Medical Malpractice by Emergency Physicians and Potential Hospital Liability

Keith B. Hunter
University of Kentucky

Comments

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INTRODUCTION

As early as 1957, courts began to recognize the evolution of modern hospital services. In a 1957 landmark decision, *Bing v. Thunig*,[1] the New York Court of Appeals stated that "[p]resent-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment."[2] This evolution was not ignored by the courts. They began to re-evaluate their traditional legal analysis regarding hospital liability and physician malpractice.[3] The factors cited to distinguish modern day hospitals from those of the past included salaried physicians, support, and administrative staffs.[4] In addition, hospitals charge patients for medical care and treatment and resort to legal measures to enforce collection of patient debts incurred during hos-

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[1] 143 N.E.2d 3 (N.Y. 1957).

[2] *Id.* at 8. "The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact." *Id.*

[3] *Id.*

[4] *Id.*

> In recent years, courts and legislatures throughout the country have come to realize that the traditional legal analyses of these relationships accord with neither contemporary realities nor societal needs. The result has been increased recognition of a duty owed by hospitals to their patients with respect to the quality of medical care offered, even in the absence of a master-servant relationship between the physician and the hospital.

Note, *Independent Duty of a Hospital to Prevent Physician Malpractice*, 15 ARIZ. L. REV. 953, 953-54 (1973).

pitalization.[5] Hospitals no longer simply shelter patients while independent physicians render medical treatment.[6]

Hospitals are complex institutions in which numerous individuals provide a myriad of services. During any hospital encounter a variety of highly skilled individuals could attend to a patient. Many patients commence a hospital stay with a visit to the emergency department,[7] which typically functions as a "feeder system" to the inpatient services.[8] Many patients are admitted directly to the hospital for inpatient care after receiving treatment in the emergency department.[9] Many other patients' only contact with the hospital is emergency department care.[10] In view

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[5] 143 N.E.2d at 8.

[6] *Id.* "We have no doubt that in a modern hospital a patient is quite likely to come under the care of a number of persons in different types of contractual and other relationships with each other." Ybarra v. Spangard, 154 P.2d 687, 690 (Cal. 1944).

[7] "The emergency department, recognized as one of the hospital's more complex, crucial, and changeable services, is now regarded as a major rather than an ancillary service." Pegalis & Wachsman, *Emergency Room Negligence*, TRIAL, May 1980, at 50. The emergency department has been defined as

> . . . the facilities and services provided primarily for the management of outpatients coming to the hospital for treatment of conditions determined clinically or considered by the patient or his representative to require immediate medical care in the hospital environment. The term is to be interpreted as synonymous with such terms as emergency room, accident room, and casualty room.

Id. (Quoting AMERICAN HOSPITAL ASSOCIATION, EMERGENCY SERVICES: THE HOSPITAL EMERGENCY DEPARTMENT IN AN EMERGENCY CARE SYSTEM (1972)).

[8] For many hospitals, especially large urban facilities, the emergency department is the portal of entry for patients in need of medical treatment. This is especially true for indigent patients who do not have private physicians.

[9] Often a significant percentage of hospital admissions come from the emergency department. *See generally* Ranseen & Thornton, *The Emergency Department: A Financial Winner for Hospitals in the 1980's?*, 15 HEALTHCARE FIN. MGMT., Jan. 1985, at 31, 35. Twenty to 90% of a hospital's admissions may come through the emergency department. In private hospitals where most patients are admitted on an elective basis, only 20% of the hospital's admissions come from the emergency department. In inner city general hospitals where patients are almost exclusively admitted through the emergency department, approximately 90% of the patients are admitted through the emergency department. Telephone interview with Mary Ann Cooper M.D., FACEP Research Director, Division of Emergency Medicine, University of Illinois (Mar. 2, 1987) [hereinafter Cooper Interview].

[10] Emergency departments often gauge the "acuity" or severity of the caseload seen in the department by the percent admitted after the visit. This ranges from a low of 10% in departments that see many rechecks and serve as private physicians clinics on the weekend, to an overall average of 16-24% to as much as 40-50% in inner city county hospitals with active "knife and gun clubs" and sick elderly population. Cooper Interview, *supra* note 9.

of the importance of emergency medical treatment and the public policy interest in promoting provider responsibility, this Comment examines current trends in hospital liability for emergency care provided by hospital emergency departments.[11]

This Comment examines several theories of hospital liability, current case law applying these theories, and the resulting effect on hospitals. This Comment concludes that current trends in determining hospital liability for medical malpractice in the emergency department sufficiently reflect the role of modern hospitals and individuals providing medical treatment.

I. THEORIES OF HOSPITAL LIABILITY FOR MEDICAL MALPRACTICE

The relationship between the emergency physician and the hospital is an important factor in determining whether the hospital will be liable, under the doctrine of respondeat superior, for the alleged negligence of an emergency physician. Three types of physicians work in the emergency department: salaried, private, and contract physicians. Salaried physicians are compensated directly by the hospital and are considered employees of the facility.[12] Private physicians are independent contractors for whom the hospital provides the necessary support personnel, equipment, and facilities to assist in the rendering of patient care.[13] Contract physicians have entered into a contractual rela-

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[11] Hospital emergency services are of growing importance. One commentator remarked, "[t]hat 'the public has taken to the emergency department like a duck to water' is certainly no exaggeration, it may be an understatement." Powers, *Hospital Emergency Service and the Open Door*, 66 MICH. L. REV. 1455, 1455-56 (1968) (quoting Blalock, *Emergency Care*, 40 HOSP. 1966, at 51, 51).

> It is quite clear, then, that the public considers the emergency room to be a community medical center. It is the only place where the best equipment and facilities and at least some care are available on any day, at any hour, and without appointment. It does not require the presence of the sometimes unavailable family doctor. In fact, one explanation for this development is undoubtedly the concurrent disappearance of the traditional family doctor and the house call, and the advent of the clinic, regular office hours and doctors' days off.

Id. at 1457.

[12] *See infra* notes 48-69 and accompanying text.

[13] *See infra* notes 70-111 and accompanying text.

tionship with the hospital to provide a specific service.[14] These physician/hospital relationships and the current theories of hospital liability for negligent acts of these physicians are analyzed separately.

A. The Doctrine of Respondeat Superior

Respondeat superior, or "let the master answer,"[15] refers to the "area within which a master is liable for the torts of servants which, although committed disobediently, are connected with the service of the employer."[16] Respondeat superior has been used effectively in various industries to hold employers liable for the acts of negligent employees.[17] Courts in the past, however, were reluctant to hold hospitals liable for the negligent acts of medical personnel not directly employed by them.[18] This reluctance was due to the independent contractor status of most hospital physicians.[19] "Even though [physicians were] employed by the hospital, they were to be regarded as independent contractors rather than employees because of the skill they exercised and the lack of control executed over that work."[20] Consequently, a body of case law developed premising hospital liability for patient injuries caused by employee negligence upon whether the injury-producing act was administrative or medical in nature.[21] The courts found substantial difficulty in differentiating

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[14] *See infra* notes 112-128 and accompanying text.

[15] BLACK'S LAW DICTIONARY 1179 (5th ed. 1979).

[16] W. SEAVEY, HANDBOOK OF THE LAW OF AGENCY § 83 (1964).

[17] *See* Atlanta Commercial Builders, Inc. v. Polinsky, 250 S.E.2d 781 (Ga. Ct. App. 1978) (construction industry); Peeples v. Kawasaki Heavy Indus., Ltd., 603 P.2d 765 (Or. 1979) (motorcycle industry).

[18] *See* Comment, *The Hospital-Physician Relationship: Hospital Responsibility for Malpractice of Physicians*, 50 WASH. L. REV. 385, 396-97 (1975).

[19] Southwick, *Hospital Liability: Two Theories Have Been Merged*, 4 J. LEGAL MED. 1, 8 (1983).

[20] Bing v. Thunig, 143 N.E.2d 3, 6 (N.Y. 1957).

[21] *Id.* at 4. *See* Berg v. New York Soc'y for Relief of Ruptured & Crippled, 136 N.E.2d 523 (N.Y. 1956) (administering wrong blood to the right patient is medical); Sutherland v. New York Polyclinic Medical School & Hosp., 82 N.E.2d 583 (N.Y. 1948) (keeping a hot water bottle on a patient too long is medical); Necolayff v. Genesee Hosp., 73 N.E.2d 117 (N.Y. 1947) (administering blood, by means of a transfusion, to the wrong patient is administrative); Iacono v. New York Polyclinic Medical School & Hosp., 68 N.E.2d 450 (N.Y. 1946) (placing a hot water bottle on a patient's body is administrative).

between medical and administrative acts.[22] Quite appropriately, this distinction eventually gave way to a more reasonable analysis. The *Bing* court stated that

> [h]ospitals should . . . shoulder the responsibilities borne by everyone else. There is no reason to continue their exemption from the universal rule of respondeat superior. The test should be . . . [whether] the person who committed the negligent injury-producing act [was] one of its employees and, if he was, was he acting within the scope of his employment.[23]

Sound policy reasons for holding hospitals accountable under respondeat superior now exist.[24] To limit its liability, the hospital will implement and enforce policies and procedures which significantly control the employee's activities.[25] When a negligent act is committed, possibly both the employee and hospital will be sued. Hospitals generally are insured more adequately and are in a superior financial position to compensate the victim. Under this analysis, public policy would seem to indicate that the institution should be held responsible for the negligent acts of its employees.

Courts eventually developed a two-prong test to determine whether a hospital was liable for the acts of physicians or other medical personnel.[26] The first part of the test queries whether

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[22] The *Bing* court felt that this distinction had long plagued the judicial system. Consistent and clearly defined distinctions between administrative and medical actions were elusive. Distinctions set forth in other decisions provided neither guiding principles nor clear delineation of policy. These decisions only caused confusion and created doubt and uncertainty. 143 N.E.2d at 4, 5.

[23] *Id.* at 8.

[24] *See* Southwick, *supra* note 19, at 4.

[25] Hospitals maintain extensive policy and procedure manuals covering numerous activities of hospital employees. Moreover, hospitals maintain a Risk Management function which seeks to limit potential problems before they occur. *See generally* JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS (1987).

[26] Adamski v. Tacoma Gen. Hosp., 579 P.2d 970, 975 (Wash. Ct. App. 1978). The seminal case that held a hospital vicariously liable for negligence or malpractice of staff physicians, irrespective of the contractual arrangement between them, was Brown v. Lasociet Francise de Bienfiasance Mutuelle, 71 P. 516 (Cal. 1903). *See also* Kober v. Stewart, 417 P.2d 476 (Mont. 1966). The *Kober* court patterned its decision after *Brown* and reversed a summary judgment favoring the hospital, finding there was genuine issue of fact as to whether the hospital would be vicariously liable for the acts of the X-ray clinic technicians. The court listed several reasons for its decision including: the fact that

the patient sought treatment from the hospital as opposed to a particular doctor.[27] The second part of the test examines whether the hospital paid the doctor a salary.[28] Using this test, "courts can more accurately determine where responsibility for malpractice lies and decide whether the hospital should share in the liability."[29] In short, changing circumstances regarding medical care and hospital services have encouraged courts to expand the doctrine of respondeat superior by finding employment relationships in situations where several decades earlier none would have been found.[30]

B. The Doctrine of Ostensible Agency

"Apparent authority is the power to affect the legal relations of another person by transactions with third persons, professedly as agent for the other, arising from and in accordance with the other's manifestations to such third persons."[31] Normally, an employer is not vicariously liable for the torts of an employee who is an independent contractor.[32] This principle frequently has

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no one requested the services of the particular radiologist, the radiologists rotated their periods of service at the hospital, a hospital employee requested that the radiologist read the X-rays, the radiologist was on call, calling its own radiologist was the hospital's standard procedure, the hospital owned and operated the equipment and sent one bill including the doctor's fee, and the clinic received a percentage of the gross profits. *Id.* at 479-80.

[27] 579 P.2d at 975.

[28] *Id.*

[29] Note, *Theories for Imposing Liability Upon Hospitals for Medical Malpractice: Ostensible Agency and Corporate Liability* 11 WM. MITCHELL L. REV. 561, 572 (1985).

[30] *See* Southwick, *supra* note 19, at 7.

> Among the changing circumstances surrounding the practice of medicine that have encouraged the courts to expand the applicability of respondeat superior are these: to an increasing extent, patients no longer select their own private physician—rather, the hospital, an employer, or some other third party furnished or provides a doctor; patients use the hospital emergency room more frequently indeed, it is not uncommon for a private physician to tell the patient to go to the emergency room on weekends or whenever the doctor is off-duty; hospital and other corporate institutions that provide medical care have increased the number and the frequency of salaried arrangements for physicians; medical practice has become increasingly institutionalized and specialized; and, contracts with hospital based specialists have dramatically increased in number and frequency.

Id.

[31] RESTATEMENT (SECOND) OF AGENCY § 8 (1958).

[32] RESTATEMENT (SECOND) OF TORTS § 409 (1965).

been used to "effectively insulate hospitals from liability for a private physician's or independent contractor's negligent acts, no matter how gross the negligence."[33]

Because many jurisdictions became dissatisfied with the ability of hospitals to contract away their liability, courts began to recognize an agency relationship when a principal erroneously led a third party to believe that another was the principal's agent.[34] In *Seneris v. Haas*,[35] the court pointed out that three things must be proved for a patient to recover damages against a principal for alleged acts of an ostensible agent. First, the person dealing with the agent must do so with the reasonable

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[33] Adams, *Kentucky Law Survey-Torts* 73 KY. L.J. 483, 504 (1984-85).

[34] Several jurisdictions recognize ostensible agency as applied to hospitals and emergency room physicians. *See* Stewart v. Midani, 525 F. Supp. 843 (N.D. Ga. 1981); Vanaman v. Milford Memorial Hosp., Inc., 272 A.2d 718 (Del. 1970); Irving v. Doctors Hosp. of Lake Worth, Inc., 415 So. 2d 55 (Fla. Dist. Ct. App. 1982); Paintsville Hosp. Co. v. Rose, 683 S.W.2d 255 (Ky. 1985); Mehlman v. Powell, 378 A.2d 1121 (Md. 1977); Hardy v. Brantley, 471 So. 2d 358 (Miss. 1985); Themins v. Emanuel Lutheran Charity Bd., 637 P.2d 155 (Or. Ct. App. 1981); Capan v. Divine Providence Hosp., 430 A.2d 647 (Pa. Super. Ct. 1980); Edmonds v. Chamberlain Memorial Hosp., 629 S.W.2d 28 (Tenn. Ct. App. 1981). *See also* Arthur v. St. Peters Hosp., 405 A.2d 443, 447 (N.J. 1979). The *Arthur* court recognized that most people have limited knowledge of those working in emergency rooms:

> This court may take judicial notice that generally people who seek medical help through the emergency room facilities of modern-day hospitals are unaware of the status of the various professionals working there. Absent a situation where the patient is directed by his own physician or where the patient makes an independent selection as to which physicians he will use while there, it is the reputation of the hospital itself upon which he would rely.

Id. Mbuda v. Benedictine Hosp., 384 N.Y.S.2d 527, 529 (N.Y. App. Div. 1976) ("Patients entering the hospital through the Emergency Room, could properly assume that the treating doctors and staff of the hospital were acting on behalf of the hospital. Such patients are not bound by secret limitations as are contained in a private contract between the hospital and the doctor."); Adamski v. Tacoma Gen. Hosp., 579 P.2d 970, 974 (Okla. Ct. App. 1978). The *Adamski* court noted the insufficiency of the traditional rules of agency:

> The experience of the courts has been that application of hornbook rules of agency to the hospital-physician relationship usually leads to unrealistic and unsatisfactory results, at least from the standpoint of the patient. Consequently, we have seen a substantial body of special law emerging in this area; the result has been an expansion of hospital liability for negligent medical acts committed on its premises.

Id.

[35] 291 P.2d 915 (Cal. 1955).

belief in the agent's authority.[36] Second, such belief must be generated by some act or neglect of the principal.[37] Finally, the third person, relying on the agent's apparent authority, must not be negligent.[38]

The application of this principle can be demonstrated in the context of a hospital emergency department where physician coverage is provided by an independent group of physicians under contract with the hospital. In this setting, patients typically receive treatment from physicians under the belief that the physicians are hospital employees. This belief frequently occurs because the hospital fails to notify the patient of the contractual relationship between the treating physician and the hospital. Ostensible agency concepts can be applied when the patient reasonably relies on this belief, negligence occurs, and the patient was not negligent.

C. *Corporate Liability*

"The doctrine of hospital corporate liability developed largely because traditional regulatory means failed to detect and discipline incompetent physicians."[39] "Under this doctrine a court holds a hospital's governing body[40] liable for the negligence of a private staff physician if the hospital fails to properly screen and supervise him."[41] This expansion of liability has been justified for several reasons. First, the expanded role of hospitals as health care providers warrants an increase in the scope of their liability.[42] Second, the expansion of hospital liability pro-

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[36] *Id.* at 927.

[37] *Id.*

[38] *Id.*

[39] Note, *Reallocating Liability to Medical Staff Review Committee Members: A Response to the Hospital Corporate Liability Doctrine*, 10 AM. J. LAW & MED. 115, 117 (1985).

[40] *Id.* The Board of Governors has ultimate authority for overseeing the proper maintenance and functioning of the hospital. The duties and responsibility of the Board are delineated in the Joint Commission's Accreditation Manual. This document, published annually by the national accrediting body, also contains a chapter on emergency services which provide a judicially recognized standard for the hospital's emergency facilities. *See* JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS (1987).

[41] Note, *supra* note 39, at 116.

[42] *Id.* at 121.

vides hospitals with a financial incentive to monitor the quality of medical care given by their staff members.[43] Third, the doctrine of respondeat superior has been unsatisfactory as a basis for holding hospitals liable for the negligence of their staff members.[44] The use of the corporate liability doctrine has been somewhat controversial and is the focus of many commentators and courts.[45]

Corporate liability and ostensible agency theories increasingly have been used to hold hospitals liable for the actions of negligent physicians.[46] If an employer/employee relationship between the hospital and physician is absent, hospital liability will rest upon application of one of these theories. This, in effect, prevents the hospital from escaping liability for negligent acts of contract physicians functioning in the emergency department.[47]

II. CASE LAW

A. Hospital Liability for Salaried Physicians

"Hospital staff physicians include those physicians who, through agreement with the hospital governing board, admit patients to the hospital."[48] Typically, these physicians are considered employees of the hospital and are directly compensated for their services by the hospital.[49] Initially, courts used the doctrine of respondeat superior to hold hospitals liable for the acts of salaried physicians.[50] Under this doctrine, the essential factor in determining hospital liability was the degree of control

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[43] *Id.*

[44] *See* Note, *supra* note 29, at 564-66.

[45] *See, e.g.*, Trail & Claybrook, *Hospital Liability and the Staff Privileges Dilemma*, 37 BAYLOR L. REV. 315 (1985).

[46] *See infra* notes 70-146 and accompanying text.

[47] *See generally* SOUTHWICK, *supra* note 19.

[48] *See* Note, *supra* note 39, at 121.

[49] *Id.*

[50] Under the theory of vicarious liability, an employer can be held liable for the negligence of an employee even though the employer had nothing to do with the occurrence of the negligent act. The employer's liability is based on the ability of the employer to control the activities of the employee. *See* W. PROSSER, LAW OF TORTS § 69, at 458 (4th ed. 1972). *See also* W. PAGE KEETON, PROSSER & KEETON ON THE LAW OF TORTS § 69, at 499 (5th ed. 1984); *supra* notes 15-30 and accompanying text.

that the hospital exercised over the physician.[51] When the hospital significantly controlled the activities of the physician, liability could be imputed to the institution.[52]

The case law with respect to physicians who are hospital employees is well settled. Hospitals, like other employers, have been held vicariously liable under the doctrine of respondeat superior for the negligence of employee physicians.[53] One recurrent issue in this area, however, is the employer/employee status of resident physicians.[54] Resident physicians are currently the most frequently encountered hospital employee physician.[55] There

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[51] An important factor to be considered in determining the status of one who performs services for another is the right of the latter to control the former. RESTATEMENT (SECOND) OF AGENCY § 220 (1958). One commentator has noted that in some jurisdictions the courts, in ascertaining whether the hospital rightfully controls the employee, look to the nature of the acts performed and the custom regarding the control ordinarily exercised in the performance of similar acts. *See* Rodriguez v. City and County of Denver, 702 P.2d 1349, 1350 (Colo. Ct. App. 1984).

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> The courts generally look to all of the facts and circumstances to determine if the hospital and doctor enjoy such a "significant relationship" that the rule of respondeat superior ought to apply. When . . . the hospital undertakes to provide medical treatment rather than merely [serve] as a place for the physician to [treat] patients, the physician employed to deliver that service for the hospital may be looked upon as an integral part of the total "hospital enterprise."

Adamski v. Tacoma Gen. Hosp., 579 P.2d 970, 975 (Wash. Ct. App. 1978). *See* Overstreet v. Doctors Hosp., 237 S.E.2d 213 (Ga. Ct. App. 1977).

[53] Brown v. Lasociet Francise de Bienfiasance Mutuello, 71 P. 516 (Cal. 1903), produced the so called "Brown formula" which courts regularly use to hold hospitals liable for the negligent acts of their interns and resident physicians. *See, e.g.*, Garfield Memorial Hosp. v. Marshall, 204 F.2d 721 (D.C. Cir. 1953); Bowers v. Olch, 260 P.2d 997 (Cal. Dist. Ct. App. 1953); (City of) Miami v. Oates, 10 So. 2d 721 (Fla. 1942); Moeller v. Hauser, 54 N.W.2d 639 (Minn. 1952); James v. Holder, 309 N.Y.S.2d 385 (N.Y. App. Div. 1970); Koubeck v. Fairview Park Hosp., 172 N.E.2d 491 (Ohio 1960); Sepaugh v. Methodist Hosp., 202 S.W.2d 985 (Tenn. 1947); Stuart Circle Hosp. Corp. v. Curry, 3 S.E.2d 153 (Va. 1939); Brant v. Sweet Clinic, 8 P.2d 972 (Wash. 1932).

[54] As a result of the numerous training programs for physicians and the need for physician coverage in the emergency department, residents often are employed by private hospitals.

[55] Resident physicians typically are affiliated with university accredited programs based in publicly-owned facilities. Quite often these facilities receive governmental immunity under state and federal torts claims acts. Many times resident physicians rotate through private institutions that do not enjoy the same immunity from prosecution for medical malpractice. When the physician is rendering care in these facilities, there is potential for liability of the site hospital. *See Malpractice in the Emergency Department:*

are numerous medical residency programs in emergency medicine and other areas of specialization.[56] Moreover, many medical school programs require a resident physician to perform medical services in the emergency department even though their specific training is focused in a different medical specialty. Much of the controversy surrounding resident physicians and hospital liability involves the element of control over resident physicians.[57] To establish hospital liability under the doctrine of respondeat superior, the hospital must have exercised sufficient control over the resident physician.

In *Kelly v. Rossi*,[58] the disputed issue was whether the resident physician was the servant of the city hospital while on rotation and working in the emergency room of a private hospital.[59] The physician's defense was based on her employment by the city of Boston as a house officer at Boston City Hospital. As a Boston City Hospital employee, she claimed she could not be held liable for medical malpractice under the Massachusetts Tort Claims Act.[60] Further, the private hospital where the alleged malpractice occurred did not maintain the requisite element of control and, therefore, would not be vicariously liable.[61]

Review of 200 Cases, 13 ANNALS OF EMERGENCY MED. 709, 709 (Sept. 1984).

> [T]he surgical specialties accounted for most . . . of the claims. Sixty-four (32%) were attributable to house officers apparently functioning in a nonsupervised capacity, or to residents on rotation from specialty training or moonlighting in an unsupervised capacity. . . . The relatively high risk for moonlighting residents has been confirmed recently by the 13 hospitals in the Harvard group practice.

Id. at 710.

[56] In 1972, there were only two residency-trained emergency physicians. By 1978, there were 336 and in 1983, there were approximately 1,000. By 1975, there were 31 emergency medicine residency programs. *A Longitudinal Study of Residency-Trained Emergency Physicians*, 12 ANNALS OF EMERGENCY MED. 20, 20 (Jan. 1983). Since 1980, when Emergency Medicine was approved as a specialty, there have been 4,250 board certified physicians. Approximately 2,600 physicians have completed the program to date. Currently there are 67 approved residency programs graduating approximately 450 emergency physicians each year. Cooper interview, *supra* note 9.

[57] *See infra* notes 58-69 and accompanying text.

[58] 481 N.E.2d 1340 (Mass. 1985).

[59] *Id.*

[60] The court indicated that they normally looked to the federal courts' treatment of the Federal Torts Claim Act in applying the Massachusetts State Torts Claim Act. In this situation, however, Congress' intent to exempt certain physicians from liability while working for the government was not clear. *Id.* at 1343 n.4.

[61] *Id.*

"The legal principles that govern the determination of whether a doctor [is] a public employee . . . are the same as those that have determined whether an agent is a servant for whose negligent acts a principal may be liable under . . . respondeat superior."[62] The court noted that the guiding principle in determining vicarious liability is whether or not the hospital has the right to control the agent's activities.[63] While case law exists that stands for the proposition that a physician is not a servant when a hospital cannot control the details of a physician's activity,[64] the general rule is that house officers are servants of the hospital.[65]

The *Kelly* court focused on the physician's activities in the emergency department to determine whether the physician was a servant of the hospital or subject to the control and direction of the city.[66] The doctor, when working in the emergency department, was required to follow the policies and procedures established by the hospital.[67] Moreover, she could not admit patients and did not have a choice in which patients she could see.[68] Generally, the physician's activities were controlled by

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[62] *Id.* at 1342.

[63] "The right to control an agent's activities has been the guiding principle in deciding cases involving an assertion of vicarious liability against the agent's principal." *Id.*

> The relationship of principal and agent or master and servant is distinguished from the relationship of employer and independent contractor by the following test: Did the employer retain control of, or the right to control, the mode and manner of doing the work contracted for? If he did, the relationship is that of principal and agent or master and servant. If he did not but is interested merely in the ultimate result to be accomplished, the relationship is that of employer and independent contractor.

Hannola v. City of Lakewood, 426 N.E.2d 1187, 1191 (Ohio Ct. App. 1980) (quoting Councell v. Douglas, 126 N.E.2d 597 (1955)).

[64] *See generally* Overstreet v. Doctors Hosp., 237 S.E.2d 213 (Ga. Ct. App. 1977).

[65] 481 N.E.2d at 1343. A house officer, such as a resident, has duties and obligations at a hospital that demonstrate that he or she is a servant.

[66] *Id.*

[67] The facts in this case indicated that "[d]uring the day the doctor worked with and studied developmental pediatrics under a doctor on the staff of the hospital. [Several nights] during the week she was assigned to emergency room duty at the hospital pursuant to a schedule established at the Boston City Hospital." *Id.* at 1344. Record keeping and administrative responsibilities were also to be conducted according to hospital policy. *Id.*

[68] "She could neither admit nor discharge a patient without the permission of a physician designated by the hospital." *Id.*

hospital policy. Therefore, the court concluded that the doctor was a servant of the hospital and not the city.[69]

B. *Hospital Liability for Private Doctors*

The courts have used several theories of liability to hold hospitals liable for the negligence of private doctors in the emergency department. One theory used in this setting is that of corporate liability.[70] The hospital's liability under this theory is not vicarious as when respondeat superior is applied.[71] "Rather, [liability] attaches directly to the corporation as a form of institutional or independent negligence."[72] *Darling v. Charleston Community Memorial Hospital*[73] is the most frequently cited corporate liability case.

In *Darling*, an 18 year-old college football player suffered a broken leg while playing in a game and was taken to the hospital's emergency department.[74] The treating physician was a private physician "on call" for the emergency department.[75] The patient's treatment included application of a plaster cast and hospitalization.[76] After several days, the patient was transferred to another facility where he was treated by a specialist in orthopedic surgery. It was discovered that the fractured leg "contained a considerable amount of dead tissue" due to improper application of the cast by the initial treating physician.[77] Efforts to save the leg were futile and it was eventually amputated just below the knee.[78]

The plaintiff alleged that the hospital was negligent in failing to oversee the actions of the treating physician.[79] The plaintiff

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[69] *Id.*

[70] *See supra* notes 39-47 and accompanying text.

[71] *See* Southwick, *supra* note 19, at 17.

[72] *Id.*

[73] 211 N.E.2d 253 (Ill. 1965), *cert. denied,* 383 U.S. 946 (1966).

[74] *Id.* at 255.

[75] The defendant physician was placed on duty according to a roster developed by the administration of the hospital. *Id.* at 256.

[76] When the cast was being applied there were indications that the patient's circulation was inhibited, including discoloration and numbness of the toes. *Id.* at 255.

[77] *Id.* at 256.

[78] *Id.*

[79] The plaintiff contended that the hospital was negligent in permitting the physi-

also alleged that the hospital was liable for the negligent acts of the emergency department nurses.[80] The Illinois Supreme Court concluded that a hospital could be held liable for the negligent acts of a private physician if it "failed to review and monitor treatment . . . [provided by] the private physician and [if it] failed to enforce the medical staff by-laws. . . ."[81] Following the *Darling* decision many jurisdictions recognized the use of corporate liability.[82]

The doctrine of ostensible agency is also recognized as an effective method for imposing liability in this area. Although private doctors function in various settings, hospitals most frequently use private doctors to provide emergency care in small rural communities where there is a shortage of emergency medicine trained physicians.[83] Physician coverage for the emergency department in rural hospitals typically is achieved through coordination of hospital administration and the medical staff by rotation of members of the hospital's medical staff.[84]

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cian "to do orthopedic work of the kind required in this case, and not requiring him to review his operative procedures to bring them up to date." *Id.* Thus, in failing to do this through its medical staff, the hospital failed to exercise proper supervision over the physician. *Id.*

[80] The court noted that "the jury could reasonably have concluded that the nurses did not test for circulation as frequently as necessary [and] that skilled nurses would have promptly recognized the conditions that signalled a dangerous impairment of circulation in the leg." *Id.* at 258. Further, having noticed that complications had set in, the nurses had the responsibility to report this to the attending physician. If he failed to take any action then it was the nurses' responsibility to bring the matter to the attention of higher authorities. *Id.* at 258.

[81] *Id.*

[82] *See, e.g.*, Tucson Medical Center, Inc. v. Miseuch, 545 P.2d 958, 960 (Ariz. 1976); Elam v. College Park Hosp., 183 Cal. Rptr. 156, 158-65 (Cal. Ct. App. 1982); Buckley v. Lavallo, 481 A.2d 1286, 1289 (Conn. App. Ct. 1984); Mitchell County Hosp. Authority v. Joiner, 189 S.E.2d 412, 414 (Ga. 1972); Ferguson v. Gonyaw, 236 N.W.2d 543, 550 (Mich. Ct. App. 1975); Gridley v. Johnson, 476 S.W.2d 475, 484 (Mo. 1972); Corleto v. Shore Memorial Hosp., 350 A.2d 534 (N.J. Super. Ct. Law Div. 1975); Felice v. St. Agnes Hosp., 411 N.Y.S.2d 901, 907 (N.Y. App. Div. 1978); Bost v. Riley, 262 S.E.2d 391, 396 (N.C. Ct. App. 1980); Pedroza v. Bryant, 677 P.2d 166, 168-70 (Wash. 1984); Johnson v. Misericordia Community Hosp., 301 N.W.2d 156, 170-75 (Wis. 1981).

[83] *A Longitudinal Study of Residency-Trained Emergency Physicians*, 12 ANNALS OF EMERGENCY MED. 20 (Jan. 1983). A 1979 study indicated that only 7% of graduating residents trained in emergency medicine practiced in rural areas. *Id.* at 21.

[84] Hospital administrators often have responsibility for developing physician rosters to ensure that there is adequate coverage for the emergency department. Prior to the late 1970's when emergency medicine received recognition as a specialty area by the American Board of Medical Specialties, there were two common modes of staffing the

For example, in *Paintsville Hospital Co. v. Rose*,[85] the Kentucky Supreme Court held that "a hospital could be held liable on principles of ostensible agency . . . for the negligence of [a] physician who furnished treatment to [a] patient in [the] emergency room . . . notwithstanding that [the] physician was not actually employed by the hospital."[86] In this case the emergency room physician failed to properly read X-rays of a 16 year-old patient brought into the emergency room in an unconscious state,[87] resulting in the "failure to diagnose a skull fracture with subdural hematoma."[88] The treating physician was a private physician and not an employee of the hospital. She was a member of the hospital medical staff and provided emergency room coverage for the hospital on an "on call" basis.[89] Although her medical specialty was obstetrics and gynecology, she was summoned to treat the patient upon his arrival.[90] The treatment of the patient by this physician was terminated upon payment for treatment by the patient's parents and by hospitalization for further observation.[91]

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emergency department of a hospital. The Pontiac (Michigan) plan used staff physicians regardless of their specialty. Physicians in this plan rotated several nights a month as the "Emergency Department Physician" to provide coverage for the department. The Alexandria (Virginia) plan utilized a group of physicians who chose to practice emergency medicine. This group entered into a contract with the hospital to provide staffing for the emergency department.

With emergency medicine becoming a specialty and board certification available, hospitals have more frequently gone to the Alexandria plan with only some rural hospitals continuing to utilize the Pontiac plan by necessity. In addition, resident physicians from a variety of specialties may be hired by some hospitals as physician groups to "moonlight." Only in a few New England hospitals and in some inner city hospitals are residents from various specialties used to staff their emergency departments. This often occurs without supervision by more senior resident staff or attending physicians in those specialties or an attending emergency physician. Cooper Interview, *supra* note 9.

[85] 683 S.W.2d 255 (Ky. 1985).

[86] *Id.* at 255.

[87] *Id.*

[88] "[W]hen the parents of [the patient] arrived at the emergency room, the doctor discussed the problem of a possible drug reaction or a head injury with them. . . ." *Id.* at 256. Also at this time, arrangements were made for the patient to be admitted and seen by a physician that could more appropriately address his needs. *Id.*

[89] *Id.*

[90] In many hospitals emergency room coverage provided by a private physician not trained in emergency medicine is not uncommon.

[91] These acts were focused upon as evidence that the parents did not believe that the physician was an agent of the hospital. 683 S.W.2d at 256.

This was a case of first impression for the Kentucky Supreme Court. In a 1983 medical malpractice appellate decision, *Williams v. St. Claire Medical Center*,[92] the court recognized the principle of ostensible agency and reversed a summary judgment in favor of the hospital to allow a jury determination of negligence of a third party.[93] In *Williams*, the appellant argued that neither he nor his parents relied on the fact that the physician was an employee of the hospital in accepting treatment.[94] The *Paintsville Hospital Co.* court, addressing a similar argument, expounded the soundness of the principle of ostensible agency as applied to situations similar to the one at bar and stated:

> [T]he principle of ostensible agency [as applied] to the hospital/emergency room physician situation, do[es] not require an express representation to the patient that the treating physician is an employee of the hospital, nor do they require direct testimony as to reliance. A general representation to the public is implied from the circumstances. Without exception evidence sufficient to invoke the doctrine has been inferred from circumstances similar to those shown in the present case, absent evidence that the patient knew or should have known that the treating physician was not a hospital employee when the treatment was performed (not afterwards).[95]

Therefore, specific representation to individuals that present themselves to the emergency department is not required. A party bringing an action can rely on the "general representation to the public" when a hospital holds itself out as providing emergency medical treatment.[96] Thus, the court concluded that "under these circumstances, it is unreasonable to put a duty on the patient to inquire of each person who treats him whether he is an employee or independent contractor of the hospital."[97] The opinion further

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[92] 657 S.W.2d 590 (Ky. Ct. App. 1983).

[93] The hospital was held liable for the negligent acts of a nurse anesthetist even though he was employed by Cave Run Clinic, a local professional service corporation. *Id.* at 590.

[94] *Id.*

[95] 683 S.W.2d at 256.

[96] *Id.*

[97] *Id.* at 258.

stated that, "[i]ndeed, it would be astonishing for courts to require a patient to ask emergency room personnel such a question considering the usual circumstances of the patient at the time he seeks out the emergency room for treatment."[98] In adopting the principle of ostensible agency, the court noted that "the circumstances under which the hospital is liable are not unlimited."[99] However, "where the public comes in expectation of medical care to be provided through normal operating procedures within the hospital," application of ostensible agency principles would be appropriate.[100]

Given different factual circumstances, however, courts have found it more difficult to hold a hospital liable for the negligence of a private doctor. For example, in *Weldon v. Seminole Municipal Hospital*,[101] the Oklahoma Supreme Court held that neither the theory of respondeat superior nor ostensible agency extended to render a hospital liable for the negligence of a doctor who was the primary medical care provider and was not paid a salary by the hospital.[102]

The *Weldon* Court distinguished this case from a recent Oklahoma appellate decision, *Smith v. St. Francis Hospital*.[103] In *Smith*, the hospital was estopped from denying responsibility for the negligence of its emergency room physicians because the hospital held itself out to the public as rendering medical care.[104] Therefore, patients seeking treatment from the hospital reasonably could be expected to rely on the hospital's representation that the treating physicians were acting on behalf of the hospital.

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[98] *Id.*

[99] *Id.*

[100] *Id.*

[101] 709 P.2d 1058 (Okla. 1985) In *Weldon*, the plaintiff brought a medical malpractice action against the hospital due to damage of her tympanic membrane which resulted in a loss of hearing in her right ear. *Id.* at 1059.

[102] The court stated:

> [B]ased on the facts before the trial court concerning the relationship between the Hospital and Dr. Price, there is no genuine issue as to whether the facts give rise to liability based on respondeat superior or ostensible agency. It was proper for the trial court to resolve this issue by summary judgment.

Id. at 1060.

[103] 676 P.2d 279 (Okla. Ct. App. 1983).

[104] *Id.* at 282.

The *Weldon* Court noted that an important factor in establishing hospital liability based on ostensible agency was the pre-existing doctor-patient relationship.[105] The court also recognized that many jursidictions do not extend the theory of respondeat superior to a hospital if the doctor exercises his own independent judgment and is an independent contractor rather than an employee.[106] Therefore, the *Weldon* court distinguished *Smith* primarily on the basis of the *Weldon* patient's pre-existing doctor-patient relationship.

The facts in *Weldon* indicated that the initial contact for treatment of the patient was made by the patient's mother by telephone to the physician at his residence.[107] It was then arranged that the patient's treatment would take place at the hospital.[108] Therefore, it is unlikely that the family was looking to the hospital to provide medical care. The hospital was utilized simply as a facility where the doctor, exercising his own independent judgment, could render medical care.[109] Citing *Smith*, the *Weldon* Court stated that the critical question is "whether the plaintiff, at the time of his admission to the hospital, was looking to the hospital for treatment of his physical ailments or merely viewed the hospital as the situs where his physician could treat him for his problems."[110] In *Weldon*, there appeared to be little question that the hospital was simply a situs for treatment and therefore liability based on respondeat superior or ostensible agency could not be imposed.[111]

C. *Hospital Liability for Contract Physicians*

Over the past several decades, hospitals increasingly have entered into contracts for services with various medical special-

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[105] 709 P.2d at 1060. The *Smith* court stated that notwithstanding the doctor's status as an independent contractor, the hospital was estopped from denying liability because the patient looked solely to the hospital to provide personnel and the patient had no reason to believe that the physicians placed in the emergency room were acting in their own behalf rather than in the hospital's. 676 P.2d at 282.

[106] 709 P.2d at 1061.

[107] *Id.* at 1060.

[108] *Id.*

[109] *Id.*

[110] The court felt that this question had to be resolved to invoke respondeat superior or agency by estoppel as set forth by the Oklahoma Court of Appeals. *Id.* at 1060.

[111] *Id.*

ists.[112] Contractual provision for emergency medicine services often is made. Hospital liability is more difficult to impose for the acts of these non-employee physicians, as independent contractors.[113] Courts, however, "eventually extended the hospital's liability to include those independent contractors whose in-house functions subjected them to a significant degree of hospital control and for whose services the hospital directly billed the patients."[114] The growing trend holding hospitals liable for the negligent acts of emergency physicians, who have contractually

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[112] This is also true with respect to Emergency Medicine where the American College of Emergency Physicians has set forth a position statement regarding contractual relationships between emergency physicians and hospitals. *See Contractual Relationships Between Emergency Physicians and Hospitals*, 14 ANNALS OF EMERGENCY MED. 76 (1985). Pertinent provisions include:

> The American College of Emergency Physicians supports the following general principles for contractual relationships between emergency physicians and hospitals:
>
> 1. Emergency physicians should not enter into an emergency service arrangement with a hospital without a written contract.
>
> 2. A contract with an emergency physician or emergency physician group should be fair to the parties involved, should be conducive to excellence of medical care, and should promote the interests of the patients and the community served by the hospital.
>
> 3. It is the right and privilege of emergency physicians to set fees for their services.
>
> 4. The College recognizes that good medical care is being provided in hospitals by physicians and under many forms of mutual agreement and many methods of compensation, and accordingly does not endorse any single type of contractual arrangement.
>
> 5. ACEP holds that physicians under contract should qualify for and maintain medical staff membership and clinical privileges in the same manner prescribed in the medical staff bylaws for other members of the medical staff.

Id.

[113] *See* Annotation, *Liability of Hospital or Sanitarium for Negligence of Physician or Surgeon*, 69 A.L.R.2d 305, 315 (1960).

> The general principle that the employer of an independent contractor is not liable for the torts of such contractor or his servants has frequently been recognized with respect to the liability of a hospital physician or surgeon. In other words, putting aside the difficult question whether, under particular circumstances, a particular medical practitioner was an independent contractor so far as the hospital in which a patient was injured through his carelessness is concerned, the conclusion that, assuming such practitioner was an independent contractor in relation to the hospital, the hospital is not liable for such injury, is supported by many decisions.

Id.

[114] Note, *supra* note 39, at 122.

agreed to provide service, is evident in a recent Mississippi decision.

In *Hardy v. Brantley*,[115] the Mississippi Supreme Court decided the question of whether a hospital, operating an emergency department, may be held vicariously liable for the conduct of emergency physicians retained under contract.[116] In this decision, a medical malpractice action was brought against an emergency service physician and the hospital for negligent failure to diagnose a perforated duodenal ulcer of a patient who came to the emergency room for treatment.[117]

The record in this case indicated that the treating physician was one of three physicians organized as a group. Under an elaborate contract with the hospital, these physicians were to provide twenty-four hour coverage of the emergency department.[118] One of the provisions of the agreement was a disclaimer clause which stated that, in the performance of their duties, the emergency group was at all times an independent contractor.[119] The court noted that "the hospital and the emergency room physicians . . . are free to make as between themselves whatever agreement they may desire."[120] However, the court's concern was with "the rights and duties of the hospital vis-a-vis the patient, not the emergency room physician."[121]

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[115] 471 So. 2d 358 (Miss. 1985).

[116] *Id.* at 371.

[117] *Id.* at 360.

[118] The contract provides that HEG, the physician group, shall have the complete and sole responsibility for furnishing professional services in the Emergency Department of Hinds General Hospital on a twenty-four hour per day basis. *Id.* at 361.

[119] *Id.*

> *Disclaimer.* In this performance of the work, duties and obligation devolving upon him under this agreement, it is mutually understood and agreed that The Hinds Emergency Group is at all times acting and performing as an independent contractor providing to the hospital the services of Emergency Physicians who are practicing their profession in medicine and surgery and specializing in Emergency care. The Hospital shall neither have nor exercise any control or direction over the methods by which the Hinds Group or its contract physicians shall perform their professional work and functions; *the sole interest and responsibility of the Hospital is to ensure that the Emergency Department and service covered by this agreement shall be performed and rendered in a competent, efficient, and satisfactory manner.*

Id. (emphasis in original).

[120] *Id.* at 369.

[121] *Id.*

Analyzing the legal obligation of the hospital to patients treated in the emergency department, the court cited cases from other jurisdictions, including *Beeck v. Tucson General Hospital*,[122] which have held hospitals vicariously liable for the negligence or malpractice of staff physicians regardless of any contract to the contrary.[123] Also, the fact that the patient sought the services of the hospital and not a particular physician was significant.[124]

Following what was characterized as a sound application of general tort principles[125] and ostensible agency principles,[126] the *Hardy* court found the hospital liable for the acts of an independent contractor.

> No longer are hospitals merely physical facilities where physicians practice their professions. Hospitals hold themselves out to the public as offering and rendering quality health care services. We notice a marked increase in advertisement and other forms of solicitations of patients as hospitals compete for the health-care dollar.
>
> It goes without saying that hospitals such as [the one here] are corporate entities capable of acting only through human beings whose services the hospital engages. In arrangements such as the existing [one] . . . the hospital places a great portion of its eggs in the baskets of the emergency room physicians. If they do their job well, the hospital succeeds in

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[122] 500 P.2d 1153 (Ariz. Ct. App. 1972).

[123] 471 So. 2d at 369. *See* Brown v. Lasociet Francise de Bienfiasance Mutuelle, 71 P. 156 (Cal. 1903) (Agency was based on the patient seeking treatment from the hospital as opposed to a particular doctor and the hospital paying the doctor a salary.); Kober v. Stewart, 417 P.2d 476 (Mont. 1966) (Irrespective of a contractual arrangement, similar to the one in *Hardy*, the Montana court held the hospital vicariously liable for the acts of an X-ray technician.).

[124] 471 So. 2d at 369.

[125] The court cited RESTATEMENT (SECOND) OF TORTS § 429 (1966) and stated:

> One [Hinds General] who employs an independent contractor [Dr. Brantley and his group] to perform services for another [Brad Ewing] 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.

Id. at 370.

[126] *Id.* at 371.

> its chosen mission, profiting financially and otherwise from the quality of emergency care so delivered.[127]

The *Hardy* court recognized the changing nature of hospitals. Increased competition in the hospital industry has resulted in advertising to promote the use of specialty services such as the emergency department.[128] At the same time, the treatment provided in this setting increasingly is contracted to groups of physicians not employed by the hospital. Hospitals, such as the one in *Hardy*, are promoting emergency care and seeking to limit their liability to injured third parties through these contractual agreements. Public policy clearly requires that hospitals should be held accountable for acts of negligent physicians in situations such as the one presented here.

III. THE EFFECT ON HOSPITAL LIABILITY

Respondeat superior, ostensible agency, and corporate liability have been used by courts in various circumstances to hold hospitals liable for the negligent acts of emergency room physicians. Current case law has responded to the hospital industry trend which reflects that most emergency care is provided by private physicians or independent contractors.[129] As a result, most jurisdictions have adopted either corporate liability or ostensible agency. Some cases have applied both theories in holding a hospital liable.[130]

In a recent decision, *Hannola v. City of Lakewood*,[131] the Ohio Court of Appeals indicated that a full service hospital would be estopped from denying that on-duty medical personnel were its agents.[132] Moreover, under corporate liability the hospital had a direct and independent responsibility to its patients

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[127] *Id.*

[128] *Id.*

[129] *See generally*, Hiser v. Randolph, 617 P.2d 774 (Ariz. Ct. App. 1980) (private doctor); Irving v. Doctors Hosp. of Lake Worth, 415 So. 2d 55 (Fla. Dist. Ct. App. 1982) (independent contractor physician); Arthur v. St. Peter's Hosp., 405 A.2d 443 (N.J. Super. Ct. Law Div. 1979) (independent contractor physician); Mbuda v. Benedictine Hosp., 384 N.Y.S.2d 527 (N.Y. App. Div. 1976) (independent contractor physician).

[130] *See supra* notes 34, 82.

[131] 426 N.E.2d 1187 (Ohio Ct. App. 1980).

[132] *Id.* at 1190.

to insure the competency of its medical staff and the quality of medical care provided, through the prudent selection, review, and continuing evaluation of the physicians granted staff privileges.[133]

The *Hannola* court further indicated that a hospital had an independent "duty to prevent a physicians' malpractice at least to the extent that it establishes procedures for the granting of staff privileges and the review of these privileges."[134] The main issue on appeal was "whether a hospital may insulate itself by contractual arrangement from liability for acts of medical malpractice committed in an emergency room located on its premises."[135] Public policy concerns regarding a patient's induced reliance on the reputation of a full service hospital with an emergency room were of particular importance. The court noted:

> [G]iven the unique nature of an emergency room and the public's lack of meaningful choice in a dire medical emergency, a hospital may well have a more specific and precise independent duty in the emergency room than in other parts of the hospital to monitor the treatment procedures and medical care provided patients.[136]

It was also stressed that a hospital has a higher independent duty of monitoring the patient care offered in its emergency room.[137] Thus, this case indicates that in certain situations both ostensible agency and corporate liability will be used to prevent a hospital from escaping liability for the negligent acts of physicians functioning in the emergency department.

Although ostensible agency and corporate liability are complementary and, therefore, are used concomitantly, there are situations where one or the other would be more appropriate. Close examination of *Paintsville Hospital Co. v. Rose*,[138] in which ostensible agency was applied, provides a good example. This case recognized that two conditions must be shown before

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[133] *Id.* at 1192.
[134] *Id.*
[135] *Id.* at 1189.
[136] *Id.* at 1192.
[137] *Id.*
[138] 683 S.W.2d 255 (Ky. 1985).

liability can be imposed upon the basis of ostensible agency. "First, the ostensible principal must have engaged in conduct of such a nature as to cause a reasonable person to believe that an agency relationship existed, although actually there was no agency.[139] Secondly, the person seeking to impose liability upon one who is ostensibly a principal for the tort of one who is ostensibly, but not actually, an agent must in fact believe that an agency relationship did exist and must act in reliance upon that belief."[140]

In *Rose*, the patient was brought to the hospital in an unconscious state. Therefore, it is questionable whether the deceased, upon his admission to the hospital, did "rely upon a belief that the emergency room physician was, in fact, an agent of the hospital."[141] Moreover, the parents of the deceased were told by the defendant physician that the deceased's injuries were beyond her expertise and that she could not offer further treatment.[142] Given this information it is unlikely that either the deceased or his parents believed that an agency relationship existed between the hospital and the physician. Therefore, ostensible agency may not have been the appropriate theory to hold the hospital liable.

Following the well-established case law set forth in *Darling*[143] and its progeny, however, the *Rose* court possibly could have found the hospital liable under the corporate liability theory. Some courts believe that this theory is applied appropriately in situations where the malpractice charges made against the hospital were for a physician or staff engaged in private practice

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[139] *Id.* at 258 (Vance, J., dissenting). The dissenting opinion asserted that this may not be the proper case for using ostensible agency and that summary judgment should be granted. This in part was due to the difficulty in finding that the conditions precedent were met. *Id.*

[140] *Id.* (Vance, J., dissenting).

[141] *Id.* at 259 (Vance, J., dissenting). (This issue will undoubtedly be a reoccuring problem because in many instances patients are brought to the emergency room in an unconscious state.)

[142] When the physician explained to the parents of the deceased that the patient's injuries were outside of her area of expertise, she also indicated that another physician would treat the patient once he was admitted. Moreover, the parents paid the physician at this time. These facts raise serious doubt as to whether the parents believed that the physician was employed by the hospital. *Id.* at 259-260 (Vance, J., dissenting).

[143] Darling v. Charleston Community Memorial Hosp., 211 N.E.2d 253 (Ill. 1965).

and otherwise wholly separate and apart from the hospital.[144] Corporate liability is premised on the notion that a hospital owes a duty directly to its patients to render quality medical care and also to protect its patients' safety.[145] There is a further duty to protect patients from negligent or incompetent treatment.[146] A hospital could be held liable, therefore, when hospital by laws or protocol are breached.

CONCLUSION

In the past several decades the courts have made significant progress in adjusting to the rapidly changing health care industry. The role of the hospital has changed as significantly as any element in the industry. The recognition of the hospital as more than a building where physicians treat their patients was an important first step in properly evaluating and allocating responsibility for negligent acts of medical care providers. The use of corporate liability and ostensible agency has filled the gaps left by the traditional theory of respondeat superior. Further progress needs to be made to ensure that the public is fully protected and that providers of poor quality health services remain fully liable for their services.

Keith B. Hunter

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[144] See Hardy v. Brantley, 471 So. 2d 358, 371 n.6 (Miss. 1985).

[145] Note, *supra* note 39, at 125.

[146] *Id.*