

Sovereign Immunity – A Primer For The UF Health Care Provider

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The Concept of Sovereign Immunity



The doctrine of sovereign immunity, also referred to as "Crown immunity," is grounded in the English common law concept that "the king can do no wrong," and was not, therefore, subject to claims and suits by his countrymen. In the United States, the doctrine takes on a more practical perspective, recognizing the reality that there is no legal right to sue the sovereign authority for rights and obligations that are conferred by laws made by the same sovereign authority. Accordingly, unless the sovereign agrees, it cannot be sued. In American jurisprudence, the doctrine of sovereign immunity applies not only to the United States government (federal sovereignty), but also to each of the individual states. The immunity enjoyed by the United States and the individual states may be waived, in whole or in part, by federal and state lawmakers, thereby permitting these sovereign entities to be sued. Any waiver of sovereign immunity, however, will be limited to the expressed parameters in the waiver statutes and will be strictly construed by the courts that interpret these statutes.

Limited Waiver of Sovereign Immunity in Florida

The State of Florida enjoys sovereign immunity to the extent that the Florida law permits. Section 13 of Article X of the Florida Constitution authorizes the state legislature to enact laws permitting claims

and lawsuits to be brought against the state. The provisions of Section 768.28 of Florida Statutes set forth the specific



conditions limiting the extent to which the state waives sovereign immunity in tort actions, including medical negligence claims and litigation. This statute

permits the state to waive sovereign immunity, to a limited extent, when personal injury or death was caused by the "negligent act or wrongful omission" of any employee of the state, state agency, or state subdivision, while the employee or agent was "acting within the scope of the employee's office or employment." The statute provides that the state, for itself and for its "agencies and subdivisions," waives sovereign immunity for liability for torts but only to the extent specified in this statute. The statutory reference to "agencies and subdivisions" includes independent establishments of the state, such as state university boards of trustees. Accordingly, when an employee of the University of Florida (UF) negligently causes personal injury, sovereign immunity is waived, subject to limitations, and the injured party may assert a claim or file a lawsuit against the University of Florida Board of Trustees.

The Basic Application of the Waiver of Sovereign Immunity to UF Health Care Providers

Within the ambit of sovereign immunity, Florida law affords immunity from personal liability for UF health care providers, when their care and treatment of patients becomes the subject of a claim or lawsuit, provided certain criteria are met. Specifically, UF health care providers will not be held personally liable for medical negligence if the negligent act or omission

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occurred while the health care provider was acting within the scope of the health care provider's UF employment and the provider was not acting in bad faith, or with malicious purpose, or in a manner exhibiting wanton and willful disregard of human rights, safety, or property. In practical terms, this means that, when a UF health care provider is performing duties within the scope of the provider's employment with UF and the provider's care is alleged in a claim or lawsuit to have been negligent, the provider will not be held responsible personally for any money damages that might result from the claim or lawsuit. This presumes, however, that the provider was acting in good faith and was not wanton and reckless, *i.e.*, grossly negligent. Section 768.28 of Florida Statutes provides further that a state employee or agent may not be named as a "party defendant" in any claim or lawsuit. The University of Florida Board of Trustees is, as a matter of law, the proper defendant in any claim or lawsuit alleging medical negligence on the part of a UF health care provider. The practical application of these statutory provisions is illustrated in the [Question-and-Answer](#) section of this article.

Limits on Recovery by Claimants and Plaintiffs

Section 768.28 of Florida Statutes not only relieves UF health care providers of personal liability for negligent acts or omissions occurring within the scope of their duties, the statute also limits the amount of money payable by the state to those injured as a result of such negligence. The amount of monetary damages payable by the University of Florida Board of Trustees to a successful claimant is limited to \$100,000 per claimant, and the aggregate that may be paid on any claim, regardless of the number of claimants, is limited to \$200,000. If, for example, a husband and wife sue the

University of Florida Board of Trustees in a medical negligence action and the jury awards the plaintiffs \$1,000,000, Florida law limits the payment to each claimant to no more than \$100,000 and limits the total payment to both plaintiffs to \$200,000. In order for the claimants to recover damages in excess of these statutory limits, they would need to pursue a claims bill in the Florida legislature. The Florida legislature can award recompense, without monetary limits, which must be paid by the University of Florida Board of Trustees. It is rare, however, that claims bills based upon medical negligence incidents are successful.

The Practical Impact of Sovereign Immunity Upon the UF Health Care Provider – Some Common Questions and Answers

Question: A UF faculty physician is named as a defendant in a Notice of Intent to Initiate Litigation for Medical Negligence. How can this happen if Florida law prohibits state employees from being named defendants in claims and suits?

Answer: The most common reason for this occurrence is simple ignorance on the part of the claimant's attorney concerning the employment status of the UF physician. Florida law requires that, before a claimant may legally file a medical negligence lawsuit, the claimant (normally through the claimant's attorney) must conduct a good faith investigation of the facts giving rise to the claim. After investigation, notice of the claim must be sent to the health care provider alleged to be negligent. At the time the notice is sent, it is not uncommon for a claimant's attorney to have insufficient information to confirm the actual employer of the health care provider. The claim package sent to the provider is called a "Notice of Intent to Initiate Litigation for Medical Negligence" (NOI). When UF health

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care providers receive NOIs, they forward them to the Self-Insurance Program (SIP) for action. SIP will investigate the claim, respond to the matters alleged in the NOI, and advise the claimant's attorney of the UF health care provider's immune status. The claimant's attorney will also be advised that Florida law prohibits the naming of the UF provider as a defendant in any lawsuit that may be pursued and that SIP will pursue legal sanctions against the claimant if the UF provider is specifically named as a defendant in future proceedings. If the claimant's attorney ignores this admonition and files suit naming a UF provider as a defendant, motions will be filed with the court to remove the name of the UF provider as a defendant and to substitute the University of Florida Board of Trustees as the proper defendant.

Question: Are UF resident physicians and physician extenders covered by the Florida sovereign immunity statute?

Answer: As is the case with all other state employees or agents, all UF residents and physician extenders, acting within the scope of their university function, are afforded immunity and are not subject to personal liability for their negligent acts or omissions that cause injury to a patient.

Question: Are there any circumstances in which the conduct of a UF health care provider might result in the loss of immunity from personal liability?

Answer: Yes. The more common occasions where immunity is lost include: (a) committing an intentionally tortuous or criminal act; (b) committing medical negligence during a time when the provider is not performing duties within the scope of employment with UF; and (c) performing an act or omission that is considered grossly negligent, *i.e.*, an act or omission exhibiting

wanton and willful disregard for safety and well-being of the patient. Providers who commit intentional acts of misconduct, such as sexual assault, battery, and defamation of character, are not immune from personal liability. Some providers engage in patient care outside of their duties with UF. Although all UF providers are required to seek permission from UF prior to accepting employment outside of the scope of their UF employment, they are not immune from personal liability for any negligence on their part that occurs during the course and scope of outside employment. The mere fact that UF has granted permission to the provider to engage in outside employment does not afford the provider immunity for negligent acts when engaging in those activities. Examples of actions rising to the level of gross negligence that would result in a loss of immunity include acts such as being intoxicated while performing a procedure or, while on call, intentionally ignoring repeated pages by the nursing staff to attend to the needs of a critical patient, solely because the provider was preoccupied with personal business.

Question: A physician is appointed to the UF faculty as an attending physician and clinical professor. Prior to her appointment she was a member of a private practice professional association. While serving in her position at UF, she receives an NOI alleging that she was medically negligent in treating a patient while she was in private practice. Does the fact that the physician was a UF employee at the time that she received the NOI render her immune from personal liability for any medical negligence that occurred in her former private practice?

Answer: No. The physician is provided immunity only for those acts or omissions occurring during the course and scope of her employment with UF. There is no immunity from personal liability for acts or

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omissions occurring at times and under circumstances when the physician was not acting within the scope of her employment with UF, even though she received the NOI when she was employed by UF.

Question: A physician leaves his employment with UF. One year later, he receives an NOI alleging medical negligence for delay in diagnosis and treatment of a patient he examined and treated while he was acting within the scope of his duties at UF. Is the former UF physician immune from personal liability for the claim of medical negligence involving this patient?

Answer: Yes. The former UF physician is immune from personal liability with respect to any medical negligence claim based upon incidents that occurred at any time that the UF physician was acting within the scope of his employment with UF, even if he received notice of the claim subsequent to terminating his relationship with UF.

Question: Is it true that if a UF health care provider is afforded sovereign immunity, he or she will not be subject to any consequences if a claim or lawsuit alleging medical negligence on the part of the provider is resolved in favor of the claimant?

Answer: Although it is true that the UF health care provider will be immune from personal liability, *i.e.*, personally paying money damages as a result of a claim or lawsuit, the provider is not shielded from the administrative consequences of medical negligence. Under current Florida law, for example, a copy of a complaint in a medical negligence lawsuit must be sent to the Florida Department of Health (DOH). Even though the University of Florida Board of Trustees will be the named defendant in a lawsuit involving alleged negligence on the part of a UF health care provider, the "body"

of the complaint will most likely contain allegations asserting negligence attributable to particular UF providers for whom the University of Florida Board of Trustees assumes responsibility if any monetary damages are awarded as a result of the suit. Upon receipt of a copy of the complaint, the DOH will review the allegations and may, based upon the review, open an investigation into the licensure of a provider alleged to have been negligent. The ensuing investigation may lead to the provider losing his or her license or may result in lesser sanctions, such as community service, mandatory education, and fines. Additionally, when UF healthcare providers are medically negligent, they may be subject to possible administrative sanctions by UF and by the facility where the negligence occurred.

Question: Are there any unique situations that are not covered in this article that might affect the immune status of a UF health care provider?

Answer: Florida and other states have "Good Samaritan" statutes that provide limited immunity to physicians and other healthcare providers who respond to medical emergencies that occur at accident scenes and during disasters. There are also some unique immunity issues that arise when a UF provider, acting within the scope of his or her UF employment, performs activities for UF outside of the state of Florida. Analysis of these special circumstances is beyond the scope of this current article but will be addressed in a future edition of Risk Rx. However, as you will learn in greater detail, UF health care providers are provided liability protection under these circumstances.

Question: Where may a UF health care provider seek additional information and

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advice concerning the impact of sovereign immunity upon his or her practice?

Answer: The staffs of the Gainesville and Jacksonville SIP offices are always available to answer questions and address concerns that a UF provider may have concerning sovereign immunity.

Of all the common questions posed, the last may be the most helpful to UF health care professionals. The two SIP offices are staffed with professionals that are ready, willing, and able to assist you and are available on a 24/7 basis. The offices may be reached as follows:

Gainesville: (352) 273-7006
Jacksonville: (904) 244-9070



Legal Case Review

Cristina Palacio, Esq.

Case Summary: *In the Matter of Baby "K"*
(4th Cir. 1994)

While this case involves a patient complaint brought under EMTALA, it is also recognized as having a subtext addressing the issue of "medical futility." Baby K was born at a hospital in Virginia in October 1992 with anencephaly. Initially, she was placed on a ventilator in order to provide respiratory support while the treating physicians confirmed their diagnosis and to give her mother, Ms. H, an opportunity to fully understand the diagnosis and Baby K's prognosis. Ms. H was informed that most anencephalic infants die within a few days

of birth due to breathing difficulties and other complications. Since aggressive medical treatment would serve no therapeutic or palliative purpose, the physicians recommended to Ms. H that Baby K be provided only supportive care (nutrition, hydration, and warmth) and discussed the possibility of a DNR order. Ms. H did not, however, agree with the physicians' recommendations and insisted that Baby K be provided the mechanical ventilation necessary. Believing that such care was inappropriate, the hospital unsuccessfully sought to transfer Baby K to another hospital; no other hospital in the area would accept Baby K. In November, Baby K was transferred to a nearby nursing home.

Subsequently, Baby K was readmitted to the hospital three times due to breathing difficulties. Each time she was stabilized and discharged back to the nursing home.

Allegation: After the second admission, the hospital asked the Court for a declaration that it had no obligation to provide emergency medical treatment to Baby K that it deemed medically and ethically inappropriate, *i.e.*, that it did not have to continue to resuscitate and/or mechanically ventilate an anencephalic infant. The hospital's petition was joined by Baby K's guardian ad litem and her father, Mr. K.

Analysis: The Court's analysis of this case focused on the purpose and requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA). The Court first noted the congressional intent "to provide an 'adequate first response to a medical crisis' for all patients" through EMTALA. In analyzing the statute and cases interpreting it, the court found that hospital emergency rooms must provide an appropriate medical screening examination to any individual coming the ER requesting treatment and

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that a hospital must offer identical screening procedures for all patients complaining of the same condition or exhibiting the same symptoms. Further, the Court stated that if a patient is found to have an emergency medical condition, then EMTALA requires the provision of stabilizing treatment.

The hospital acknowledged that mechanical ventilation was necessary to stabilize Baby K. But, the hospital argued, (1) EMTALA only requires uniform treatment of all patients exhibiting the same condition, and they were proposing to treat Baby K in the same manner they would treat any anencephalic infant; (2) EMTALA only applies to patients who are transferred in an unstable condition; (3) Congress did not intend to require physicians to provide treatment outside the prevailing standard of medical care; and, finally, (4) under Virginia law, a physician is permitted to refuse to provide medical treatment that s/he considers medically or ethically inappropriate. Virginia's Health Care Decisions Act provides that "nothing in this article shall be construed to require a physician to prescribe or render medical treatment to a patient that the physician determines to be medically or ethically inappropriate."

The Court found the hospital's arguments "unavailing." The relevant emergency medical condition, it said, was not anencephaly, but rather respiratory distress; and patients in respiratory distress are treated by providing resuscitative efforts. Additionally, it dismissed the argument that EMTALA applies only when transferring patients, stating that such reasoning would allow physicians to avoid providing stabilizing treatment by simply refusing to transfer the patient. With respect to Congress's intent regarding a physician's duty to provide treatment that exceeds the standard of care, the Court recognized "the

dilemma facing physicians who are requested to provide treatment they consider morally and ethically inappropriate." Notwithstanding, the Court could find no language in the statute or legislative history to indicate "an exception to the duty to provide stabilizing treatment when the required treatment would exceed the prevailing standard of medical care." Neither did the Court find an EMTALA exception for providing stabilizing treatment that a physician may deem medically or ethically inappropriate. Therefore, the Court held, to the extent that Virginia state law conflicts with the requirements of EMTALA, it was preempted by EMTALA. (The Court also noted that the Virginia law relied upon by the hospital was actually inapplicable to *Baby K*, as the relevant section was found in the statute related to advance directives and surrogate medical decisions.)

While analyzed within the context EMTALA, *Baby K* nevertheless provides some insight into several aspects of "medical futility." For example, *Baby K* highlights an important question in deciding medical futility -- what is "futile" care? Under the *Baby K* analysis, if the aim of CPR is to resuscitate, then futility could be argued to exist only if CPR is not expected to result in effective resuscitation, *e.g.*, even if the patient can momentarily start breathing again, s/he will continue to suffer repeated cardiac arrests within relatively short periods of time. A significant aspect of this case is the existence of specific state law regarding a physician's right to withhold treatment s/he believes to be medically or ethically inappropriate. While not part of the Court's analysis, it is interesting to note that the statute requires a physician who does not want to provide treatment to make a reasonable effort to transfer the patient and to provide a life-sustaining period for at least two weeks to permit the patient to effect a transfer. (In the case of *Baby K*,

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the hospital was unable to transfer to another hospital.) There is no provision in Florida's Advance Directives statute (F.S. Chapter 765) permitting a physician to make a unilateral decision to withhold or withdraw life prolonging procedures. According to Florida statute, such decisions are to be made by the patient or the patient's legal alternate decision maker (surrogate, proxy, or guardian, as appropriate).

Soon after the *Baby K* decision, the same court tangentially addressed medical futility again in *Bryan v Rectors and Visitors of the University of Virginia (4th Circuit 1996)*. In *Bryan*, the hospital admitted Mrs. Robertson for an emergency condition, treated her for 12 days, and entered a DNR order despite requests by her husband and children that all necessary measures to keep her alive be provided. Relying on the *Baby K* decision, the case was once again brought as an alleged EMTALA violation, and was analyzed within that context. Essentially, the Court found that EMTALA was inapplicable, as the patient was an inpatient and had been provided treatment for 12 days. Unlike *Baby K*, the Court did not consider the Virginia statute regarding a physician's ability to refuse medically or ethically inappropriate care. Rather, the Court stated that "the legal adequacy of [the care provided was]...governed...by the state malpractice law that...EMTALA was not intended to preempt." Given the narrow legal theory upon which Mrs. Robertson's representative filed suit, the Court was not able to directly address futility issues; significantly, however, it did choose to state in concluding its opinion that "[w]hether the conduct alleged may have violated other law is not before us. We hold only that it did not violate EMTALA...."

There appears to be no similar case in Florida to provide guidance. However, a Board of Medicine disciplinary action against

a Bon Secours-St. Joseph's Hospital Emergency Department physician may provide some illumination. In March of 2003, patient M.L., a 76-year-old female, present to the hospital with loss of consciousness, respiratory distress, and prior history of cerebrovascular accident. Dr. Pfeilsticker diagnosed her as having an acute cerebrovascular accident. He discontinued supplemental oxygen and placed her in a supine position, despite the fact that she was unconscious and at risk of aspirating. The BOM found that Dr. Pfeilsticker had failed to practice medicine within the prevailing standard of care. He was not, however, directed to take any remedial clinical education. He was required to complete a medical ethics course and an end-of-life care course (and fined approximately \$3,000). One possible interpretation of this BOM action is that Dr. Pfeilsticker decided that further care was medically futile, given the patient's history and diagnosis. It is noteworthy that the BOM rejected a proposed consent agreement that did not include the ethics and end-of-life course, and merely included a fine and community service.



Risk Reduction Strategies:

1. It is important to know the state law regarding medical futility and/or the withholding and withdrawal of life-sustaining procedures. As mentioned above, Florida Statutes do not recognize the concept of "medical futility" as it relates to a unilateral decision by the health care provider to withhold/withdraw life-sustaining procedures. Under Chapter 765, such decisions may

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- only be made, under appropriate circumstances, by the patient or his/her alternate decision maker.
2. To avoid disagreements with the decision maker, it is advisable to provide not only full information, but a reasonable amount of time for the decision maker to fully digest, understand, and come to terms with the reality of the patient's diagnosis and poor prognosis.
 3. Disagreements will still happen. Resolution can sometimes be obtained with the involvement of social workers, clergy, and/or use of the hospital's ethics consult mechanism.
 4. When the health care providers continue to be in disagreement as to the provision of life-sustaining procedures, the best solution may be transfer of the patient.
 5. Under Florida law, it is not advisable at any time to withhold or withdraw life-sustaining procedures against the wishes of the patient (as expressed directly or in an advance directive) or the patient's alternate decision maker. In certain situations, it may be appropriate to seek judicial intervention. If this is believed to be necessary, the hospital's legal counsel should be consulted.

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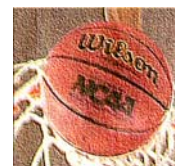
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