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Edwin L. Barnes Jr.

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VICTIMS OF THEIR OWN SUCCESS? SOUTH CAROLINA HOSPITALS NOW HAVE AN ABSOLUTE, NONDELEGABLE DUTY TO PROVIDE COMPETENT EMERGENCY ROOM CARE

I. INTRODUCTION

In *Simmons v. Tuomey Regional Medical Center*[1] the South Carolina Court of Appeals held a hospital liable for the negligent acts of emergency room physicians acting as independent contractors.[2] Under the rule announced in *Simmons*, hospitals have an absolute, nondelegable duty[3] to provide competent emergency room care and services.[4] This ruling renders hospitals in South Carolina strictly liable for malpractice committed by emergency room physicians including those acting as independent contractors.[5] If not altered by the South Carolina Supreme Court on appeal,[6] the *Simmons* rule will profoundly affect the allocation of malpractice liability among South Carolina health care providers.

The *Simmons* court based its decision solely on public policy,[7]

1. 330 S.C.115, 498 S.E.2d 408 (Ct. App. 1998).

2. *Id.* at 124, 498 S.E.2d at 413. An independent contractor is defined as "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).

3. The term "nondelegable duty" as used by the *Simmons* court and other authorities is somewhat of a misnomer. The idea is more accurately described as nondelegable liability, meaning that the delegator of such a duty will be liable for negligence of the delegatee. *See* Martin C. McWilliams, Jr. & Hamilton E. Russell, III, *Hospital Liability for Torts of Independent Contractor Physicians*, 47 S.C. L. REV. 431, 452 (1996).

4. *Simmons*, 330 S.C. at 119-20, 498 S.E.2d at 410.

5. *Id.* at 124, 498 S.E.2d at 412.

6. A petition for certiorari has been filed with the South Carolina Supreme Court. The supreme court advance sheets dated February 27, 1999 indicate the petition is sixth among all pending petitions for certiorari. Simmons v. Tuomey Reg'l Med. Ctr., Petition No. 2788 (Davis Adv. Sh. No. 8 at iii).

7. *Simmons*, 330 S.C. at 119-23, 498 S.E.2d at 410-12.

choosing not to address the actual agency[8] and apparent agency[9] theories of liability presented at the trial level. The court concluded that public policy in South Carolina with respect to hospital liability for emergency room malpractice had undergone a significant change defined by three factors: public reliance on the availability of emergency room services,[10] the existence of state accreditation regulations that require emergency room services,[11] and a "public perception of the unity of hospitals and their emergency rooms."[12] The third factor weighed most heavily in the court's analysis. Because people reasonably associate emergency rooms with the hospitals in which they are housed rather than with the physicians staffing the emergency rooms,[13] hospitals must be held liable for the malpractice of their emergency room physicians regardless of the contractual, legal, or functional relationship between the hospital and the physicians.[14] The court noted that this changed perception stems largely from the commercialization of hospitals and health care in general.[15] In many respects, the hospitals have become victims of their own success as they have actively solicited business and marketed themselves as multifaceted health care providers.[16]

Simmons does not present any facts that would distinguish it from typical emergency-room-negligence cases.[17] Thus, the court's holding, if upheld, will end the supreme court's silence on this issue and have broad application for current plaintiffs or others allegedly subjected to acts of malpractice by emergency room physicians. More importantly, the *Simmons* holding will have long-term effects on the business operations of both hospitals and nonemployee emergency room physicians. As hospitals and physicians evaluate risks, they will likely renegotiate, if not fundamentally restructure, the private agreements that define their relationships.[18] Ultimately, the *Simmons* court's assertion of a public policy shift may influence hospital liability for the malpractice of nonemergency room physicians providing medical care on

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8. See Part III.B for a discussion on the theory of actual agency or respondeat superior. South Carolina courts have accepted and applied this doctrine in various contexts. *See, e.g.*, Sams v. Arthur, 135 S.C. 123, 128, 133 S.E. 205, 207 (1926) (recognizing the doctrine of respondeat superior).

9. See Part III.C for a discussion on the theory of apparent agency. South Carolina courts have accepted and applied this doctrine. *See, e.g.*, Watkins v. Mobil Oil Corp., 291 S.C. 62, 67, 352 S.E.2d 284, 287 (Ct. App. 1986) (recognizing the doctrine of apparent agency).

10. *Simmons*, 330 S.C. at 120-21, 498 S.E.2d at 410-11.

11. *Id.* at 121-22, 498 S.E.2d at 411.

12. *Id.* at 121, 498 S.E.2d at 411.

13. *See id.*

14. *Id.* at 122-23, 498 S.E.2d at 411-12.

15. *Id.*

16. *Id.*

17. *Id.* at 116-18, 498 S.E.2d at 408-09.

18. After *Simmons*, the advantages of using independent contractor physicians to staff emergency rooms may be nonexistent for large organizations and greatly diminished for small hospitals. *See infra* Part IV.

hospital premises.[19]

Part II of this Note describes the law governing hospital emergency room liability as it existed in South Carolina prior to *Simmons* and summarizes the facts, analysis, and authority on which the *Simmons* court relied. Part III examines alternative theories of liability (and defenses of nonliability) applied in other jurisdictions. Part IV offers several conclusions regarding the immediate and long-term implications of the new rule.

Specifically, this Note projects that the *Simmons* decision's most immediate effect will be to provide alleged victims of emergency room malpractice with access to another, probably deeper, pocket for relief. In reaction to *Simmons*, hospitals currently contracting out emergency room operations may decide to take over operations of their emergency rooms in order to exert more control over the care provided and to capture the profits currently accruing to the independent contractors. The ability of an individual hospital to take this step will depend in large part on its size, growth potential, and affiliation, or ability to affiliate, with a larger organization. The few remaining small, independent hospitals in South Carolina may very well go the way of many independent-physician practices and be forced into acquisition by larger organizations. A more troublesome implication of the *Simmons* decision for all hospitals, regardless of size, is the potential extension of the *Simmons* rule to other types of medical services provided in hospitals by independent contractor physicians. Finally, as noted below, the public policy basis for the *Simmons* decision may prove to be either good or bad for hospitals depending on how South Carolina courts interpret and apply the case.

II. BACKGROUND

A. The Old Rule: Hospitals Are Not Liable for the Malpractice of Independent Contractors

The doctrine of respondeat superior[20] generally has been followed in

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19. Hospitals commonly staff their emergency rooms with independent contractors to insulate themselves from liability. This business practice is common in other high-risk areas of medical practice such as radiology, pathology, anesthesiology, and clinical laboratories. *See* McWilliams & Russell, *supra* note 3, at 437.

20. Under this doctrine, masters are vicariously liable for the tortious acts of their servants acting within the scope of employment. RESTATEMENT (SECOND) OF AGENCY § 219 (1957); W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 69, at 499-500 (5th ed. 1984). An agent is considered a servant when the agent's activities are subject to a certain level of control by the principal. RESTATEMENT (SECOND) OF AGENCY § 2(2) (1957). In contrast, an agent is considered an independent contractor when this control is not present. *Id.* § 2(3). *Cf.* Bell v. Evening Post Publ'g Co., 318 S.C. 558, 561 n.2, 459 S.E.2d 315, 317 n.2 (Ct. App. 1995) (recognizing that an independent contractor may be an agent).

South Carolina.[21] The corollary rule that principals are not liable for the physical torts of their independent contractors[22] is also recognized in South Carolina.[23] Hence, hospitals have long taken advantage of the facets of limited liability by employing emergency room physicians as independent contractors. An excellent example of this is *Self v. Goodrich*,[24] which involved a malpractice action against an emergency room physician.[25] The hospital defended the plaintiff's attempt to hold it liable on the grounds that Self failed to introduce evidence of an agency relationship.[26] After examining the evidence and considering the hospital's control of the physician, the court of appeals found that the physician was an independent contractor and affirmed summary judgment in favor of the hospital.[27]

After *Self* the court of appeals decided two cases, *Shuler v. Tuomey Regional Medical Center*[28] in 1993 and *Strickland v. Madden*[29] in 1994, both of which involved alleged torts by independent contractor physicians performing services in hospital emergency rooms.[30] The plaintiffs in both cases asked the court to impute liability to the hospitals using an apparent agency theory.[31] Both the *Shuler* and *Strickland* courts applied the traditional test for liability under an apparent agency theory which requires that a plaintiff "prove:

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21. Sams v. Arthur, 135 S.C. 123, 128, 133 S.E. 205, 207 (1926) (recognizing the doctrine of respondeat superior). No reported South Carolina decisions indicate that a court has found a hospital liable for a physician's negligence using the doctrine of respondeat superior. 18 S.C. JUR. *Hospitals* § 15 (1993). However, in *Self v. Goodrich*, 300 S.C. 349, 387 S.E.2d 713 (Ct. App. 1989), the court of appeals considered the "question of whether there is any evidence to support a finding that [the physician] was the agent or servant of the hospital so that his alleged negligence may be imputed to the hospital." *Id.* at 354, 387 S.E.2d at 716. The court ultimately concluded that the physician was an independent contractor. *Id.* Presumably, a finding of servant status would have led to vicarious liability for the hospital. McMillan v. Durant, 312 S.C. 200, 203 n.2, 439 S.E.2d 829, 831 n.2 (1993) ("A hospital as an entity cannot practice medicine, diagnose an illness, or establish a course of treatment; however, the hospital may be held vicariously liable for the negligence of its employees.").

22. RESTATEMENT (SECOND) OF AGENCY § 250 (1957); KEETON ET AL., *supra* note 20, § 71, at 509; 41 AM. JUR. 2D *Independent Contractors* § 29 (1995).

23. Young v. Morrisey, 285 S.C. 236, 242, 329 S.E.2d 426, 429 (1985) (nonhospital case); Conlin v. City Council, 49 S.C.L. (15 Rich.) 201, 211 (1868) (nonhospital case).

24. 300 S.C. 349, 387 S.E.2d 713 (Ct. App. 1989).

25. *Id.* at 350, 387 S.E.2d at 713-14.

26. *Id.* at 353, 387 S.E.2d at 715.

27. *Id.* at 354, 387 S.E.2d at 716.

28. 313 S.C. 225, 437 S.E.2d 128 (Ct. App. 1993).

29. 323 S.C. 63, 448 S.E.2d 581 (Ct. App. 1994).

30. *Strickland*, 323 S.C. at 65, 448 S.E.2d at 582 ("Evangeline Strickland brought this action against Arthur Madden, M.D. and Providence Hospital seeking to recover for emotional and physical injuries suffered when Dr. Madden informed Strickland her father had died when in fact he was alive."); *Shuler*, 313 S.C. at 226, 437 S.E.2d at 129 ("Linda Shuler brought this action for outrage against Tuomey Regional Medical Center, after the hospital's emergency room physician misdiagnosed her as having gonorrhea. Donald Shuler claims damages for loss of consortium.").

31. *Strickland*, 323 S.C. at 70, 448 S.E.2d at 585; *Shuler*, 313 S.C. at 226-27, 437 S.E.2d at 129-30.

(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."[32] Each court concluded that the plaintiff failed to establish the necessary elements of apparent agency and found the hospital was not liable.[33]

Significantly, the *Strickland* court acknowledged that other jurisdictions had adopted nondelegable duties based on the "public's perception of and reliance on hospital[s] as multifaceted health care facilit[ies], as well as hospital[s'] superior position to monitor and control physician performance."[34] In their article published after *Strickland*, but prior to *Simmons*, McWilliams and Russell concluded: "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 . . . ."[35]

B. The New Rule: Simmons v. Tuomey Regional Medical Center

Judge Howell's opinion in *Simmons* delivers a powerful blow to efforts by South Carolina hospitals to insulate themselves from liability by engaging emergency room physicians as independent contractors rather than as direct employees. As mentioned earlier, the facts presented in *Simmons* are typical of these cases. On January 24, 1994, following a head injury sustained in a moped accident, P.J. McBride arrived at the emergency room at Tuomey Regional Medical Center ("Tuomey").[36] McBride received treatment for contusions and was subsequently released by two attending emergency room physicians, Dr. Cooper and Dr. Anderson.[37] Both were employees of Coastal Physicians Services ("Coastal"), the firm responsible for the operations of the Tuomey emergency room pursuant to a June 1987 contract.[38] McBride returned to Tuomey the next day where another physician properly diagnosed his head injury as a subdural hematoma.[39] McBride was transported to Richland Memorial Hospital and died approximately six weeks later from complications

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32. *Shuler*, 313 S.C. at 227, 437 S.E.2d at 129-30 (citing Watkins v. Mobile Oil Corp., 291 S.C. 62, 67, 352 S.E.2d 284, 287 (Ct. App. 1986)); *see Strickland*, 323 S.C. at 70, 448 S.E.2d at 585 (citing *Shuler*, 313 S.C. at 227, 437 S.E.2d at 129-30).

33. *Strickland*, 323 S.C. at 70, 448 S.E.2d at 585 ("[T]here is nonetheless no evidence to support the remaining elements of reliance and change of position by Strickland."); *Shuler*, 313 S.C. at 227, 437 S.E.2d at 130 ("Shuler fails, as noted by the trial court, to point to any evidence from which reliance could be inferred so as to support an apparent agency theory.").

34. *Strickland*, 323 S.C. at 71-72, 448 S.E.2d at 586.

35. McWilliams & Russell, *supra* note 3, at 472.

36. Simmons v. Tuomey Reg'l Med. Ctr., 330 S.C. 115, 117, 498 S.E.2d 408, 408-09 (Ct. App. 1998).

37. *Id.* at 117, 498 S.E.2d at 409.

38. *Id.*

39. *Id.*

involving the subdural hematoma which Dr. Cooper and Dr. Anderson had failed to diagnose.[40]

McBride's daughter, Alethia Simmons, as personal representative of his estate, brought an action against the two physicians, Coastal, and Tuomey for medical malpractice.[41] The trial court granted summary judgment for Tuomey on the grounds that the hospital was not liable under theories of actual agency, apparent agency, or nondelegable duty for the allegedly negligent actions of the independent contractor physicians.[42] The trial court placed emphasis on both the June 1987 contract between Tuomey and Coastal and a standard hospital admission form signed by Simmons.[43] Both documents clearly identified Coastal and its staff of emergency room physicians as independent contractors of Tuomey.[44]

The court of appeals reversed the trial court's decision and found that "hospitals have a nondelegable duty to provide competent emergency room services. A nondelegable duty is essentially an exception to the general rule that principals are not liable for the torts of independent contractors."[45] The court went on to clarify the idea of nondelegable duty as being more accurately described as nondelegable liability.[46] The duty can be delegated, but the associated liability cannot, so the delegator of such a duty will be held liable for any negligence of the delegatee.[47]

The creation of a nondelegable duty as an exception to the general rule that principals are not liable for the torts of their independent contractors is not a novel concept in South Carolina.[48] The idea of an absolute, nondelegable duty has its roots in public policy;[49] accordingly, public policy was the basis for the *Simmons* holding. The court relied heavily on Dean Prosser,[50] who long ago recognized:

> A different approach, manifested in several of the exceptions to the general rule of nonliability [for independent contractors], has been to hold that the employer's enterprise, and his relation to the plaintiff, are such as to impose upon him a duty which cannot be delegated to the

40. *Id.*
41. *Id.* at 116, 498 S.E.2d at 408.
42. *Id.* at 116-18, 498 S.E.2d at 408-09.
43. *Id.* at 117, 498 S.E.2d 408-09.
44. *Id.*
45. *Id.* at 119-20, 498 S.E.2d at 410 (footnotes omitted).
46. *Id.* at 123, 498 S.E.2d at 412.
47. *Id.*
48. *See id.* at 118, 498 S.E.2d at 409.
49. *Id.* at 119-23, 498 S.E.2d at 410-12.
50. *Id.* at 120, 498 S.E.2d at 410.

> contractor . . . .
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> . . . .
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> 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.[51]

The court concluded that the changed public policy in South Carolina with respect to hospital liability for emergency room services is defined by three factors and used these factors as the basis for its holding.[52]

First, the court noted that emergency rooms, by definition, are the health care provider of last resort: "Few things are more comforting in today's society than knowing that immediate medical care is available around-the-clock at any hospital."[53] Though comforting as such an availability of care may be, the patient is in no position to bargain for services in an emergency situation and is likely to be treated by physicians acting as independent contractors rather than employees.[54]

Second, the court, quoting the South Carolina Department of Health and Environmental Control regulations entitled Minimum Standards for Licensing Hospitals and Institutional General Infirmaries,[55] noted that state-hospital-accreditation regulations require that all hospitals provide on-site emergency room services, personnel, and equipment twenty-four hours a day.[56] The court also noted that in the context of landlord-tenant law, statutory and contractual imposition of specific duties was sufficient to create a nondelegable duty.[57]

Finally, and most significantly, the court recognized that members of the public now view a hospital as a single entity providing medical services.[58] The public perception is that "patients come to the hospital to be cured, and the doctors who practice there are the hospital's instrumentalities, regardless of the

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51. KEETON ET AL., *supra* note 20, § 71, at 511-12.
52. *See supra* notes 10-12 and accompanying text.
53. *Simmons*, 330 S.C. at 120, 498 S.E.2d at 410.
54. *Id.* at 120-21, 498 S.E.2d at 410-11 (citing Sampson v. Baptist Mem'l Hosp. Sys., 940 S.W.2d 128, 136 (Tex. Ct. App. 1996), *rev'd*, 969 S.W.2d 945 (Tex. 1998)). The Texas Supreme Court reversed the court of appeals decision in *Sampson v. Baptist Memorial Hospital System* on May 21, 1998, three months after *Simmons*. The Texas Court of Appeals held that hospitals have a nondelegable duty to provide competent emergency room services. *Sampson*, 940 S.W.2d at 136. However, the Texas Supreme Court rejected the theory of nondelegable duty outright. Baptist Mem'l Hosp. Sys. v. Sampson, 969 S.W.2d 945, 949 (Tex. 1998).
55. 24A S.C. CODE ANN. REGS. 61-16 § 613 (1992).
56. *Simmons*, 330 S.C. at 121-22, 498 S.E.2d at 411.
57. *Id.* at 122, 498 S.E.2d at 411.
58. *Id.* at 121, 498 S.E.2d at 411.

nature of the private arrangements between the hospital and the physician."[59] The *Simmons* court acknowledged the commercialization of the industry and specifically cited advertising, active solicitation of business, and other commercial efforts by hospitals as contributing to the public's perception.[60]

The court's recognition of this third factor—changed public perception—as a component of public policy is noteworthy for two reasons. First, public perception is distinguished from the other two factors, public reliance and regulatory requirements, in that public perception has truly undergone rapid, significant change while public reliance[61] and regulatory requirements[62] have not. An opinion built on the change in public policy—if defined only by public reliance and regulatory requirements—probably would not have led to a radical departure from the general rule of nonliability. The recent, significant change in public *perception* provided the true impetus for the court's conclusion.

Second, public perception is the only one of the three factors that is, at least theoretically, largely controlled by the hospitals themselves. Commentators have observed that an "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."[63] Hospitals truly are victims of their own commercial success.

In summary, *Simmons* establishes a powerful new theory for holding hospitals liable for the malpractice of their emergency room physicians. Prior to *Simmons*, general applicability of the doctrine of respondeat superior, finding support in the court's holding in *Self*, established that hospitals were probably liable for the malpractice of emergency room servants. The cases of *Shuler* and *Strickland* provided that hospitals may even be liable for the malpractice of emergency room independent contractors under the theory of apparent agency. However, the *Simmons* rule now renders these classifications largely irrelevant. Whether an emergency room physician is contractually, legally, or functionally a servant or independent contractor—or an agent or nonagent—does not matter; the hospital will be held strictly liable for the malpractice of its emergency room physicians.

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59. McWilliams & Russell, *supra* note 3, at 473.

60. *Simmons*, 330 S.C. at 122, 498 S.E.2d at 411.

61. Public reliance on emergency rooms may have increased as the practice of house calls by local doctors has all but disappeared, but such a change has come about gradually and with relatively insignificant effect on the public. As health care costs have risen, uninsured individuals and those on Medicaid have increasingly come to rely on emergency room services, but this reliance is not likely the generalized reliance to which the *Simmons* court referred. *See* Helena G. Rubinstein, *Nonprofit Hospitals and the Federal Tax Exemption: A Fresh Prescription*, 7 HEALTH MATRIX 381, 412 (1997) (discussing reliance by the poor on emergency room services).

62. *Compare* 24A S.C. CODE ANN. REGS. 61-16 § 613 (1992), *with* 24 S.C. CODE ANN. REGS. 61-16 § 613 (1979). This comparison indicates that the basic requirement that hospitals maintain a perpetually open emergency room has been in place for at least the last 20 years.

63. McWilliams & Russell, *supra* note 3, at 436 (footnote omitted).

III. ALTERNATIVE THEORIES EXPANDING HOSPITAL LIABILITY FOR EMERGENCY ROOM MALPRACTICE

A. Background

The independent contractor arrangement between Tuomey and Coastal is typical. Nationwide, hospitals have successfully avoided liability for malpractice of emergency room physicians by engaging these physicians as independent contractors or otherwise divesting themselves of control over these physicians.[64] The result of the *Simmons* case is not unusual either, as a recognizable trend toward holding hospitals liable in this context is developing.[65] Various theories of liability have been analyzed and adopted to impute liability to hospitals.[66] Most of these theories attack the general rule that principals are not liable for the negligent acts of their independent contractors.[67] In most cases courts have considered more than one theory of liability,[68] and in many cases hospitals have been found liable on more than one ground.[69] A common thread in recent applications of these theories in the hospital context is the recognition of changed or changing public perception of hospitals and a concomitant change in the public policy basis for holding hospitals liable.[70]

This Part does not discuss the intricacies of the various theories or analyze the relative advantages and disadvantages of each as a vehicle for holding hospitals liable. The purpose of this Part is to outline (1) the theories

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64. *Id.* at 437.

65. *Id.* at 434.

66. The doctrines discussed in this Part are actual agency and respondeat superior, apparent agency, ratification, and inherently dangerous activity. Because nondelegable duty has been discussed previously in this Note, it will not receive treatment in this Part. This Part also summarizes application of the corporate-practice doctrine as a defense to the theories of actual and apparent agency. This Part does *not* address theories of *direct* liability. For a discussion of these theories in the hospital context, see *id.* at 462-71. The form of direct liability most commonly found in hospital cases is corporate negligence in failing to maintain safe and adequate facilities and equipment; select, retain, and supervise competent physicians and staff; promulgate and enforce rules and policies to ensure quality patient care; or keep physicians informed of a patient's condition to ensure proper diagnosis and treatment. *Id.* at 463. *See generally* Thompson v. Nason Hosp., 591 A.2d 703 (Pa. 1991) (discussing the doctrine of corporate negligence); Pedroza v. Bryant, 677 P.2d 166 (Wash. 1984) (same).

67. *See* McWilliams & Russell, *supra* note 3, at 434 ("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).").

68. *See, e.g.*, Sampson v. Baptist Mem'l Hosp. Sys., 940 S.W.2d 128, 133-36 (Tex. Ct. App. 1996), *rev'd*, 969 S.W.2d 945 (Tex. 1998) (considering the theories of apparent agency and nondelegable duty).

69. *See, e.g.*, Mduba v. Benedictine Hosp., 384 N.Y.S.2d 527, 529-30 (N.Y. App. Div. 1976) (finding a hospital liable under the doctrine of respondeat superior and, alternatively, under the apparent agency theory).

70. *See, e.g.*, Simmons v. Tuomey Reg'l Med. Ctr., 330 S.C. 115, 121-22, 498 S.E.2d 408, 411 (Ct. App. 1998).

of liability available to courts considering hospital liability for emergency room malpractice, and (2) the important role public policy considerations have played in recent jurisprudence in the area of hospital emergency room malpractice.[71]

B. Actual Agency and Respondeat Superior

As noted above, the general rule is that principals are liable for the torts of their servants acting within the scope of the agency relationship, but not for the torts of independent contractors. Courts have commonly held hospitals liable for the negligence of emergency room physicians by establishing the existence of a master-servant relationship and then applying the doctrine of respondeat superior.[72] The decisions in which hospital liability has been imputed range from clear cases of emergency room physicians acting as the hospital's employees[73] to less clear independent contractor cases[74] requiring very "elastic interpretations of *respondeat superior*."[75] These decisions are generally very fact-driven, and the courts usually confine the analysis to an examination of factors defining the relationship between the hospital and the physician.[76] An analysis of control—including examination of both the extent

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71. This Part does not discuss the doctrine of charitable immunity. This doctrine is perhaps the oldest and most widely used theory by which hospitals have been shielded from liability. For a brief discussion of the doctrine's demise as applied to hospitals, see McWilliams & Russell, *supra* note 3, at 434-38. This portion of their article cites authority applying the doctrine in other jurisdictions; tracks the erosion of the doctrine in South Carolina; and attributes much of its demise to the courts' recognition of the change in the operations, economics, and public perception of the modern hospital.

72. *See* Daniel L. Icenogle, Annotation, *Hospital Liability as to Diagnosis and Care of Patients in Emergency Room*, 58 A.L.R.5th 613, § 8, at 638-41 (1998).

73. *See, e.g.*, *Mduba*, 384 N.Y.S.2d at 529 (concluding "as a matter of law, that Dr. Bitash was an employee of the defendant hospital and not an independent contractor").

74. *See, e.g.*, Felter v. Mercy Community Hosp., 664 N.Y.S.2d 321, 323 (N.Y. App. Div. 1997) (stating that "[w]hether or not a physician qualifies as an independent contractor is a factual conclusion" to be made by the jury).

75. McWilliams & Russell, *supra* note 3, at 433.

76. The *Restatement (Second) of Agency* provides a commonly used list of factors for courts to consider:

> (a) the extent of control which, by the agreement, the master may exercise over the details of the work;
> (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 supervision;
> (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

of control actually exerted over an emergency room physician and the scope of the hospital's right of control—is central in nearly all recent decisions on hospital liability.[77]

State and federal courts have considered numerous fact patterns in the hospital emergency room context,[78] with results differing from state to state.[79] In analyzing the issues, courts use inconsistent methodologies.[80] However, a common thread in many of these cases is a concern for public policy, leading some to conclude 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."[81]

In sum the doctrines of actual agency and respondeat superior are vibrant and available to emergency room plaintiffs given the right set of facts. However, these facts must relate not only to the hospital-physician relationship, but also to the plaintiff's and public's view of the allegedly controlling hospital.

C. *Apparent, Implied, or Ostensible Agency (or Agency by Estoppel)*

Application of the doctrine of apparent agency (or agency by

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employed;
(g) the method of payment, whether by the time or by the job;
(h) whether or not the work is 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(2) (1957).

77. *See* McWilliams & Russell, *supra* note 3, at 439-40; Icenogle, *supra* note 72, § 2[b], at 632-33 (noting that in determining control, courts have considered such factors as "the scheduling of the physician's time, who supplies material needed by the physician, whether the physician is free to practice elsewhere, who determines the physician's fees and bills the patients for the physician's services, and who is custodian of the medical records"); *see also* Dunn v. Praiss, 606 A.2d 862, 868 n.4 (N.J. Super. Ct. App. Div. 1992) (listing various provisions of a contract between a physician and a hospital which collectively precluded a directed verdict for the hospital on the question of a master-servant relationship); Willoughby v. Wilkins, 310 S.E.2d 90, 95-96 (N.C. Ct. App. 1983) (same).

78. For a survey of jurisdictions applying the doctrines of actual agency and respondeat superior in the emergency room context, see Icenogle, *supra* note 72, §§ 8-9.

79. *Compare Dunn*, 606 A.2d at 869 (holding an HMO liable for a physician's action because of agency and direct-employment relationships), *with* Latham v. Ohio State Univ. Hosp., 594 N.E.2d 1077, 1080 (Ohio Ct. App. 1991) (finding insufficient hospital control over a physician to establish a master-servant relationship).

80. *See* McWilliams & Russell, *supra* note 3, at 442-44.

81. *Id.* at 445.

estoppel)[82] is very fact-driven. Moreover, changing public perception of hospitals has influenced the doctrine. As noted above, principals are not liable for the physical torts of their independent contractors. While analysis based on the doctrine of actual agency never really reaches this rule, apparent agency analysis operates as an exception. The doctrine of apparent agency is described in the *Restatement (Second) of Agency* as follows:

> 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.[83]

The *Shuler* court's three-part test[84] is typical of traditional apparent agency analysis. This analysis differs from actual agency analysis in its primary focus on the plaintiff's reasonable expectations rather than on the contract and overall relationship between the alleged controlling principal and his agent. The traditional theory of apparent agency "is not in any way agency-based. Indeed, where agency is present, apparent agency is superfluous. Rather, [the *Restatement*] is based upon the elements of estoppel: a representation causing justifiable reliance and resulting harm."[85]

One of the earliest applications, even though only a nominal application,[86] of the doctrine of apparent agency to hospitals was the California Supreme Court's decision in *Seneris v. Haas*.[87] Over half of the states have

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82. McWilliams and Russell characterized agency by estoppel as a "close cousin" of apparent agency, *id.* at 445-46, and noted that apparent agency has application in tort and contract while agency by estoppel has application in contract only. *Id.* at 445-46 nn.75-76.

83. RESTATEMENT (SECOND) OF AGENCY § 267 (1957).

84. Shuler v. Tuomey Reg'l Med. Ctr., 313 S.C. 225, 227, 437 S.E.2d 128, 129-30 (Ct. App. 1993) (requiring that the plaintiff "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").

85. McWilliams & Russell, *supra* note 3, at 447.

86. *Id.* at 446 n.77.

87. 291 P.2d 915 (Cal. 1955). The California Supreme Court applied the following three-part test:

> (First) The person dealing with the agent must do so with belief in the agent's authority and this belief must be a reasonable one; (second) such belief must be generated by some act or neglect of the principal sought to be charged; (third) and the third person in relying on the agent's apparent authority must not be guilty of negligence.

Id. at 927. As noted below, such a nonrigorous application of the doctrine of apparent agency

followed.[88] However, the doctrine's widespread acceptance has wrought equally widespread versions of its application.[89] Similar to the analysis and results when courts have applied the *actual* agency theory, application of the *apparent* agency theory varies widely from state to state[90] and even within certain states.[91]

McWilliams and Russell characterized these varying, and largely nonrigorous, applications of the apparent agency doctrine to hospitals as follows: "It might be said that these courts have developed a new, policy-based doctrine by loosely adopting the outlines of traditional apparent agency."[92] Furthermore, McWilliams and Russell made three important points. First, many courts have come to realize that strict application of the doctrine presents a nearly insurmountable hurdle for the injured patient seeking imputation of liability to the hospital.[93] Second, the courts have recognized the importance of the plaintiff's perception of the treating hospital as well as the public's perception of the treating hospital and, in some cases, hospitals in general.[94] Third, decisions relaxing the required analysis are largely result-oriented.[95] McWilliams and Russell ultimately concluded that collectively these decisions signal the need for a "new, hospital-specific doctrine of liability based on

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is not inconsistent with subsequent decisions and analysis in other jurisdictions.

88. Icenogle, *supra* note 72, § 10, at 645-48 (providing cases from 29 jurisdictions that have applied the doctrine of apparent agency in the hospital emergency room context).

89. After recognizing one court for its "unusually accurate application of [the *Restatement*]," McWilliams and Russell noted that "[o]ther courts, however, assume away or ignore great chunks of the required analysis." McWilliams & Russell, *supra* note 3, at 451.

90. *Compare* Gasbarra v. St. James Hosp., 406 N.E.2d 544, 554-55 (Ill. App. Ct. 1979) (characterizing the doctrine as "agency on the basis of estoppel" and considering the traditional elements of equitable estoppel: induced reliance and change of position), *with* Chase v. Independent Practice Ass'n, 583 N.E.2d 251, 255 (Mass. App. Ct. 1991) (recognizing a variation of the apparent agency theory and concluding that "an HMO may be liable if the HMO creates an appearance that the physician is its employee, regardless of a physician's actual status").

91. *Compare* Clark v. Southview Hosp. & Family Health Ctr., 628 N.E.2d 46, 53 (Ohio 1994) (concluding that, under the doctrine of agency by estoppel, a hospital may be liable "if it holds itself out to the public as a provider of medical services and in the absence of notice or knowledge to the contrary, the patient looks to the hospital, as opposed to the individual practitioner, to provide competent medical care"), *with* Albain v. Flower Hosp., 553 N.E.2d 1038, 1049 (Ohio 1990) (recognizing and accepting "the doctrine of agency by estoppel akin to Section 267 of the Restatement").

92. McWilliams & Russell, *supra* note 3, at 448.

93. *Id.* ("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." (footnote omitted)).

94. *Id.* ("Confronted with the flowing tide of changing public perception, however, courts have employed the doctrine [of apparent agency] without rigor and, arguably, have much damaged it in the process." (footnote omitted)).

95. *Id.* at 451 ("[Courts] 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." (footnote omitted)).

public policy."[96]

D. *Corporate-Practice-of-Medicine Doctrine as a Defense to Agency Theories*

The corporate-practice-of-medicine doctrine provides that medicine can be practiced only by an individual and not by a corporation.[97] Thus, a hospital itself cannot practice medicine[98] and seemingly cannot control or have the right to control those individuals who do. This would seem to be a bullet-proof defense for a hospital facing liability for the negligent acts of its physicians, whether they be employees or independent contractors.[99] However, the viability of this defense has been virtually eliminated in cases involving employee physicians[100] as courts have focused on hospital "control over the methods and materials of practice"[101] rather than control over the decision-making, skill, and other professional aspects of a physician's work.[102] In some jurisdictions the corporate-practice doctrine continues to have limited viability as a defense to imputed liability based on the torts of physicians acting as

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96. *Id.* at 451. Indeed, an important suggestion made by McWilliams and Russell is that the best basis for hospital liability for independent contractor physicians is a variety of nondelegable duty labeled "nondelegability based on reliance." *Id.* at 457-62. The basis of this theory is section 429 of the *Restatement (Second) of Torts* which 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.

RESTATEMENT (SECOND) OF TORTS § 429 (1965). McWilliams and Russell concluded that the strained application of traditional apparent agency theory would have fit better under section 429. McWilliams & Russell, *supra* note 3, at 460-62; *see also* Icenogle, *supra* note 72, § 2[a], at 629. ("In the context of medical malpractice . . . the distinction between doctrine derived from . . . [section 429 of the *Restatement (Second) of Torts* and section 267 of the *Restatement (Second) of Agency*] has been erased and the terms 'apparent authority' and 'authority by estoppel' are treated synomously . . . .").

97. *See* Jeffrey F. Chase-Lubitz, Note, *The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry*, 40 VAND. L. REV. 445, 446-47 (1987).

98. *See* Dunn v. Praiss, 606 A.2d 862, 868 (N.J. Super. Ct. App. Div. 1992) (noting that an HMO "could not practice medicine"); McMillan v. Durant, 312 S.C. 200, 203 n.2, 439 S.E.2d 829, 831 n.2 (1993) ("A hospital as an entity cannot practice medicine, diagnose an illness, or establish a course of treatment . . . .").

99. McWilliams & Russell, *supra* note 3, at 441.

100. *Id.*

101. Icenogle, *supra* note 72, § 2[b], at 632.

102. McWilliams & Russell, *supra* note 3, at 441 & n.52.

independent contractors,[103] but as noted by McWilliams and Russell, in many others it is "criticized as an anachronism and an obstacle to innovative health care reform."[104]

E. Minor Doctrines: Ratification and Inherently Dangerous Activity

Two additional exceptions to the general rule of nonliability for principals for the torts of their independent contractors are worthy of mention. The doctrine of ratification is a relatively minor doctrine by which the liability of an independent contractor can be imputed to a principal even when actual agency or apparent agency has not been established.[105] The doctrine applies when a principal knows of a tort committed by his agent and acts in a manner viewed as accepting the benefits of the tortious act.[106] Although there are no known cases in South Carolina and very few cases in other jurisdictions applying ratification to hospitals,[107] the doctrine could be used by an emergency room plaintiff under an appropriate set of facts.

The characterization of an activity as inherently dangerous is another vehicle by which courts have imputed liability to noncontrolling principals. The doctrine operates in similar fashion to the imposition of a nondelegable duty in that principals are held strictly liable for their agents' tortious conduct if committed while engaged in a certain category of activity.[108] Inherently dangerous activities are those "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."[109] This doctrine is relatively minor and courts that have considered whether specific nonemergency medical services were inherently dangerous have concluded that they were not insofar as medical services, when

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103. *Id.* at 441-42. *See, e.g.*, Banks v. St. Mary's Hosp. & Med. Ctr., 558 F. Supp. 1334, 1338 (D. Colo. 1983) (applying Colorado law and concluding that an earlier recognition of the corporate-practice doctrine by the same court required dismissal of "any claim attempting to hold the hospital vicariously liable for the negligence of [the doctors]" practicing in its emergency room).

104. McWilliams & Russell, *supra* note 3, at 442 (footnote omitted).

105. *See* F. PATRICK HUBBARD & ROBERT L. FELIX, THE SOUTH CAROLINA LAW OF TORTS 654 (2d ed. 1997).

106. *Id.* (footnote omitted) ("For example, if a principal knowingly accepts the benefits of fraud by his agent, he has ratified the wrongful conduct and made himself liable even if the agent was an independent contractor.").

107. *See, e.g.*, Manning v. Twin Falls Clinic & Hosp., Inc., 830 P.2d 1185, 1194 (Idaho 1992) (concluding that a jury could not find that the hospital had ratified the grossly negligent conduct of a nurse).

108. McWilliams & Russell, *supra* note 3, at 456.

109. KEETON ET AL., *supra* note 20, § 71, at 514 (footnote omitted).

provided properly, are not dangerous.[110] Likewise, in the one known case in which this question was considered with respect to emergency room services, the Missouri Court of Appeals reached the same result.[111] In short, given the other theories of liability available to modern plaintiffs and courts, this doctrine is not likely to gain widespread acceptance or otherwise significantly affect hospital liability for emergency room physicians.

IV. CONCLUSION: EFFECT OF THE NEW RULE IN SOUTH CAROLINA

A. Short-term Implications

The full effect of the *Simmons* rule remains uncertain and may be altered by the South Carolina Supreme Court. As noted earlier, the rule has immediate and far reaching implications in the emergency room context. Alleged victims of emergency room malpractice have immediate access to another, possibly deeper, pocket for relief. If *Simmons* does stand as the new rule, the best course for hospitals currently using independent contractors in the emergency room may be to assume complete control over emergency operations. Thus, hospitals will exert more control over the quality of care provided and will capture the profits currently accruing to the independent contractor operators.[112] Such a tactical reaction will not be inconsistent with strategic efforts toward vertical integration, which is the industry's trend. However, among South Carolina's smaller, independent hospitals, the elimination of an important advantage of contracting out emergency room services and the resulting necessity of taking over emergency room operations may well be the proverbial last straw. These small hospitals will either face acquisition or alliances with larger organizations.[113]

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110. *See, e.g.*, Arthur v. St. Peters Hosp., 405 A.2d 443, 445 n.3 (N.J. Super. Ct. Law Div. 1979) (finding that taking x-rays was not an inherently dangerous activity); Rosenberg v. Equitable Life Assurance Soc'y, 595 N.E.2d 840, 844 (N.Y. 1992) (finding that administering an electrocardiogram was not an inherently dangerous activity).

111. *See* Kelly v. St. Luke's Hosp., 826 S.W.2d 391, 395-96 (Mo. Ct. App. 1992) (affirming the trial court's holding that "the practice of emergency medicine is not an inherently dangerous activity").

112. Foregoing these profits was previously justified as a cost of avoiding liability. However, in a post-*Simmons* environment, no such reason for foregoing these profits exists, and the hospitals will likely need these profits to cover, or at least to offset, the costs associated with the additional liability. Such costs will likely be primarily in the form of higher insurance premiums.

113. McWilliams and Russell have suggested that South Carolina policy makers should consider whether "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.)." McWilliams & Russell, *supra* note 3, at 472 n.245.

B. *Implications for Liability Beyond the Emergency Room*

Looking beyond the immediate influence on emergency room operations, the decision in *Simmons* may have longer-term implications for other areas of hospital liability. Because of the specific public policy basis of the court's decision, the *immediate* effect of the *Simmons* decision will be limited to the emergency room context and not extended to other cases in which physicians provide medical services within hospital facilities. A holding based on either actual or apparent agency theory as the exception to the general rule of nonliability would likely have had immediate application to other, and maybe all, instances in which physicians provide services on hospital premises. At the very least, such a holding would be only a short extension away from general applicability. From this standpoint, the hospitals and their advisors may find that, if a finding of liability was inevitable, the public policy basis adopted by the *Simmons* court was perhaps the best basis for such a holding.

On the other hand, the public policy (public perception) basis could prove to be the worst possible basis for liability from the standpoint of the hospital industry. The idea that hospital liability should be determined by how hospitals, either individually or collectively, are perceived by their users and the public could be given such elasticity by the courts that hospital liability may quickly expand. Hospitals could find themselves liable for the negligent acts of all physicians performing services on their premises.[114]

In conclusion, the long-term implications of *Simmons* aside, the court's recognition of changing public perceptions of hospitals has buried the idea of a hospital as a charitable "sanctuar[y] where medical care is made available."[115] Such a change and the accompanying effect on hospital liability can hardly be considered a surprise by the investors, managers, and advisors of hospitals that have been the beneficiaries of the changed public perception and have experienced tremendous economic success over the last decade.

Edwin L. Barnes, Jr.

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114. This is the same potential result, although reached through a different method of analysis, as if the *Simmons* court had based its decision on either an actual or apparent agency theory.

115. McWilliams & Russell, *supra* note 3, at 434.