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HOSPITAL LIABILITY FOR TORTS OF INDEPENDENT CONTRACTOR PHYSICIANS

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Hamilton E. Russell, III**

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I. INTRODUCTION

Within living memory, most hospitals were immune from tort liability on the basis of charitable immunity. As this is written, however, hospitals find themselves exposed to the expanding possibility of liability not only for their "own" torts—torts committed by their own servants, breaching duties owed directly by the hospital—but for the torts of others, including the malpractice of independent contractor physicians committed on hospital premises. With respect to such malpractice, hospitals seek to rely on the general rule that principals are not liable for the physical torts of independent contractors. In the hospital context, however, this traditional rule is crumbling before

1. "Hospital" is typically defined by statute in such terms as the following:

[A hospital is] a facility organized and administered to provide overnight medical or surgical care or nursing care of illness, injury, or infirmity and may provide obstetrical care, and in which all diagnoses, treatment, or care is administered by or under the direction of persons currently licensed to practice medicine, surgery, or osteopathy.


Although this article speaks for the most part in terms of hospitals in the statutory sense, its principles likely apply to other varieties of health-care providers. See Chase v. Independent Practice Ass'n, 583 N.E.2d 251, 254 (Mass. App. Ct. 1991) ("Surprisingly little case law exists on the liability of HMOs [health maintenance organizations] for the negligence of their participating physicians. That which does exist tends to suggest that the same principles of liability have been applied to hospitals will apply to HMOs.") (citations omitted); Boyd v. Albert Einstein Medical Ctr., 547 A.2d 1229, 1234 (Pa. Super. Ct. 1988) (finding that policy considerations of the hospital's changing role in society are "certainly applicable" to HMOs); see also Dunn v. Praiss, 606 A.2d 862 (N.J. Super. Ct. App. Div. 1992) (analogizing an HMO case to a hospital context); Hill v. St. Clare's Hosp., 490 N.E.2d 823 (N.Y. 1986) (stating that a physician-owner of a medical clinic may be liable for the malpractice of a treating physician); William A. Chittenden, III, Malpractice Liability and Managed Health Care: History and Prognosis, 26 TORT & INS. L.J. 451, 454 (1991).

2. According to the Restatement,

(1) Agency is the fiduciary relation which results from the manifestation of consent by one person to another that the other shall act on his behalf and subject to his control, and consent by the other so to act. (2) The one for whom action is to be taken is the principal. (3) The one who is to act is the agent.

RESTATEMENT (SECOND) OF AGENCY § 1 (1957).

enthusiastic applications of the doctrine of "apparent" or "ostensible" agency, direct actions based on duties (including nondelegable duties) owed directly to patients by hospitals, and even elastic interpretations of respondeat superior. The large number of such cases and the wide variety of theories being successfully employed against a hospital's traditional defenses make inescapable the conclusion that the courts are responding to an expanding public expectation of the responsibility that hospitals should bear for the success of medical treatment within their walls.

By its decisions in Shuler v. Tuomey Regional Medical Center and Strickland v. Madden, the South Carolina Court of Appeals has added South Carolina to those states that have expanded hospital exposure. Shuler and Strickland announce acceptance of an apparent agency theory of hospital liability, finding apparent agency where (1) a hospital as principal consciously or impliedly represents another to be its agent, (2) there is reliance upon the representation, and (3) there is a change in position to the relying party's detriment. Further, in Strickland the Court of Appeals suggests that, if presented with a proper case, it might apply the doctrine of "corporate negligence," based on a hospital's duty owed to patients of care in selecting and in monitoring the competence of physicians using hospital facilities.

Compared to some opinions discussed in this article, Shuler and Strickland are tentative in their recognition of hospital liability for independent contractor malpractice, reflecting a relatively traditional balancing of interests, and, as is discussed in Part V, a more traditional application of doctrine. The fundamental issues involved are ones of public policy, and neither Shuler nor Strickland purports to make a comprehensive review of applicable South Carolina public policy. By contrast, shifting public policy strongly influences opinions on the leading edge of hospital liability. This public policy shift in

6. Strickland, __ S.C. at __, 448 S.E.2d at 585; Shuler, 313 S.C. at 227, 437 S.E.2d at 129. On the apparent agency issue, Shuler and Strickland both affirmed summary judgment for the hospital based on lack of reliance by the plaintiff. The requirements of reliance and causation are discussed infra text accompanying note 92. For a criticism of Shuler's application of traditional apparent agency analysis in the hospital context, see Houghland v. Grant, 891 P.2d 563, 569 (N.M. Ct. App. 1995).
8. Strickland, __ S.C. at __, 448 S.E.2d at 586 (citing Pedroza v. Bryant, 677 P.2d 166 (Wash. 1984)).
certain other states makes apparent that, although it was once thought that the public was benefitted indirectly by protecting care-giving hospitals from liability, the perception of hospitals and medical care is changing. The emerging view is that the care-giving aspect of hospitals entails significant duties owed by hospitals to those within their care and that the public is benefitted by enforcing these duties and, where injury occurs, by giving the public access to the resources of hospitals (and their insurers). Put another way, in such states hospitals are still performing a charity-like distributive function, not as sanctuaries where medical care is made available but virtually as insurers of the well-being of their patients.9 The critical public policy questions to be decided in each state concern the duties owed by a hospital to its patients, and to what extent those duties should be fault-based. The latter question will be answered by the theory selected to enforce hospital duties to patients.

This article reviews the national movement toward increased hospital liability for independent-contractor malpractice, reviews in a general way the major theories on which such liability is based, and draws several conclusions. First, the movement reflects changing public perceptions, and concomitantly changing judicial views of public policy, based largely on changes originating within the health care system itself. Second, despite the variety of avenues employed by courts in reaching hospital liability for the malpractice of independent contractors, the element that unites the cases is this changed public perception, viewing the hospital, not the individual physician, as the person responsible for delivering reasonable health care. Finally, sufficient tools exist to serve public policy in this developing area of the law without torturing the law of agency.

II. THE EXPOSURE OF HOSPITALS TO TORT LIABILITY: THE DEMISE OF CHARITABLE IMMUNITY

Throughout the country, charity hospitals and other charitable organizations were traditionally protected from liability by the doctrine of charitable immunity,10 which rested on various fictional premises.11 Underlying these fictions was a public policy favoring charity and charitable hospitals, reflecting the view that by benefitting such public-purpose institutions, the public as a

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9. Albain, 553 N.E.2d at 1046 ("This expansion of a hospital’s duties . . . has progressed in varying degrees . . . towards imposing strict liability upon hospitals.").
11. One such fictional premise is the “trust fund theory” that donated funds are held in trust in order to carry out the intent of the donor and, therefore, that charitable organizations should not be required to divert donated funds to defending suits and paying judgments. Id.; see also KEETON ET AL., supra note 3, § 133, at 1069-70.
whole was benefitted. Charity hospitals were accordingly granted the public subsidy of immunity.

In 1957 the death knell of charitable immunity for hospitals was sounded by the New York Court of Appeals in Bing v. Thunig. The reasoning of Bing was based squarely on the perceived evolution of hospitals into business enterprises upon which patients relied directly for treatment. The Bing opinion concluded that the rule of immunity for hospitals was antiquated and "should be discarded." 15

In 1977 the South Carolina Supreme Court took a step in the direction of Bing in Brown v. Anderson County Hospital Ass'n, modifying the doctrine of charitable immunity as applied to charitable hospitals, and in 1981 completed the job in Fitzer v. Greater Greenville South Carolina YMCA, abolishing altogether what the court referred to as "this archaic doctrine." 19

14. Id. at 8. According to recent statistics gathered by the American Hospital Association, approximately 13.8% of hospitals are for-profit. In addition, for-profit hospitals account for 9.2% of total patient days spent in the hospital, 9.8% of admissions, and 11.5% of available hospital bed space. William J. Link, Nonprofit Hospital Mergers and the Exercise of Market Power, 38 J.L. & ECON. 437, 438 (1995). Estimates indicate also that if those nonprofit and public hospitals actually managed by for-profit organizations are included in the statistics, for-profit controlled hospitals total almost 20%. Michael Rustad & Thomas Koenig, Reconceiving Punitive Damages in Medical Malpractice: Targeting Amoral Corporations, Not "Moral Monsters", 47 RUTGERS L. REV. 975, 1083 n.263 (1995) (citing BRADFORD H. GRAY, THE PROFIT MOTIVE AND PATIENT CARE: THE CHANGING ACCOUNTABILITY OF DOCTORS AND HOSPITALS 16-17 (1991)).
15. Bing, 143 N.E.2d at 9. Although the court was undoubtedly giving proper recognition to changes in medical practice and societal attitudes, it is quite likely that the court was also motivated by the increasing desire to find a "deeper pocket" from which to compensate those injured by medical malpractice. See G. Keith Phoenix & Anne L. Schlute, Hospital Liability for the Acts of Independent Contractors: The Ostensible Agency Doctrine, 30 ST. LOUIS U. L.J. 875, 877 n.18 (1986).
17. In Brown the court held that a charitable hospital was liable if an injury occurred because of the heedless and reckless disregard of a plaintiff's rights. Id. Although the plaintiff was required to prove more than simple negligence, Brown's relaxed standard began to expose charitable hospitals to liability. See also Hupman v. Erskine College, 281 S.C. 43, 46, 314 S.E.2d 314, 316 (1984) (Harwell, J., dissenting) (stating that "during the past decade, the doctrine of charitable immunity has been gradually eroded in South Carolina") (citing S.C. CODE ANN. § 44-7-50 (Law. Co-op. 1976) (regarding waiver of hospital immunity for employee's tortious acts)); Jeffcoat v. Caine, 261 S.C. 75, 198 S.E.2d 258 (1973) (stating that there is no charitable immunity for intentional torts).
19. Id. at 4, 282 S.E.2d at 231. The General Assembly responded to Fitzer by enacting, over the following several years, what can now be viewed as the statutory remnants of charitable
In recent years a great deal has been written about the change in public perception of hospitals to a view that, no matter how they are organized or what they call themselves, they are not donative charities but profit-making businesses, ever more so in today’s climate of amalgamation in the health care system.20 Perceived as large and growing businesses, hospitals have become attractive litigation targets, probably more attractive than individual physicians and evidently carrying higher-limit insurance policies than those of physicians.21 Reference to the decided cases, however, indicates that the most important driver in the shift in public perception has been hospitals’ marketing of themselves—using the tools of mainstream commerce—as full-service healthcare providers.22

Hospitals must resort to such activity in order to maintain pace with rapidly changing technologies, to remain in a position to provide the highest levels of care, and to support their undeniable public service role. These results, doubtless, are demanded by the public. Nevertheless the twin effects of the commercialization of hospitals have been a loss of public sympathy and an enhanced view of the hospital’s duty to patients. Public expectations, raised by the hospitals’ own marketing, are being taken strongly into account by courts in many states in assessing duties owed by hospitals to patients.

Although this sea change in public perception cuts across a comprehensive range of issues relating to hospital liability to patients, among its most controversial effects are those relating to hospital liability for the torts of nonemployee, or independent contractor, physicians. “Independent contractor” is the rubric applied by the Restatement of Agency both to true independent


21 E.g., Diane M. Jamulis & Alan D. Hornstein, Damned If You Do, Damned If You Don’t: Hospitals’ Liability for Physicians’ Malpractice, 64 Neb. L. REV. 689, 691 (1985); see also supra note 15.

22 See, e.g., Jackson v. Power, 743 P.2d 1376, 1385 (Alaska 1987) (stating that the enhanced duty of hospitals “is . . . consonant with the public perception of the hospital as a multifaceted health care facility responsible for the quality of medical care and treatment rendered, [and] . . . is consistent with the commercialization of American medicine”); Sharüsseldorf v. Hill, 764 P.2d 667, 672 (Wyo. 1988) (“[H]ospitals are ‘corporate entities capable of acting only through human beings whose services the hospital engages’ and [from whom] hospitals derive financial profit by holding ‘themselves out to the public as offering and rendering quality health care services.’”) (quoting Hardy v. Brantley, 471 So. 2d 358, 371 (Miss. 1985)).

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contractors and to agents who are not servants. The physical torts of independent contractors are not imputed to principals, under the well-established general rule. By contrast, when an agent can be shown to be a servant—an agent subject to the principal’s right of physical control of the details of the agency—the principal is liable for the agent’s physical torts committed within the scope of the agent’s employment, under the familiar doctrine of respondeat superior.

In the case of torts committed by independent contractor physicians, then, the general rule apparently would insulate the hospital from liability. As will be seen in Section III, the independent contractor rule is all but defunct with respect to physicians who are employed directly by hospitals and are therefore the hospitals’ agents. The rule continues to have some viability, however, with respect to “true,” or non-agent, independent contractors. Hospitals strive to take advantage of this remaining viability by engaging many high-risk specialties such as radiology, pathology, anesthesiology, clinical laboratories and, in particular, emergency room services from true independent contractor physicians. The relevant hospital-physician contracts commonly describe the physician’s relationship to the hospital as that of independent contractor. By the terms of these contracts, the independent contractor physician does not receive a salary from the hospital, and the hospital has no right of control over the physician in providing professional services. The

23. An independent contractor is a person who contracts with another to do something for him but who is not controlled by the other nor subject to the other’s right to control with respect to his physical conduct in the performance of the undertaking. He may or may not be an agent.

Restatement (Second) of Agency § 2(3) (1957); see generally Restatement (Second) of Torts §§ 409-429 (1965). However, by definition, an independent contractor is never a servant. This is due to a number of factors, the one most emphasized being the principal’s right of control over the agent’s physical performance of his duties. See Restatement (Second) of Agency § 220 (1957); see also infra note 43, discussing the test for servant status.

24. See supra note 3 and accompanying text.

25. “A servant is an agent employed by a master to perform service in his affairs whose physical conduct in the performance of the service is controlled or is subject to the right to control by the master.” Restatement (Second) of Agency § 2(2) (1957).

The word “servant” is thus used to distinguish a group of persons for whose physical conduct the master is responsible to third persons. . . . [T]he term “independent contractor” is used to indicate all persons for whose conduct, aside from their use of words, the employer is not responsible except in the performance of non-delegable duties.

Id. § 2 cmt. b.

26. “A master is subject to liability for the torts of his servants committed while acting in the scope of their employment.” Id. § 219; see also id. §§ 220-249.

27. Classen, supra note 20, at 471 n.7.


29. Id. at 9.

30. Id. These characterizations in employment contracts are often ineffective. See infra notes
focus of this article is on such “true,” nonagent, independent contractor physicians.

The broadening view of hospital responsibility to patients, however, manifests itself in a number of doctrines skirting the independent contractor rule. The South Carolina Court of Appeals’ decisions in Strickland and Shuler touch upon two such doctrines: direct liability and apparent agency. These and other vicarious and direct theories of hospital liability for independent contractor malpractice are reviewed in the sections that follow.

III. VICARIOUS LIABILITY

No longer shielded by charitable immunity, hospitals are liable for the torts of servants agents under various theories of vicarious liability. The most familiar and best developed such theory is respondeat superior, against which hospitals employ the defense of the independent contractor rule.

A. Actual Agency: Respondeat Superior

Since the demise of charitable immunity, all hospitals, like other businesses, are subject to imputed liability for the negligence of hospital employees through the doctrine of respondeat superior. This doctrine is the traditional method of imputing liability to employers for employees’ torts; perhaps for this reason, the doctrine is often used by plaintiffs in the hospital context. For reasons that will appear below, however, respondeat superior is problematic in the hospital context.

Respondeat superior is agency-based strict liability. No fault of the principal need be shown to hold the principal liable for the servant’s physical torts. To establish this derivative liability, however, the plaintiff must carry a substantial burden of proof in satisfying the technical requirements of respondeat superior. In the hospital context, the plaintiff must first prove

67-72 and accompanying text.

32. For present purposes, “employee” is not distinguishable from “servant” and the terms will be used interchangeably. See RESTATEMENT (SECOND) OF AGENCY § 220 (1957); see also id. § 2 cmt. d (“The word ‘employee’ is commonly used in current statutes to indicate the type of person herein described as servant.”); id. § 220 cmt. g (“In general, [employee] is synonymous with servant.”).
33. See KEETON ET AL., supra note 3, § 70, at 501; Southwick, supra note 20, at 1-8.
34. See, e.g., Classen, supra note 20, at 472.
35. “The point is that a causative element of the tort does not create the liability [in the principal]; it is only the relation of master and servant which creates the liability. The basis of liability is not any tort rule, but simply the relation of master and servant.” HAROLD G. REUSCHELIN & WILLIAM A. GREGORY, THE LAW OF AGENCY AND PARTNERSHIP § 26, at 69 (2d ed. 1990).
malpractice against the physician. Second, the plaintiff must prove that the physician is the hospital’s agent and, third, not only the hospital’s agent, but its servant. Finally, the plaintiff must show that the tort occurred within the scope of the agency. Once these technical requirements of respondeat superior are met, the agent’s negligence is imputed to the principal, without regard to fault on the principal’s part.

By contrast, as already discussed, principals are not liable under respondeat superior for the physical torts of independent contractors. As a practical matter, principals such as hospitals do not want to be and should not be liable for the torts of true independent contractors, who by definition operate their own businesses, the technical aspects of which are beyond the control or right of control of the principal and may well be beyond the principal’s understanding.

To aid in the analysis of whether an agent is a servant, as opposed to an independent contractor, courts take into account various factors, a list of which is found in the Restatement of Agency. Of these, the right to physical

36. A medical malpractice action is essentially a tort action in negligence unless the patient is relying on a specific warranty of the physician. See Mayhue v. Sparkman, 653 N.E.2d 1384 (Ind. 1995); Sciacc v. Polizzi, 403 So. 2d 728 (La. 1981); KETTON ET AL., supra note 3, § 32, at 185-89.

37. In order for agency to exist, therefore, one person (the “principal”) must intend that another (“the agent”) act on his behalf, the agent must intend to accept the authority of the principal and act on it, and the intention of each must be manifest either in words or conduct between them.


38. Albain, 553 N.E.2d at 1043. A servant is an agent over the performance of whose duties the principal has the right to a high degree of physical control. RESTATEMENT (SECOND) OF AGENCY § 220 (1957).

39. See Emory Univ. v. Lee, 104 S.E.2d 234 (Ga. Ct. App. 1958); Waynick v. Reardon, 72 S.E.2d 4 (N.C. 1952); RESTATEMENT (SECOND) OF AGENCY § 219(1) (1957) (“A master is subject to liability for the torts of his servants committed while acting in the scope of their employment.”); see also id. § 2(2); id. § 228 cmt. b (“Proof that the actor was in the general employment of the master does not of itself create an inference that a given act done by him was within the scope of employment.”).


41. See supra note 3 and accompanying text.

42. In the words of one commentator, “Since the basis of the respondeat superior theory is the employer’s right to control the means and methods of the employee’s work, it follows logically that the employer is not liable vicariously for the tort or the negligence of an independent contractor.” Southwick, supra note 20, at 4.

43. Among the factors to be considered to determine whether one is a servant or an independent contractor are the following:

(a) the extent of control which, by the agreement, the master may exercise over the details of the work;
control is widely regarded to be the crucial factor in imputing liability under
*respondeat superior*.

Because the principal's right to control the tortfeasor is required to support
a finding of liability under *respondeat superior*, the doctrine is theoretically
problematic in the hospital context. Under the corporate practice doctrine,
which is the law of all but two states, hospitals have traditionally been
prohibited from practicing medicine. If a hospital cannot practice medicine,

(b) whether or not the one employed is engaged in a distinct occupation or business;
(c) the kind of occupation, with reference to whether, in the locality, the work is
usually done under the direction of the employer or by a specialist without supervi-
sion;
(d) the skill required in the particular occupation;
(e) whether the employer or the workman supplies the instrumentalities, tools, and the
place of work for the person doing the work;
(f) the length of time for which the person is employed;
(g) the method of payment, whether by time or by the job;
(h) whether or not the work is a part of the regular business of the employer;
(i) whether or not the parties believe they are creating the relation of master and
servant; and
(j) whether the principal is or is not in business.

RESTATEMENT (SECOND) OF AGENCY § 220 (1957); see also Stewart v. Midani, 525 F. Supp.

order to establish actual agency, it must be shown that the employer/hospital controlled or had
the right to control the physical conduct of the servant/physician in the performance of the ser-
vant/physician's work. . . . [If the requisite right of control does not exist, the physician is
considered an independent contractor and the hospital is generally not liable for the negligence
of an independent contractor.”) (citations omitted); Albain, 553 N.E.2d at 1042, 1044 n.5; see
also 23 S.C. JUR. Agency § 2 (1994) (“The right of control, and in particular control of the
physical execution of the agent’s undertaking, is rightly given prominence in making the
distinction between a servant and a non-servant agent.”).

45. For a comprehensive discussion of the corporate practice doctrine, see Jeffrey F. Chase-
Lubitz, Note, *The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern

46. Nebraska and Missouri do not follow the corporate practice doctrine. See Karen A. Butler,
Comment, *Health Care Quality Revolution: Legal Landmines for Hospitals and the Rise of the
Ct. App. 1907); State Electro-Medical Inst. v. Nebraska, 103 N.W. 1078 (Neb. 1905)). Like the
majority of states, however, South Carolina historically has adhered to the corporate practice
doctrine. Until the recent advent of the professional corporation statute in South Carolina, a
corporation could not engage in the practice of medicine even through its licensed employees.
Co-op. 1976).

47. The corporate practice doctrine, which arose because of historical mistrust of corporations
and concerns about physician autonomy, has been variously inferred from state licensing statutes,
judicially created in case law, and expounded upon in state attorney general opinions. See, e.g.,
Butler, supra note 46, at 863-64; Chase-Lubitz, supra note 45, at 455-67.
then presumably the hospital cannot control or have the right to control the professional acts of physicians.\textsuperscript{48} For their part, physicians are under ethical constraints to act for the benefit of the patient free from the control of any nonphysician.\textsuperscript{49} Accordingly, no matter how a physician’s relationship to the hospital is contractually defined, the attending physician is ethically constrained to “act as an advocate and coordinator of care for the patient and should assume appropriate responsibility.”\textsuperscript{50} Thus, the prohibition on the corporate practice of medicine would seem to be a valid defense to hospital liability under \textit{respondeat superior} for the malpractice of any physician, whether an employee of the hospital or a true independent contractor.\textsuperscript{51}

After \textit{Bing},\textsuperscript{52} however, courts have imposed liability on hospitals for the torts of their employee physicians based on \textit{respondeat superior},\textsuperscript{53} a result hard to reconcile with the corporate practice doctrine. While such judicial decisions call into question the continued viability of the doctrine in the hospital context, the corporate practice doctrine is still used to argue that a hospital cannot control its nonemployee independent contractor physicians, and

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\textsuperscript{49} The physician’s independence is intended to insulate the relationship between the patient and the physician from the business orientation of the hospital. \textit{See Thomas M. Garrett et al., Health Care Ethics: Principles and Problems} 17 (1993).


\textsuperscript{52} Bing v. Thunig, 143 N.E.2d 3, 6 (N.Y. 1957) (stating that traditionally \textit{respondeat superior} was not a viable theory of recovery in the hospital context because “[\textit{t}he court’s thought that, even though employed by the hospital, [nurses and physicians] were to be regarded as independent contractors rather than employees because of the skill they exercised and the lack of control exerted over their work”]; \textit{see Adamski v. Tacoma Gen. Hosp.}, 579 P.2d 970, 975 (Wash. Ct. App. 1978) (”[\textit{t}he majority of courts chose to follow . . . Bing” in applying \textit{respondeat superior} to hospitals for torts of medical personnel.).

\textsuperscript{53} \textit{See}, e.g., Mduba v. Benedictine Hosp., 384 N.Y.S.2d 527, 529-30 (App. Div. 1976) (finding, in an emergency room case, that the hospital was liable as the employer of defendant physician); \textit{see also} Sloan v. Metropolitan Health Council, 516 N.E.2d 1104, 1108 (Ind. Ct. App. 1987) (noting, in an HMO case, that it is a \textit{non sequitur} to conclude that because a hospital, or HMO, cannot practice medicine, it cannot be liable for the actions of its agents and servants who are licensed to practice); Dunn v. Praiss, 606 A.2d 862, 868-69 (N.J. Super. Ct. App. Div. 1992) (holding that an HMO, like a hospital, can be liable under \textit{respondeat superior}).
\end{flushleft}
thus cannot render them servants, because the hospital’s control would constitute the unauthorized practice of medicine.\textsuperscript{54} Because of such internal inconsistencies and selective enforcement of the doctrine, the corporate practice doctrine has been increasingly criticized as an anachronism and an obstacle to innovative health care reform.\textsuperscript{55} In addition, certain traditional ethical formulations prohibiting physicians from working for corporations or on a contract basis have come under fire and have been held to violate federal antitrust laws.\textsuperscript{56}

Nevertheless, the theoretical difficulties faced by plaintiffs asserting \textit{respondeat superior} continue to be substantial in the independent contractor area.\textsuperscript{57} For example, a traditional application of \textit{respondeat superior} was employed by the Wisconsin Supreme Court in \textit{Pamperin v. Trinity Memorial Hospital},\textsuperscript{58} an emergency room case. The court observed that \textit{respondeat superior} applies only in the master/servant relationship, based primarily on the master’s right of control of the physical conduct of the agency, but also taking into account such other factors as described in section 220 of the Restatement of Agency.\textsuperscript{59} The court concluded that the negligent radiologist in that case was not a servant because, first, in its contract with the radiologist, the hospital did not reserve any right of control over the radiologist’s professional activities and, second, the radiologist maintained his own office, billing

\textsuperscript{54} See generally Milliron v. Francke, 793 P.2d 824, 827 (Mont. 1990) (holding that the general rule of hospital nonliability for the negligence of independent contractor physicians “‘reflect[s] the belief that a physician’s knowledge and services are so specialized and personal that he cannot be controlled by a layman in the practice of his calling.’”) (quoting 40 AM. JUR. 2D \textit{Hospitals and Asylums} § 28 (1968)); see also Anderson & Clausing, supra note 50, at 1206.

\textsuperscript{55} See, e.g., Brown v. Coastal Emergency Servs., 354 S.E.2d 632, 635 (Ga. Ct. App.) (stating that for a physician to relinquish control over the time, manner, and method of executing medical practice in a manner rendering him a servant “would almost certainly be violative of a physician’s professional ethics”; therefore, a “literal application” of the doctrine of \textit{respondeat superior} would render hospitals immune from liability for malpractice), aff’d sub nom. Richmond County Hosp. Auth. v. Brown, 361 S.E.2d 164 (Ga. 1987); see also Chase-Lubitz, supra note 45. But see Frances J. Serbaroli, \textit{Corporate Practice of Medicine: A Clear and Present Danger}, 7 S.P.G. HEALTH L. 6 (1994).

\textsuperscript{56} See \textit{In re} American Medical Ass’n, 94 F.T.C. 980 (1979) (enjoining the AMA from enforcing ethical prohibitions against physicians’ practicing medicine in corporate settings because of the anticompetitive effect of the AMA’s control over economic and organizational aspects of the practice of medicine), aff’d, 455 U.S. 676 (1982).

\textsuperscript{57} No reported South Carolina appellate decision directly applies the doctrine of \textit{respondeat superior} to a hospital for a physician’s negligence. S.C. JUR. \textit{Hospitals} § 15 (1993). However, in Self v. Goodrich, 300 S.C. 349, 354, 387 S.E.2d 713, 716 (Ct. App. 1989), the South Carolina Court of Appeals stated that the alleged negligence of a physician who is not an agent or servant of a hospital may not be imputed to the hospital, suggesting that a finding of servant status for a malpracticing physician could lead to vicarious liability for the hospital.

\textsuperscript{58} 423 N.W.2d 848 (Wis. 1988).

\textsuperscript{59} \textit{Id. at} 852 n.4 (quoting \textit{RESTATEMENT (SECOND) OF AGENCY} § 220 (1957)).
service, and malpractice insurance and served hospitals other than the defendant.  

Despite the continuing viability of the independent contractor rule in cases involving nonemployee independent contractors, courts have applied respondeat superior in a number of cases in the physician/hospital context to hold the hospital liable for the torts of such contractors. There are indications in some cases that this liability may result from careless use of the term respondeat superior. In several cases, courts have found servant status based on control of the physician by the hospital through a medical director (a licensed physician who is also an administrator) or through a committee of medical directors. In other cases, courts have concluded as a matter of fact that general operating guidelines imposed on physicians by hospitals constitute sufficient control over an alleged independent contractor physician to support respondeat superior liability. The weight of authority, however, holds that such general guidelines, rules, and regulations do not meet respondeat superior’s requirement that the principal have the right to control the physical execution of an agent’s duties.

60. Id. at 852-53.
61. See infra notes 75-84 and accompanying text (discussing the liability of hospitals for the malpractice of independent contractor physicians under apparent agency).
62. See, e.g., Hardy v. Brantley, 471 So. 2d 358, 371 (Miss. 1985) (stating that an independent contractor physician may render a hospital liable under respondeat superior where the patient relies on the hospital to deliver health care without regard to physician’s identity).
63. By having a physician-administrator oversee other doctors, hospitals can avoid the prohibition on the corporate practice of medicine yet still wield some influence on doctors’ medical decisions. See, e.g., Schleir v. Kaiser Found. Health Plan, 876 F.2d 174, 177 (D.C. Cir. 1989) (finding it significant, in an HMO case, that a malpracticing physician was supervised by another physician rather than a layman); Sloan, 516 N.E.2d at 1109 (same).
64. In Mduba, an emergency room case, the court stated:

While conducting the operations of the Emergency Room, the doctor was to do so in accordance with the rules and regulations of the defendant hospital’s governing board. Thus, under the contract, the doctor was not only bound to achieve a certain result, i.e., direct and supervise the Emergency Room, but was controlled by the defendant hospital as to the means or manner of achieving this result. Since the hospital controlled the manner in which the doctor operated the Emergency Room, [the doctor] was not an independent contractor but an employee of defendant hospital.

Mduba, 384 N.Y.S.2d at 529 (emphasis added). The quoted words appear to constitute an indirect statement of a direct duty owed by the hospital, rather than a true agency analysis.

65. See Kashishian v. Port, 481 N.W.2d 277, 280 (Wis. 1992) ("[The hospital] may have required that physicians . . . be members [of its] staff, and required the physicians to comply with the policies, by-laws, rules, and regulations of [the hospital]. That does not indicate that a master-servant relationship existed."); see also Albain, 353 N.E.2d at 1044 ("The mere granting of staff privileges to an independent private physician, which the hospital may later revoke under its [review] procedures, does not establish the requisite level of authority or control over such physician to justify imposing liability [against the hospital] under the doctrine of respondeat superior."); Clark v. Southview Hosp. & Family Health Ctr., Nos. 12845 & 13060, 1992 WL
Many hospitals have attempted to bolster agency-based defenses by shifting performance of certain services from salaried physicians to true independent contractors.\textsuperscript{66} The hospital and physician often explicitly describe their relationship as that of principal and independent contractor in the contract for services.\textsuperscript{67} Additionally, in a well-drafted contract, the independent contractor physician does not receive a salary from the hospital, and the contract makes plain that the hospital has no right of control over the physician in providing professional services.\textsuperscript{68}

Although the belief of the agent and principal about their relationship is among the factors to be considered in determining agency status,\textsuperscript{69} characterizations in employment agreements are far from conclusive in the tort context. Some courts have denounced the independent contractor designations as self-serving "secret arrangements"\textsuperscript{70} between physician and hospital, not binding upon patients or the courts.\textsuperscript{71} Even where hospitals have taken steps to inform patients of the independent contractor status of physicians practicing on the premises, courts have disregarded the arrangements.\textsuperscript{72}

\textsuperscript{66} Southwick, supra note 20, at 9-10.
\textsuperscript{67} Id. at 9.
\textsuperscript{68} Id.
\textsuperscript{69} Restatement (Second) of Agency § 220 (1957); see supra note 43 (listing factors determinative in deciding whether an agent is a servant or an independent contractor).
\textsuperscript{71} In Smith v. St. Francis Hosp., 676 P.2d 279 (Okla. Ct. App. 1983), the court stated: [T]he hospital must be held accountable for the negligence, if any, of its authorized emergency room physician regardless of whether or not he is an independent contractor by secret limitations contained in private contract between the hospital and doctor or by virtue of some other business relationship unknown to the patient and contrary to the hospital's conduct and representations.\textsuperscript{72} Id. at 282; see also Drexel v. Union Prescription Ctrs., 582 F.2d 781, 796 (3d Cir. 1978) ("The issue, we note, is not what agreements were entered into between [principal and agent] to establish a relationship other than agency, but rather what representations were actually made to the customers of the . . . store."); Fulton, 1993 WL 19674 at *5 ([T]he doctor is unfair to allow 'secret limitations' on liability, . . . premised on a doctor/hospital contract, to bind the unknowing patient." (citing Arthur, 405 A.2d at 447); Mduba, 384 N.Y.S.2d at 529 (same); Kashishian, 481 N.W.2d at 282 (same); Hardy, 471 So. 2d at 371 (discussing as ineffectual the "details of any undisclosed agreement between the hospital and the person acting in its behalf"); Classen, supra note 20, at 471 ("Though widely utilized, most courts now view [independent contractor clauses] as thinly veiled attempts by hospitals to shirk their responsibility to the patient.").

\textsuperscript{72} Johnson v. Lutheran Hosp., H.C.A. 82-146 (Md. Health Claims Arb. 1984); see also
These results indicate that, at least in the view of some courts, public perceptions and patients’ reasonable expectations are more important in assessing hospital liability than are the bargained-for relationship between hospital and physician and the policies traditionally underlying principal liability for the negligence of agents. In so deciding, these courts ignore or overlook the traditional distinction between servant and independent contractor, which is oriented toward allocating to the employer that burden directly flowing from an employer/employee relationship. The judicial focus on public expectations points in the direction of nondelegable duty, raised by hospital representations and public policy, as the true informing doctrine in the respondeat superior cases.

B. Apparent Agency and Estoppel: Restatement of Agency Section 267

The difficulties posed by the independent contractor rule as an impediment to hospital liability for independent contractor malpractice have led to increased judicial emphasis on approaches outside of actual agency. The approach most similar in appearance to respondeat superior is another form of vicarious liability, the doctrine of apparent (or “ostensible”) agency, and

Fulton, 1993 WL 19674 at *6-7 (stating that disputed inferences even as to plaintiff’s admitted, actual knowledge of physician’s agency relationship with a hospital must be taken in light most favorable to the plaintiff on motion to dismiss); Hannola v. City of Lakewood, 426 N.E.2d 1187, 1190 (Ohio 1980) (“[S]ound public policy demands that the full-service hospital not be permitted to contractually insulate itself from liability . . . .”); Janulis & Hornstein, supra note 21, at 700-01, 718.

73. See Dunn, 606 A.2d at 868-69, where the court stated:

[I]t is apparent to us that Health Care Plan of New Jersey is responsible for Dr. Marmar’s actions on theories of respondeat superior or agency . . . . Neither he nor his group was paid on a fee-for-service basis; rather they were paid on a per capita basis, based upon the number of subscribers to the HMO. They were not free to accept or reject a particular patient. Additional referrals were at the HMO’s option. They examined decedent at the HMO’s office . . . . Of course, the HMO could not practice medicine and therefore the individual examination and diagnostic decisions of . . . Dr. Marmar were professional doctor-patient matters. Yet the overall control exercised by the HMO over [the physician] clearly caused Dr. Marmar to be both actually and apparently the agent of the HMO. . . . [These factors] require a finding of agency.

Id. Compare the analysis employed by the New Jersey Superior Court in Dunn with the factors listed in note 43, supra, from the RESTATEMENT (SECOND) OF AGENCY § 220 (1957).

74. See infra notes 108-19 and accompanying text (discussing nondelegable duty).

75. Apparent agency is often confused with “apparent authority.” Although both sound alike and have roots in estoppel, they are very different in context and application. Apparent authority is defined as “the power to affect the legal relations of another person by transactions with third persons, professedly as agent for the other, arising from and in accordance with the other’s manifestations to such third persons.” RESTATEMENT (SECOND) OF AGENCY § 8 (1957). Accordingly, apparent authority supplies an agent with the power to bind the principal in contract,
its close cousin, agency by estoppel. Decisions holding hospitals liable on the basis of apparent agency date at least from the California Supreme Court’s decision in 1955 in *Seneris v. Haas*.

Apparent agency and *respondeat superior* are similar in appearance and indeed in effect, as both lead to imputed liability for the physical torts of another. They are fundamentally different, however, in doctrinal underpinning, a difference that also suggests a difference in application. *Respondeat superior* proceeds from the existence of a servant-type agency and reflects the cost assigned to the principal’s choice to act through servants, based upon the structure of the master/servant relationship. By contrast, apparent agency is estoppel-based.

Apparent agency is recognized by the Restatement of Agency in section 267:

One who represents that another is his servant or other agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such.

According to the comments to section 267, “The rule [of section 267] normally applies where the plaintiff has submitted himself to the care or protection of an apparent servant in response to an invitation from the defendant to enter into such relations with such servant.” Apparent agency

or by representations, but apparent authority has no application in tort. See id. § 8 cmt. d. Apparent agency, by contrast, estops an assertion of nonagency, in effect supplying the missing agency, and defines the scope of the agency. Apparent agency can be effective in either contract or tort. See id. § 267 and comments.


Some courts take the view that there is no meaningful distinction between apparent agency and agency by estoppel. See, e.g., Orlando Executive Park, Inc. v. P.D.R., 402 So. 2d 442, 449 (Fla. Dist. Ct. App. 1981). However, the Restatement of Agency treats them separately, describing agency by estoppel in terms of liability and apparent agency in terms of injury. *Compare Restatement (Second) of Agency § 8B (1957) with id. § 267.*

77. 291 P.2d 915 (Cal. 1955) (nominally applying the doctrine of apparent authority and ruling that when a physician performs a typical hospital function, or when a patient so believes, the hospital can be liable for injuries resulting from the physician’s negligence).

78. See, e.g., *Restatement (Second) of Agency §§ 8, 27, 31, 43, 267, 319 (1957).*

79. *Id.* § 267.

80. *Id.* § 267 cmt. a. Illustrations 3 and 4 of the comments to § 267 provide as follows:

P, a department store, contracts with T, as an independent contractor, to give medical attention to patrons of the store, T appearing as an employee. . . . [B]y mistake T
as described by section 267 is not in any way agency-based. Indeed, where agency is present, apparent agency is superfluous. Rather, section 267 is based upon the elements of estoppel: a representation causing justifiable reliance and resulting harm. It functions when agency does not exist, but to permit a defense of nonagency would be unfair.81

In cases in which respondeat superior is inappropriate as a path to hospital liability for independent contractor physician malpractice, apparent agency as described in section 267 has become a popular rationale,82 accepted in many jurisdictions.83 As an exception to the independent contractor rule, its application does no violence to that rule, and at the same time it holds the hospital accountable for the arguably foreseeable results of its mode of doing business, where fairness so indicates.84

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gives poison to a patron of the store, who takes it in the belief that it is medicine. P is liable for the harm.

Id. § 267 cmt. a., illus. 3-4 (emphasis added).

81. See, e.g., Combs, supra note 40, at 714-15 (stating that if the elements of apparent agency are present, "the hospital is estopped from denying that the physician was its agent"); Steven R. Owens, Note, Pamperin v. Trinity Memorial Hospital and the Evolution of Hospital Liability: Wisconsin Adopts Apparent Agency, 1990 Wis. L. Rev. 1129, 1142 n.58 (1990).

82. Brown v. Coastal Emergency Servs., 354 S.E.2d 632, 636 (Ga. Ct. App. 1987) (stating that "the doctrine of apparent or ostensible agency . . . appears to have been adopted . . . by the courts of every other state in which it has been asserted as a basis for liability"). As explained by one commentator:

[N]o order to impose liability on a hospital under the respondeat superior or corporate negligence theories, either a tort by a servant/agent/employee corporate wrongdoing must exist. Faced with a situation in which neither exists, the plaintiffs' bar was compelled to rely upon the frequently inadequate resources of private practitioners to respond in damages. Consequently, the doctrine of apparent agency developed.

See Anderson & Clasing, supra note 50, at 1206.


84. See generally Ira S. Bushey & Sons, Inc. v. United States, 398 F.2d 167 (2d Cir. 1968), where the court stated:

[Respondeat superior, even within its traditional limits, rests not so much on policy grounds consistent with the governing principles of tort law as in a deeply rooted sentiment that a business enterprise cannot justly disclaim responsibility for accidents which may fairly be said to be characteristic of its activities . . . . Put another way,
For all the doctrine's facial attractiveness, the requisites of apparent agency—a representation causing reasonable reliance and resulting harm—would present substantial difficulties for plaintiffs if applied with rigor by the courts in the hospital context. Confronted with the flowing tide of changing public perception, however, courts have employed the doctrine without rigor and, arguably, have much damaged it in the process. It might be said that these courts have developed a new, policy-based doctrine by loosely adopting the outlines of traditional apparent agency. The new doctrine cannot be said to be estoppel-based, because, as will be seen, it lacks the requisites of estoppel.

A rigorous application of apparent agency should take into account two of the doctrine's fundamental attributes: its role as a species of estoppel and its function as the door to fictional agency. These attributes will be discussed in order.

Generally speaking, estoppel can proceed either from "some definite misrepresentation of fact, made with reason to believe that another will rely upon it," or from silence in the knowledge that another misunderstands the silence and is acting in reliance on the misunderstanding. In the latter case, because the relying party is not actively misled, "the courts have insisted upon some fault in connection with the conduct of the one to be estopped." Where one remains silent "reasonably and in good faith," there is no estoppel; in order for estoppel to operate the silent party "must realize that the other is about to act under a mistaken belief." Accordingly, estoppel based on silence requires "either an intent to mislead or unreasonable conduct amounting to negligence in failing to act." In short, estoppel, although founded in fairness, works fairness for a party only where there is some element of fault in the behavior of the other party. Although apparent agency leads to imputed liability based on the apparent agent's fault, the estoppel basis of apparent agency also brings into the doctrine a flavor of fault on the part of the principal in the form either of an inaccurate representation or of a failure, unreasonable or not in good faith, to correct a mistaken impression.

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[agent] Lane's conduct was not so "unforeseeable" as to make it unfair to charge [his principal] with responsibility.

Id. at 171 (emphasis added).

85. See, e.g., Coastal Emergency Servs., 354 S.E.2d at 637 (adopting a rule based on section 267 but granting the hospital's motion for summary judgment because of lack of reliance on the part of the plaintiff).

86. KEETON ET AL., supra note 3, § 105, at 733.

87. Id. at 734.

88. Id.

89. Id.

90. Id.
Apparent authority’s flavor of fault and foreseeability on the part of the putative principal is congruent with the Restatement’s two-sided formulation of the doctrine. Under the Restatement view, the “mere fact” of the belief of the plaintiff is insufficient to engage the doctrine.91 There must be intentional misleading, or an unreasonable or bad faith failure to speak after notice, on the one side, “causing a third party justifiably to rely” upon the apparent agent.92

Section 267 is not, however, a self-executing source of liability. It operates only to open the door to a fictional application of the normal rules of agency liability, and these rules inform the required content of representation and reliance.92 This proposition can be discerned in the words of section 267: Where one represents that another is his “servant or other agent”, causing the plaintiff reasonably to rely on that other’s services, the representor is liable for the acts of the other “as if he were such” servant or other agent—liable, in other words, to the extent appropriate were the other the kind of agent represented.94 Put another way, apparent agency does no more than estop a putative principal from employing nonagency as a defense, thereby giving the plaintiff the opportunity to prove the principal’s liability based on agency rules.

It follows that if the defendant has represented another to be a servant, causing justified reliance, then the defendant may be liable for that other’s torts as usual under the doctrine of respondeat superior; nonagency will not be a defense, but the elements of respondeat superior must still be proved in order for the plaintiff to succeed.95 It also follows that, if the defendant has

91. Porter v. Sisters of St. Mary, 756 F.2d 669, 674 (8th Cir. 1985) (noting that ostensible agency does not apply under Missouri law “simply because the party claiming has acted upon his conclusions . . . .” Thus, a mere subjective assertion of reliance by a third party is not enough, for it must be judged within objective constraints.) (quoting Jeff-Cole Quarries, Inc. v. Bell, 454 S.W.2d 5, 13 (Mo. 1970)); see RESTATEMENT (SECOND) OF AGENCY § 267 cmt. a (1957), which provides:

The mere fact that acts are done by one whom the injured party believes to be the defendant’s servant is not sufficient to cause the apparent master to be liable. There must be such reliance upon the manifestation as exposes the plaintiff to the negligent conduct. . . . in response to an invitation from the defendant to enter into such relations with such [apparent] servant.

Id.

92. RESTATEMENT (SECOND) OF AGENCY § 267 & cmt. a (1957).
93. Billops v. Magness Constr. Co., 391 A.2d 196, 198 (Del. 1978) (From apparent agency “spring[s] the same legal consequences as those which result from an actual agency.”) (citations omitted).
94. See RESTATEMENT (SECOND) OF AGENCY § 267 (1957).
95. See RESTATEMENT (SECOND) OF AGENCY § 267 cmt. a, illus. 3 (1957) (An employer is liable to the harmed patient for the negligence of an independent contractor physician “appearing as an employee.”) (emphasis added). As discussed earlier, the concept of “employee” is congruent with that of “servant.” See supra note 32. Professor Hynes refers to § 267 as “vicarious liability by estoppel.” J. DENNIS HYNES, AGENCY AND PARTNERSHIP 106 (abridged 4th ed.)
represented another to be an agent of the independent contractor variety, then the defendant will be estopped to deny agency, but the independent contractor rule will be available as a defense. Under this view, of course, hospital liability for independent contractor malpractice through apparent agency is a two-step process: The elements of apparent agency must be met in order to estop the hospital to deny agency, whereupon the elements of respondeat superior must be proved.96

In summary, in order sufficiently to satisfy the traditional requisites of apparent agency to hold a putative principal liable for the physical torts of an independent contractor, the defendant must be shown either to have represented the contractor to be his servant (one over whose actions the defendant has the right of physical control) with reason to believe that the representation would be relied upon or to have remained silent unreasonably or not in good faith. Moreover, the plaintiff must thereby have been induced to rely upon the care or skill of the apparent servant with resulting harm. Finally, the harm must be within the scope of the agency represented.98 This is a steep hill for a hospital patient to climb.

Why should the rule be so cluttered? Consider the policies involved. Apparent agency is a double fiction: The defendant is estopped to assert the truth (that the tortfeasor is not his servant) in order to give the plaintiff an opportunity to invoke the fictional liability of respondeat superior, which is policy-based liability without fault.99 If our tort system is indeed fault-based, as Professor Owen asserts,100 then the hill of apparent agency is no more than appropriately steep.

In view of this steepness, it is not surprising that no court assigning hospital liability for independent contractor malpractice on the nominal basis of apparent agency has applied the doctrine with rigor. In a thoughtful opinion focusing on the representation and causation requirements of section 267, the Ohio Supreme Court determined that, in an emergency room context, there was "no genuine issue of material fact as to whether [the plaintiff] was induced

1994).

96. See, e.g., KEETON ET AL., supra note 3, § 105, at 733 (When estoppel can be shown, "the plaintiff prevails, not on the theory that the defendant's misrepresentation is tortious in itself, but because the defendant is not allowed to assert the truth, which would otherwise be a defense to some other action.") (emphasis added).

97. See Albain v. Flower Hosp., 553 N.E.2d 1038, 1049 (Ohio 1990) ("The doctrine of agency by estoppel . . . is not applicable where there is no showing of induced reliance upon an ostensible agency.") (quoting Johnson v. Wagner Provision Co., 49 N.E.2d 925, 925 (Ohio 1943)); see also Porter, 756 F.2d at 674.

98. RESTATEMENT (SECOND) OF AGENCY § 267 cmt. b (1957).

99. See supra notes 34 & 81 and accompanying text; see generally Abraham & Weiler, supra note 20, at 388.

100. See David G. Owen, The Fault Pit, 26 GA. L. REV. 703, 703 (1992) ("Fault lies at the heart of tort law, the private law of wrongs.").

https://scholarcommons.sc.edu/sclr/vol47/iss3/3
to rely" on the negligent physician’s relationship to the defendant hospital.  
As to the inducement element, in an unusually accurate application of section 
267, the court stressed “that the question is whether the plaintiff relied on the 
ovidable agency relationship, not whether the plaintiff relied on the reputation 
of the hospital.”

Other courts, however, assume away or ignore great chunks of the 
required analysis. They advance policy justifications for outcomes 
favorable to the plaintiff, but such justifications are result-oriented, 
hospital-specific, and emanate from the changing public perception of 
hospitals. They do not justify rejigging the established doctrine. If these result-
oriented policies are justification for anything, it is for the emergence of a 
new, hospital-specific doctrine of liability based on public policy. Indeed, 
when established doctrines are stretched as section 267 has been, it appears 
that the law is moving from the framework of an existing doctrine toward a 
new doctrine based on new policies, but that, in grappling with this transfor-
mation, the courts have yet to free themselves from the vocabulary of the 
existing doctrine.

To the argument that section 267 is in the process of being “streamlined” 
or modernized, one could respond that the doctrine as a whole is not being 
affected; the most extreme cases of such “streamlining” are not just hospital

101. Albain, 553 N.E.2d at 1050.
102. Id. at 1049-50. The court noted that, given the situational practicalities, “reliance is rarely 
present in an emergency situation.” Id. at 1050 n.12; accord Porter, 756 F.2d at 674 (“For 
section 267 to apply, Porter would have had to present evidence that his decision to allow Dr. 
Schneider to perform surgery on him was made because he believed that Dr. Schneider was an 
agent of St. Joseph Hospital.”).

Williams involved the negligence of an independent contractor nurse-anesthetist. In evaluating 
hospital liability, the court first discussed apparent authority, then quoted section 267, and 
concluded as follows:

In applying the above legal principles... it logically follows that the appellant 
justifiably believed Johnson to be a hospital employee. By taking no action to give 
appellant notice otherwise, the hospital “held-out” [sic] Johnson as an employee, thus 
creating an apparent agency.

Id. at 596. Compare the above-quoted language from Williams with that of Chase v. Independent 

Standing alone, Ms. Chase’s statement... that she was not “made aware that the 
doctors... were not employees” is insufficient to raise a claim of ostensible 
agency.... In order to hold IPA liable under an ostensible agency theory, there 
would have to be a showing of reliance on representations by IPA....

Id. (citation omitted).

104. See, e.g., Adamski, 579 P.2d at 974 ("[A]pplication of hornbook rules of agency to the 
hospital-physician relationship usually leads to unrealistic and unsatisfactory results, at least from the 
standpoint of the injured patient. Consequently, we have seen a substantial body of special 
law emerging in this area; the result has been an expansion of hospital liability for negligent 
medical acts committed on its premises.").
cases, but emergency room cases, where causation and reliance as a practical matter are very difficult to prove, and where it is most likely that the patient is looking to the institution itself for care. Where the patient has time for reflection and therefore for reliance, section 267 is applied more in accord with its terms.

C. Nondelegable Duty

The doctrine of nondelegable duty has traditionally been used to describe a form of vicarious liability, liability on the part of the delegating party regardless of any fault on its part. The doctrine evidently made its entrance into the hospital malpractice field in Darling v. Charleston Community Memorial Hospital, with the Illinois Supreme Court’s assertion that a hospital owes a direct and nondelegable duty to provide for a patient’s care, safety, and management.

The real effect of finding a duty to be nondelegable is to render not the duty, but the liability, not delegable; the person subject to a nondelegable duty is certainly free to delegate the duty, but will be liable to third parties for any negligence of the delegatee, regardless of any fault on the part of the delegator. The concept has been established at least since 1811:

105. See Richmond County Hosp. Auth. v. Brown, 361 S.E.2d 164, 166 (Ga. 1987) (noting that section 267 has been most widely applied in emergency room settings).

106. See Albain, 553 N.E.2d at 1050 n.12 (stating that “[t]he element of reliance is rarely present in an emergency situation”).

107. E.g., Porter, 756 F.2d at 674-75. Plaintiff Porter discussed surgery with a staff physician and waited two days to make his decision. The court stated: For section 267 to apply, Porter would have had to present evidence that his decision to allow Dr. Schneider to perform surgery on him was made because he believed that Dr. Schneider was an agent of St. Joseph Hospital. This he did not do. . . . [T]he district court did not err in granting judgment notwithstanding the verdict for St. Joseph Hospital.

Id.


109. Keeton et al., supra note 3, § 71, at 511. When the court finds a nondelegable duty, it will hold the employer liable for the independent contractor’s negligence even though the employer exercised reasonable care. See, e.g., S.F. Harper et al., The Law of Torts § 26.11, at 83-88 (2d ed. 1986); Classen, supra note 20, at 475.

In some recent hospital cases, however, the term is used much more loosely to apply to cases in which hospitals are held liable only when they can be shown to have been negligent, and their negligence to have had a causal relationship to the plaintiff’s injury. These cases are discussed in the next section. See infra notes 229-31 and accompanying text.


111. See id. at 257-59; Southwick, supra note 20, at 29-31.

A person causing something to be done, the doing of which casts upon him a duty, cannot escape from the responsibility attaching to him of seeing that duty performed, by delegating it to a contractor. He may bargain with the contractor that he shall perform the duty, and stipulate for an indemnity from him if it is not performed, but he cannot thereby relieve himself from liability to those injured by the failure to perform it. ¹¹³

Reflected in this description is the result that, where duties are found to be nondelegable, liability for harm to the one to whom the duty is owed is not escaped by delegation to an independent contractor. In other words, the doctrine of nondelegable duty is an exception to the general rule of nonliability for the torts of independent contractors. Similarly clear is that nondelegable duty does not describe direct liability in the sense of breach by or fault of the delegator; it is a species of vicarious liability, liability for the fault of another based not on the delegator's fault but on policy considerations.

Nondelegable duty is liability without fault and therefore, in our fault-based tort system,¹¹⁴ is strong medicine, assigned only on the basis of potent policy.¹¹⁵ Nondelegable duties may be created by statute, contract, franchise or charter, or the common law,¹¹⁶ the latter category including the identification of inherently dangerous activities.¹¹⁷ Of interest in the present circumstances are duties arising at common law, and the fundamental question is when will such a duty be found? One commentator has observed, "In general,


¹¹³. Fit. Lowell-NSS Ltd. Partnership, 800 P.2d at 966-67 (citation omitted).

¹¹⁴. Keeton et al., supra note 3, § 71, at 511.

¹¹⁵. [A] non-delegable duty operates, not as a substitute for liability based on negligence, but to assure that when a negligently caused harm occurs, the injured party will be compensated by the person whose activity caused the harm and who may therefore properly be held liable for the negligence of his agent, whether his agent was an employee or an independent contractor. To the extent that recognition of non-delegable duties tends to assure that there will be a financially responsible defendant available to compensate for the negligent harms caused by that defendant's activity, it ameliorates the need for strict liability to secure compensation.


¹¹⁶. Keeton et al., supra note 3, § 71, at 511.

¹¹⁷. "Inherently dangerous activities" came into the lexicon to describe activities that posed an inherent threat or danger even when performed with all reasonable care, such as blasting or keeping vicious animals. Keeton et al., supra note 3, § 71, at 513. The concept has been expanded, according to Prosser, "to work which, in its nature, will create some peculiar risk of injury to others unless special precautions are taken." Id. Prosser treats inherently dangerous activities as an exception to the independent contractor rule separate from nondelegable duty. But see Feliberty, 527 N.E.2d at 264 (where the court, discussing the nature and creation of nondelegable duties, included in its list of nondelegable duties "work contracted for [that] was inherently or abnormally dangerous.") (citations omitted).
non-delegable duties are those that the employer is not allowed to transfer to another because the responsibility to the community is considered so important."\textsuperscript{118} Beyond this observation, unfortunately, the cases in which such duties have been found exhibit no unifying theme. As Professor Prosser famously observed, "It is difficult to suggest any criterion by which the non-delegable character of such duties may be determined, other than the conclusion of the courts that the responsibility is so important to the community that the employer should not be permitted to transfer it to another."\textsuperscript{119} Put another way, nondelegable duties established by common law are reflections of particularly significant public policy, as perceived by the courts.

Although a number of courts have used the term "nondelegable duty" to refer to certain duties owed directly by hospitals to patients, in most such cases the term is being used not in the traditional sense; rather, the hospital is found liable for its own negligence in breaching a duty owed directly to the patient, not for the negligence of an attempted delegee. Those cases are discussed in Part IV of this paper.

A few courts have, however, applied the doctrine of nondelegable duty in independent contractor physician malpractice cases. The best known example is the Alaska Supreme Court's opinion in \textit{Jackson v. Power}.*\textsuperscript{120} In \textit{Jackson} an accident victim who had been airlifted to the Fairbanks Memorial Hospital emergency room later brought suit against the hospital on three vicarious liability theories: enterprise liability, apparent authority, and nondelegable duty.\textsuperscript{121} The emergency room physician was conceded by the plaintiff to be an independent contractor.\textsuperscript{122} The case exhibits several distinguishing factors. Fairbanks was "at the time of Jackson's accident . . . the only civilian hospital north of Anchorage providing emergency room services in Alaska."\textsuperscript{123} In addition, the hospital conducted "no advertising at all."\textsuperscript{124} Finally, at the time of the accident, Alaska hospital accreditation rules required "acute care" hospitals, such as Fairbanks, to provide around-the-clock emergency room physicians.\textsuperscript{125}

On appeal, the Alaska Supreme Court rejected the plaintiff's enterprise liability theory\textsuperscript{126} and returned the apparent agency question to the jury.\textsuperscript{127}

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\textsuperscript{118} Classen, \textit{supra} note 20, at 475; see also \textit{Fr. Lowell-NSS Ltd. Partnership}, 800 P.2d at 967.
\textsuperscript{119} Keeton ET AL., \textit{supra} note 3, \$ 71, at 512.
\textsuperscript{120} 743 P.2d 1376 (Alaska 1987).
\textsuperscript{121} Id. at 1378.
\textsuperscript{122} Id. at 1379.
\textsuperscript{123} Id. at 1381.
\textsuperscript{124} Id.
\textsuperscript{125} \textit{Jackson}, 743 P.2d at 1382. This regulation was later rescinded. Id.
\textsuperscript{126} Id. at 1379. For a discussion of enterprise liability, see notes 198-200 and accompanying text, \textit{infra}.
\textsuperscript{127} \textit{Jackson}, 743 P.2d at 1382. The court distinguished between \$ 429 of the Restatement of
\end{flushright}
The essence of the opinion, as indicated by its first paragraph,\(^\text{128}\) is the issue of nondelegable duty.

Characterization of a duty as nondelegable, the court observed, is based on a determination of public policy, answering the question whether in light of the “importance to the community” of emergency room service, a hospital should be able to escape liability for malpractice under the independent contractor rule.\(^\text{129}\) The court found expressions of Alaska public policy in hospital regulations, in particular the accreditation rule. This scheme, the court determined, “manifests the legislature’s recognition that it is the hospital as an institution which bears ultimate responsibility for complying with the mandates of the law.”\(^\text{130}\) Accordingly, the court held that “a general acute care hospital’s duty to provide physicians for emergency room care is non-delegable” and that the hospital, being responsible for such physicians, would be liable for their negligence.\(^\text{131}\) The court explained this finding of liability by reference to the role of hospitals themselves:

We are persuaded that the circumstances under which emergency room care is provided in a modern hospital mandates the rule we adopt today. Not only is this rule consonant with the public perception of the hospital as a multifaceted health care facility responsible for the quality of medical care and treatment rendered, it also treats tort liability in the medical arena in a manner that is consistent with the commercialization of American medicine.\(^\text{132}\)

Jackson strongly states the case for a public-policy informed exception to the independent contractor rule. Perhaps in part because of the exceptional circumstances of the case, its holding concerning nondelegable duty has not been widely followed.\(^\text{133}\) The Ohio Supreme Court, for example, in Albain

\(^{128}\) Torts and § 267 of the Restatement of Agency, but refers to § 429 as “‘ostensible’ or ‘apparent’ agency,” and to § 267 as “[a]gency by estoppel.” Id. at 1380. This is despite section 267’s reference in comment a to “the apparent servant,” and despite the absence in § 429 of any reference to any holding out of another as an agent. See Restatement (Second) of Agency § 267 cmt. a (1957); Restatement (Second) of Torts § 429 (1965). The authors believe that the court got these terms exactly backward and deplore their continued inverse use in the literature. As will be seen, the authors believe that § 429 of the Restatement of Torts is much more in the spirit of nondelegable duty than any form of agency or fictional agency.

\(^{129}\) Jackson, 743 P.2d at 1377.

\(^{130}\) Id. at 1384.

\(^{131}\) Id. at 1385. The court limited the holding to emergency rooms, and to circumstances in which the negligent physician was not the patient’s own. Id.

\(^{132}\) Id. at 1385.

\(^{133}\) As noted, some courts attempting to follow Jackson appear to have misunderstood its premise. See, e.g., Mason v. Labig, No. 87-CA-91, 1989 WL 72234, at *12 (Ohio Ct. App.)
v. *Flower Hospital*, 134 characterized extensions of nondelegable duty to hospitals employing independent contractors as “misdirected attempts to circumvent the necessity of proving agency by estoppel [that] confuse the proper scope of a hospital’s duty in selecting competent physicians.” 135 *Albain* goes on to hold, in effect, that the practice of medicine is delegable: “The practice of medicine in a hospital by an independent physician with staff privileges does not involve the type of risks and precautions required as contemplated by the ‘nondelegable duty’ exception.” 136

*Jackson*’s rhetoric raises a further, related question. Is medical practice amenable to the “inherently dangerous” exception to the usual rule of nonliability for independent contractors? This subdoctrine “seems to be limited to work in which there is a high degree of risk in relation to the particular surroundings, or some rather specific risk or set of risks to those in the vicinity, recognizable in advance as calling for definite precautions.” 137 Originally applied to work which was deemed dangerous even if performed with reasonable care, such as blasting or the keeping of vicious animals, the doctrine has expanded but is still considered “exceptional.” 138

Performance of medical practice has been said not to be dangerous if performed properly, and therefore is not “inherently dangerous” in the traditional sense. 139 Thus, medical practice should be delegable and should

June 29, 1989) (purportedly agreeing “with the Alaska Supreme Court’s recent decision wherein it held a general acute care hospital’s duty to provide physicians for emergency room care was non-delegable,” but nonetheless finding that the hospital itself breached its duty to follow “acceptable standards”) (citing *Jackson*, 743 P.2d 1376).

134. 553 N.E.2d 1038 (Ohio 1990).

135. *Id.* at 1047.

136. *Id.* at 1048 & n.9. The court continued:

This [section of the Restatement] has no reference to such a general anticipation of the possibility that the contractor may in some way be negligent. It is not concerned with the taking of routine precautions. . . . Such precautions are the responsibility of the contractor; and if the employer has exercised reasonable care to employ a contractor who is competent and careful (see § 411), he is not required to provide, in the contract or otherwise, that the contractor shall take them.

*Id.* at 1048 n.9 (citing RESTATEMENT (SECOND) OF TORTS § 416 cmt. b (1965)).


138. *Id.*; see *W. Edward Sell*, *Sell on Agency* 82 (Harry W. Jones ed. 1975) (“A person who has a duty of due care to protect another cannot, in general, relieve himself of liability for any harm to the other by delegating his duty to an agent.” This concept has been attached to “‘inherently dangerous activity[ies],’ such as the demolition of a building, even though the activity is not an ‘ultrahazardous’ one which would give rise to strict liability.”) (quoting Majestic Realty Assocs. v. Toti Contracting Co., 149 A.2d 288 (N.J. Super. Ct. App. Div. 1959)).

fall within the general rule that "the principal will not be liable to a third party harmed by his agent if either the agent had a delegable privilege to act, as where the third party consented to his acting." Nevertheless, some courts, relying on the above-quoted observation by Prosser, have implied that medical practice is, indeed, inherently dangerous.

Other courts, although not going so far as to categorize the practice of medicine as an inherently dangerous activity, have come close in describing their perceptions of the public policies involved:

Having undertaken one of mankind's most critically important and delicate fields of endeavor, concomitantly therewith the hospital must assume the grave responsibility of pursuing this calling with appropriate care. The care and service dispensed through this high trust, however technical, complex and esoteric its character may be, must meet standards of responsibility commensurate with the undertaking to preserve and protect the health, and indeed, the very lives of those placed in the hospital's keeping.

Although nondelegability of medical care has not swept the field, the determination of some courts that hospitals are, even under limited circumstances, subject to traditional nondelegable duty reflects changing perceptions of public policy at the most potent level. As the Ohio Supreme Court observed in Albain, the movement is "towards imposing strict liability on hospitals" for medical care of patients.

D. Restatement Section 429: Nondelegability Based on Reliance

The Restatement of Torts includes a topic entitled "Harm Caused by Negligence of a Carefully Selected Independent Contractor." This topic, the theme of which is nondelegability of duties, would seem a natural starting place for plaintiffs seeking to avoid the independent contractor rule. Portions of this subject matter already have been discussed. Of specific interest, and

140. Sell, supra note 138, at 83 ("Where the agent had a privilege to act and could exercise that privilege on behalf of the principal, the principal will also escape liability.").
143. See Milliron v. Francke, 793 P.2d 824, 827 (Mont. 1990) ("Jackson appears to stand alone as the only case applying the nondelegable duty exception to employer nonliability to a hospital for a doctor's negligence."); Abraham & Weller, supra note 20, at 389 ("Only the Alaska Supreme Court has explicitly held that the hospital's legal responsibility for malpractice by its physicians is non-delegable and non-waivable.").
144. Albain, 553 N.E.2d at 1046.
now warranting separate discussion, is section 429, so similar in import to section 267 of the Restatement of Agency that the two are very often cited together in hospital cases. They share fundamental characteristics: both are informed by estoppel and both are doctrines of vicarious liability, with liability for the actions of nonservants waiting at the finish line. The basis of liability under section 429 is very different, however, having the effect of substantially lowering the hurdles facing a section 429 plaintiff. Significantly, the policy-based rhetoric encountered in many nominal section 267 cases fits nicely into section 429.

Section 429 provides:

One who employs an independent contractor to perform services for another which are accepted in the reasonable belief that the services are being rendered by the employer or by his servants, is subject to liability for physical harm caused by the negligence of the contractor in supplying such services, to the same extent as though the employer were supplying them himself or by his servants.\(^{146}\)

The estoppel basis of section 429 is clear.\(^{147}\) The fault component lies in the requirement of near-deceit concerning the provider of the proffered services. The section stands for the proposition that, at least as to physical harm, the purchaser should have the benefit of the bargain struck.

Fundamentally, section 429 is a variety of nondelegable duty, as indicated by its inclusion in Chapter 15, Topic 2 of the Restatement. Although the rule of section 429 has been referred to as "ostensible agency"\(^{148}\) by some courts and commentators, the section itself does not base liability on any appearance or representation of agency. Liability is based upon the reasonable belief of the plaintiff that the services in question would be performed by the defendant (or the defendant’s alter ego, its servant).\(^{149}\) Nondelegability is founded upon the defendant's undertaking to provide those services\(^{150}\) and the patient’s reasonable expectations created thereby.\(^{151}\)


\(^{146}\) RESTATEMENT (SECOND) OF TORTS § 429 (1965).


\(^{149}\) E.g., id. at 650 ("[T]he jury could have concluded that [the plaintiff] relied upon the hospital rather than [the individual physician] himself for treatment.").

\(^{150}\) The analogous provision of the law of agency would be the concept of the agent’s agent—a further agent engaged by an agent who has no authority to delegate and is accordingly liable to the principal for harm caused by the agent’s agent. See REUSCHLEIN & GREGORY, supra note 35, § 8, at 20-21.

\(^{151}\) See, e.g., Arthur, 405 A.2d 443. In discussing § 429, the Arthur court stated:
The point is aptly illustrated by *Marek v. Professional Health Services*,\(^{152}\) where the plaintiff was injured on the job and was sent to the defendant, “PHS,” for diagnosis. PHS arranged for an independent contractor physician to conduct the diagnosis, which was performed negligently. The trial court found that PHS was liable as a matter of law, despite its use of an independent contractor, and PHS appealed. On appeal the Appellate Division of the Superior Court of New Jersey ruled that “the duty assumed by PHS to plaintiff . . . was a nondelegable duty.”\(^{153}\) The court observed that PHS had undertaken to provide services to the plaintiff, that the plaintiff neither knew of nor had any choice in the selection of the contractor, and that the plaintiff should not be required to seek a remedy against a contractor who could be under-insured or amenable to suit only in some foreign forum.\(^{154}\) The court then quoted section 429 in full, referring to it as “another” exception, recognized by the Restatement, to the independent contractor rule.\(^{155}\) In other words, the court’s analysis and justification in finding liability under section 429 were the same as that used in finding a nondelegable duty.

As a variety of nondelegable duty, section 429 has significant advantages over section 267 in the physician/hospital context. First, it is self-executing. Whereas section 267 merely removes nonagency as a defense to proof of liability under agency doctrine, section 429 requires proof only that the plaintiff reasonably believed that the defendant was to provide the services, and that the one who in fact provided them was negligent.\(^{156}\) In effect, section 429 embodies the conclusion that the plaintiff should not have to prove agency, or even liability under agency principles, when his expectation was

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The logic of these cases is persuasive, particularly when examined in terms of what may be viewed as the reasonable expectations of the public. This court may take judicial notice that generally people who seek medical help through the emergency room facilities of modern-day hospitals are unaware of the status of the various professionals working there. . . . [Rather,] it is the reputation of the hospital itself upon which he would rely. . . . [and] it would be natural for him to assume that these people are employees of the hospital. . . . At the very least, a factual question is presented.

*Id.* at 447. Earlier in its opinion, the court had noted:

[Section 429] imposes liability, not as the result of the reality of a contractual relationship but rather because of the actions of a principal or an employer in somehow misleading the public into believing that the relationship or the authority exists. The concept is essentially one of estoppel. . . .

*Id.* at 446. Thus, “absent notice to the contrary,” the plaintiff had a right to assume that the physician was an employee and the hospital would be responsible for harm. *Id.* at 447.

153. *Id.* at 542.
154. *Id.* at 542-43.
155. *Id.* at 543.
156. See RESTATEMENT (SECOND) OF TORTS § 429 & cmt. c (1965).
that the service would be provided, and presumably warranted by, the defendant.

Section 429 has the further advantage over section 267 of not requiring proof either of any representation that the tortfeasor was a servant or of reliance on such a representation. The representation requirement of section 267 has been a particular obstacle, which courts, presumably in response to perceived public policy, have been nimble to avoid. In Fulton v. Quinn,157 for example, the plaintiff was on notice that the treating physician was an independent contractor,158 seemingly negating the possibility of representation and causation. The Superior Court of Delaware characterized this notice as merely evidence of the hospital/physician relationship. The court reduced the requirements of representation and causation to the “critical question” whether “a hospital nurtured the patient’s belief, even if by mere acquiescence, that the doctor was the hospital’s agent.”159 This question was then reduced even further by the court’s suggestion that it agreed with the proposition that “absent notice to the contrary, a patient has a right to assume that the treatment received in a hospital’s emergency room is being rendered through hospital employees and that any negligence associated with that treatment renders the hospital responsible.”160 Even in the motion-to-dismiss context, the Delaware court’s logic tortures the requirements of section 267.161 Section 429 would be a better fit, focusing as it does not on the apparent legal relationship between hospital and doctor, of which the patient would almost certainly not be aware,162 but on the reasonable perceptions of the plaintiff.

The better fit of section 429 to hospital independent contractor cases is illustrated by Arthur v. St. Peters Hospital.163 In that case of first impression in New Jersey, brought by an emergency room patient, the court discussed estoppel based on “the actions of a principal or an employer in somehow misleading the public into believing that the relationship or the authority

158. Id. at *6.
159. Id. at *5 (citing Stewart v. Midani, 525 F. Supp. 843 (N.D. Ga. 1981)).
160. Id. at *6 (citing Paintsville Hosp. Co. v. Rose, 683 S.W.2d 255 (Ky. 1985)).
161. Silence can constitute a “representation” for purposes of § 267, but only when it is unreasonable or in bad faith after notice to the hospital that its silence is being inappropriately relied upon. See supra notes 86-90 and accompanying text. The Restatement itself discourages application of apparent agency upon the “mere fact” of the plaintiff’s belief; it calls for an “invitation” and reasonable reliance thereon. See RESTATEMENT (SECOND) OF AGENCY § 267 & cmt. a (1957); see also supra note 92 and accompanying text.
162. Cf. Fulton, 1993 WL 19674, at *5 (“[B]oth courts and commentators now often characterize as ‘absurd’ the requirement that a patient . . . be familiar with the law of respondeat superior and inquire as to the status of each physician from whom treatment is received.”) (citations omitted).
163. 405 A.2d 443.
exists."\(^{164}\) For this proposition the court rather questionably relied on a case concerning the apparent authority of an agent to bind his principal in contract.\(^{165}\) The court then quoted section 429, holding:

In those cases where it can be shown that a hospital, by its actions, has held out a particular physician as its agent and/or employee and that a patient has accepted treatment from that physician in the reasonable belief that it is being rendered in behalf of the hospital, then the hospital will be liable for the physician’s negligence.\(^{166}\)

The court’s focus on the words “holding out,” or representations, is not dissimilar from the language of many cases nominally based on section 267. Section 267 does not fit here, however, because the hospital did not represent anyone as its servant, and there was no reliance upon such a representation. Section 429 is a better fit both by its terms and as a matter of policy. The plaintiff in Arthur was not injured because he was misled into believing that someone was someone else’s servant. Rather, he was injured because he submitted himself to the hospital for a cure. The outcome in Arthur is consistent with the emerging public perception that the hospital itself is the provider of services.

As a justification for a hospital exception to the independent contractor rule, section 267 is unsatisfactory because, ultimately, it assigns liability on the agency principle that one who controls the physical performance of another’s duties should be liable for resulting harm—liability based on the structure of the relationship. Put another way, section 267 suggests that when an employer extends the reach of his competence by employing agents over whose physical acts he retains a right of control, part of the price he pays is liability for the agent’s physical torts. If the agent is the extension of the master, the agent’s torts are the master’s torts. Where courts find as a fact, however, that a physician is an independent contractor, liability should not result from the structure of the relationship absent the demanding requisites of estoppel: The defendant’s inaccurate (and in some degree wrongful) representation of a master/servant relationship must cause the plaintiff’s reliance on the skill of the apparent servant.\(^{167}\) The hospital exception to the independent contractor rule, however, is based on the plaintiff’s reliance on the hospital, not the physician, as the source of cure. Where the courts are satisfied that this reliance is justified, liability may be available under section 429 without

\(^{164}\) *Id.* at 446.

\(^{165}\) *Id.* (citing Hudson & Co. Loan Ass’n v. Horowitz, 186 A. 437, 438 (N.J. Sup. Ct. 1936)); see supra note 75 (discussing the distinction between apparent authority and apparent agency).

\(^{166}\) Arthur, 405 A.2d at 446.

\(^{167}\) RESTATEMENT (SECOND) OF AGENCY § 267 (1957).
requiring a court to be creative concerning the law of master and servant or representation and causation.

Although section 429 is often cited in cases holding hospitals liable for malpractice, courts have rarely relied upon it independent of section 267. In opinions in which both sections are cited, the holding is most often premised on some variation on the theme of "holding out,"\(^{168}\) which, Jackson v. Power\(^{169}\) notwithstanding, is much more the premise of section 267 than section 429. At least one court has rejected section 429 as a basis for hospital malpractice liability in favor of section 267.\(^{170}\) The less well-fitting theory is the more popular.

IV. DIRECT LIABILITY

A. Direct Liability Based on Hospital Negligence

Direct hospital liability is based on breach by the hospital of some duty owed directly to the patient.\(^{171}\) From that simple description, direct negligence would appear straightforward, but this appearance is scotched by the lack of uniformity among courts applying the concept. The direct liability concept is evolving to reflect the changing public perception of the role of the hospital and the courts' increasing acceptance of this perception. Two general areas of confusion appear in the cases: What duties are owed directly by the hospital to the patient, and what is the nature of these duties? The latter question again raises issues of nondelegable duty and inherently dangerous activities.

A hospital's nondelegable duties have generally been classified into four areas:

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168. The Arthur court, for example, nominally relied on section 429. It held:

In those cases where it can be shown that a hospital, by its actions, has held out a particular physician as its agent and/or employee and that a patient has accepted treatment from that physician in the reasonable belief that it is being rendered in behalf of the hospital, then the hospital will be liable for the physician's negligence. . . . "Patients entering the hospital through the Emergency Room, could properly assume that the treating doctors and staff of the hospital were acting on behalf of the hospital."


171. See, e.g., Williams v. St. Claire Medical Ctr., 657 S.W.2d 590, 593 (Ky. Ct. App. 1983) (noting that where a negligent physician was the plaintiff's private physician, the hospital may not be liable for the physician's negligence but that such result "has no bearing on the separate issue of whether the hospital itself was negligent in failing to enforce its anesthesiology policies").
(1) a duty to use reasonable care in the maintenance of safe and adequate facilities and equipment;
(2) a duty to select and retain only competent physicians;
(3) a duty to oversee all persons who practice medicine within its walls as to patient care; and
(4) a duty to formulate, adopt and enforce adequate rules and policies to ensure quality care for the patients.¹⁷²

Hospitals have also been held directly liable for the failure of employees to follow physicians’ instructions concerning medical care¹⁷³ and to keep the attending physician informed of a patient’s condition to permit appropriate diagnosis and treatment.¹⁷⁴

Where vicarious liability may be impossible to prove, a breach of direct duties imposed on hospitals may permit plaintiffs to reach a hospital in connection with the malpractice of independent contractor physicians.¹⁷⁵ Unlike some theories of vicarious liability, direct liability applies with equal force regardless of whether the patient was treated by a physician who was the hospital’s employee, the hospital’s independent contractor staff physician, or the patient’s personal physician.¹⁷⁶

Hospitals’ duties to furnish adequate facilities and equipment and to promulgate and follow rules for patient safety are relatively well-established.¹⁷⁷ The more significant of the two duties in the present context is the promulgation and administration of patient safety rules, as it can be employed either cumulatively or as a substitute to permit a plaintiff to hold a hospital directly liable for the malpractice of a physician whose torts would otherwise

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¹⁷⁴ Id. at 1051 (citing Lambert v. Sisters of Mercy Health Corp., 369 N.W.2d 417, 420 (Iowa 1985)). Additionally, “it must be . . . shown that such breach was the proximate cause of the patient’s injury before the hospital will be held vicariously liable therefore.” Id.

¹⁷⁵ “[C]orporate liability is broader than agency liability in the sense that the hospital may be held liable even if the physician (for example, an obstetrician) was selected by the patient and practices in the hospital as an independent contractor.” Abraham & Weiler, supra note 20, at 389-90; see also Purcell v. Zimbelman, 500 P.2d 335 (Ariz. Ct. App. 1972); Joiner v. Mitchell County Hosp. Auth., 186 S.E.2d 307 (Ga. Ct. App. 1971), aff’d, 189 S.E.2d 412 (Ga. 1972); Holton v. Resurrection Hosp., 410 N.E.2d 969 (Ill. App. Ct. 1980); Bost v. Riley, 262 S.E.2d 391 (N.C. Ct. App.), cert. denied, 269 S.E.2d 621 (N.C. 1980); Hannola v. City of Lakewood, 426 N.E.2d 1187 (Ohio Ct. App. 1980).

¹⁷⁶ See, e.g., Williams, 657 S.W.2d at 594 (“There is no rational reason or public policy why a hospital’s [direct] duty to properly administer its policies should be any less to one patient than another depending upon how the patient initially arrived at the hospital.”).

¹⁷⁷ See generally supra note 172.
not be attributable to the hospital. For example, failure of a hospital’s governing board to implement an operating certification committee to supervise physician practice within the hospital might constitute a negligent breach of a direct duty to patients, rendering the hospital liable to a victim of malpractice.\footnote{178}

Negligent admission of physicians to staff privileges, often referred to as “negligent selection,” is a more controversial source of hospital liability. Negligence in engaging agents, including independent contractors, is a familiar source of direct liability for principals,\footnote{179} recognized, for example, in the Restatements of Agency\footnote{180} and Torts.\footnote{181} In such cases, the principal is responsible for its own negligence, not that of employees or contractors, and the principal’s negligence must be shown to be a proximate cause of the plaintiff’s injury.\footnote{182}

In a number of jurisdictions hospitals have been held to owe a similar, direct duty to patients to exercise care in selecting physicians to practice on the premises.\footnote{183} The crucial distinction to be made, however, is that physician selection, which involves professional medical judgments normally exercised by physician committees,\footnote{184} is not necessarily the same thing as the hospital’s engaging an agent. Courts have only infrequently made this distinction. In Joiner, for example, the trial court granted summary judgment to a hospital

\footnote{178} See Bost, 262 S.E.2d 391; see also Southwick, supra note 20, at 24-29.


\footnote{180} The Restatement of Agency states: “A person conducting an activity through servants or other agents is subject to liability for harm resulting from his conduct if he is negligent or reckless in the employment of improper persons or instrumentalities in work involving risk or harm to others.” RESTATEMENT (SECOND) OF AGENCY § 213(b) (1957).

\footnote{181} The Restatement of Torts states that “[a]n employer is subject to liability for physical harm to third persons caused by his failure to exercise reasonable care to employ a competent and careful contractor to do work which will involve a risk of physical harm unless it is skillfully and carefully done.” RESTATEMENT (SECOND) OF TORTS § 411(a) (1965).

\footnote{182} Greening, 393 N.W.2d at 58 (holding that “a plaintiff must not only show that the employer negligently selected a person incapable of performing the work but also show that the conduct of the incompetent employee was a proximate cause of injury to another”); see RESTATEMENT (SECOND) OF AGENCY § 213 cmt. d (1957); RESTATEMENT (SECOND) OF TORTS § 411 cmt. b. (1965); KEeton ET AL., supra note 3, § 71, at 511.

\footnote{183} Darling v. Charleston Community Memorial Hosp., 211 N.E.2d 253 (Ill. 1965), cert. denied, 383 U.S. 946 (1966); Janulis & Hornstein, supra note 21, at 702-08; Southwick, supra note 20, at 17-44.

The theory of corporate negligence supported in Darling has been expanded by other courts to hold a hospital liable for failure to exercise due care in selecting and monitoring staff. See, e.g., Purcell, 500 P.2d at 335; Joiner, 186 S.E.2d at 307; Holton, 410 N.E.2d at 969; Hannola, 426 N.E.2d at 1187; Southwick, supra note 20, at 17-45; see generally S.C. CODE ANN. § 33-8-101 (Law. Co-op. 1976).

\footnote{184} See generally Southwick, supra note 20, at 29-44.
on the ground that the medical staff, not the hospital, was responsible for granting staff privileges to the physician in question.\textsuperscript{185} The Georgia Court of Appeals reversed and remanded for trial on the question of whether the hospital itself had been negligent, and the Georgia Supreme Court affirmed.\textsuperscript{186} Similarly, where a review of a physician’s practice record would have revealed questions concerning competence, but no review was made before the physician was granted surgical staff privileges, the selecting hospital was held liable by a Wisconsin court for negligence in selection.\textsuperscript{187} The court determined that the duty to investigate was the hospital’s and that the failure to investigate gave rise “to a foreseeable risk of unreasonable harm.”\textsuperscript{188} The Ohio Supreme Court has allocated the duty of selection to the hospital itself.\textsuperscript{189} Hospitals also have been held subject to a direct duty of care in renewing staff privileges, a duty analogous to that of careful selection.\textsuperscript{190}

Related to but more controversial than the duty of care in renewing staff privileges is the direct duty to supervise physicians practicing on the premises.\textsuperscript{191} The duty to supervise has been described as the requirement of an effective mechanism “to monitor . . . the treatment which is prescribed and administered by physicians practicing at the facility.”\textsuperscript{192} At least one thoughtful opinion has suggested a higher level of duty to monitor in the emergency room.\textsuperscript{193}

\begin{itemize}
    \item \textsuperscript{185} Joiner, 186 S.E.2d at 307.
    \item \textsuperscript{186} Id. at 308-09 (“[T]he plaintiff does not seek to hold the [hospital] liable under the doctrine of \textit{respondeat superior} or principal and agent, but upon the doctrine of independent negligence in permitting the alleged negligent physician to practice his profession in the hospital, when his incompetency is known.”).
    \item \textsuperscript{187} Johnson v. Misericordia Community Hosp., 301 N.W.2d 156 (Wis. 1981).
    \item \textsuperscript{188} Id. at 164.
    \item \textsuperscript{189} Albain, 553 N.E.2d at 1045.
    \item \textsuperscript{190} Hannola, 426 N.E.2d at 1192.
    \item \textsuperscript{191} Albain, 553 N.E.2d at 1045.
    \item \textsuperscript{192} Bost, 262 S.E.2d at 396; see Campbell v. Pitt County Memorial Hosp., 352 S.E.2d 902 (N.C. Ct. App.), aff’d, 362 S.E.2d 273 (N.C. 1987); Sharsmith v. Hill, 764 P.2d 667, 673 (Wyo. 1988) (“[A] hospital should be required to exercise reasonable care not only in determining whether to extend or continue staff privileges, but also in maintaining adequate supervision and review of treatment rendered by those physicians. . . . [Hospitals] may be liable for negligent supervision . . . only if [the plaintiff] can demonstrate obvious negligence or show that the hospital knew or should have known of negligent treatment or procedures.”).
    \item \textsuperscript{193} A hospital clearly does have a duty to prevent a physician’s malpractice at least to the extent that it establishes procedures for the granting of staff privileges and for the review of these privileges. . . . [A] hospital may well have a more specific and precise independent duty in the emergency room . . . to monitor the treatment procedures and medical care provided patients.

\textit{Hannola}, 426 N.E.2d at 1192.
\end{itemize}
Why the hospital, a corporate entity, should be burdened with liability for evaluating physician performance is not always clearly dealt with in the cases. In Albain, the Ohio Supreme Court treated the duty as directly analogous to any other employment of independent contractors and therefore relied on the Restatement of Torts section 411. This approach begs the question of whether granting staff privileges is the same thing as hiring an employee. In Corleto v. Shore Memorial Hospital, a case of first impression in New Jersey, the Superior Court relied on Hull v. North Valley Hospital for this proposition:

[T]he integration of a modern hospital becomes readily apparent as the various boards, reviewing committees, and designation of privileges are found to rest on a structure designed to control, supervise, and review the work within the hospital. The standards of hospital accreditation, the state licensing regulations, and [hospital’s] bylaws demonstrate that the medical profession and the other responsible authorities regard it as both desirable and feasible that a hospital assume certain responsibilities for the care of the patient.

This analysis, relied upon in at least three states as a basis for hospital liability for physician selection, has the ring of enterprise liability. Under this approach, the aggregate of jural persons, associations, and committees that come together at a hospital are in truth one, and therefore their framework, the hospital, justifiably is liable for the actions of all. Enterprise liability

194. Albain, 553 N.E.2d at 1045; see supra note 181.
197. Corleto, 350 A.2d at 537 (quoting Hull, 498 P.2d at 143); see Darling, 211 N.E.2d at 257 (finding it “both desirable and feasible that a hospital assume certain responsibilities for the care of the patient”).

When . . . the hospital undertakes to provide medical treatment rather than merely serving as a place for a private physician to administer to his patients, the physician employed to deliver that service for the hospital may be looked upon as an integral part of the total “hospital enterprise.” In such cases, it should make no difference that the physician is compensated on some basis other than salary or that he bills his patient directly. These are artificial distinctions, the efficacy of which has long since disappeared and to the perpetuation of which we do not subscribe.

Id. at 975.
199. Enterprise liability was rejected as a basis for hospital liability in Jackson v. Power, 743 P.2d 1376, 1378-79 (Alaska 1987). The theory advanced in Jackson was that an act by an independent contractor “for the benefit of or in the interest of the enterprise” renders the enterprise liable. Id. at 1379. Treating enterprise liability as a shortcut to respondeat superior liability, the Alaska Supreme Court observed that “we have applied the theory of respondeat
carries with it a strong element of liability without fault. It is for this reason, perhaps, that direct liability is sometimes described in terms of nondelegable duty, as is discussed below. In any event, the foregoing analysis illustrates clearly the changing public image of the hospital and the increasing burden of duty applied by the courts in response thereto. One is tempted to conclude that the real source of the hospital’s duties is that public policy, expressed through accrediting and other governing regulations, puts the responsibility and therefore the duty on the hospitals, as suggested in Jackson v. Power.200

In the general run of cases, liability based on negligent selection or supervision is not treated as imputed liability for physician malpractice,201 although damages for breach of the duty might be measured similarly. They are theories of fault-based, direct negligence,202 recognizing an independent duty, owed directly by the hospital to patients, to scrutinize the qualifications of its physicians with an acceptable level of care.203 They require the plaintiff to prove negligence on the part of the hospital in the selecting or supervising process.204 Particularly where the hospital’s alleged negligence is not active, but constitutes a failure to act, foreseeability of the harm that resulted is required.205 The hospital’s negligence must also be causally

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200. Id. at 1384-85.

201. See Albain, 553 N.E.2d at 1046 (“A physician’s negligence does not automatically mean that the hospital is liable, and does not raise a presumption that the hospital was negligent in granting the physician staff privileges.”). In addition to showing that the hospital was negligent in its selection, the plaintiff must show that the conduct of the one selected was the proximate cause of the plaintiff’s injury. Cf. Greening, 393 N.W.2d at 58.

202. Corleto, 350 A.2d at 536-37. According to the Restatement of Agency, the finding must rest upon a finding that the employer has acted unreasonably:

One who employs another to act for him is not liable under the rule stated in this section merely because the one employed is incompetent, vicious, or careless. If liability results it is because, under the circumstances, the employer has not taken the care which a prudent man would take in selecting the person for the business in hand.


203. Washington, for example, has recognized what its courts describe as a nondelegable duty of hospitals to patients to “exercise reasonable care to ensure that only competent physicians are selected as members of the hospital staff.” Alexander v. Gonser, 711 P.2d 347, 351 (Wash. Ct. App. 1986).

204. Corleto, 350 A.2d at 536-37; see Abraham & Weiler, supra note 20, at 391. In Johnson, for example, the court cast the hospital’s duty in terms of foreseeability of harm to patients. The burden of proof of foreseeability rested with the plaintiff. The hospital was not strictly liable or held to absolute knowledge of the physician’s background; it could have defended itself by showing a reasonable level of care. See Johnson, 301 N.W.2d at 156.

related to the plaintiff’s injury.\textsuperscript{206} In \textit{Douglas v. Freeman},\textsuperscript{207} the patient was treated by an unlicensed dentist without the assistance of a dental assistant or supervision by a licensed dentist. The court, focusing on the lack of proximate cause, stated, “Despite this evidence of negligence, however, the record is devoid of any testimony establishing that [the dental clinic’s] negligence proximately caused Douglas’ injury . . . . The evidence does not establish that the \textit{absence} of a dental assistant, a supervising dentist, or a licensed dentist caused Douglas’ injury.”\textsuperscript{208}

That the duty in such cases is increasingly placed upon the hospital reflects the courts’ growing view that the public looks to the hospital for treatment and that it is the hospital’s responsibility to provide it.\textsuperscript{209} In \textit{Johnson}, for example, the court cast the hospital’s duty in terms of foreseeability of harm to patients, reflecting the court’s view that the hospital is not an arena for physicians to practice, but an institution that itself admits patients for treatment for which it has the responsibility.

\textbf{B. Direct Liability Nominally Based on Nondelegable Duty}

Corporate negligence is sometimes described in terms of nondelegable duties.\textsuperscript{210} Unfortunately, insufficient discipline is exercised by courts and commentators in the use of this term. The term nondelegable duty has traditionally been used to describe a form of vicarious liability,\textsuperscript{211} liability on the part of the delegating party regardless of any fault on its part.\textsuperscript{212} In recent hospital cases, however, the term is used much more loosely to apply to cases in which hospitals are held liable only when they can be shown to have been negligent, and when their negligence can be shown to have had a causal relationship to the plaintiff’s injury. In \textit{Douglas v. Freeman},\textsuperscript{213} for

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  \item \textsuperscript{206} Albain, 553 N.E.2d at 1051 (“[I]t must further be shown that such breach was the proximate cause of the patient’s injury before the hospital will be held vicariously liable therefor.”).
  \item \textsuperscript{207} 787 P.2d 76 (Wash. Ct. App. 1990).
  \item \textsuperscript{208} Id. at 80-81.
  \item \textsuperscript{209} See, e.g., Sharsmith, 764 P.2d at 673 (noting that “the preservation of quality health care for Wyoming citizens was an important public policy”) (citations omitted).
  \item \textsuperscript{212} Keeton ET AL., \textit{supra} note 3, § 71, at 511. When the court finds a nondelegable duty, it will hold the employer liable for the independent contractor’s negligence even though the employer exercised reasonable care. See, e.g., Harper ET AL., \textit{supra} note 109, § 26.11, at 83-88; Classen, \textit{supra} note 20, at 475.
  \item \textsuperscript{213} 787 P.2d 76 (Wash. Ct. App. 1990).
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example, the Court of Appeals of Washington began with the observation, "Under the doctrine of corporate negligence, a hospital owes a nondelegable duty directly to the patient to 'exercise reasonable care to ensure that only competent physicians are selected as members of the hospital staff.'" The court went on to observe that there was ample evidence of the defendant clinic's negligence in permitting a nonlicensed dentist to perform extractions. Overturning a jury verdict for the plaintiff, however, the Court of Appeals absolved the clinic from liability because of a lack of adequate causal connection between the clinic's negligence and the patient's injury. The court distinguished Harbeson v. Parke-Davis, Inc., where the "plaintiffs clearly established that but for the defendant's negligence" the harm to the patient would not have occurred. In contrast, the Douglas plaintiff "established cause only with respect to [the physician's] alleged negligence. None of [plaintiff's] witnesses testified that the alleged negligence of [the clinic] caused the . . . injury." This sort of analysis falls far short of liability regardless of the fault of the delegator.

Similarly, Thompson v. Nason Hospital describes four categories of nondelegable duties for breach of which a hospital can be found liable "independently of the negligence of its employees or ostensible agents." But Thompson goes on to require plaintiffs to show that the hospital itself breached a duty and that the hospital knew or should have known of the negligent acts. The Pennsylvania Superior Court, in construing Thompson, concluded that "a hospital's corporate negligence will be measured against what a reasonable hospital under similar circumstances should have done. . . . Thompson does not propound a theory of strict liability . . . . Though broadly defined, Thompson liability is still fault based."

215. Id. at 80.
216. Id. at 81.
217. 656 P.2d 483 (Wash. 1983).
220. Although Thompson speaks in terms of "hospitals," the holding has been applied to the extent appropriate to an HMO using no facilities or equipment, and therefore not "over[it] . . . patient care." See, e.g., McClellan v. Health Maintenance Organization, 604 A.2d 1053, 1059 (Pa. Super. Ct. 1992). The duties of selection and retention of competent physicians and adopting and enforcing appropriate rules and policies have been extended to HMOs. See id.; see also supra note 1.
221. Thompson, 591 A.2d at 707.
222. Id. at 708.
The United States District Court for the Eastern District of Pennsylvania, granting summary judgement for the hospital in *Engel v. Minissale*,\(^{224}\) quoted *Thompson* for the proposition that in a corporate negligence action "a plaintiff must 'show that the hospital had actual or constructive knowledge of the defect or procedures which created the harm and that the hospital's negligence must have been a substantial factor in bringing about the harm.'"\(^{225}\) In its discussion of the duties recognized by *Thompson*, the court did not describe them as nondelegable.\(^{226}\)

Again, in *Mason v. Labig*, an unpublished Ohio Court of Appeals opinion,\(^{227}\) the court, observing that "[s]ound public policy considerations require that the full service hospital be held accountable for emergency room malpractice,"\(^{228}\) concluded, "We agree with the Alaska Supreme Court's recent decision [in *Jackson v. Power*] wherein it held [that] a general acute care hospital's duty to provide physicians for emergency room cases was nondelegable."\(^{229}\) In its discussion of the breach for which hospital liability was sought, however, the court determined that the hospital deviated from acceptable standards in not ensuring that an appropriate consultant was available to the emergency room. In other words, the hospital had itself been negligent in performing a duty that it owed directly. This is direct liability, not vicarious liability for the tort of another regardless of the delegator's fault.

The conclusion is difficult to escape that courts such as those that decided *Mason* and *Thompson* are not using "nondelegable" in the traditional sense, but in the sense that hospitals cannot, by delegating patient care to independent contractors, escape liability for their own negligence in performing directly owed duties. As illustrated by the cases above, this approach requires the plaintiff to prove the hospital's duty and breach, and that the hospital's negligence was the proximate cause of the plaintiff's injuries.\(^ {230}\) That the term "nondelegable" is used at all, however, reflects the trend of public reliance on the hospital itself as the care provider and therefore as the

\(^{225}\) Id. at *2.
\(^{226}\) Id. at *1.
\(^{228}\) Id. at *12.
\(^{229}\) Id. (citing *Jackson v. Power*, 743 P.2d 1376 (Alaska 1987)).
\(^{230}\) Whether the duties discussed in this section are nondelegable in the traditional sense would come into focus in cases where the hospital delegated the duty in question to an independent body, such as a physician committee, then defended on the basis of the independent contractor rule. In *Albain* the Ohio Supreme Court observed: "The hospital may delegate this duty [to grant and continue staff privileges] to a staff physician committee, but it cannot escape its duty of due care in the process of granting and continuing staff privileges by doing so." *Albain v. Flower Hosp.*, 553 N.E.2d 1038, 1045 (Ohio 1990). This statement can be read to refer to traditional nondelegable duty, or to charge the hospital with supervision of the staff committee's work.
responsible party,\textsuperscript{231} driving perceived public policy toward enhanced hospital responsibility for the fate of patients.

\textbf{V. SHULER AND STRICKLAND}

Two recent decisions illustrate that South Carolina courts have not been unaffected by the general trend toward expansion of hospital liability for the torts of independent contractor physicians committed on hospital premises. \textit{Shuler v. Tuomey Regional Medical Center},\textsuperscript{232} the earlier of the two South Carolina cases recognizing apparent agency, addresses three points of appeal but is able to deal with them in five paragraphs. Nondelegable duty, argued at trial, was not preserved for appeal. Actual agency, raised on appeal, was supported by "no evidence" in the trial record.\textsuperscript{233} \textit{Shuler} treats apparent agency as the real issue; the doctrine was familiar in South Carolina in nonhospital contexts.\textsuperscript{234} The court read established precedent as mandating a three-part test: "To establish an apparent agency . . . [the plaintiff] must prove: (1) that the purported principal consciously or impliedly represented another to be his agent; (2) that there was a reliance upon the representation; and (3) that there was a change of position to the relying party's detriment."\textsuperscript{235} The court found nothing in the trial record to evidence reliance by the plaintiff on any manifestation by the defendant\textsuperscript{236} and sustained summary judgment. This is a relatively rigorous application of apparent agency in the hospital context. It is consistent with the reasoning in similar Georgia cases.\textsuperscript{237}

\textit{Shuler} was followed in \textit{Strickland}, a case that stimulated a rather more formal opinion. In \textit{Strickland} the plaintiff agreed that the physician in question was an independent contractor\textsuperscript{238} and sought to hold the hospital liable on the basis of apparent authority. Citing the \textit{Shuler} test, the court declined to consider whether a fact question had been raised as to the hospital's representation, because in any event there was "no evidence to support the remaining

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\textsuperscript{231} See, e.g., Pedroza, 677 P.2d 166.
\textsuperscript{232} 313 S.C. 225, 437 S.E.2d 128 (Ct. App. 1993).
\textsuperscript{233} Id. at 228, 437 S.E.2d at 130.
\textsuperscript{235} Shuler, 313 S.C. at 227, 437 S.E.2d at 129 (citation omitted).
\textsuperscript{236} Id., 437 S.E.2d at 129 ("Apparent authority may serve as a basis of liability for a principal only when the principal manifests . . . that the agent has certain authority and the third party reasonably relies on that manifestation."). (quoting Vereen v. Liberty Life Ins. Co., 306 S.C. 423, 412 S.E.2d 425 (Ct. App. 1991)).
\textsuperscript{238} Strickland v. Madden, ___ S.C. ___, 448 S.E.2d 581, 585 (Ct. App. 1994).
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elements of reliance and change of position” by the plaintiff. In particular, the court observed that the plaintiff “makes no claim she changed her position to her detriment based upon her reliance upon the hospital’s alleged representation.” Again, the South Carolina Court of Appeals applied the estoppel theory with some rigor, in this case in terms consistent with section 267.

The Strickland plaintiffs preserved the direct liability issue by appealing the trial court’s grant of summary judgment with respect to the hospital’s failure to withdraw the allegedly negligent physician’s staff privileges. The court observed that negligence “becomes actionable only when it violates some specific legal duty owed to the plaintiff” and did not further address whether such a duty might exist in South Carolina. The court recognized the adoption of such duties in other jurisdictions, however, based on the “public’s perception of and reliance on [the] hospital as [a] multi-faceted health care facility, as well as [the] hospital’s superior position to monitor and control physician performance.” The court observed further that, were it to recognize such duties, their “application would . . . require a standard of care to be established, for example, pursuant to national hospital accreditation requirements or the hospital’s own bylaws.” While Strickland does not enter into considerations of public policy beyond its passing reference to “public perception,” the opinion strongly suggests that South Carolina courts will not remain immune to the changing tide of public perception and attendant public policy, doctrinal difficulties notwithstanding.

239. Id.
240. Id. at ___, 448 S.E.2d at 586.
241. Id.
242. Id.
243. Strickland, ___ S.C. at ___, 448 S.E.2d at 586 (citing Pedroza v. Bryant, 677 P.2d 166 (Wash. 1984)).
244. Id. (citing Pedroza, 677 P.2d 166).
245. Although beyond the scope of this article, any comprehensive review of applicable South Carolina public policy should include a review of the extensive body of statutory law governing hospitals in South Carolina to determine the extent to which these laws contain expressions of public policy. See Jackson v. Power, 743 P.2d 1376, 1384-85 (Alaska 1987) (employing such a methodology and stating that Alaska’s “regulatory scheme and the purpose underlying it along with the statutory definition of a hospital, manifests the legislature’s recognition that it is the hospital as an institution which bears ultimate responsibility for complying with the mandates of the law”); see also S.C. CODE ANN. §§ 44-7-110 to -370 (Law. Co-op. 1976 & Supp. 1995). Similarly, any effort to define a new standard of care should consider whether, in light of public policy, all hospitals should be treated alike, or should be subject to varying legal regimes depending upon the nature of the hospital (i.e., profit versus nonprofit, private versus public, private nonprofit community versus private nonprofit religious, etc.).
VI. CONCLUSION

The eagerness of many courts to find hospital liability for the malpractice of independent contractor physicians illustrates the larger phenomenon of the courts' supportive reaction to the changing public perception of hospitals. This perception has changed in two ways: First, the hospital has lost its perch as an institution functioning in the public interest and therefore deserving of support in the form of insulation from liability. Second, the hospital itself has come to be perceived as the provider of medical services. According to this view, patients come to the hospital to be cured, and the doctors who practice there are the hospital's instrumentalities, regardless of the nature of the private arrangements between the hospital and the physician. Whether or not this perception is accurate seemingly matters little when weighed against the momentum of changing public perception and attendant public policy. Both of these changes in public perception can be ascribed in large part, in the view of the authors, to the health service industry's re-invention of the hospital as the center for comprehensive health care delivery. This re-invention of the image of the hospital has, in turn, generated an increased need for resources, thus stimulating hospitals to market themselves, using the tools of mainstream commerce, as comprehensive health care delivery centers.

The essence of the change in public policy is this: Whereas the basis of hospital liability analysis was once that protecting the hospital benefitted the public as a whole, the focus is shifting to the expectations of the public and the individual patient, who is to be protected at the hospital's expense. This new public policy assigns to the hospital a distributive role bordering on strict liability. In the common law system, of course, the courts' perception of public policy is made state by state. It is therefore for the courts of each state to determine whether the perceptions of public policy in their state require hospitals to be cast in this new role.

If these various strands of authority are indeed destined to be woven into the fabric of strict liability of hospitals for medical care of patients, based upon medical results for which the hospital is found liable on the basis of public policy, one wonders why the hospital's liability is beginning to exceed so substantially that of the physicians who perform the medical procedures. Physicians, after all, are not guarantors or insurers of the results of their own procedures.246 Physicians are held to an established standard of care, and are liable only when they have failed to attain that standard and the failure is the proximate cause of the injury.247 Is the hospital's responsibility so great, and

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246. Starnes v. Taylor, 158 S.E.2d 339, 343 (N.C. 1968) (cited in Banks v. Medical Univ. of S.C., ___ S.C. ___, ___, 444 S.E.2d 519, 521 (1994) ("South Carolina has followed the established tenet that a physician is not an insurer or guarantor of a beneficial result.").

247. Id. (citing Hunt v. Bradshaw, 88 S.E.2d 762 (N.C. 1955)).
the public policy in favor of enforcing this responsibility so irresistible, that as a principled matter the hospital’s exposure to liability should not similarly be framed? In some states, it appears, the hospitals—and their insurance companies—have been driven outside the pale.