HOSPITAL LIABILITY FOR THE RIGHT REASONS: A NON-DELEGABLE DUTY TO PROVIDE SUPPORT SERVICES

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I. INTRODUCTION

The goal of the tort system can be reduced to one basic principle: the judiciary imposes legal responsibility on certain actors for certain conduct in order to remedy past harms and influence prospective behavior. Over the course of its existence, our judiciary has designated particular actors deserving of legal responsibility for various reasons. Guiding this imposition, however, is the will and perception of the general public. Because legal responsibility is attributed, in large part, on the basis of public perception, the community of actors to which it applies will change in step with those interests and activities that our society deems most important.

One of the most recent—and most dramatic—changes to our tort system concerns the judiciary's imposition of legal responsibility on hospitals for the negligent conduct of independent contractor physicians. The medical community's ability to offer safe and effective healthcare services has improved significantly since the turn of the twentieth century. Aided by advanced technologies, medical professionals are now more capable of providing local communities with quality care. Through the eyes of the treated public, this development has been most clearly witnessed within the landscape of hospital operations.

So influenced by the public recognition of hospitals as vessels for medical treatment, such institutions have endeavored to distinguish themselves in the healthcare field. This undertaking has been marked by increased self-advertising and overall commercialization of

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the industry.[1] Through the success of this practice, however, hospitals have observed both positive and negative consequences of heightened public exposure. Despite benefiting institutions monetarily, the long-desired image of hospitals as complete-care institutions has compelled social reliance.[2] This, in turn, has given rise to greater legal responsibility and resulted in expanded notions of liability for negligent conduct born within hospital facilities.[3]

Heightened expectations of accountability are most evident in the judiciary's recent assignment of liability to hospitals for the tortious conduct of independent contractor physicians.[4] Notwithstanding hospitals' ostensible contractual delegation of liability, courts have increasingly held hospitals liable for the negligent actions of independent contractor physicians.[5] Though this accurately reflects societal expectations, the vehicle through which courts have apportioned fault is inconsistent with the underlying goals of the tort system.

This Comment seeks to explore the evolution of hospital liability as motivated by changes in societal expectations of the institution. Part II of this Comment analyzes the impact of public policy on hospital liability for both employee and independent contractor physicians. Part III explains and criticizes the procedural methods presently used in apportioning fault to hospitals for the negligent conduct of independent contractor physicians. Part IV of this Comment concludes that the imposition of anon-delegable duty to provide non-negligent support services on hospitals will realign current schemes of liability with the underlying goals of the tort system, while simultaneously reflecting the honest expectations of the public.

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[1] Glover v. St. Mary's Hosp., 551 S.E.2d 31, 35 (W. Va. 2001).

[2] Burless v. W. Va. Univ. Hosp., Inc., 601 S.E.2d 85, 93 (W. Va. 2004)

[3] *See id.* ("The public's confidence in the modern hospital's portrayal of itself as a full service provider of health care appears to be at the foundation of the national trend toward adopting a rule of apparent agency to find hospitals liable, under the appropriate circumstances, for the negligence of physicians providing services within its walls.").

[4] *See id.*

[5] *See* Sword v. NKC Hosps., Inc., 714 N.E.2d 142, 152 (Ind. 1999) ("[U]nder some circumstances, . . . written notice may not suffice if the patient had an inadequate opportunity to make an informed choice.").

II. EVOLUTION OF HOSPITAL LIABILITY

A. *Early Hospital Immunity*

Hospitals were traditionally immune from suit in tort under the doctrine of charitable immunity.[6] The charitable immunity doctrine exempted charitable organizations from claims of tort liability brought by the beneficiaries of the subject entity's health care offerings.[7] Application of this general immunity was motivated in large part by public perception of hospital organizations as caregivers insulated from profit-based incentives.[8] Standards of hospital operation in the nineteenth century necessitated the exemption of hospitals from tort suits brought by aggrieved patients.[9] During that time, hospitals were known for "providing medical services to the lowest classes of society, without regard to a patient's ability to pay."[10] Given the philanthropic motivation of such institutions, the application of tort liability was thought to be inappropriate and inconsistent with societal interest.[11]

In addition to policy-based considerations, the roots of charitable immunity are also traceable to trust doctrine.[12] Under this doctrine, charitable hospitals maintained insulation from suit in tort in order to prevent the unintended diversion of trust funds.[13] Specifically, it was understood that donations made for the benefit of the hospital's mission were held in public trust for the same purpose.[14] It was therefore observed that if such funds "could be used to compensate persons for negligently inflicted injuries, the trust fund would be di-

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[6] ARTHUR F. SOUTHWICK, THE LAW OF HOSPITAL AND HEALTHCARE ADMINISTRATION 539 (2d ed., 1988).

[7] *See* Howard Levin, *Hospital Vicarious Liability for Negligence by Independent Contractor Physicians: A New Rule for New Times*, 2005 U. ILL. L. REV. 1291, 1292 (2005).

[8] *See* Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381, 385 (1994).

[9] *Id.*

[10] Levin, *supra* note 7, at 1294.

[11] *See* Abraham & Weiler, *supra* note 8, at 385 ("The main justification for charitable immunity was an implied waiver by patients who were receiving services free of charge. But the implied waiver applied to paying as well as non-paying patients, and to unconscious as well as conscious admittees to the hospital.").

[12] *See* Rhoda v. Aroostook Gen. Hosp., 226 A.2d 530, 532 (Me. 1967) ("The rationale of the immunity rule in favor of charitable institutions lay in the bounden duty of a public charity as a trustee to apply its funds in furtherance of its beneficent purpose.").

[13] *See id.*

[14] *See, e.g.*, Fisher v. Ohio Valley Gen. Hosp. Ass'n, 73 S.E.2d 667 (W. Va. 1952).

verted to purposes never intended by the donor."[15] Because of these concerns, courts generally immunized charitable hospitals from suit to preserve the funds available for the hospitals' use and to further incentivize charitable donations in the healthcare field.[16]

B. Demise of Charitable Immunity

Though well intentioned, even at the outset of its application, the charitable immunity doctrine was criticized by some members of the judiciary.[17] In *Georgetown College v. Hughes*, the Court of Appeals for the District of Columbia condemned the liability exemption because of its inconsistency in application and confused premise.[18] The *Georgetown College* court criticized the immunity's basis in trust doctrine—noting that "[n]o statistical evidence has been presented to show that the mortality or crippling of charities has been greater in states which impose full or partial liability than where complete or substantially full immunity is given."[19] Thus, the court determined that the exposure of hospitals to liability in tort would not critically obstruct the purpose of such charitable organizations.[20]

Changes in the nature of hospital operations motivated further criticism of the doctrine of charitable immunity.[21] At its outset, the doctrine of charitable immunity was premised on the understanding that hospitals provided mere facilities within which individual physicians administered actual care.[22] Based on their separation from patient care, hospitals could not bear the responsibility for the wrongdoings of acting physicians.[23]

The gradual evolution of hospital offerings, however, significantly diminished the viability of such justifications. Specifically, the medical field witnessed a growing trend towards greater hospital involvement in patient care.[24] Consistent with this development, hospitals began to adopt the role of "full-service healthcare providers" and rejected the notion that their role was limited to the provision of a

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[15] *Id.* at 669.

[16] *See, e.g.*, Downs v. Harper Hosp., 60 N.W. 42 (Mich. 1894).

[17] *See, e.g.*, Georgetown Coll. v. Hughes, 130 F.2d 810, 812 (D.C. Cir. 1942).

[18] *Id.*

[19] *Id.* at 823.

[20] *Id.*

[21] *See, e.g.*, Bing v. Thunig, 143 N.E.2d 3, 8 (N.Y. 1957).

[22] Martin C. Williams & Hamilton E. Russell, III, *Hospital Liability for Torts of Independent Contractor Physicians*, 47 S.C. L. REV. 431, 435 (1996).

[23] *Id.*

[24] *Id.* at 436.

physical structure alone.[25] The Court of Appeals of New York in *Bing v. Thunig* accurately summarized this perceived evolution.[26] Specifically, the court stated that

> [t]he 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. Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment.[27]

Judicial recognition of this reality gradually compelled the realization that hospital accountability in tort was no longer inconsistent with society's interests.[28]

Observation of this trend and newfound public image was motivated further by hospital advertisements of offered services.[29] Arguably, the increased presence of hospitals in patient care and the resulting commercialization of such practices significantly affected public perception of hospitals as healthcare providers.[30] Commentators have identified the consequences of this commercialization as including both a "loss of public sympathy" and a perceived expansion of legal accountability.[31]

The court in *Bing* determined that "the person who avails himself of 'hospital facilities' expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility."[32] Thus, the *Bing* court rejected the application of charitable immunity and held that hospital liability was to be construed under the same legal principles as those guiding general employer liability.[33] Following the signaled demise of charitable immunity in *Georgetown College* and *Bing*, all states gradually rejected the doctrine by the latter half of the twentieth century.[34]

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[25] *Id.*

[26] *Bing*, 143 N.E.2d at 8–9.

[27] *Id.*

[28] *Id.*

[29] *See, e.g.*, Simmons v. Tuomey Reg'l Med. Ctr., 498 S.E.2d 408, 411 (S.C. Ct. App. 1998); Kashishian v. Port, 481 N.W. 2d 277, 278 (Wis. 1992).

[30] Williams & Russell, *supra* note 22, at 436.

[31] *Id.*

[32] *Bing*, 143 N.E.2d at 8.

[33] *Id.*

[34] Abraham & Weiler, *supra* note 8, at 385.

C. *Contemporary Hospital Liability*

The obvious consequence of charitable immunity's erosion was increased hospital liability for the negligent activity of hospital staff. Consistent with most organizations, present analysis of hospital liability for actions in tort is necessarily dependent upon the employment classification of subject staff members.[35] Hospitals have traditionally staffed their facilities with both direct employees and independent contractors.[36] In most cases, hospitals enter into employer-employee relationships with nurses, technicians, and resident physicians.[37] Beyond that, however, the vast majority of physicians regarded as "hospital staff" enjoy an independent contractor relationship with the overseeing institution rather than an employer-employee relationship.[38] Hospitals will generally be liable for the tortious conduct of their employees under the doctrine of respondeat superior.[39] Respondeat superior is a form of strict liability imputed to a principal employer based on its legal relationship with the subject agent.[40]

As a condition of employer liability under respondeat superior, the court must find that an employee of the employer committed the underlying tort, and that the tortious act occurred while the employee was acting within the scope of his or her employment.[41] Within the specific context of hospital operations, the plaintiff must first prove his or her claim of medical malpractice against the acting physician.[42] Next, the plaintiff must set forth facts sufficient to prove the existence of an agency relationship between the acting physician and the subject hospital.[43] Finally, the plaintiff must demonstrate that the actions of the treating physician that gave rise to medical malpractice were committed within the scope of that employer-employee relationship.[44] Where a plaintiff succeeds in satisfying these elements of a respondeat superior claim, the hospital will be held liable for the actions of treating employee-physicians without inquiry into any potential fault of the institution.[45]

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[35] Levin, *supra* note 7, at 1295.
[36] Abraham & Weiler, *supra* note 8, at 387.
[37] *Id.*
[38] *Id.*
[39] RESTATEMENT (SECOND) OF AGENCY § 220 (1957).
[40] *Id.*
[41] RESTATEMENT (SECOND) OF AGENCY § 219 (1957).
[42] *Id.*
[43] *Id.*
[44] *Id.*
[45] *Id.*

The doctrine of respondeat superior, however, would not impose liability on hospitals for torts that independent contractor physicians who practice within the same facility commit.[46] Section 2 of the Restatement (Second) of Agency defines an independent contractor as one "who contracts with another to do something for him but who is not controlled by the other nor subject to the other's right to control with respect to his physical conduct in the performance of the undertaking."[47] The primary difference between an employer-employee relationship and an independent contractor relationship is the extent to which an employer-principal may exercise control over the actions of the subject agent.[48] In theory, the independent contractor relationship is predicated on autonomy in execution of the contracted service and is largely removed from the principal's controlling influence.[49]

Courts hold that principals may not be held liable for the negligent conduct of independent contractor agents because of the absence of control in this relationship.[50] Within the specific context of tort liability, courts have generally indicated that "it would be unfair to hold a master liable for the conduct of another when the master has no control over that conduct."[51] Thus, principal non-liability within this relationship is a consequence of the tort system's underlying purpose.[52] The tort system assumes "that imposing liability on the immediate tortfeasor will deter future actors from engaging in malpractice."[53] If one recognizes that an objective of imputing liability under the doctrine of respondeat superior concerns the influence of prospective behavior, it logically follows that only those principals capable of exercising control over the tortfeasor should be subject to liability. Hence, where hospitals lack control over their agents in providing healthcare services, such institutions, in theory, should not be liable for tortious conduct arising therefrom.

A hospital traditionally contracts for the services of independent contractor physicians for the very purpose of insulating the institution from liability in tort: "[P]rincipals such as hospitals do not want to be . . . liable for the torts of true independent contractors" as the

[46] *Id.* § 219 cmt. a.
[47] RESTATEMENT (SECOND) OF AGENCY § 2 (1957).
[48] *Id.* § 220.
[49] *See id.*
[50] *See, e.g.*, Sword v. NKC Hosps., Inc., 714 N.E.2d 142, 148 (Ind. 1999).
[51] *Id.* (citing RESTATEMENT (SECOND) OF TORTS § 409 cmt. b (1965)).
[52] Abraham & Weiler, *supra* note 8, at 407.
[53] *Id.*

conduct of such agents is necessarily "beyond the control or the right of control of the principal."[54] Given the potential for independent-contractor-based defenses to negligence suits, most hospitals expressly describe their relationships with physicians as those of principal and independent contractor in their contracts for services.[55] Based on this common practice, hospitals should generally escape liability for the misconduct of staff physicians. Despite their attempted insulation from liability, however, hospitals have been exposed to liability for the actions of independent contractor physicians with increasing frequency.[56] As with the policy considerations motivating the judicial erosion of charitable immunity, the public perception of hospitals as complete-care institutions has influenced the relaxation of agency principles concerning hospital liability for the tortious conduct of independent contractor physicians.[57]

Increased adoption of exceptions to the independent contractor liability rule of principal non-liability reflects the public recognition that hospitals are "corporate entities capable of acting only through human beings."[58] Recently, marketing tactics undertaken by the same institutions have heavily influenced public perception of hospitals' roles in healthcare provision.[59] In reviewing the potential liability of a hospital for the tortious conduct of an independent contractor physician, courts have observed that

> [m]odern hospitals have spent billions on marketing to nurture the image that they are full-care modern facilities. Billboards, television commercials and newspaper advertisements tell the public to look to its local hospital for every manner of care, from the critical surgery and life-support required by a major accident to minor tissue repairs resulting from a friendly game of softball.[60]

Representations of "full-service offerings" create the impression that hospitals provide medical services directly to the public.[61] While such

[54] Williams & Russell, *supra* note 22, at 439.

[55] *Id.*

[56] *See* Abraham & Weiler, *supra* note 8, at 388.

[57] Burless v. W. Va. Univ. Hosp., Inc., 601 S.E.2d 85, 93 (W. Va. 2004) ("The public's confidence in the modern hospital's portrayal of itself as a full service provider of health care appears to be at the foundation of the national trend toward adopting a rule of apparent agency to find hospitals liable, under the appropriate circumstances, for the negligence of physicians providing services within its walls.").

[58] *Id.* at 94 n.8 (quoting Hardy v. Brantley, 471 So. 2d 358, 371 (Miss. 1985)) (internal quotation marks omitted).

[59] *Id.*

[60] *Id.* at 93 (quoting Glover v. St. Mary's Hosp., 551 S.E.2d 31, 35 (W. Va. 2001)) (internal quotation marks omitted).

[61] *Id.*

measures have likely resulted in increased business for the hospital-advertiser, this "new role" of hospital service offerings has also resulted in "heightened exposure to lawsuits."[62] Courts have observed that contemporary society generally relies on hospitals as institutions during patient admission.[63] Specifically, courts have recognized that "the changing role of the hospital in society creates a likelihood that patients will look to the institution rather than the individual physician for care."[64] Judicial treatment of hospital liability for the actions of its contract physicians demonstrates that such social reliance is deserving of legal protection.

Owing to such considerations, judicial analysis of hospital liability has yielded two primary exceptions to the general rule of principal non-liability. Courts have evaluated hospital liability through the lens of either agency by estoppel or apparent agency.[65] The following discussion seeks to analyze the efficacy of applying such tests to the relationship between hospitals and independent contractor physicians. Analysis of these rules reveals that, though seemingly reflective of societal expectations, application of agency-based exceptions to the general rule of principal non-liability presents a number of procedural and substantive challenges for the judiciary.

III. HOSPITAL LIABILITY FOR INDEPENDENT CONTRACTOR PHYSICIANS

A. *Agency by Estoppel*

Following the complete erosion of hospital charitable immunity, courts in various jurisdictions began imposing liability on hospitals for the acts of independent contractor physicians operating within the hospital facility under theories of agency by estoppel.[66] Application of agency by estoppel is appropriate in circumstances in which, as in the case of the relationship between a hospital and an independent contractor physician, no agency exists between the tortfea-

[62] *Id.*

[63] *Id.*

[64] Burless v. W. Va. Univ. Hosp., Inc., 601 S.E.2d 85, 94 n.8 (W. Va. 2004) (quoting Parker v. Freilich, 803 A.2d 738, 747 (Pa. Super. Ct. 2002)) (internal quotation marks omitted).

[65] *See* Jackson v. Power, 743 P.2d 1376, 1380 (Ak. 1987) ("Cases from other jurisdictions show a strong trend toward liability against hospitals that permit or encourage patients to believe that independent contractor/physicians are, in fact, authorized agents of the hospitals. These courts have held hospitals vicariously liable under a doctrine labeled either 'ostensible' or 'apparent' agency or 'agency by estoppel.'")

[66] *See, e.g.*, Hannola v. City of Lakewood, 426 N.E.2d 1187, 1190 (Ohio Ct. App. 1980).

sor and the apparent principal.[67] Though designated "apparent agency," Section 267 of the Restatement (Second) of Agency recognizes an estoppel-based exception to the general rule of principal non-liability.[68] The doctrine of agency by estoppel applies to those situations in which a person or entity "represents that another is his servant or other agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent."[69] Courts will impose liability under these circumstances because of the "appearance" that the apparent agent was acting on behalf of the person or entity at issue.[70]

In order to satisfy the doctrine's requirements, a plaintiff must demonstrate that he or she submitted to the care of an apparent agent in response to an invitation extended by the apparent principal.[71] Agency by estoppel "rests upon the theory that one has been led to rely upon the appearance of agency to his detriment."[72] Fundamentally, this exception to the rule of principal non-liability depends on the existence of (1) representations made by an apparent principal indicating the existence of an agency relationship between the apparent principal and agent and (2) the plaintiff's reliance thereon.[73] Where an individual patient is harmed as a result of his or her reliance on the hospital's representation, agency by estoppel creates a channel for recovery despite the hospital's contractual insulation from liability.

Upon review of this test's requirements, it appears that the challenging plaintiffs bear a significant burden in establishing hospital liability.[74] Yet contemporary application of this agency-based exception has yielded waves of relaxation designed to impose hospital liability in particular instances. That the judiciary has refrained from applying this test with deserving rigor reflects the public recognition that, under certain circumstances, hospitals should be liable for the actions of their independent contractor physicians.[75] The following analysis of

[67] Williams & Russell, *supra* note 22, at 447.
[68] RESTATEMENT (SECOND) OF AGENCY § 267 (1958).
[69] *Id.*
[70] *Id.*
[71] *Id.* § 267 cmt. a.
[72] Johnson v. Wagner Provision Co., 49 N.E.2d 925, 928 (Ohio 1943).
[73] Williams & Russell, *supra* note 22, at 447.
[74] *Id.* at 448 (citing Brown v. Coastal Emergency Servs., 354 S.E.2d 632, 637 (Ga. Ct. App. 1987)).
[75] *Id.*

the judicial departure from the test's explicit requirements illustrates this purpose.

1. Agency by Estoppel: Representation Requirement

Under the articulated terms of the test, a plaintiff must first prove that the hospital represented that a plaintiff's treating physician was a servant or another agent of the hospital.[76] Proof of this representation or "holding out" by the hospital must consist of acts committed by the subject hospital that demonstrate its apparent relationship with the treating physicians.[77] Comments to section 267 of the Restatement (Second) of Agency specifically provide that "[t]he mere fact that acts are done by one whom the injured party believes to be the defendant's servant is not sufficient to cause the apparent master to be liable."[78] This element of agency by estoppel seeks to determine whether hospitals took actions sufficient to influence the reasonable conclusion that a treating physician was an agent of the hospital.[79]

At first glance, it appears that the requirement of a representation or "holding out" on the part of the hospital stands as a significant obstacle to plaintiff's recovery.[80] In order to satisfy the general requirements of agency representation, courts should require a plaintiff to show that the hospital engaged in an "intentional misleading, or an unreasonable or bad faith failure to speak after notice . . . causing a third party justifiably to rely upon the apparent agent."[81]

Despite this seemingly weighty standard, courts have more frequently loosened the plaintiff's burden of proving active representations.[82] Rather than requiring plaintiffs to set forth actual proof of hospital representations, courts have actually *presumed* the hospital to have "held itself out" as maintaining an agency relationship with treating physicians.[83] Justification for this broad-based easing in application wholly derives from "[t]he public's confidence in the modern hospital's portrayal of itself as a full service provider of health care."[84] As a consequence of this recognized social reliance, future

[76] Albain v. Flower Hosp., 553 N.E.2d 1038, 1049 (Ohio 1990).
[77] RESTATEMENT (SECOND) OF AGENCY § 267 cmt. a (1958).
[78] *Id.*
[79] Espalin v. Children's Med. Ctr., 27 S.W.3d 675, 684 (Tex. Ct. App. 2000).
[80] Williams & Russell, *supra* note 22, at 448.
[81] *Id.* at 449 (internal quotation marks omitted).
[82] *Id.* at 448.
[83] Mejia v. Cmty. Hosp., 122 Cal. Rptr. 2d 233, 237 (Cal. Ct. App. 2002).
[84] Burless v. W. Va. Univ. Hosp., Inc., 601 S.E.2d 85, 93 (W. Va. 2004).

review of the "representation" requirement will likely be minimal. In future litigation, hospitals will generally be deemed to have represented the existence of an agency relationship with its independent contract physicians unless it is proven otherwise.

Relaxation of the representation requirement reflects the beginnings of a result-oriented approach towards hospital liability. Presumptive findings of hospital representation have undoubtedly eased the burden of persuasion that aggrieved plaintiffs carry, and, importantly, this practice suggests judicial approval of hospital liability in certain circumstances. Indeed, this manner of treatment is also evident in the judiciary's analysis of the test's remaining requirements.

2. Agency by Estoppel: Reliance Requirement

True application of agency by estoppel requires plaintiffs to demonstrate both the existence of a hospital representation and their reliance thereon.[85] Early application of the reliance requirement within the context of agency by estoppel focused primarily upon detrimental reliance.[86] Though courts initially adhered to this principle, a majority of jurisdictions applying the agency-by-estoppel test to determine hospital liability have now replaced the requirement of detrimental reliance with mere "justifiable reliance."[87] This transition indicates a judicial trend toward substantiating claims by aggrieved patients against apparent principal hospitals. Importantly, courts have permitted plaintiffs to satisfy the reliance requirement upon a showing of reliance on the general *reputation* of a specific hospital rather than demanding proof of reliance upon specific acts of the institution.[88]

Even accepting this relaxed standard, however, frequently occurring factual scenarios which give rise to medical malpractice have forced courts to strain the bounds of this analysis. For example, proof of reliance may be particularly difficult within the context of emergency room admission. In a typical scenario, individuals requir-

[85] *Id.* at 95.

[86] *See* N. Trust Co. v. St. Francis Hosp., 522 N.E.2d 699, 704 (Ill. App. Ct. 1st Dist. 1988) ("A third person cannot invoke the doctrine of apparent agency, thereby establishing rights against the principal, without detrimental reliance.").

[87] *See* Sanchez v. Medicorp Health Sys., 618 S.E.2d 331, 334 (Va. 2005) ("Under the stricter standard of § 267 of the Restatement (Second) of Agency, which embraces the theory of agency by estoppel, a showing of justifiable reliance by the injured person upon the representations of the principal is required; whereas, reliance is not a factor in § 429 of the Restatement (Second) of Torts.").

[88] Chi. Title & Trust Co. v. Sisters of St. Mary, 637 N.E.2d 543, 546 (Ill. App. Ct. 1994).

ing immediate medical attention will likely call an ambulance, family member, or close friend for transportation to the hospital. This situation presents two distinct questions for proof of reliance under any standard. First, can it truly be said that a patient maintains a meaningful choice when determining which hospital he or she should visit in an emergency scenario? Second, if the patient is relying on others for care in transit to the hospital facility, can reliance on possible representations by a hospital be accurately attributed to the individual patient?

Given the common occurrence of such scenarios, courts have often gone to great lengths to manipulate the reliance requirement of estoppel in order to accommodate plaintiffs' claims. The most illustrative example of judicial manipulation in answering the first question concerns instances of claimed negligence where the plaintiff was not admitted to the hospital's emergency room in a conscious state. In *Monti v. Silver Cross Hospital*, the court encountered a factual scenario in which the plaintiff was admitted to the hospital's emergency room while unconscious.[89] The plaintiff complained that the hospital's failure "to have personnel available who were competent to diagnose and treat closed head injuries" caused her a permanent injury.[90]

The court determined that the individuals acting on behalf of the plaintiff "sought care from the hospital, not from a personal physician, and thus, a jury could find that they relied upon the fact that complete emergency room care, including diagnostic testing and support services, would be provided through the hospital staff."[91] The court in *Monti* added further, "The same is true for all seriously ill or badly injured patients, whether conscious or not, who come to a hospital emergency room for emergency medical care."[92] The court determined that the facts of the dispute demonstrated plaintiff's "implied reliance" on the hospital.[93]

Addressing the second question posed, courts have also permitted proof of reliance upon a showing of plaintiff's reliance on others.[94] In *Kane v. Doctors Hospital*, the plaintiff sued the hospital at issue for the negligent conduct of an independent contractor physician.[95]

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[89] 637 N.E.2d 427, 428 (Ill. App. Ct. 1994).
[90] *Id.*
[91] *Id.* at 430.
[92] *Id.*
[93] *Id.*
[94] Kane v. Doctors Hosp., 706 N.E.2d 71, 76 (Ill. App. Ct. 1999).
[95] *Id.* at 72.

It was undisputed that the plaintiff did not choose to be admitted to the defendant hospital.[96] Therefore, the hospital argued that because the plaintiff did not choose to avail himself of the hospital's services, he could not have possibly relied on any representations made by the same institution.[97] The court in *Kane* rejected the defendant's contention and held that, in general, relying on others to choose a particular medical facility for treatment was sufficient to establish reliance.[98]

Judicial analysis in *Monti* and *Kane* reflects current trends in finding ad hoc exceptions to the general requirement of reliance on hospital representations.[99] Furthermore, these decisions illustrate the general inapplicability of estoppel-based measures to determine hospital liability for negligent independent contractor physicians. The judiciary has manipulated this test's requirements to permit recovery against hospitals in certain circumstances despite the hospitals' contractual insulation from liability. This manipulation has been driven by the public's belief that hospitals directly administer care. Such practices reflect the understanding that social reliance on hospitals in their provision of medical treatment is sufficient to warrant judicial protection. Notwithstanding the widespread relaxation of agency-by-estoppel requirements, however, courts have increasingly resorted to a less stringent—but similarly artificial—theory of hospital liability to expand the breadth of this protection.

B. Apparent Agency

Courts have more recently transitioned their analysis to the doctrine of apparent agency in response to the obvious shortcomings of agency by estoppel.[100] Similar to the doctrine of agency by estoppel,

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[96] *Id.* at 72–73. Plaintiff was admitted to the defendant hospital at the direction of his primary care physician. *Id.*

[97] *Id.* at 74 ("[T]he Hospital argues that the trial court correctly granted its motion for summary judgment because the record established that (1) Kane knew Dr. Song was not the Hospital's employee; (2) neither the Hospital nor Dr. Song made any representations to Kane that Dr. Song was an agent of the Hospital; (3) Kane did not act reasonably in ascertaining Dr. Song's employment status; and (4) Kane did not rely on any representations by the Hospital when he sought radiological treatment.").

[98] *Id.* at 78.

[99] *See id.*; Monti v. Silver Cross Hosp., 637 N.E.2d 427, 428 (Ill. App. Ct. 1994).

[100] It should be noted that, while apparent agency and agency by estoppel are distinct tests, courts frequently refer to both processes within the same analysis. *See, e.g.*, Houghland v. Grant, 891 P.2d 563, 568 (N.M. Ct. App. 1995) ("Although each theory is based on a slightly different rationale, the two theories have been used interchangeably, resulting in misapplication of the law in some cases.").

apparent agency is an exception to the general rule that a principal is immune from liability for the negligence of an independent contractor in the performance of contracted services.[101] Apparent agency imposes liability on an apparent principal when the actions of that entity mislead the public that a legal relationship exists between the apparent principal and agent.[102]

Section 429 of the Restatement (Second) of Torts dictates the parameters of this exception to the rule of principal non-liability.[103] Section 429 provides that a person or entity who contracts with an agent "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."[104]

Though similar in many respects, the principle difference between agency by estoppel under Section 267 of the Restatement (Second) of Agency and apparent agency under Section 429 of the Restatement (Second) of Torts concerns the requirement of reliance.[105] The court in *Estate of Cordero v. Christ Hospital* concluded that, in contrast to the express reliance requirement in Section 267, "[r]eliance is an element of apparent authority under section[] . . . 429 only to the extent that it is subsumed in the requirement that the person accepting an agent's services do so in the 'reasonable belief' that the service is being rendered in behalf of the principal."[106] Thus, under Section 429, a plaintiff must only demonstrate his or her reasonable belief rather than justifiable reliance to discharge the burden of proof.[107] Additionally, Section 429 disposes of the specific representation re-

[101] Basil v. Wolf, 935 A.2d 1154, 1172 (N.J. 2007).

[102] *Id.*

[103] *See* Stewart v. Midani, 525 F. Supp. 843, 851 (N.D. Ga. 1981); Jackson v. Power, 743 P.2d 1376, 1380 (Alaska 1987); Irving v. Doctors Hosp. of Lake Worth, Inc., 415 So. 2d 55, 60 (Fla. Dist. Ct. App. 1982); Richmond Cnty. Hosp. Auth. v. Brown, 361 S.E.2d 164, 166 (Ga. 1987); Gilbert v. Sycamore Mun. Hosp., 622 N.E.2d 788, 795 (Ill. 1993); Arthur v. St. Peters Hosp., 405 A.2d 443, 446–47 (N.J. Super. Ct. Law Div. 1979); Mduba v. Benedictine Hosp., 52 A.D.2d 450 (N.Y. App. Div. 1976); Smith v. St. Francis Hosp., 676 P.2d 279, 282 (Okla. Ct. App. 1983); Capan v. Divine Providence Hosp., 430 A.2d 647, 648–50 (Pa. Super. Ct. 1980); Simmons v. Tuomey Reg'l Med. Ctr., 533 S.E.2d 312, 317 (S.C. 2000) (citing Walker v. Winchester Mem'l Hosp., 585 F. Supp. 1328, 1330 (W.D. Va. 1984)) ("Numerous courts have relied on section 429 in decisions allowing a plaintiff to attempt to hold a hospital vicariously liable for a purportedly independent physician's negligent acts."); Sharsmith v. Hill, 764 P.2d 667, 672 (Wyo. 1988).

[104] RESTATMENT (SECOND) OF TORTS § 429 (1977).

[105] 958 A.2d 101, 106 n.3 (N.J. Super. Ct. App. Div. 2008).

[106] *Id.*

[107] Jones v. HealthSouth Treasure Valley Hosp., 206 P.3d 473, 478 (Idaho 2009).

quirement necessary for a valid claim of agency by estoppel under Section 267.[108]

Within the context of hospital liability, courts have indicated that "where it can be shown that a hospital, by its actions, has held out a particular physician as its agent and/or employee and that a patient has accepted treatment from that physician in the reasonable belief that it is being rendered in behalf of the hospital," the hospital will be liable for the negligent conduct of that physician.[109] Upon satisfaction of this test, courts hold hospitals liable for the negligent misconduct of independent contractor physicians despite the hospitals' contractual insulation from liability.[110]

Widespread adoption of apparent agency as a means of imputing liability was necessitated by the seemingly rigid obstacles that agency by estoppel imposed.[111] Yet, the underlying motivation for this test derives from the same public policy considerations that led to the discussed collapse of charitable immunity.[112] The Court of Appeals of Oregon accurately summarized this recognition in *Jennison v. Providence St. Vincent Medical Center*.[113] There, the court concluded that the general public "is unaware of and unconcerned with the technical complexities and nuances surrounding the contractual and employment arrangements between the hospital and the various medical personnel operating therein."[114] Accordingly, contractual obstacles should not limit the tort recovery of those "looking to the hospital" for medical care.[115]

The court's declaration in *Jennison* is consistent with that of other jurisdictions.[116] In *Mduba v. Benedictine Hospital*, the New York Court of Appeals criticized hospitals for benefitting from the appear-

[108] Williams & Russell, *supra* note 22, at 460.

[109] Arthur v. St. Peters Hosp., 405 A.2d 443, 446 (N.J. Super. Ct. Law Div. 1979).

[110] *Id.*

[111] *See* Houghland v. Grant, 891 P.2d 563, 568 (N.M. Ct. App. 1995) (finding that, upon comparison to apparent agency, "[a]gency by estoppel appears to have a stricter standard because it requires actual reliance upon the representations of the principal")

[112] *See* Burless v. W. Va. Univ. Hosp., Inc., 601 S.E.2d 85, 93 (W. Va. 2004) ("The public's confidence in the modern hospital's portrayal of itself as a full service provider of health care appears to be at the foundation of the national trend toward adopting a rule of apparent agency to find hospitals liable, under the appropriate circumstances, for the negligence of physicians providing services within its walls.").

[113] 25 P.3d 358, 372 (Or. Ct. App. 2001).

[114] *Id.* at 367.

[115] *Id.*

[116] *See, e.g.*, Mduba v. Benedictine Hosp., 384 N.Y.S.2d 527, 529 (N.Y. App. Div. 1976).

ance of their relationship with contract physicians while escaping liability by relying on "secret limitations . . . in a private contract between the hospital and the doctor."[117] On the basis of such public policy considerations, hospital liability for independent contractor physicians has been pursued expansively under theories of apparent agency.[118]

Demonstration of hospital liability under apparent agency theories has proven to be comparatively easier than proof of the same under agency by estoppel.[119] Rather than bearing the burden of proving an active representation by the subject hospital, plaintiffs under Section 429 must merely demonstrate that the hospital's actions created the reasonable belief that doctors who operate within the facility acted on behalf of the hospital.[120]

As the Superior Court of New Jersey, Appellate Division indicated in *Estate of Cordero*, plaintiffs need not establish an active misrepresentation to satisfy the hospital-action requirement under Section 429.[121] Significantly, the court concluded that "[a] principal can manifest assent to a person's action on its behalf by employing an independent contractor and sending that contractor to render performance requested by another without disclosing that relationship."[122] Thus, the court suggested that plaintiffs could satisfy the hospital-action requirement of apparent agency by demonstrating the nature and position of certain treating physicians who operate within the hospital facility.[123]

The *Estate of Cordero* court commented on the trend in other jurisdictions of courts finding reasonable belief where plaintiffs received "specialized care from medical professionals with whom they

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[117] *Id.*; *see also* Jessamy v. Parkmed Assocs., 761 N.Y.S.2d 639, 640 (N.Y. App. Div. 2003).

[118] *See* Sword v. NKC Hosp., 714 N.E.2d 142, 150 (Ind. 1999); Elizabeth Isbey, Note, Diggs v. Novant Health, Inc. *and the Emergence of Hospital Liability for Negligent Independent-Contractor Physicians in North Carolina*, 43 WAKE FOREST L. REV. 1127, 1137 (2008).

[119] *See* Sanchez v. Medicorp Health Sys., 618 S.E.2d 331, 334 (Va. 2005) ("Under the stricter standard of § 267 of the Restatement (Second) of Agency, which embraces the theory of agency by estoppel, a showing of justifiable reliance by the injured person upon the representations of the principal is required; whereas, reliance is not a factor in § 429 of the Restatement (Second) of Torts.").

[120] RESTATEMENT (SECOND) OF TORTS § 429 (1977).

[121] Estate of Cordero v. Christ Hosp., 958 A.2d 101, 109 (N.J. Super. Ct. App. Div. 2008).

[122] *Id.* at 106.

[123] *Id.*

[did] not have a prior or ongoing relationship."[124] The court further added that in situations in which hospitals provide doctors to patients without taking further action to "dispel the appearance" of an agency relationship, "courts generally treat the hospital's inaction as additional conduct manifesting the hospital's assent to having the specialist care for the patient in its behalf."[125] In *Estate of Cordero*, the court correctly identified the common trend within various jurisdictions of focusing critically on the existence of a doctor's prior relationship with the patient to determine hospital liability.[126] The judiciary's emphasis on the existence of a prior relationship suggests that, where no physician-patient relationship exists before hospital admission, the hospital reasonably appears to be offering the medical service directly.[127] The *Estate of Cordero* court indicated that this expectation is most relevant within the context of hospitals' providing specialized support services.[128] These specialized support services—anesthesia, pathology, radiology, and emergency care—are typically provided to patients at the direction of the hospital as an institution and as a direct consequence of the patient's immediate medical needs.[129] Judicial scrutiny of the hospital's role in providing these services strongly suggests the importance of considering specialized support services in future analysis.[130]

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[124] *Id.* at 107.

[125] *Id.*

[126] *Id.*

[127] Citron v. N. Dutchess Hosp., 198 A.D.2d 618, 620 (N.Y. App. Div. 1993) (finding that when a plaintiff entered the hospital through the emergency room, the hospital's employees called a number of physicians to treat the plaintiff, and the plaintiff had no prior physician-patient relationship with any of the treating physicians, the plaintiff "could properly assume that the treating doctors and staff of the hospital were acting on behalf of the hospital").

[128] *Estate of Cordero*, 958 A.2d at 109.

[129] *See e.g.*, Pamperin v. Trinity Mem'l Hosp., 423 N.W.2d 848, 857 (Wis. 1988) ("An individual who seeks care from a hospital itself, as opposed to care from his or her personal physician, accepts care from the hospital in reliance upon the fact that complete emergency room care—from blood testing to radiological readings to the endless medical support services—will be provided by the hospital through its staff.").

[130] *See, e.g.*, Seneris v. Haas, 291 P.2d 915, 927 (Cal. 1955) (holding that trial court erred in taking issue of hospital's ostensible agency for anesthesiologist from jury); Roessler v. Novak, 858 So. 2d 1158, 1162–63 (Fla. Dist. Ct. App. 2003) (finding genuine issue of material fact as to the hospital's liability for radiologist's negligence when radiology department was located within hospital grounds under doctrine of apparent agency); Sword v. NKC Hospital, 714 N.E.2d 142, 152–53 (Ind. 1999) (finding issue of fact as to hospital's liability for anesthesiologist); *Estate of Cordero*, 958 A.2d at 109 (finding that patients can reasonably assume that a hospital furnishes the care rendered in its facility and holding hospital liable under doctrine of apparent au-

Given the continued trend towards expanding hospital liability for the negligence of independent contractor physicians, one can anticipate that, in almost all circumstances of future medical harm arising out of specialized support services, aggrieved patients will name the hospital as an additional defendant. This conclusion is drawn on the basis of consistent prior success:

> [V]icarious liability suits have been successfully launched against hospitals for the alleged negligence of anesthesiologists, radiologists, pathologists, and even occasionally against a surgeon whose services the patient used *because* he was on hospital staff. . . . Under the doctrine of apparent authority, the fact that the medical specialists performing these functions happen to have an independent-contractor rather than employment relationship with the hospital will not insulate the hospital from vicarious liability for their malpractice.[131]

Indeed, the only genuine obstacle to patient recovery against hospitals for negligence arising out of specialized support services is the requirement that the patient's belief be reasonable.[132] Consistently with the general trend in hospital liability, however, courts have shown no hesitation in massaging the reasonableness requirement to accommodate factual circumstances giving rise to claims of medical malpractice.[133]

Courts have generally presumed that hospitals hold themselves out as the providers of care unless they afford "notice to the patient that [they are] not the provider[s] of care and that the care is provided by a physician who is an independent contractor and not subject to the control and supervision of the hospital."[134] In order to rebut the presumption of reasonableness, courts have required proof establishing the hospital's provision of "meaningful written notice" delivered to the patient upon hospital admission that demonstrates the "true" nature of its relationship with staff physicians.[135] Again, it appears that the availability of a notice rebuttal would generally pre-

thority for anesthesiologist's negligence); Jennisort v. Providence St. Vincent Med. Ctr., 25 P.3d 358, 367 (Or. Ct. App. 2001) (finding that radiological services are "integral to the overall medical services provided by the hospital").

[131] Abraham & Weiler, *supra* note 8, at 388.

[132] Isbey, *supra* note 118, at 1146–47.

[133] *Id.*

[134] Sword v. NKC Hospital, 714 N.E.2d 142, 152 (Ind. 1999); *see also* Henry v. Flagstaff Med. Ctr., 132 P.3d 304, 306 (Ariz. Ct. App. 2006); Wishard Mem. Hosp. v. Kerr, 846 N.E.2d 1083, 1091 (Ind. Ct. App. 2006); *Estate of Cordero*, 958 A.2d at 106 n.3; Butler v. Domin, 15 P.3d 1189, 1196 (Mont. 2000).

[135] *Henry*, 132 P.3d at 306; *Sword*, 714 N.E.2d at 152; *Wishard Mem. Hosp.*, 846 N.E.2d at 1091; *Butler*, 15 P.3d at 1196.

vent the imputation of liability to an apparent-principal hospital. Due to the unique nature of most hospital admissions and the public demands for hospitals' accountability, however, courts have largely disregarded hospitals' attempts at liability disclaimer.[136]

Judicial analysis of the "meaningfulness" requirement has generally resulted in three specific problems. First, courts are often inconsistent in their determinations of what constitutes "meaningful notice."[137] Second, where individual patients are admitted to the hospi-hospital facility through emergency room entry, courts are not likely to deem these individuals capable of reflecting on the notice provided.[138] In these circumstances, courts will typically disregard hospitals' attempts at notice, even where the form provided a sufficient disclaimer.[139] Finally, courts have increasingly disregarded liability disclaimers on public policy grounds.[140] Some courts have found that hospitals should not be permitted to "give notice that operates as a waiver of liability under any circumstances because of patients' inability to make a reasonable choice as to their physician, whether an employee or independent contractor, once they arrive at the hospital."[141]

Theoretically, any demonstration of a patient's *actual* knowledge of the subject hospital's legitimate non-servant relationship with a physician should be sufficient to dispel claims of apparent agency.[142] This is so because apparent agency is predicated on a patient's reasonable belief that the physician is acting on behalf of the hospital.[143] Yet, courts have continually disregarded hospitals' attempts to educate patients through the use of admission forms that indicate that

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[136] *See, e.g.*, Beeck v. Tucson Gen. Hosp., 500 P.2d 1153 (Ariz. Ct. App. 1972); *Henry*, 132 P.3d 304; Burless v. W. Va. Univ. Hosp., Inc., 601 S.E.2d 85, 94 (W. Va. 2004);.

[137] Isbey, *supra* note 118, at 1146–47.

[138] Mejia v. Cmty. Hosp. of San Bernardino, 122 Cal. Rptr. 2d 233, 237 (Cal. Ct. App. 2002) ("Many courts have even concluded that prior notice may not be sufficient to avoid liability in an emergency room context, where an injured patient in need of immediate medical care cannot be expected to understand or act upon that information.").

[139] *See id.*

[140] Sampson v. Baptist Mem. Hosp. Sys., 940 S.W.2d 128, 136 (Tex. App. 1996).

[141] Isbey, *supra* note 118, at 1146–47.

[142] Jennison v. Providence St. Vincent Med. Ctr., 25 P.3d 358, 368 (Or. Ct. App. 2001). In order to satisfy the requirements for apparent agency, plaintiffs must demonstrate that "a person in similar circumstances reasonably would have believed that the physician who treated him or her was a hospital employee." *Id.* A patient's actual knowledge that a physician was not a hospital employee would render that assumption unreasonable. *Id.*

[143] RESTATEMENT (SECOND) OF TORTS § 429 (1977).

treating physicians are not employees of the institution.[144] While such action should be adequate to preclude liability on the basis of apparent agency, courts have often found hospital notice to be artificial and therefore insufficient to immunize the institution from the actions of its physicians.[145] Modern judicial treatment of this "notice" issue is reflective of the judiciary's reaction to societal expectations compelling hospital accountability.

C. *Judicial Error in Analysis*

The above analysis reveals a common motivator driving judicial apportionment of hospital liability generally, and, specifically, for the negligent misconduct of independent contractor physicians operating within the hospital facility. Initial erosion of charitable immunity was first compelled by the birth in public perception that "[p]resent-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment."[146] Upon the collapse of total immunity, courts were placed in the difficult position of apportioning liability in a unique hospital environment. Given the pervasive nature of these relationships between hospitals and independent contractor physicians, courts applied commonly employed exceptions to the independent contractor rule of principal immunity.[147] While the inclination of courts to apply common agency excep-

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[144] *See, e.g.*, Beeck v. Tucson Gen. Hosp., 500 P.2d 1153, 1159 (Ariz. Ct. App. 1972); Burless v. W. Va. Univ. Hosp., Inc., 601 S.E.2d 85, 94 (W. Va. 2004).

[145] *See, e.g.*, Clark v. Southview Hosp. & Family Health Ctr., 628 N.E.2d 46, 54 (Ohio 1994) (citing Steven R. Owens, Pamperin v. Trinity Memorial Hospital *and the Evolution of Hospital Liability: Wisconsin Adopts Apparent Agency*, 1990 WIS. L. REV. 1129, 1147(1990)) (finding that notice of independent contractor relationship will "rarely provide the patient with the ability to choose at a meaningful time").

> The plaintiff, who by definition is injured and under stress, is relying upon the hospital to provide the services that the hospital has held out that it can provide. The plaintiff's reliance upon the hospital's competence has been demonstrated by her walking (or being wheeled) into the emergency room. Simply informing her that some doctors and staff have a different technical relationship with the hospital than the one she expected does not lessen the reasonableness of her reliance upon the hospital. Even if the patient understood the difference between an employee and an independent-contractor relationship, informing her of the nature of the relationship after she arrives is too late. The purpose of any notice requirement is to impart knowledge sufficient to enable the plaintiff to exercise an informed choice. The signs suggested by the dissent are too little, too late.

Clark, 628 N.E.2d at 50 n.1.

[146] Bing v. Thunig, 143 N.E.2d 3, 8 (N.Y. 1957).

[147] *See* Sanchez v. Mary Wash. Hosp., Inc., 618 S.E.2d 331, 335 (Va. 2005) ("In virtually all of these cases imposing vicarious liability, the particular jurisdiction in-

tions was expected, the judiciary failed to account for the unique environment upon which such theories would fall. Clearly, agency-by-estoppel and apparent-agency theories, though readily applicable to commercial encounters, are poorly suited to guide liability imputation in hospital settings.

Judicial manipulation of these guidelines reflects the very public policy that compelled the erosion of charitable immunity.[148] The Supreme Court of Ohio accurately identified this driving recognition in *Clark v. Southview Hospital & Family Health Center*.[149] The *Clark* court stated that "[t]he public, in looking to the hospital to provide such care, is unaware of and unconcerned with the technical complexities and nuances surrounding the contractual and employment arrangements between the hospital and various medical personnel operating therein."[150] The court then concluded that "[p]ublic policy dictates that the public has every right to assume and expect that the hospital is the medical provider it purports to be."[151] While the reality of this expectation is undoubted, the process by which courts have attempted to advance the same has ultimately hindered its purpose.

Plainly, the overriding significance of the public's concept of the contemporary hospital image has led courts to employ a result-oriented approach to determining hospital liability. Yet, the judiciary has employed a generally inappropriate means to achieve this end. Though well-intentioned and accurately reflective of societal expectations, the modern practice of attributing hospital liability is inherently flawed. The consequences of this inconsistency are plainly evident

volved had already adopted the theory of apparent agency or agency by estoppel as a basis of tort liability when the jurisdiction used the theory to hold a hospital vicariously liable for the negligent medical care rendered by an . . . independent contractor.").

[148] *Compare Bing*, 143 N.E.2d at 9 (noting that "today's hospital is quite different from its predecessor of long ago; it receives wide community support, employs a large number of people and necessarily operates its plant in businesslike fashion" in its decision to abandon charitable immunity), *with Clark*, 628 N.E.2d at 53 ("With hospitals now being complex full-service institutions, the emergency room has become the community medical center, serving as the portal of entry to the myriad of services available at the hospital. As an industry, hospitals spend enormous amounts of money advertising in an effort to compete with each other for the health care dollar, thereby inducing the public to rely on them in their time of medical need. The public, in looking to the hospital to provide such care, is unaware of and unconcerned with the technical complexities and nuances surrounding the contractual and employment arrangements between the hospital and the various medical personnel operating therein.").

[149] *Clark*, 628 N.E.2d at 53.

[150] *Id.*

[151] *Id.*

in the judiciary's common relaxation and manipulation of tests employed to impute hospital liability.[152] Judicial dedication to theories of agency by estoppel and apparent agency has resulted in widespread artificiality in application. Simply stated, courts are not being true to the tests that they purport to rely on.

While the misapplication of these processes is certainly deserving of criticism, the true consequence of this practice runs deeper than being a mere procedural error. Indeed, continued application of agency-by-estoppel and apparent-agency theories to the hospital setting is inconsistent with the basic principles of liability imputation. Courts should reject this practice because it fails to advance the tort system's "crucial objective" of preventing future harm.[153]

In addition to victim compensation, imputation of liability in tort should aim to address the underlying departure from standards of care and prevent an incident's reoccurrence.[154] This rationale serves as the very basis of principal non-liability and the independent-contractor rule.[155] As the principal in a true independent contractor relationship cannot, by definition, exert control over the acting agent, the principal is deemed poorly suited to prevent agent neglect.[156] Accordingly, on the basis of this relationship, courts have generally declined to impute liability to the removed principal.[157]

The nature of this premise plainly illustrates the frailty of modern judicial analysis of hospital liability for the tortious conduct of independent contractor physicians. By holding hospitals liable under

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[152] *See, e.g.*, Kane v. Doctors Hosp., 706 N.E.2d 71, 76 (Ill. App. Ct. 1999); Monti v. Silver Cross Hosp., 637 N.E.2d 427, 428 (Ill. App. Ct. 1994).

[153] Abraham & Weiler, *supra* note 8, at 407; *see also* Rizzuto v. Davidson Ladders, Inc., 905 A.2d 1165, 1175 (Conn. 2006); Roberts v. Williamson, 111 S.W.3d 113, 118 (Tex. 2003).

[154] Abraham & Weiler, *supra* note 8, at 407.

[155] *Clark*, 628 N.E.2d at 53. The court in *Clark* indicated that vicarious liability will be imposed upon the relationship of master-servant, but not on the employer of and independent contractor. *Id.* In making this determination, the court must find that "the employer retain[ed] control, or the right to control, the mode and manner of doing the work contracted for." *Id.* (citing Miller v. Metro. Life Ins. Co., 16 N.E.2d 447 (Ohio 1938)).

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

[157] *See id.* § 409 cmt. a ("The general rule stated in this Section, as to the nonliability of an employer for physical harm caused to another by the act or omission of an independent contractor, was the original common law rule. The explanation for it most commonly given is that, since the employer has no power of control over the manner in which the work is to be done by the contractor, it is to be regarded as the contractor's own enterprise, and he, rather than the employer, is the proper party to be charged with the responsibility of preventing the risk, and bearing and distributing it.").

theories of agency by estoppel or apparent agency, courts are attributing liability on the basis of *exceptions* to the general independent-contractor rule of principal non-liability. In so doing, however, courts are still honoring the existence of the independent contractor relationship between the hospital and treating physician. Implicit in the acceptance of this relationship is the understanding that hospitals do not maintain control, or capability to control, the independent contractor physicians.

Judicial acknowledgement of hospital liability as an *exception* to principal non-liability incentivizes hospitals to emphasize more outwardly their lack of control over physicians operating within hospital facilities so that they can insulate themselves from liability more effectively. This contemplated reaction is most clearly witnessed in the modern practice of hospitals who disclaim liability through the use of admission forms indicating that treating physicians are independent contractors and not employees of the hospital. Yet, the judiciary's increasing disregard for such disclaimers suggests that hospitals will be held liable, not on the basis of exercised control, but rather as a result of the publicly recognized appearance that hospitals are necessary full-service healthcare facilities.

The consequence of this inconsistency between analysis and motivation is the imputation of liability to an entity that is still acknowledged to be incapable of controlling the tortfeasor at issue. What is more, that same entity maintains an incentive to further distance itself from the underlying actor. By disincentivizing hospital involvement in medical practice, the judiciary has arguably prevented hospitals from realizing their potential as organizations to prevent future harm. This practice is inconsistent with principles of liability due to the fact that hospitals do not maintain additional incentives to implement corrective measures, which are intended to prevent the reoccurrence of an independent contractor physician's negligent act.[158] Rather, hospitals that are held liable under apparent agency or agency by estoppel will have an incentive to take actions to remove themselves from the *exception* and restore their anticipated exemption from suit under the independent contractor rule. Though compensating aggrieved patients individually, this practice of imputation fails to serve the underlying purpose of liability—that of injury prevention.

[158] Significantly, if it was determined that the hospital did in fact exercise control over a particular physician, the hospital would be held liable under the doctrine of respondeat superior.

IV. NONDELEGABLE DUTY

The judiciary has erred in its continued adherence to feigned agency principles. Given the leniency of present standards, plaintiffs will face no legitimate obstacles in demonstrating hospital liability upon proof of the underlying tort. This Comment therefore assumes that, going forward, hospitals will be held liable for the actions of independent contractor physicians in certain circumstances. In light of that assumption, this Comment proposes a solution to the above-discussed error in analysis. This Comment argues for the imposition of a nondelegable duty on hospitals to provide specialized support services to the general public.

The doctrine of non-delegable duty is a legal theory under which principals maintain primary responsibility for the negligent conduct of an independent contractor despite having delegated performance to another agent.[159] The South Carolina Supreme Court explained the doctrine in *Simmons v. Tuomey Regional Medical Center* as a strict liability concept whereby "[a] person may delegate a duty to an independent contractor, but if the independent contractor breaches that duty by acting negligently or improperly, the delegating person remains *liable* for that breach."[160] The court noted further that "[i]t is the liability, not the duty, that is not delegable. The party which owes the nondelegable duty is vicariously liable for the negligent acts of the independent contractor."[161]

Application of this doctrine depends in large part on the social importance attached to the underlying activity that gave rise to the action in tort.[162] Significantly, scholars have concluded that "[i]t is difficult to suggest any criterion by which the nondelegable character of such duties may be determined, other than the conclusion that the responsibility is so important to the community that the employer should not be permitted to transfer it to another."[163] Duties presently considered to be nondelegable include the duty of a common carrier to transport passengers safely, of a municipality to keep its streets in good repair, of a landlord to maintain common spaces, and of a railroad to properly maintain its tracks and safe crossings.[164] Though fac-

[159] Renown Health, Inc. v. Vanderford, 235 P.3d 614, 616 (Nev. 2010).

[160] 533 S.E.2d 312, 317 (S.C. 2000).

[161] *Id.*

[162] Marek v. Prof'l Health Servs., Inc., 432 A.2d 538, 546 (N.J. Super. Ct. App. Div. 1981).

[163] W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS, § 71 at 511–12 (5th ed. 1984).

[164] *Id.*

tually dissimilar, these accepted nondelegable duties are considered so important to the community that the responsibility for their execution cannot be transferred to another entity.[165]

Courts should extend the doctrine of nondelegable duty to hospital operations for the same reason. The importance of hospital accountability has fueled the evolution of hospital liability since the initial demise of charitable immunity.[166] Following the erosion of this immunity, public expectations of hospitals as direct caregivers have driven courts' decisionmaking and has lead courts to validate these public beliefs in its near assurance of legal protection.[167] This observation alone demonstrates that the overriding importance of hospital operations is sufficient to warrant the application of a nondelegable duty.

Yet, in addition to that of the judiciary, legislative, and executive focus on hospital responsibility for its provision of healthcare services has also demonstrated the social importance of the provision of such services. Specifically, hospitals participating in Medicare must comply with a wide range of federal regulations.[168] Hospitals are required to establish a program for "quality assessment" and "performance improvement."[169] Under the terms of this program, the participating hospital must ensure that it "focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors."[170] By the very terms of this regulation, hospitals are compelled to take affirmative measures towards the improvement of patient care.[171] These federal regulations demonstrate the government's interest in requiring hospitals to act for the benefit of its patients in particular circumstances.

In addition to the efforts taken by the federal legislature, some courts have devised additional means for ensuring patient safety during hospital stays. Notably, certain jurisdictions have imposed an independent duty upon hospitals to monitor the practice and care of all physicians, which is actionable under the doctrine of negligent

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[165] *See id.*

[166] *See* Burless v. W. Va. Univ. Hosp., Inc., 601 S.E.2d 85, 93 (W. Va. 2004) ("The public's confidence in the modern hospital's portrayal of itself as a full service provider of health care appears to be at the foundation of the national trend toward adopting a rule of apparent agency to find hospitals liable, under the appropriate circumstances, for the negligence of physicians providing services within its walls.").

[167] *See id.*

[168] 42 C.F.R. § 482.1(a)(1)(i) (2011).

[169] *Id.* § 482.21.

[170] *Id.*

[171] *Id.*

credentialing.[172] Under this doctrine, courts impose a duty on hospitals to ensure patient safety through the monitoring of physician practice within the hospital facility.[173] In *Johnson v. Misericordia Community Hospital*, the Wisconsin Supreme Court held that this theory of liability forces on a hospital "a direct and independent responsibility to its patients . . . to take reasonable steps to (1) insure that its medical staff is qualified for the privileges granted and/or (2) to evaluate the care provided."[174] Importantly, the court in *Johnson* "pointed out that the physician's status was irrelevant, explaining that the hospital was liable under the duty it owed to the plaintiff itself, not for the breach of duty by the physician under the theory of respondeat superior."[175] Thus, the concept of negligent credentialing further illustrates the social importance attached to the role of hospitals in delivering patient care.

On the basis of this recognition, courts should employ an analysis more true to its underlying motivation when apportioning liability for the medical malpractice of independent contractor physicians. Where, as here, relevant public policy considerations are the driving force behind hospital liability, courts should be honest about their motivation and hold that societal expectations of hospital accountability are "so important to the community that the employer should not be permitted to transfer it to another."[176] Significantly, nondelegation should apply to those contexts of medical malpractice in which the public policy commanding hospital liability is most strong.

Courts have continually relied on the public perception "of the hospital as a health care facility responsible for the quality of medical care and treatment rendered" as a reason to manipulate established guidelines to apportion fault-based liability.[177] This manipulation is most evident where a hospital is named as a defendant for the negligent conduct of an independent contractor physician who did not es-

[172] *See, e.g.*, Carter v. Hucks-Folliss, 505 S.E.2d 177 (N.C. Ct. App. 1998).

[173] *See, e.g.*, Fletcher v. S. Peninsula Hosp., 71 P.3d 833 (Alaska 2003); Elam v. Coll. Park Hosp., 183 Cal. Rptr. 156 (Cal. Ct. App. 1982); Pedroza v. Bryant, 677 P.2d 166 (Wash. 1984); Johnson v. Misericordia Cmty. Hosp., 301 N.W.2d 156 (Wis. 1981).

[174] *Johnson*, 301 N.W.2d at 165.

[175] Whitney Foster, *Health Law—Negligent Credentialing and You: What Happens When Hospitals Fail to Monitor Physicians*, 31 U. ARK. LITTLE ROCK L. REV. 321, 324 (2009).

[176] PROSSER ET AL., *supra* note 163, at § 71, at 511–12.

[177] *Id.*

tablish a relationship with the patient prior to admission.[178] The Appellate Division of New Jersey, in *Estate of Cordero*, commented on the fact that, in a prior decision, "the court found conduct manifesting agency primarily because of the position in which the hospital placed the doctors."[179] The court in *Estate of Cordero* further added that "[c]ourts of other jurisdictions take [this] approach when a hospital has established and staffed facilities or departments through which patients receive specialized care from medical professionals with whom they do not have a prior or ongoing relationship."[180] Thus, in the absence of a prior or ongoing physician-patient relationship, courts will likely conclude that the hospital has manifested its assent to an agency relationship with the treating independent contractor physician.[181] Courts have strained to hold hospitals liable in these situations despite the express limitations of the tests applied because, in circumstances where no prior relationship exists, it reasonably appears that the hospital is providing the services at issue.[182] Continued judicial focus on the existence of a prior relationship suggests its functional significance in apportioning liability.

But the presence or absence of a prior relationship should not alone serve as the standard upon which a nondelegable duty will be imposed. Determination of this relationship would necessarily involve a fact-based inquiry into the circumstances of a plaintiff's hospital entry. Where, as in this Comment, the purpose of the proposed change in analysis is to force responsibility on an entity, the vehicle employed should be as brightline as possible. Therefore, the object of non-delegation should be the type of medical service provided within the hospital facility. The Illinois Supreme Court recapitulated the importance of this benchmark in *York v. Rush-Presbyterian-St. Luke's Medical Center*.[183] The court in *York* stated, "If a patient does select a particular physician to perform certain procedures within the hospital setting, this does not alter the fact that a patient nevertheless still reasonably relies upon the hospital to provide the remainder of

[178] *See* Estate of Cordero v. Christ Hosp. 958 A.2d 101, 109 (N.J. Super. Ct. App. Div. 2008); Citron v. N. Dutchess Hosp., 198 A.D.2d 618, 620 (N.Y. App. Div. 1993).

[179] *Estate of Cordero*, 958 A.2d at 109.

[180] *Id.*

[181] *Id.*

[182] *Citron*, 198 A.D.2d at 620 (finding that where a plaintiff entered the hospital through the emergency room, the hospital's employees called a number of physicians to treat the plaintiff, and the plaintiff had no prior physician-patient relationship with any of the treating physicians, the plaintiff "could properly assume that the treating doctors and staff of the hospital were acting on behalf of the hospital").

[183] 854 N.E.2d 635 (Ill. 2006).

the support services necessary to complete the patient's treatment."[184] Through this acknowledgement, the court in *York* implicitly recognized that this benchmark applies to both methods of patient admission—emergency room and pre-arranged surgical entry. In so doing, the court in *York* suggested that in nearly all cases of patient treatment the hospital must provide medical services incidental to the primary reason for admission.[185]

Thus, this Comment argues that courts should impose a nondelegable duty on hospitals for the offering of specialized support services to the general public. For the purposes of this discussion, specialized support services are defined to include emergency room care, radiology, pathology, and anesthesia. In almost all cases, the range of treating physicians with whom patients do not maintain a prior relationship will be coextensive with that range of physicians charged with the responsibility of providing specialized support services within the hospital facility. Therefore, courts utilizing this standard would impose liability on hospitals in the circumstances in which the judiciary has found public policy to be most compelling; but they will do so by using a brightline rule, which will be sufficient to accurately guide subject hospitals.

The imposition of a nondelegable duty to hospitals that provide specialized support services to the general public would achieve the same result as that desired under the strained agency-by-estoppel and apparent-agency theories. Yet, it will do so in a manner true to the analysis employed and more outwardly reflective of underlying motivation. The need for patient protection and the patients' reliance on hospital offerings have forced this evolution in hospital liability. This proposed change is necessary because it stands to protect such interests through the tort system's natural process.

Indeed, it is only through the adoption of a nondelegable duty that this system might operate as desired and decrease the likelihood of future harm. By forcing hospitals to accept liability in certain instances, such institutions are more likely to leverage their strengths as organizations in directly overseeing certain aspects of patient care. Through this oversight, hospitals would be permitted to freely consider aggregate data arising out of institution-wide patient interaction and more accurately gauge trends in performance. The application of a nondelegable duty directly incentivizes such practices because it

[184] *Id.* at 670.
[185] *Id.*

is only through the avoidance of harm that such institutions might escape liability.[186]

Though its purpose is broad, the effect of this change would necessarily be precise. By limiting a hospital's nondelegation to specialized support services, courts will effectively target only those hospital-physician relationships that create the appearance of an agency relationship. This change in doctrine would specifically target specialized support services because courts recognize that these services as offered by the hospital rather than rendered through an independent contractor physician.[187] The court in *Doctors Hospital of Augusta v. Bonner* accurately identified this understanding by observing that "anesthesiologists, pathologists, radiologists, and emergency room physicians all share the common characteristic of being supplied through the hospital rather than being selected by the patient."[188] Furthermore, these fields of medical offerings have been traditionally characterized as "integral services" provided within the hospital facility.[189] On the basis of this categorization, courts have distinguished radiology, pathology, anesthesia, and emergency room services from medical fields that are traditionally private.[190] In each of these specialized fields of practice, the treating physician does not maintain a relationship with the patient prior to admission.[191] Thus, under this theory of imputation, a hospital will only be held liable for those services that it reasonably appears to offer.

Courts have more frequently applied theories of nondelegation to some individual components of specialized support services. Significantly, courts in the states of Alaska, Florida, and New York have applied the theory of non-delegable duty when construing a hospital's role in providing medical care in its emergency room facility.[192] In *Jackson v. Power*, the Supreme Court of Alaska emphasized the commercialization of modern medicine and its resulting impact on

[186] *See, e.g.*, *Simmons*, 341 S.C. at 42 ("A person may delegate a duty to an independent contractor, but if the independent contractor breaches that duty by acting negligently or improperly, the delegating person remains liable for that breach. It actually is the liability, not the duty, that is not delegable. The party which owes the nondelegable duty is vicariously liable for negligent acts of the independent contractor.")

[187] Doctors Hosp. v. Bonner, 392 S.E.2d 897, 907 (Ga. Ct. App. 1990); Paintsville Hosp. Co. v. Rose, 683 S.W.2d 255, 257 (Ky. 1985).

[188] *Doctors Hosp.*, 392 S.E.2d at 908.

[189] Jones v. Salem Hosp., 762 P.2d 303, 314 (Or. Ct. App. 1988).

[190] *Id.*

[191] Hardy v. Brantley, 471 So. 2d 358, 371 (Miss. 1985).

[192] Simmons v. Tuomey Reg'l Med. Ctr., 533 S.E.2d 312, 318 (S.C. 2000).

the public perception of hospitals as institutions.[193] As a consequence of this change in expectation, the court concluded that the imposition of a nondelegable duty on hospitals for their provision of emergency room services was "consonant with the public perception of the hospital as a multifaceted health care facility responsible for the quality of medical care and treatment rendered."[194] The court held that, with respect to emergency room offerings, "[i]t is the hospital's duty to provide the physician, which it may do through any means at its disposal. The means employed, however, will not change the fact that the hospital will be responsible for the care rendered by physicians it has a duty to provide."[195]

Some courts have also adopted the doctrine of nondelegable duty for the provision of anesthesia to admitted patients.[196] In *Wax v. Tenet Health Sytem. Hospitals, Inc.*, the Court of Appeals of Florida concluded that, on the basis of statutory regulation of anesthesia within the state of Florida, the subject hospital had a nondelegable duty to provide anesthesia in a reasonably safe fashion.[197] Commenting on the court's decision in *Wax*, the court in *Kristensen-Kepler v. Cooney* found that the "imposition of a non-delegable duty under such circumstances makes sense."[198] The court concluded that, in situations in which a hospital is obligated to provide medical services and directs a physician to perform the same, the offering hospital should bear a nondelegable duty to provide that service in a non-negligent manner.[199] The court's recognition that the patient "has little, if any, control over who administers" medical care served as the basis for its conclusion.[200]

Although no court has imposed a nondelegable duty on a hospital to provide all specialized support services, Chief Judge Altenbernd of the Florida District Court of Appeals advanced this argument in his concurrence to the majority's opinion in *Roessler v. Novak*.[201] Specifically, Chief Judge Altenbernd concluded that

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[193] 743 P.2d 1376, 1385 (Alaska 1987).

[194] *Id.*

[195] *Id.*

[196] *See, e.g.*, Wax v. Tenet Health Sys. Hosps., Inc., 955 So. 2d 1 (Fla. Dist. Ct. App. 2007).

[197] *Id.* at 9.

[198] 39 So. 3d 518, 520 (Fla. Dist. Ct. App. 2010).

[199] *Id.*

[200] *Id.*

[201] 858 So. 2d 1158, 1163 (Fla. Dist. Ct. App. 2003) (Altenbernd, C.J., concurring).

> [g]iven modern marketing approaches in which hospitals aggressively advertise the quality and safety of the services provided within their hospitals, it is quite arguable that hospitals should have a nondelegable duty to provide adequate radiology departments, pathology laboratories, emergency rooms, and other professional services necessary to the ordinary and usual functioning of the hospital.[202]

Chief Judge Altenbernd justified the imposition of a duty on the grounds that, within the context of those service offerings, "the patient does not usually have the option to pick among several independent contractors at the hospital and has little ability to negotiate and bargain."[203] Since the decision in *Roessler*, a number of courts have expressed their approval of Judge Altenbernd's concurring opinion.[204]

The imposition of a nondelegable duty on hospitals to provide specialized support services within their facilities should not disrupt present methods of talent acquisition. Under this doctrine, hospitals would still be permitted to engage in the current practice of contracting for the services of medical doctors with physician groups.[205] Such hiring practices would not be disturbed by this Comment's argument. Rather, the goal of this proposal is to change the subject hospital's expectations of that contractual arrangement.

V. CONCLUSION

As the above analysis plainly demonstrates, courts have increasingly held hospitals liable for the actions of independent contractor physicians despite the hospitals' legitimate contractual insulation from liability. This Comment concedes that, though generally inconsistent, this practice has advanced a major objective of the tort system. By holding hospitals liable for the negligent conduct of independent contractor physicians, the courts have undoubtedly facilitated an alternate and potentially more reliable mechanism for compensation of aggrieved patients. In so doing, however, courts have ignored the

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[202] *Id.*

[203] *Id.*

[204] *Kristensen-Kepler*, 39 So. 3d 518 (Fla. Dist. Ct. App. 2010); Wax v. Tenet Health Sys. Hosps., Inc., 955 So. 2d 1 (Fla. Dist. Ct. App. 2007).

[205] Simmons v. Tuomey Reg'l Med. Ctr., 533 S.E.2d 312, 317 (S.C. 2000) ("A person may delegate a *duty* to an independent contractor, but if the independent contractor breaches that duty by acting negligently or improperly, the delegating person remains *liable* for that breach. It actually is the liability, not the duty, that is not delegable. The party which owes the nondelegable duty is vicariously liable for negligent acts of the independent contractor.").

most critical purpose of the tort system—that of injury prevention. Within this very context, courts have demonstrated that, the judiciary has overlooked the tort system's inherent desire to "give parties with crucial duties a keen incentive to do everything possible to avoid violating those duties" by holding hospitals liable under *exceptions* to the general rule of non-liability.[206] This Comment recommends adopting principles of nondelegation for hospital offerings specialized support services to rectify this omission.

The most significant consequence of adopting non-delegation in this context lies within the theory's harmony with the doctrinal principles of liability. By eliminating the possibility of hospital non-liability, hospitals will lose incentive to distance themselves from certain aspects of care delivery. This is because, under theories of nondelegation, hospitals would not be permitted to escape liability on the basis of a legitimate appearance of true independent contractor relationships. In mandating accountability of hospitals in their provision of specialized support services, courts may motivate an entity to prevent instances of future neglect more adequately.

[206] *Simmons*, 533 S.E.2d at 321.