L. Britton

150. *See id.* (Watt, J., dissenting).
151. *See id.* (Watt, J., dissenting).