South Carolina Law Review

Volume 54 | Issue 2 Article 10

Winter 2002

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Recommended Citation
Kelly M. Jolley, Simmons v. Tuomey Regional Medical Center and Osborne v. Adams: Expanding or Limiting Patinets' Access to Quality Care?, 54 S. C. L. Rev. 519 (2002).

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SIMMONS V. TUOMEY REGIONAL MEDICAL CENTER AND *OSBORNE V. ADAMS*: EXPANDING OR LIMITING PATIENTS' ACCESS TO QUALITY CARE?

I. INTRODUCTION

"Public policy is a dynamic not static concept, and what was valid in the past is not necessarily a valid policy today."[1] Over the last century, hospitals have undergone a metamorphosis, changing from charitable institutions providing care for the poor (and receiving immunity from tort suits as a reward) into today's hybrid corporate-community institutions—part medical service provider and part corporate enterprise.[2] This change in hospital organization has been mirrored by a change in public perception.[3] Today's hospitals have adopted many of the advertising tactics of corporations in other industries,[4] and the lack of adequate health insurance has forced many under-insureds to use hospital emergency rooms as sources of both primary and acute medical care. As a result, hospitals are now often perceived as providers of medical services rather than institutions in which physicians treat patients with acute or chronic illnesses.[5]

With its decisions in *Simmons v. Tuomey Regional Medical Center*[6] (*Simmons II*) and *Osborne v. Adams*,[7] (*Osborne II*) the South Carolina Supreme Court expanded hospital tort liability and brought it into compliance with changed public perceptions regarding hospitals as medical providers. Recognizing that a hospital holding itself out to the public as a provider of medical services has a duty to insure the quality of those services, the court adopted a new test in *Simmons II* and *Osborne II* for determining a hospital's liability for the torts of its independently contracted physicians. To determine whether a hospital should be liable for a physician's negligence, the court focused on the way a hospital was perceived within the community rather than

1. Fitzer v. Greater Greenville S.C. Young Men's Christian Ass'n, 277 S.C. 1, 3, 282 S.E.2d 230, 231 (1981).

2. Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381, 385-87 (1994); Steven R. Owens, Note, Pamperin v. Trinity Memorial Hospital *and the Evolution of Hospital Liability: Wisconsin Adopts Apparent Agency*, 1990 WIS. L. REV. 1129, 1135-36.

3. Martin C. McWilliams, Jr. & Hamilton E. Russell, III, *Hospital Liability for Torts of Independent Contractor Physicians*, 47 S.C. L. REV. 431, 436 (1996).

4. *See id.* at 436; Owens, *supra* note 2, at 1137.

5. *See* McWilliams & Russell, *supra* note 3, at 436.

6. 341 S.C. 32, 533 S.E.2d 312 (2000) [hereinafter *Simmons II*].

7. 346 S.C. 4, 550 S.E.2d 319 (2001) [hereinafter *Osborne II*].

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the way the patient perceived the relationship between the hospital and the treating physician.

In *Simmons II* the South Carolina Supreme Court adopted a test for a hospital-owed nondelegable duty based on section 429 of the *Restatement of Torts*.[8] In *Osborne II* the court solidified its stance on hospital liability, holding that a hospital may be responsible for the quality of care provided by physicians treating patients in areas of the hospital beyond the emergency room.[9] In both cases, the court used public policy as the foundation for its decision, claiming that a hospital, which holds itself out as a provider of medical services and a supplier of qualified physicians, cannot evade responsibility when treatment goes awry.[10] However, the court unfortunately treats public policy in each case as a single, mobilized concern and ignores other policy considerations that may be detrimentally affected by the court's decisions.

This Note discusses *Osborne II* and the South Carolina Supreme Court's reasons for broadening hospital liability. Part II of this Note traces the erosion of hospital immunity in South Carolina and describes the supreme court's adoption of the nondelegable duty doctrine for hospital emergency rooms. Part III briefly examines the national trend regarding the expansion of hospital tort liability. Part IV discusses the importance of the court's decision in *Simmons v. Tuomey Regional Medical Center*. Finally, Part V analyzes *Osborne II* and possible problems and other issues resulting from the decision. This Note concludes that, although *Osborne II* effectively applies the test outlined in *Simmons II*, the court's expansion of the nondelegable duty doctrine disregards public policy concerns, such as access, that may ultimately have a negative impact on patient care in South Carolina.

II. BACKGROUND

A. The Erosion of the Charitable Immunity Doctrine

Traditionally, most private, for profit hospitals were charitable organizations that were immune from tort liability under the common law doctrine of charitable immunity because of the public service function they served.[11] For example, in *Lindler v. Columbia Hospital*[12] the South Carolina Supreme Court explained that "[t]he true ground upon which to rest the exemption from liability is that it would be against public policy to hold a charitable institution [such as a hospital] responsible for the negligence of its

8. *Simmons II*, 341 S.C. at 53, 533 S.E.2d at 323.

9. *Osborne II*, 346 S.C. at 4, 550 S.E.2d at 321.

10. *See id.* at 4, 550 S.E.2d at 321; *Simmons II*, 341 S.C. at 50-51, 533 S.E.2d at 322.

11. Abraham & Weiler, *supra* note 2, at 385-86; McWilliams & Russell, *supra* note 3, at 434-35; Owens, *supra* note 2, at 1135-36.

12. 98 S.C. 25, 81 S.E. 512 (1914).

servants, selected with due care."[13] Although Justice Fraser dissented, arguing that charitable institutions should be required to remedy the harm they cause,[14] the popular view was that supporting charitable organizations benefitted the public as a whole.[15] After all, hospitals at the time predominantly served the poor and very ill. Those that could afford medical treatment were treated by family physicians at home. Hospitals provided limited treatment and served primarily as places of last resort before death.[16] Many courts reasoned that the funds collected by such institutions should be put to use for their patients and not used to satisfy legal judgments for negligent care.[17]

However, as the function of hospitals and the public perception of their place in society changed, states began reexamining the policy grounds for immunizing hospitals from tort liability.[18] In *Brown v. Anderson County Hospital Ass'n*,[19] decided in 1977, South Carolina joined many other states in modifying the charitable immunity doctrine. In *Brown* a widow with nine children brought a wrongful death suit against a hospital whose employee had left her husband strapped to his hospital bed during a fire.[20] Basing its discussion on Justice Fraser's dissent in *Lindler*, the majority held that a charitable hospital could be held liable if the plaintiff could prove "the injuries occurred because of the hospital's heedlessness and reckless disregard of the plaintiff's rights."[21] Although *Brown* required the plaintiff to prove more than simple negligence, the decision began the decline of charitable immunity in South Carolina, which was completed when the South Carolina Supreme Court abolished the doctrine in *Fitzer v. Greater Greenville S.C. Young Men's Christian Ass'n*.[22]

In *Fitzer* the court examined the ideas that once served as the foundation for the charitable immunity doctrine for hospitals, and the court found these notions no longer existed.[23] Justice Ness explained:

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13. *Id.* at 28, 81 S.E. at 513.

14. *Id.* at 35, 81 S.E. at 515 (Fraser, J., dissenting) ("It is a principle of law as well as morals, that men must be just before they are generous. There is no higher or more just principle than that a trust fund shall remedy the evil itself has done, before it attempts to remedy the evils done by others.").

15. *See* Jensen v. Maine Eye & Ear Infirmary, 78 A. 898 (Me. 1910); Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92 (N.Y. 1914); Vermillion v. Woman's Coll. of Due West, 104 S.C. 197, 88 S.E. 649 (1916).

16. *See* Owens, *supra* note 2, at 1131-32.

17. *See Schloendorff*, 105 N.E. at 92; McWilliams & Russell, *supra* note 3, at 434-35.

18. *See, e.g.*, Bing v. Thunig, 143 N.E.2d 3, 9 (N.Y. 1957) (holding that a hospital may be liable to patients for injuries caused by the negligence of the hospital employees acting within the scope of employment and consequently abandoning the doctrine of hospital immunity for the negligence of its employees).

19. 268 S.C. 479, 234 S.E.2d 873 (1977).

20. *Id.* at 482, 234 S.E.2d at 874.

21. *Id.* at 487, 234 S.E.2d at 876-77.

22. 277 S.C. 1, 282 S.E.2d 230 (1981).

23. *Id.* at 3-4, 282 S.E.2d at 231-32.

> Public policy is a dynamic not static concept, and what was valid in the past is not necessarily a valid policy today. Moreover, when the reason for a declared public policy no longer exists, we should not hesitate to abolish it and the rules which are supported by the policy.[24]

Reference to the dynamic nature of public policy was to become a recurring theme in later appellate court cases discussing hospital liability.

B. Liability for the Torts of Independent Contractors

Although South Carolina courts abrogated hospitals' charitable immunity, courts continued to shield hospitals from liability with other traditional doctrines, including respondeat superior and vicarious liability, until the early 1990s. In 1993 and 1994, the South Carolina Court of Appeals decided two cases, *Shuler v. Tuomey Regional Medical Center, Inc.*[25] and *Strickland v. Madden*,[26] both accepting hospital liability based on a theory of apparent agency. Although both *Shuler* and *Strickland* affirmed summary judgment for the hospital, the cases allowed a hospital to be held vicariously liable under an apparent agency theory if the plaintiff establishes (1) the hospital consciously or impliedly represents the negligent individual to be its agent, (2) the plaintiff relied upon the hospital's representation, and (3) the plaintiff detrimentally changed his position based on that reliance.[27]

According to the court of appeals' decisions, the South Carolina test corresponded to the elements of apparent agency and estoppel from the popularly applied[28] *Restatement of Agency* section 267:

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24. *Id.* at 3, 282 S.E.2d at 231. Justice Ness's opinion states in no uncertain terms that "[t]he doctrine of charitable immunity has no place in today's society." *Id.* However, following *Fitzer*, the state legislature enacted some limited statutory vestiges of charitable immunity by including a cap on damages recoverable against charitable organizations, *see* S.C. CODE ANN. § 33-56-180 (Supp. 2001), and giving limited protection for members of the governing boards of certain nonprofit organizations, *see* S.C. CODE ANN. § 33-31-202(b), -834 (Supp. 2001).

25. 313 S.C. 225, 437 S.E.2d 128 (Ct. App. 1993).

26. 323 S.C. 63, 448 S.E.2d 581 (Ct. App. 1994); *see also* Robin Sloan Cromer, Note, *Court Considers Limitations on Recovery for Emotional Distress, Adoption of Doctrine of Corporate Negligence*, 47 S.C. L. REV. 160 (1995) (summarizing the facts, reasoning, and holding of *Strickland*).

27. *Strickland*, 323 S.C. at 70, 448 S.E.2d at 585; *Shuler*, 313 S.C. at 227, 437 S.E.2d at 129.

28. *See, e.g.*, Brown v. Coastal Emergency Servs., Inc., 354 S.E.2d 632, 636 (Ga. Ct. App. 1987) (noting that the doctrine of apparent agency has been adopted "by the courts of every other state in which it has been asserted as a basis of liability"). Many other jurisdictions have accepted the doctrine of apparent or ostensible agency. *See* Stewart v. Midani, 525 F. Supp. 843 (N.D. Ga. 1981); Jackson v. Power, 743 P.2d 1376 (Alaska 1987); Paintsville Hosp. Co. v. Rose, 683 S.W.2d 255 (Ky. 1985); Hannola v. City of Lakewood, 426 N.E.2d 1187 (Ohio Ct. App. 1980); Adamski v. Tacoma Gen. Hosp., 579 P.2d 970 (Wash. Ct. App. 1978).

> 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 for 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.[29]

As the comments to section 267 explain, "The rule 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."[30] The popularity of applying section 267 is understandable because of the inherent difficulty in proving hospital liability for the malpractice of independent contractor physicians via respondeat superior.[31] In addition, the court of appeals' adoption of the apparent agency doctrine in *Shuler* and *Strickland*[32] was fairly traditional, focusing more on a strict application of the doctrine itself than on the shifting public policy upon which the adoption was based.[33] However, other courts have not enforced the test for apparent agency as strictly.

III. APPROACHES IN OTHER JURISDICTIONS

South Carolina is not alone in applying the doctrine of apparent agency in order to make determinations of hospital tort liability. Courts across the country have held that liability may be imposed when the actions of the physician are reasonably viewed to be the actions of the hospital either through apparent authority or agency.[34] Although many courts agree that apparent agency may support imposing liability based on estoppel, courts have adopted different standards for determining when the appearance of agency exists.

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

30. *Id.* § 267 cmt. a.

31. *See* McWilliams & Russell, *supra* note 3, at 438-45.

32. *Strickland* does recognize that other courts have adopted the doctrine of corporate negligence 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," 323 S.C. at 72, 448 S.E.2d at 586 (citing Pedroza v. Bryant, 677 P.2d 166 (Wash. 1984)), and suggests that if South Carolina adopted the doctrine and resulting duties, then a standard of care would have to be established. 323 S.C. at 72, 448 S.E.2d at 586. However, the court mentioned no public policy considerations beyond this brief discussion.

33. McWilliams & Russell, *supra* note 3, at 433, 472.

34. *See* Bynum v. Magno, 125 F. Supp. 2d 1249 (D. Haw. 2000); Butkiewicz v. Loyola Univ. Med. Ctr., 724 N.E.2d 1037 (Ill. App. Ct. 2000); Guadagnoli v. Seaview Radiology, P.C., 712 N.Y.S.2d 812 (App. Div. 2000); Espalin v. Children's Med. Ctr. of Dallas, 27 S.W.3d 675 (Tex. Ct. App. 2000); Valdez v. Pasadena Healthcare Mgmt., 975 S.W.2d 43 (Tex. Ct. App. 1998); Kashishian v. Al-Bitar, 535 N.W.2d 105 (Wis. Ct. App. 1995); *see also* 40A AM. JUR. 2d *Hospitals and Asylums* § 47 (1999) (citing additional cases).

For instance, in Illinois and Wisconsin, courts have held that a hospital may be liable under an apparent agency theory when a patient could reasonably assume that a physician was employed by the hospital, even if no express representation had been made.[35] However, in Texas, Connecticut, and Hawaii, plaintiffs bear a more demanding burden of proof. In these jurisdictions, a plaintiff must prove three elements, which are similar to those found in section 267: (1) a reasonable belief that the physician was the employee of the hospital; (2) the belief is prefaced on some act of the hospital or physician; and (3) the patient justifiably relied on the representation of authority.[36] Unfortunately, it is difficult to classify the existing case literature because so many of the cases apply different tests in the name of apparent or ostensible agency. A recent California Court of Appeals opinion claims that

> [a]lthough the cases discussing ostensible agency use various linguistic formulations to describe the elements of the doctrine, in essence, they require the same two elements: (1) conduct by the hospital that would cause a reasonable person to believe that the physician was an agent of the hospital, and (2) reliance on that apparent agency relationship by the plaintiff.[37]

However, the simplicity of this owes more to courts' desire to allow plaintiff's access to hospital defendants than it does to any theory of agency liability like that found in the *Restatement*.[38] Undoubtedly, the California court is correct in claiming that "there is really only one relevant factual issue: whether the patient had reason to know that the physician was not an agent of the hospital."[39] In most jurisdictions imposing liability under the guise of apparent agency,

> hospitals are generally deemed to have held themselves out as the provider of services unless they gave the patient

35. *Butkiewicz*, 724 N.E.2d at 1040 (finding that a hospital may be liable for the torts of an independent contractor physician, unless the patient knows or should know that the physician is an independent contractor, regardless of whether the physician is or is not an emergency room doctor); *Kashishian*, 535 N.W.2d at 108 (finding that patients, especially those in an emergency room, are entitled to assume that unfamiliar hospital workers are employees instead of independent contractors).

36. *Bynum*, 125 F. Supp. 2d at 1266 (holding that recovery based on apparent authority requires a plaintiff to show that the hospital "actually did something to imply authority" and to show that the plaintiff relied on that representation of authority); *Valdez* , 975 S.W.2d at 46-47 (granting summary judgment for defendant when the plaintiff could not designate any action by which the hospital presented the physician as its agent, even though the physician was an emergency room doctor).

37. Mejia v. Cmty. Hosp. of San Bernardino, 122 Cal. Rptr. 2d 233, 236 (Ct. App. 2002).

38. *See* RESTATEMENT (SECOND) OF AGENCY § 267 (1957).

39. *Mejia*, 122 Cal. Rptr. 2d at 237.

> contrary notice, and the patient is generally presumed to have looked to the hospital for care unless he or she was treated by his or her personal physician. Thus, unless the patient had some reason to know of the true relationship between the hospital and the physician—i.e., because the hospital gave the patient actual notice or because the patient was treated by his or her personal physician—ostensible agency is readily inferred.[40]

Some courts have gone so far as to conclude that a hospital which provides emergency room services to the public is estopped from denying an agency relationship between the hospital and its emergency room staff.[41] Most of these court decisions, like that of the California court, rely on public perception rather than the *Restatement* for their authority: "[B]ecause it is commonly believed that hospitals are the actual providers of care, ostensible agency can be readily inferred whenever someone seeks treatment at a hospital."[42] Compared to this simplistic rationale, it is imminently reasonable to impose a nondelegable duty, based on section 429 of the *Restatement of Torts*, on hospitals to provide competent care to emergency room patients after a plaintiff satisfies the test.

IV. *SIMMONS V. TUOMEY REGIONAL MEDICAL CENTER*

Simmons v. Tuomey Regional Medical Center[43] (*Simmons I*) involved a medical malpractice action against both a hospital and two emergency room physicians, alleging that the physicians' negligent diagnosis and treatment contributed to a patient's death.[44] The trial court granted the hospital's summary judgment motion, relying primarily on a contract between the hospital and a practice group that supplied the hospital's emergency room physicians.[45] The contract referred to the physicians many times as "independent contractors" and stated that the hospital agreed that it would not exercise "any control over the means, manner, or methods by which any Physician supplied by [the group] carries out his duties."[46] The plaintiff

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40. *Id.*

41. Torrence v. Kusminsky, 408 S.E.2d 684, 692 (W.Va. 1991); *see also* Paintsville Hosp. Co. v. Rose, 683 S.W.2d 255, 258 (Ky. 1985) (stating that although hospital liability is not limitless, "the operation of a hospital emergency room open to the public, where the public comes expecting medical care to be provided through the normal operating procedures within the hospital, falls within the limits for application of the principles of ostensible agency and apparent authority").

42. *Mejia*, 122 Cal. Rptr. 2d at 239.

43. 330 S.C. 115, 498 S.E.2d 408 (Ct. App. 1998) [hereinafter *Simmons I*].

44. *Id.* at 116, 498 S.E.2d at 408.

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

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

appealed, arguing that the trial court erred in granting summary judgment on the issues of actual agency, apparent agency, and nondelegable duty.[47] The South Carolina Court of Appeals only ruled on the third issue, holding "that a hospital's duty to its emergency room patients to provide competent medical care has evolved into an absolute duty that is incapable of being delegated."[48]

Unlike *Strickland*[49] and *Shuler*[50] the court of appeals' decision in *Simmons I* acknowledged the decisive role of public perceptions and noted that "[c]onsideration of the effect of public policy in the medical care arena leads us to this conclusion."[51] Chief Judge Howell's opinion notes the important role hospital emergency rooms have in providing immediate care and the resulting public reliance on hospital emergency rooms.[52] Citing a South Carolina Department of Health and Environmental Control regulation that requires hospitals to maintain a perpetually open emergency room,[53] the opinion concludes that the public's perception unifying hospitals and their emergency rooms effectively abrogates a hospital's immunity for the torts of independent contractors: "Given the cumulative public policies surrounding the operation of emergency rooms and the legal requirement that hospitals provide emergency services, we firmly believe that hospitals must be accountable in tort for the actions of care givers working in their emergency rooms."[54]

The change from *Shuler* and *Strickland* is marked. While *Strickland* merely alluded to the possibility of adopting corporate negligence when hospitals negligently select and supervise employees,[55] *Simmons I* effectively abandons the concept in favor of strict liability for hospitals whose employees and independent contractors act negligently.[56] Furthermore, the *Simmons I* court made no attempt to ground the decision in preexisting law, endorsing a New York court opinion, which stated that "it is public policy, and not traditional rules of the law of agency or the law of torts, which should underlie the decision to hold hospitals liable for malpractice which occurs in their emergency rooms."[57] In affirming the court's decision, the South Carolina Supreme Court focused on two aspects of it—the strict, nondelegable duty

47. *Id.*

48. *Id.* at 118, 498 S.E.2d at 409.

49. 323 S.C. 63, 448 S.E.2d 581 (Ct. App. 1994).

50. 313 S.C. 225, 437 S.E.2d 128 (Ct. App. 1993).

51. 330 S.C. at 118, 498 S.E.2d at 409.

52. *Id.* at 120-22, 498 S.E.2d at 410-11.

53. 24A S.C. CODE ANN. REGS. 61-16 § 613 (1976) (requiring each hospital to provide various emergency services, unless all the hospitals in a subdivision plan designate a specific hospital within the plan to be the provider of emergency medical services).

54. *Simmons I*, 330 S.C. at 124, 498 S.E.2d at 412.

55. *Strickland*, 323 S.C. at 72, 448 S.E.2d at 586.

56. *See Simmons I*, 330 S.C. at 123, 498 S.E.2d at 412.

57. *Id.* at 124, 498 S.E.2d at 412 (quoting Martell v. St. Charles Hosp., 523 N.Y.S.2d 342, 352 (App. Div. 1987)).

placed on hospitals and the lack of traditional authority for imposing that duty.[58]

The supreme court ultimately agreed with the court of appeals that the changed public perception of hospitals necessitated additional imposition of liability.[59] It also agreed that South Carolina law allows for the imposition of a nondelegable duty in certain circumstances.[60] As the court explained, various South Carolina cases impose nondelegable duties on individuals:

> A principle that applies in cases of poorly repaired brick floors and sloppily loaded cargo certainly applies to situations in which people must entrust that most personal of things, their physical well-being, to physicians at an emergency room intimately connected with and closely controlled by a hospital.[61]

However, the supreme court limited the nondelegable duty so that it does not necessitate a holding of strict liability on the hospital.[62]

The court's reasons for imposing liability on hospitals is based on claims of nondelegable duties and the apparent agency principle adopted in *Shuler* and *Strickland*. Under apparent agency, the court noted that "[t]he focus is on the acts and conduct of the principal, not the agent."[63] Because the apparent agency doctrine is difficult to satisfy, requiring representation from the hospital and proof of reliance on behalf of the plaintiff, most courts have relaxed the requirements when applying the doctrine in the emergency room setting in order to impose liability on the hospital.[64] Although the resulting "application" of the doctrine has been criticized, the supreme court agreed

> that expecting a patient in an emergency situation to debate or comprehend the meaning and extent of any representations by the hospital—which likely would be based on an opinion gradually formed over the years and not on any single representation—imposes an unfair and improper burden on the patient.[65]

Thus, the court decided to impose a nondelegable duty on hospitals rather than improperly apply apparent agency.[66]

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58. *Simmons II*, 341 S.C. 32, 533 S.E.2d 312 (2000).
59. *Id.* at 50, 533 S.E.2d at 322.
60. *Id.* at 42-44, 533 S.E.2d at 317-18.
61. *Id.* at 44, 533 S.E.2d at 318.
62. *Id.* at 50, 533 S.E.2d at 322.
63. *Id.* at 46, 533 S.E.2d at 319.
64. *Simmons II*, 341 S.C. at 48, 533 S.E.2d at 320.
65. *Id.* at 48, 533 S.E.2d at 321.
66. *Id.*

The court's opinion makes several points that support imposing a nondelegable duty. Imposing a nondelegable duty fulfills both the compensation and incentive goals of tort law, recognizes that hospitals play a pivotal role in a range of actions that comprise the practice of medicine today, and acknowledges the importance of hospital reputation in patient selection. Noting these considerations, the court decided:

> Given the fundamental shift in the role that a hospital plays in our health care system, the commercialization of American medicine, and the public perception of the unity of a hospital and its emergency room, we hold that a hospital owes a nondelegable duty to render competent service to its emergency room patients.[67]

However, unlike the court of appeals, the supreme court did not conclude that changed public perception required that the nondelegable duty imposed on hospitals be absolute. Instead, the Supreme Court adopted the approach outlined in section 429:[68]

> 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.[69]

Under section 429, the party accepting the services does not need to be the party actually receiving the services.[70] The section applies when the third party, who accepts services on behalf of the injured party, reasonably believes the service provider is the employer of the independent contractor performing the services.[71]

As a result, the test in section 429 is very similar to the test for apparent agency outlined in section 267 of the *Restatement of Agency*; however, the burden imposed on the plaintiff is not as great. As stated by the South Carolina Supreme Court:

> Under section 429, the plaintiff must show that (1) the hospital held itself out to the public by offering to provide

67. *Id.* at 50, 533 S.E.2d at 322.
68. *Id.* at 50-51, 533 S.E.2d at 322.
69. RESTATEMENT (SECOND) OF TORTS § 429 (1965).
70. *Id.* § 429 cmt. a.
71. *Id.*

> services; (2) the plaintiff looked to the hospital, rather than the individual physician, for care; and (3) a person in similar circumstances reasonably would have believed that the physician who treated him or her was a hospital employee.[72]

If the plaintiff can satisfy this test, the hospital will be held vicariously liable; however, the hospital can avoid liability by showing that the plaintiff failed to prove the required elements.[73]

Therefore, the test under section 429 allows a court to increase a hospital's exposure for the torts of its independent contractor physicians without requiring either the plaintiff or the court to try and force the doctrine of apparent agency to fit facts that often fail to prove the *Restatement of Agency* test.[74] Section 429 requires that the plaintiff look to the hospital's representations, rather than those of the provider, to prove reliance.[75] This is usually easier for the plaintiff to show, especially given hospitals' marketing campaigns.[76] Even so, the plaintiff is still required to show that she looked to the hospital rather than the physician for medical services and must show reasonable reliance.[77] In other words, section 429 is not a rubber stamp imposing the court of appeals' strict liability in a different guise.

As the supreme court notes, many other jurisdictions have endorsed section 429.[78] However, from the beginning, South Carolina has given the rule greater reach than many courts have directly acknowledged.[79] The court's opinion clearly states that the applicability of the nondelegable duty rule is not limited to cases involving emergency room physicians.[80] The only limitation is that supplied by the test itself: the patient must have sought the services of the hospital as an institution rather than relying on the recommendation of the patient's own physician, and the service provider must be someone who could reasonably be viewed as a hospital's employee.[81] Thus, after *Simmons II*, South

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72. *Simmons II*, 341 S.C. at 51, 533 S.E.2d at 322.

73. *Id.*

74. McWilliams & Russell, *supra* note 3, at 461-62.

75. *See id.* at 460.

76. *See id.*

77. *Simmons II*, 341 S.C. at 52, 533 S.E.2d at 322.

78. *Id.* at 51, 533 S.E.2d at 322 (citing cases).

79. Unlike South Carolina courts, many courts in other jurisdictions have based their holdings on the notion that a hospital holds itself out as a provider of medical services through its emergency room. These courts have either limited their decision to emergency room patients or have simply not directly stated that the liability of the hospital may extend beyond the emergency room. *See* Jackson v. Power, 743 P.2d 1376, 1382-83 (Alaska 1987); Brown v. Coastal Emergency Servs., Inc., 354 S.E.2d. 632, 639 (Ga. Ct. App. 1987); Paintsville Hosp. Co. v. Rose, 683 S.W.2d 255, 258 (Ky. 1985); Hannola v. City of Lakewood, 426 N.E.2d 1187, 1190 (Ohio Ct. App. 1980); Adamski v. Tacoma Gen. Hosp., 579 P.2d 970, 979 (Wash. Ct. App. 1978); Torrence v. Kusminsky, 408 S.E.2d 684, 692 (W. Va. 1991).

80. *Simmons II*, 341 S.C. at 52, 533 S.E.2d at 323.

81. *Id.*

Carolina allowed claims against hospitals for the torts of independent contractor physicians based on both the doctrine of apparent agency (under section 267 of the *Restatement of Agency*) and the nondelegable duty of hospitals to provide competent medical care for their emergency room patients when the patient can satisfy the test provided in section 429 of the *Restatement of Torts*.

V. *OSBORNE V. ADAMS*

With its decision in *Osborne II*,[82] the South Carolina Supreme Court dismissed any suppositions that the nondelegable duty of hospitals is a conservative doctrine. In the case, Marianne Osborne's son, Connor, was born nine weeks premature and received care at McLeod Regional Care Center's neonatal intensive care unit (NICU).[83] After Connor developed severe problems, including cerebral palsy and mental retardation, Osborne brought claims against the hospital and the two neonatalogists that provided care to Connor in McLeod's NICU.[84] She alleged that Connor's health problems developed as a result of the mismanagement of his respiratory distress while in the NICU.[85] Osborne argued that the hospital had an absolute, nondelegable duty to care for its NICU patients and, therefore, was liable for the torts of its neonatalogists, despite their status as independent contractors.[86]

The trial court granted McLeod's motion for summary judgment, finding that Osborne "failed to present any expert testimony whatsoever . . . which creates an issue of fact as to any negligence on the part of [McLeod]."[87] The court of appeals, which heard and decided the case before the supreme court issued its decision in *Simmons II*, refused to extend its holding in *Simmons I* on the ground that newborn care in a hospital's NICU does not present the same public policy reasons that compelled the *Simmons I* decision.[88] The court of appeals distinguished *Simmons I* by noting that Osborne went to McLeod at the direction and under the care of her regular obstetrician, rather than through an emergency room, and there is no regulatory requirement for a hospital to operate a Level III perinatal unit.[89] However, the supreme court reversed the court of appeals and retroactively applied its *Simmons II* rule, overturning the trial court's grant of summary judgment in favor of McLeod.[90]

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82. 346 S.C. 4, 550 S.E.2d 319 (2001).
83. *Id.* at 6, 550 S.E.2d at 320.
84. *Id.*
85. *Id.*
86. *Osborne v. Adams*, 338 S.C. 82, 86, 525 S.E.2d 268, 271 (Ct. App. 1999) [hereinafter *Osborne I*].
87. *Id.* at 85, 525 S.E.2d at 270.
88. *Id.* at 89, 525 S.E.2d at 272.
89. *Id.*
90. *Osborne II*, 346 S.C. at 13, 550 S.E.2d at 324.

A. Goals of a Nondelegable Duty and the Reasons Behind the Decision

At first glance, the supreme court's decision in *Osborne II* may appear less important than *Simmons II* because *Osborne II* simply applied the *Simmons II* holding. However, *Osborne II* offers a concrete example and application to which *Simmons II* only hinted. The court's opinion in *Osborne II* lays out each element of the *Simmons II* test to establish liability and ultimately determines that Osborne presented evidence which showed McLeod had a nondelegable duty, as defined by section 429 of the *Restatement of Torts*.[91] First, McLeod had "[held] itself out to the public as having specialized facilities, equipment and staff for the provision of high quality obstetrical care."[92] Second, Osborne decided to have her baby at McLeod rather than another hospital, based largely on the marketing of its birthing and neonatology facilities and staff.[93] Osborne alleged that she had assumed the neonatologists were employees of McLeod and that she never selected any of them to care for her son.[94] Finally, Osborne stated that she could not remember any distinction between the hospital's employees and the independent-contractor neonatologists in the McLeod marketing materials.[95] The court found it may be reasonable for Osborne to have assumed that the neonatologists were McLeod employees.[96]

The supreme court's application of the *Simmons II* test in *Osborne II* is straightforward. Because the supreme court clearly stated in *Simmons II* that its holding was not limited to the context of emergency room physicians and patients,[97] imposing a nondelegable duty on a hospital for the negligence of an independent-contractor neonatologist in the hospital's NICU was not a large inferential step for the *Osborne II* court. It did not introduce a new test into South Carolina law. However, like other small steps that turn out to be giant leaps into new territory, the *Osborne II* decision brings issues to the forefront that were not immediately obvious when the court initially imposed nondelegable duties on hospitals.

As the supreme court noted, overturning McLeod's summary judgment did not mean that Osborne would prevail on the facts at trial.[98] Despite the pro-plaintiff posture of the section 429 test, various facts present in the case weigh against Osborne. For example, the *Simmons II* court limited its holding to patients who entered the hospital emergency room solely based on their reliance of the hospital's reputation.[99] Thus, a hospital did not assume a

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91. *Id.* at 8-10, 550 S.E.2d at 321-23.
92. *Id.* at 8, 550 S.E.2d at 322.
93. *Id.* at 9, 550 S.E.2d at 322.
94. *Id.*
95. *Id.* at 10, 550 S.E.2d at 322.
96. *Osborne II*, 346 S.C. at 10, 550 S.E.2d at 322.
97. 341 S.C. 32, 52, 533 S.E.2d 312, 323 (2000).
98. *Osborne II*, 346 S.C. at 13, 550 S.E.2d at 324. The supreme court's holding simply reversed the trial court's grant of summary judgment. *Id.*
99. 341 S.C. at 52, 533 S.E.2d at 323.

nondelegable duty to provide competent care for patients who come to the hospital based on their physician's advice or who enter an emergency room in order to meet with their regular physician. However, the facts of *Osborne II* fall into a gray area not discussed in *Simmons II*. First, Osborne came to the hospital under the care of her general gynecologist and was already receiving care when her son entered the NICU.[100] If the allegedly negligent physicians were the only neonatologists practicing at McLeod, then it may be difficult for Osborne to prove her reliance was based on the hospital's reputation rather than a medical necessity.[101] In addition, because Osborne was a pharmacist employed by McLeod, the trial court will have to gauge the extent to which Osborne chose McLeod based on the economic benefits it offered to her as an employee.[102] The court will also have to determine whether, as a pharmacist at McLeod, Osborne knew or should have known that the hospital's physicians were independent contractors and not employees.[103]

These factual issues probably do not exist in most nondelegable duty cases. In most cases, it is unlikely a hospital can show that a patient failed to prove reliance if the hospital has engaged in any marketing in the community.[104] The *Simmons II* decision discounted the value of printed notices that disclaim any liability for the torts of independent contractors, so it is difficult to see how hospitals can effectively market a lack of liability.[105] Therefore, statements in hospital magazines and bulletins that say something similar to "physicians, and only physicians, practice medicine at McLeod hospital" are of dubious value. Practically, it appears hospitals may be saddled with an absolute duty after all.

B. A Closer Look: Public Policy and Expansion of Hospital Tort Liability

The supreme court's decision in *Osborne II* is exemplary on many counts. Unlike most courts, which rely on a loose doctrine of apparent agency or impose nondelegeable duties in order to impose liability on hospitals for the torts of their independent contractors, the South Carolina Supreme Court has analyzed the new perceptions of hospitals as medical service providers with traditional legal principles.[106] Recognizing that public policy requires greater hospital liability than the traditional apparent agency doctrine can provide, the

100. *Osborne I*, 338 S.C. 82, 85, 525 S.E.2d 268, 270 (Ct. App. 1999).

101. *See Osborne II*, 346 S.C. at 9, 550 S.E.2d at 322.

102. *See Osborne I*, 338 S.C. at 85, 525 S.E.2d at 270.

103. *See id.*

104. For example, if a hospital has participated in any community-wide marketing activities, like mailings or newspaper ads, it will be difficult for a hospital to prove that the plaintiff did not see any of these marketing attempts and, therefore, rely on them. Such marketing activities may essentially satisfy both the first and the second elements of section 429: (1) it has held itself out as a medical service provider and (2) it has enabled the plaintiff to say she chose the hospital for the benefits it provides. *See Osborne II*, 346 S.C. at 810, 550 S.E.2d at 321-22.

105. 341 S.C. 32, 47-48, 533 S.E.2d 318, 320 (2000).

106. *See* McWilliams & Russell, *supra* note 3 (discussing how courts have interpreted and applied tests adopted from the *Restatement of Torts* and *Restatement of Agency*).

court has adopted a different, more lenient test based on section 429 of the *Restatement of Torts*, instead of loosening the requirements of the traditional apparent agency doctrine under section 267 of the *Restatement of Agency*.[107] The court has walked a thin line between liberally imposing liability on hospitals and throwing up its hands in the face of a changing policy climate to allow public perception to dictate the law.

However, there is a problem with imposing a nondelegable duty on a hospital for torts occurring outside of the emergency room, though this problem is not plainly evident from the courts' reasoning. Both the court of appeals and the defendant hospital in *Osborne II* attempted to distinguish the actions of an independent contractor physician in the emergency room from those of an independent contractor neonatologist based on the fact that South Carolina hospitals are required to maintain emergency rooms but not NICUs. In response, the supreme court noted that, although McLeod was not required to operate a NICU, it sought and acquired the Level III designation from the Department of Health and Environmental Control and thereby voluntarily assumed the duties required of an entity with a Level III designation.[108] It should be noted that, based on this reasoning, the supreme court rightly declined to distinguish *Osborne II* from *Simmons II*. It correctly recognized that enforcing a public policy based on the public's perception of hospitals as medical service providers should extend to all services that the public perceive as being performed by the hospital, regardless of whether these services take place in an emergency room or a NICU.

However, a different view of this issue reveals a problem. South Carolina courts, like most other courts, treat public policy as if it were a single, mobilized concern, and nothing in *Simmons II* or *Osborne II* offers guidance for those situations when public policies conflict. There is conflict between imposing a duty based on public perception and the results of imposing such duties. Burdened by the duty under the extension of *Osborne II*, some hospitals may seek to close down a particular medical facility to avoid that duty. Hospitals must maintain emergency rooms, yet they are not required to have NICUs.[109] Therefore, courts can impose a nondelegable duty on hospitals to provide competent care for their emergency room patients without worrying about the ultimate impact of the duty on patient access. After all, a hospital would not choose to close down entirely in order to avoid the additional liability imposed by the *Simmons II* decision.

The situation is not as clear in the case of NICUs. As the supreme court noted, hospitals "opt in" for additional requirements when they seek a Level III designation.[110] Supposedly they do this because, in today's commercialized medical environment, NICUs make good economic sense. For example, if

107. *Simmons II*, 341 S.C. at 50-52, 533 S.E.2d at 322-23.
108. *Osborne II*, 346 S.C. at 10, 550 S.E.2d at 322.
109. *Id.*
110. *Id.*

NICUs become too expensive to operate due to increased liability insurance, why would a hospital not simply opt out and close down its NICU? Already, hospital departments across the country are facing closure because of these increased insurance costs.[111] Imposing greater liability on hospitals may improve the quality of care available to patients, but it may also decrease the range of services available. At some level, imposing quality at the cost of the services themselves is itself against public policy.

VI. CONCLUSION

As courts across the country have noted, public perception of the role of hospitals in society has changed. A community hospital today is simply another medical service provider that should not deserve special legal immunity. The demise of the doctrine of charitable immunity clearly follows this change in public perception. However, it is not clear that today's hospitals deserve to have a special liability imposed on them any more than they deserve to have special immunity from liability. In its *Simmons II* decision, the South Carolina Supreme Court avoided the murky precedent set by most state courts and imposed a nondelegable duty on hospitals to provide competent care for their emergency room patients. By relying on section 429 of the *Restatement of Torts*, the court has skirted the difficult issue of patient reliance under the doctrine of apparent agency and has avoided the direct imposition of strict liability on hospitals for the torts of all employees and independent contractors. However, except in cases with facts very similar to *Osborne II* in which a plaintiff has or should have special knowledge of the hospital, the elements of section 429 appear easy to satisfy.

In fact, section 429 may prove to be such an easy burden for plaintiffs to carry that it paves the way toward strict hospital liability. Decreased access to care may result if courts apply a nondelegable duty on hospitals as a whole, rather than limiting the duty to hospital emergency rooms. All hospitals have independent contractors performing functions without which the hospital could not operate. These functions—emergency room services, anesthesiology, and radiology—are usually required by statute and support other hospital services. Patients enter hospitals reasonably assuming that the hospital will offer certain services; the current perception of hospitals as medical service providers

111. *See* Betsy Bates, *Liability Crisis Drives Away OBs*, OB. GYN. NEWS, June 15, 2002, at 1; Bob LaMendola, *Hospitals to Close Maternity Wards; High Malpractice Insurance Costs Have Forced Two Providers to Stop Delivering Babies, A Choice Other Sites are Weighing*, S. FLA. SUN-SENTINEL, Oct. 21, 2002, at 1B; Marie McCullough, *High Costs Shrink Maternity Care—In 2 Years, 7 Hospital Units in the Region Have Closed Because of Malpractice Premiums. Some Fear Losses Will Bring Danger*, THE PHILA. INQUIRER, July 7, 2002, at A1; Margaret Ann Miille, *Doctors Hospital Will Close Obstetrics*, SARASOTA HERALD-TRIB. (Florida), Aug. 30, 2002, at A1; *Small Maternity Wards Closing*, THE CINCINNATI POST, Apr. 22, 2002, at 6A; Donna Wright, *Hospitals in Area Expect More Births*, THE BRADENTON HERALD (Florida), Oct. 3, 2002, at 1.

supports the imposition of a nondelegable duty on the hospital to provide these services competently. After all, these are the essential services that a hospital must provide in order to operate as a hospital.

However, imposing nondelegeable duties on hospitals to provide competent, non-inherent function services is not as easy to justify. When a patient can show that she detrimentally relied on a hospital's marketing in choosing to receive care at the hospital, it seems appropriate to impose a duty on that hospital to provide that care competently. However, practically, the only way hospitals can avoid liability from a nondelegable duty imposed under section 429 is to (1) not market any physicians or services or (2) publicize the relationship of the hospital and its physicians in a manner the court will accept as a waiver of liability. Situations that fulfill the second possibility are unlikely, and neither option is attractive for hospitals competing in today's commercialized medical arena.

Unfortunately, imposing increased liability on hospitals may ultimately hurt those it is meant to benefit—the patients. Hospitals may simply choose to eliminate those services, like neonatology, that become cost prohibitive. Increased costs and limited access would then impose an even greater burden on individuals for whom quality care will remain out of reach.

Kelly M. Jolley