IN THE SUPREME COURT OF FLORIDA

CASE NO. SC17-1562

ROLANDO P. RUIZ, as Personal Representative of the Estate of MARIA ELENA ESPINOSA,

Petitioner,

vs.

ANESCO MEDICAL SERVICES–THH, LP and ARTURO LORENZO, M.D.,

Respondents.

ON DISCRETIONARY REVIEW OF AN OPINION OF THE THIRD DISTRICT COURT OF APPEAL

AMICI CURIAE BRIEF OF THE AMERICAN MEDICAL ASSOCIATION AND FLORIDA MEDICAL ASSOCIATION IN SUPPORT OF RESPONDENTS

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INTEREST OF *AMICI CURIAE*

The American Medical Association ("AMA") is the largest professional association of physicians, residents and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all U.S. physicians, residents and medical students are represented in the AMA's policy making process. The AMA was founded in 1847 to promote the science and art of medicine and the betterment of public health, and these remain its core purposes. AMA members practice in every medical specialty area and in every state, including Florida.

The Florida Medical Association ("FMA") is a not-for-profit corporation, which is organized and maintained for the benefit of the licensed Florida physicians who comprise its membership. The FMA was created and exists for the purpose of securing and maintaining the highest standards of practice in medicine and to further the interests of its members. One of the primary purposes of the FMA is to act on behalf of its members by representing their common interests before the courts of the State of Florida.

The AMA and FMA join this brief on their own behalves and as representatives of the Litigation Center of the AMA and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each state, plus the District of Columbia, whose purpose is to represent the viewpoint

of organized medicine in the courts. Amici's participation on behalf of their physician memberships will help educate the Court on the potential impact of this case on the practice of medicine in Florida.

INTRODUCTION AND SUMMARY OF ARGUMENT

Over the past fifteen years, the medical profession has been encouraging physicians to collaborate, participate in team-based approaches to patient care, and offer to assist colleagues to advance patient care and well-being. Dr. Lorenzo acted accordingly. Mrs. Espinosa had been waiting for more than an hour for her anesthesiologist, who had been detained. Dr. Lorenzo offered to start the pre-anesthesia evaluation, spending a few minutes talking with Mrs. Espinosa, reviewing her medical records, and performing a portion of the evaluation to determine whether she could tolerate anesthesia. Dr. Lorenzo had no more interactions with Mrs. Espinosa. When the treating anesthesiologist arrived, that physician took over, completing the full evaluation of Mrs. Espinosa, determining that she could tolerate anesthesia, and administering anesthesia during surgery. After Mrs. Espinosa tragically died from exsanguination during surgery, Petitioner sued Dr. Lorenzo along with the surgeons and tending anesthesiologist.

The trial court properly ordered a directed verdict for Dr. Lorenzo at trial. After the presentation of the Petitioner's case, it was clear that Dr. Lorenzo did not cause Mrs. Espinosa's death. The jury determined that Mrs. Espinosa, who was

undergoing brain surgery, exsanguinated when her surgeons failed to control the bleeding after cutting into a bone and found the surgeons fully liable. Even now, Petitioner does not argue that Dr. Lorenzo caused her exsanguination. In pursuing this appeal, Petitioner's theory for liability is premised on a *post hoc ergo propter hoc* fallacy: Dr. Lorenzo assisted in clearing Mrs. Espinosa for surgery, and had he not cleared her for unrelated reasons, she would not have continued on to surgery where she died from the surgeons' apparent negligence.

As this *amici* brief explains, the attempt by Petitioners to create causation over facts unrelated to the exsanguination contradicts decades of well-settled Florida law on proximate cause. Proximate cause is injury-specific, and the lower courts properly applied that law in finding that "[t]here is no competent, substantial evidence at trial from which a jury could reasonably conclude" that Dr. Lorenzo caused Mrs. Espinosa's exsanguination. *Ruiz v. Tenet Hialeah Healthsystem, Inc.*, 224 So. 3d 828, 830 (Fla. 3d DCA 2017). If this Court were to reverse this ruling, it would mean subjecting Dr. Lorenzo to liability for the apparent negligence of other physicians. Any such new duty to stop others from negligently treating patients would represent an unprecedented expansion of liability, in Florida and around the country. It also would chill physicians, like Dr. Lorenzo here, from offering to help other physicians when needed, which would set back progress on collaboration and

lead to worse, not better, patient care. For these reasons, *amici* respectfully urge the Court to uphold the rulings below.

ARGUMENT

I. The Trial Court Properly Directed a Verdict for Dr. Lorenzo Because He Could Not Have Proximately Caused the Injury

Proximate causation is a legal determination when, as here, the material facts support only one conclusion. This Court has consistently directed that, when it is clear that evidence does not exist whereby a reasonable jury could determine a defendant to be the cause of the plaintiff's injuries, the court must dismiss that defendant from the case. *See Helman v. Seaboard Coast Line R. Co*., 349 So. 2d 1187, 1189 (Fla. 1977); *Owens v. Publix Supermarkets, Inc.,* 802 So.2d 315, 322 (Fla. 2001). This dismissal can occur at summary judgment, or as here, after the plaintiff's presentation of its case. *See Gooding v. Univ. Hosp. Bldg., Inc.*, 445 So. 2d 1015, 1018 (Fla. 1984) ("[I]t becomes the duty of the court to direct a verdict for the defendant."). The lower courts were properly following this Court's instructions when they issued a directed verdict for Dr. Lorenzo.

As this Court has long held, the proximate cause determination must be specific to the plaintiff's harm. It "requires a factual showing that the dangerous activity foreseeably caused the *specific harm* suffered by those claiming injury." *Dorsey v. Reider*, 139 So. 3d 860, 864 (Fla. 2014) (emphasis added). Thus, the court must assess "whether and to what extent the defendant's conduct foreseeably and

substantially caused the *specific injury that actually occurred*." *McCain v. Fla. Power Co.*, 593 So. 2d 500, 502 (Fla. 1992) (emphasis added). In order for Dr. Lorenzo to bear any liability for Mrs. Espinosa's death, at a minimum, it must have been foreseeable during the pre-surgery evaluation, where Dr. Lorenzo was assisting in determining that Mrs. Espinosa could tolerate anesthesia, that her surgeons would allow her to exsanguinate on the table. Petitioner, though, has made no allegation and introduced no evidence at trial that Dr. Lorenzo could have foreseen that Mrs. Espinosa would die during surgery, let alone in this manner.

Petitioner also does not allege that Dr. Lorenzo, during the pre-surgery evaluation, created a "broader zone of foreseeable risk" for Mrs. Espinosa's exsanguination. *Dorsey*, 139 So. 3d at 864; *see also* Restatement (Second) of Torts § 281 cmt. g (1965) (referring to the "scope-of-the-risk" test); R. Keeton, Legal Cause in the Law of Torts 9–10 (1963) (the "Risk Rule"). The general rule for this avenue for proximate cause is that "[a]n actor's liability is limited to those physical harms that result from the risks that made the actor's conduct tortious." *Id.* If the plaintiff's injury is not the result of a risk that a defendant created, there can be no recovery. In *Dorsey*, the key to allowing liability was the fact that the defendant was "present and able to exercise any control over the instrumentalities when the injuries occurred." 139 So. 3d at 865. Those dynamics were not present here, as Petitioner does not allege Dr. Lorenzo created a broader risk of exsanguination, was in the

surgery room when the exsanguination occurred, or had any control over the surgeons or her exsanguination. *See Dep't of Transp. v. Anglin*, 502 So. 2d 896, 899 (Fla. 1987) (requiring a fair assessment of the danger created by the defendant's conduct).

Rather, Petitioner alleges solely that Dr. Lorenzo should have stalled the surgery due to some irregularities identified during the pre-surgery anesthesia evaluation and, therefore, he put her in the position to be injured during surgery. Even if true, this Court has been clear that merely providing the occasion for another's negligence does not satisfy the proximate cause requirement. *Anglin*, 502 So. at 898 (setting forth the test for a superseding cause). In *Anglin*, the defendant created a puddle that caused the plaintiff in that case to stall in the road, which provided the occasion for a passing driver's negligence that caused the plaintiff's injury. *See Anglin*, 502 So. 2d at 899-900. The Court explained that "furnishing an occasion for the injury" is not the same as being the proximate cause of the injury. *Id.; compare Stahl v. Metro. Dade County*, 438 So. 2d 14, 22-23 (Fla. 3d DCA 1983) (negligently blocking a sidewalk could set in motion a chain of events that will foreseeably force a bike rider with momentum into the street) *with Pope v. Cruise Boat Co.*, 380 So. 2d 1151, 1153 (Fla. 3d DCA 1980) (but merely furnishes the occasion for a pedestrian to stop and step into traffic).

Petitioner's theory of liability—that Dr. Lorenzo put Mrs. Espinosa in the position to be injured by other physicians' negligence—does not meet this Court's longstanding proximate cause jurisprudence. Otherwise, Dr. Lorenzo would be subject to liability for all acts of medical negligence during surgery or, potentially, afterwards. As it turned out, the trial court's decision to issue a directed verdict for Dr. Lorenzo was buttressed by the jury's determination that the treating anesthesiologist, who ultimately cleared Mrs. Espinosa for surgery and was in the room during her exsanguination, also bore no responsibility for her death. The jury found the two surgeons solely liable, allowing her family a financial recovery.

II. Allowing Liability Here Would Create An Unprecedented Duty for One Physician to Prevent Negligence by Other Physicians

Reversing the lower courts' rulings and subjecting Dr. Lorenzo to liability for the negligence of other physicians would have implications far beyond this case. Physicians would be forced to oversee other physicians even when they have entirely different specialties, are completely unaffiliated, and have no control over the other physicians' treatment decisions or performance. Such an ongoing duty to prevent against others' negligence would be unprecedented and impractical, as it would interfere with patient care. Here, Dr. Lorenzo, after assisting with the pre-surgery evaluation, should be encouraged to provide anesthesia-related services to other patients, not follow Mrs. Espinosa into the operating room to make sure the surgeons and other medical professionals do not negligently cause her any injuries.

As a general premise, this Court has long held that "a party has no legal duty to prevent the misconduct of third persons." *Dorsey*, 139 So. 3d at 864. It carved out three limited exceptions: "where the defendant is in care of or constructive control of (1) the instrumentality; (2) the premises on which the tort was committed; or (3) the tortfeaser." *Id.* Accordingly, lower courts have been "loath to impose liability based on a defendant's failure to control the conduct of a third party." *Boynton v. Burglass*, 590 So. 2d 446, 448 (Fla. 3d DCA 1991); *Anguila v. Hilton, Inc.*, 878 So. 2d 392, 398 (Fla. 1st DCA 2004) (same).

Under these and similar principles, courts in Florida, and around the country, have found that physicians are not responsible for the care provided to patients by other physicians; thus, the essential element of control is missing. *See* Marcia Mobilia Boumil et al., *Medical Liability in a Nutshell* 189-94 (2d ed. 2003) ("[N]o liability will result unless there is control over such other physician."). Courts have largely determined that "an attending physician is not vicariously liable for the negligence of a covering physician unless the plaintiff can show a relationship between the two physicians such that the attending physician has a right to control the medical performance of the covering physician." Steven E. Pegalis, *Physician and Surgeon Liability, American Law of Medical Malpractice* 3d § 3:17 (2005); *see also* D. Sullivan & D. Gee, Annotation, *Vicarious Liability of Physician for Negligence of Another*, 38 Am. Jur. Proof of Facts 2d 445, §§ 2, 5 (1984) (updated

Feb. 2018) (noting that physicians acting independently are not liable for other's negligence). Here, Dr. Lorenzo completed his task, was not in the operation room at the time of the patient's injury, and had no control over the surgeons' apparent negligence.

Even if Dr. Lorenzo were in the operating room at the time of Mrs. Espinosa's exsanguination, longstanding precedents here and around the country recognize that surgeons and anesthesiologists have separate specialties and are not responsible for each other's negligence. In *Dohr v. Smith*, this Court found that a surgeon, who it called the "captain of the ship," not liable for an anesthesiologist's negligence because "it is clear to us that he and the anesthetist were working in highly expert fields peculiar to each and that despite the common goal, the successful repair of the patient's ulcer, their responsibilities were not inextricably bound together." 104 So. 2d 29, 32 (Fla. 1958). Similarly, anesthesiologists "are not insurers against harm nor guarantors of a favorable result" of surgery. 53 A.L.R. 2d 142 Malpractice: Duty and Liability of Anesthetist. Anesthesiologists and surgeons, as well as other medical professionals working together on patient care teams, have their own skillsets, making it inappropriate to be responsible for the other's negligence. *See, e.g., Thompson v. Presbyterian Hosp., Inc.*, 652 P.2d 260, 265 (Okla. 1982) (an operating surgeon is not an insurer against the negligent act of an anesthesiologist); *Harris v. Miller*, 438 S.E. 2d 731 (N.C. 1994) (same).

To this end, the purpose of Dr. Lorenzo's pre-surgery evaluation was limited to determining Mrs. Espinosa's ability to undergo anesthesia, not assess her overall health or suitability for surgery. Many surgical patients are in poor health, including in such poor health that they may not withstand surgery. In this scenario, making that determination was likely the responsibility of the surgeons, such as through testing and other evaluations that in many cases is completed before a patient is scheduled for surgery. The dissent, however, appears to infer that the purpose of Dr. Lorenzo's evaluation was to inform the surgeons if Mrs. Espinosa could suffer complications from the surgery. Any such inference would be wrong. His goal was solely to ensure that she is a proper candidate for anesthesia.

If the Court were to subject Dr. Lorenzo to liability for Mrs. Espinosa's exsanguination, therefore, it would reverse longstanding jurisprudence. It also would create ripple effects, not just in hospital care, but potentially other areas of care as well. For example, physicians commonly refer patients to other physicians, particularly when they do not have the appropriate specialty a patient needs. In these situations, courts have been clear that making a referral does not create a joint or common duty to the patient that makes the referring physician responsible for the other doctor's negligence. See *Dalhberg v. Ogle*, 373 N.E. 2d 159 (Ind. 1978) (family physician is not liable for negligence of a surgeon he recommended to a patient); *Tramutola v. Bortone,* 304 A.2d 197 (N.J. 1973) (same). But, if Dr.

Lorenzo could be subject to liability for the negligence here, would that raise the possibility that referring physicians could have such new liability? What about physicians who provide consultation services to other physicians in order to enhance or guide that physician's treatment decisions?[1] What about physicians who are on call and responsible for covering for other physicians?[2]

Also, what would be the limits of this new liability? For example, what if the negligence in the case at bar occurred during post-operation recovery? Would Dr. Lorenzo be responsible for any negligence that occurred in post-surgery care too? The Court should uphold the lower courts' rulings because there are no principled limits to the new liability that Petitioner seeks to create here. Physicians should not have a duty to patients to protect them against harms proximately caused by other physicians.

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[1] "Courts have taken these public policy concerns to heart and have routinely refused to extend liability . . . to doctors who have acted solely in the role of an informal . . . consultant. This has been true even when the doctors' involvement in giving advice to the attending physician has been very extensive." *Irvin v. Smith*, 31 P.3d 934, 943 (Kan. 2001).

[2] "To hold that an 'on call' physician can . . be liable for the negligence of others that occurs prior to the 'on call' physician being summonsed would make the 'on call' physician potentially liable twenty-four hours a day. . . . [T]he assistance of such physicians (most of whom apparently have much more experience than the interns and hospital residents) would be lost to the medical treatment system." *Rivera v. Prince George's County Health Dep't*, 649 A.2d 1212, 1231-32 (Md. Ct. Spec. App. 1994).

III. Reversing the Lower Court Ruling Would Undermine Progress to Advance Collaboration and Teamwork Among Physicians

Finally, subjecting Dr. Lorenzo to liability here would chill collaboration among physicians, which would set back more than a decade of efforts toward enhancing teamwork. Physicians in Dr. Lorenzo's position are highly encouraged to "not refuse a request from a colleague to assist in the care of a patient who is having an emergency, whether or not that physician has a preexisting duty to do so." Stewart R. Reuter, *Physicians As Good Samaritans,* 20 J. Legal Med. 157 (1999). As here, "the duration of care provided is generally short—until the hospital's [assigned] team arrives." *Id*. at 189. But, if such collaborations are to continue unabated, liability "must be balanced against the need to encourage physicians to render emergency care when they otherwise might not." *Id*. at 159.

Particularly in hospital settings, "shift-work schedules and suboptimal communication and pass-offs can result in fragmented [and] impersonal care." A. Goroll, M.D. & D. Hunt, M.D., *Bridging the Hospitalist-Primary Care Divide Through Collaborative Care*, 372 N. Engl. J. Med. 308 (2015). As a result, hospitals have been looking for ways "to improve collaboration and team-based care." Team-Based Health Care Delivery: Lessons from the Field, Am. Hosp. Ass'n Physician Leadership Forum (2012), at 8, *available at* http://www.ahaphysicianforum.org/resources/leadership-development/team-based-care/team-delivery-report.pdf (finding that "better collaboration with physicians is

critical to improving health and health care in our communities"); *see also* Physician-led Team-based Care, Am. Med. Ass'n, at https://www.ama-assn.org/delivering-care/physician-led-team-based-care (last visited Apr. 4, 2018) ("The most effective way to maximize complementary skill sets of all health care professionals is to work as a team."). The key is for each physician to provide the treatment in accordance with his or her own education, training, and licensure.

One such program, TeamSTEPPS, was launched in 2006 to teach physicians to actively collaborate in order "to improve quality and patient safety." Team-Based Health Care Delivery: Lessons from the Field, *supra*, at 4. As Dr. Lorenzo did here, the program taught physicians to be flexible and "cover roles across the team as needed" in an effort to enhance patient care and experiences regardless of physician schedules. *Id.* at 8-9. Success has been seen with specific settings, including rapid response teams and in inpatient care. *See id.* at 7. In particular, team-based approaches have proven to have measurable benefits for chronic care patients and patients with hypertension. *See* J. Sochalski, et al., What Works in Chronic Care Management: The Case of Heart Failure, *Health Affairs*, 28(1): 179-189 (2009) (finding a reduction in readmissions of chronic care patients through team-based care); J. L. Feder, At Martin's Point in Maine, Primary Care Teams for Chronic Disease Patients, *Health Affairs,* 30(3):394-396 (2011) (finding similar gains in controlling hypertension through team-based care).

The Court should uphold the rulings below to make sure that liability law does not discourage such collaborations in Florida hospitals and patient care facilities. Including Dr. Lorenzo as an additional defendant in this litigation when, based on the presentation of evidence at trial, his actions could not have proximately caused Mrs. Espinosa's exsanguination does not advance the interests of justice and would improperly discourage physicians from assisting each other. The trial judge properly directed the verdict for Dr. Lorenzo so that he would not be subjected to potential liability that is entirely out of his control, unprecedented in scope and harmful to patient care.

CONCLUSION

For these reasons, the AMA and FMA request that this court approve the decision of the Third District Court of Appeal in *Ruiz v. Tenet Hialeah Healthsystem, Inc.*, 224 So. 3d 828 (Fla. 3d DCA 2017).

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH RULE 9.210

I hereby certify the foregoing Brief is submitted in Times New Roman 14-point font and complies with the font requirements of Florida Rule of Appellate Procedure Rule 9.210(a)(2).

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CERTIFICATE OF SERVICE

I certify the foregoing Brief was filed electronically on April 9, 2018, in compliance with the Florida Rules of Administration and has been served via e-mail to the following recipients:

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