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Nancy R. Levin

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HOSPITAL'S LIABILITY FOR INDEPENDENT EMERGENCY ROOM SERVICE

Nancy R. Levin*

I. INTRODUCTION

The hospital is the fulcrum for the health maintenance system of its surrounding community. The institution's emergency room is frequently the entrance point into today's health care system. Hospitals face two difficulties in providing emergency service. First, it is difficult to staff full-time emergency departments. Second, the malpractice fees to cover the emergency rooms are prohibitive. As a result, hospitals look to independent professional corporations to administer their emergency rooms. This article will show that this decision does not limit hospitals' liability for malpractice actions by the corporations' physicians in the emergency rooms.

Utilization of the emergency room in the United States has increased dramatically over the past thirty years. The American Hospital Association reports that 78.3% of the nation's hospitals operate emergency departments.[1] Emergency outpatient visits in 1954 numbered approximately nine million. By 1958, that figure had doubled, and by 1968 nearly thirty-six million were recorded. Projections indicate that visits will total almost 160 million by 1984.[2]

There are numerous reasons for the large number of emergency departments and the substantial growth in the number of patient visits. First, there has been a significant decline in the number of general practitioners who are willing to make housecalls. Second, the emergency room is open

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* B.S.S., Northwestern University, 1974; M.A., University of Michigan, 1975; J.D., Illinois Institute of Technology School of Law, 1981; Visiting Professor of Law and Public Policy, School of Management, Syracuse University; Member, New York Bar; Member, Florida Bar.

1. Cross, *Transfer of the Emergency Patient: Avoiding Legal Complications*, 35 TEX. HOSP. 11 (1979).

2. Kucera, *Narrow Definition of "Emergency" Can Spell "Litigation,"* 7 HOSP. MED. STAFF 21 (1978).

twenty-four hours each day and is able to handle most medical situations with better equipment and facilities than private offices. Third, many people consider the emergency department to be their community medical center.[3]

The hospitals find it financially rewarding to provide such care. Under Internal Revenue Ruling 69-545,[4] hospitals are able to qualify for tax exempt status in one of two ways. The hospital can either operate "to the extent of its financial ability" for those patients incapable of paying their bills or can conduct its emergency room services on an "open door" basis, even if all inpatients are expected to pay for all medical services.[5] In *Simon v. Eastern Kentucky Welfare Rights Organization*,[6] the United States Supreme Court effectively disallowed any further challenges to the Internal Revenue Ruling.

In addition, hospitals have established emergency services to comply with their state penal statutes. Six states have required their hospitals to give aid to persons in need of emergency care.[7] In 1927, Illinois enacted a statute which has served as a model for the other statutes. In its present form the statute provides:

> Every hospital required to be licensed by the Department of Public Health pursuant to the Hospital Licensing Act . . . which provides general medical and surgical hospital services shall provide a hospital emergency service in accordance with rules and regulations adopted by the Department of Public Health and shall furnish such hospital emergency services to any applicant who applies for the same in case of injury or acute medical condition where the same is liable to cause death or severe injury or serious illness.[8]

Violation of the statute is a petty offense[9] punishable by a fine not to exceed $10,000.[10]

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3. *Id.* at 22.

4. Rev. Rul. 69-545, 1969-2 C.B. 501(c)(3).

5. Bernstein, *Hospital Emergency Services and The Law*, 51 HOSPITALS 100 (1977).

6. 426 U.S. 26 (1976).

7. Kucera, *supra* note 2, at 22. The six states are Illinois, Tennessee, California, New York, Florida, and Wyoming.

8. Emergency Medical Treatment Act § 1, ILL. ANN. STAT. ch. 111½, § 86 (Smith-Hurd 1977).

9. *Id.* at § 87.

10. *Id.* at § 87(2) (Smith-Hurd Supp. 1980-81).

New York enacted a general statute in 1969 which has an unusual variation. The statute specifies that: "Every general hospital shall admit any person who is in need of immediate hospitalization with all convenient speed and shall not before admission question the patient . . . concerning insurance, credit or payment of charges . . . ."[11] Moreover, the legislature added the following section in 1973 which necessitates that, "[I]n cities with a population of one million or more, a general hospital must provide emergency medical care and treatment to all persons in need of such care and treatment."[12] Noncompliance with the statute can result in suspension or revocation of the hospital's license.[13]

Florida's statute requires all hospitals with emergency departments to open that facility to the public, providing that: "[N]o person shall be denied treatment for any emergency medical condition which will deteriorate from failure to provide such treatment at any hospital . . . that operates an emergency department providing emergency treatment to the public."[14] Statutory violation constitutes a second degree misdemeanor.[15] Conviction may result in imprisonment up to sixty days and a fine not to exceed five hundred dollars.[16]

Recently, federal legislation has been enacted reflecting the public's interest in developing, financing, and expanding all aspects of emergency medical services.[17] These acts have imposed on hospitals a duty to treat all patients seeking medical help.

Finally, some physicians prefer to work for emergency room services. As contract physicians, they have guaranteed incomes, flexible scheduling, and no "on-call" involvement. This allows for leisure time to fulfill personal and family interests and obligations. Contract physicians have no professional overhead expenses such as secretarial salaries or office space. Moreover, they are not involved in patient billing or collection. The physicians can practice medicine without be-

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11. N.Y. PUB. HEALTH LAW § 2805-b(1) (McKinney 1977).
12. *Id.* at § 2805-b(2).
13. Kucera, *supra* note 2, at 23.
14. FLA. STAT. ANN. § 401.45 (West Supp. 1982).
15. *Id.* at § 401.41.
16. *Id.* at §§ 775.082-.083.
17. *See* 42 U.S.C. §§ 295f-2(a)(14), 295f(6), 300d to 300d-9 (1976), discussed in Commentary, *The Emergency Medical Service Systems Act of 1973,* 230 J. A.M.A. 1139 (1974).

ing cognizant of the business ramifications.

The emergency room situation appears an ideal arrangement for the hospital, public, and physicians. As the number of emergency room facilities and the number of patient visits have increased, however, the number of malpractice claims arising out of the emergency room have also increased. In 1971 and 1972, for example, the emergency room accounted for twelve percent of all malpractice claims against the hospital.[18]

II. PHYSICIAN-HOSPITAL RELATIONSHIPS

Three types of physicians work in the emergency room of the hospital: staff physicians, private doctors, and contract physicians. The courts have placed legal responsibility for the negligent injury of patients by the hospital's staff physician directly on the hospital.[19] A master-servant relationship exists between the hospital and the physician, under the doctrine of respondeat superior, whereby the institution is liable for any injury to a patient due to negligence of the physician acting within his scope of employment.[20] The courts use four main criteria to substantiate the existence of the master-servant relationship: the physician (1) is salaried by the hospital, (2) spends all his working hours under the direction of the hospital, (3) devotes all of his professional energies to the hospital, and (4) does not maintain a practice of his own.[21]

The private physician is an independent contractor.[22] The hospital merely provides the necessary equipment and services to care for the patient. Under these conditions the hospital cannot be responsible for the negligence of the private doctor even though the injury occurs within the hospital[23] and the patient has come in contact with other members of the

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18. Kucera, *supra* note 2, at 22. *See generally* Sachs, *Malpractice Prophylaxis: Emergency Room Liability*, 75 KAN. MED. SOC'Y J. 360, 360 (1974).

19. *See, e.g.*, Valentin v. La Societe Francaise, 76 Cal. App. 2d 1, 172 P.2d 359 (1946); Newton County Hosp. v. Nickolson, 132 Ga. App. 164, 207 S.E.2d 659 (1974); Noel v. Menninger Foundation, 175 Kan. 751, 267 P.2d 934 (1954).

20. Newton County Hosp. v. Nickolson, 132 Ga. App. 164, 166, 207 S.E.2d 659, 661-62 (1974).

21. *See* Annot., 69 A.L.R. 2d 305, 309 (1960).

22. *Id.* at 315.

23. *See, e.g.*, Mayers v. Litlow, 154 Cal. App. 2d 413, 316 P.2d 351 (1957); Hundt v. Proctor Community Hosp., 5 Ill. App. 3d 987, 284 N.E.2d 676 (1972); Lundahl v. Rockford Memorial Hosp. Ass'n, 93 Ill. App. 2d 461, 235 N.E.2d 671 (1968).

hospital's staff.[24] It is irrelevant whether the outside attending physician has "staff privilege" at the hospital because such privilege merely allows the physician to use the hospital for his or her private patient.[25] The courts have recognized that the outside attending physician receives no salary from the hospital, and, as such, he or she is an independent contractor relieving the hospital of any liability for the physician's malpractice.[26]

Many hospitals have signed contracts with professional corporations to staff their emergency rooms with physicians. The scope of liability of the contract agency, the hospital, and the contract physician, in the event of a malpractice claim is unclear. If the physician is an employee of the hospital, then that institution is responsible under the doctrine of respondeat superior.[27] If the physician is an independent contractor, the hospital can still be held liable under the "ostensible agency" theory.[28] Regardless of the physician's status, the hospital may be held accountable under a corporate negligence theory.[29] This article examines the medical malpractice liability of hospitals for negligent acts committed by physicians who are not on the hospital's staff under each of three theories: (1) respondeat superior, (2) ostensible agency, and (3) corporate negligence.

A. *Respondeat Superior*

Earlier cases reflected the belief that a hospital was only responsible for administrative acts of the physicians.[30] Administrative acts which have given rise to liability have included: transfer of a patient from one hospital to another,[31] use of an electric cauterizing instrument which ignited alcohol on the

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24. *See* Annot., 69 A.L.R. 2d at 325-32.

25. *See* Smith v. Klebenoff, 84 N.M. 50, 499 P.2d 368, *cert. denied*, 84 N.M. 37, 499 P.2d 355 (1972); Southwick, *The Hospital as an Institution—Expanding Responsibilities Change Its Relationship with the Staff Physician*, 9 CAL. W.L. REV. 429, 440 (1973).

26. *See* cases cited *supra* note 23; Fiorentino v. Wenger, 19 N.Y.2d 407, 227 N.E.2d 296, 280 N.Y.S.2d 373 (1967).

27. *See infra* notes 30-35 and accompanying text.

28. *See infra* notes 57-73 and accompanying text.

29. *See infra* notes 74-88 and accompanying text.

30. *See* Annot., 69 A.L.R. 2d 305, 317-320 (1960).

31. Jones v. City of New York Hosp., 134 N.Y.S.2d 779 (1954), *rev'd on other grounds*, 286 A.D. 825, 143 N.Y.S.2d 628 (1955).

patient's abdomen,[32] administration of transfusions without written orders,[33] and having a suicidal patient moved to a dangerous location.[34] The courts, however, refused to hold the hospital responsible for medical acts of the physician.[35] Negligent medical acts which resulted from the physician's specialized knowledge could not be imputed to the hospital. The courts considered such acts as part of and treatment of the illness itself.

This administrative act—medical act dichotomy was firmly rejected by the New York Court of Appeals in *Bing v. Thunig*.[36] The court saw no valid reasons for specifically excluding material practitioners if other highly skilled professionals were not excluded from the applicaton of the doctrine of respondeat superior. The New York Court of Appeals commented on the changing role of hospitals in our society:

> 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. Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. They regularly employ on a salary basis a large staff of physicians, nurses and interns, as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such services, if necessary, by legal action. Certainly, the person who avails himself of 'hospital facilities' expect that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility.
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> Hospitals should, in short, shoulder the responsibilities borne by everyone else. There is no reason to continue their exemption from the universal rule of respondeat superior.[37]

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32. City of Miami v. Oates, 152 Fla. 21, 10 So.2d 721 (1942).

33. Necolayff v. Genesee Hosp., 270 A.D. 648, 61 N.Y.S.2d 832 (1946), *aff'd per curiam*, 296 N.Y. 936, 73 N.E.2d 117 (1947).

34. Fowler v. Norways Sanatorium, 112 Ind. App. 347, 42 N.E.2d 415 (1942).

35. *See, e.g.*, Schloendorff v. Society of New York Hosp., 211 N.Y. 125, 105 N.E. 92 (1914); Lewis v. Columbus Hosp., 1 A.D.2d 444, 151 N.Y.S.2d 391 (1956); Davie v. Lenox Hill Hosp., 81 N.Y.S.2d 583 (1948).

36. 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957).

37. *Id.* at 666, 143 N.E.2d at 8, 163 N.Y.S.2d at 11.

Today, under the doctrine of respondeat superior, the hospital is liable to a third person for any injury which proximately results from the tortious conduct of any employee acting within his scope of employment.[38] A determination must first be made as to whether the relationship between the hospital and the physician is that of master-servant. Although the factors the courts have developed to test this relationship are simple and certain, applying them is extremely difficult. A master-servant relationship is one in which the employer assumes the right to control the time, manner, and method of executing the work, as distinguished from the right to require certain definite results.[39] Actual control is the critical factor. The test of control should be viewed objectively. Hospitals manage the actual operations of their emergency rooms. They virtually control the actions of the contract physician through medical staff rules and regulations.[40] A pertinent example is the Emergency Service Guidelines prepared by the Joint Commission on Accreditation of Hospitals (JCAH). The 1981 JCAH Manual imposes responsibility on the hospital to insure and monitor the quality of health care provided at the hospital.[41] Specifically it declares that emergency patient care rules and procedures must be approved and reviewed annually by medical staff and hospital administrators.[42] The manual lists specific preestablished criteria that must be included in the rules and procedures.[43] Contract physicians are "members of the medical staff" and must meet all requirements necessary to become staff members.[44] The hospital must continuously review the quality and appropriateness of patient care

38. *See* 53 Am. Jur. 2d, *Master Servant* § 404 (1970).

39. Blair v. Smith, 201 Ga. 747, 41 S.E.2d 133 (1947); St. Paul-Mercury Indem. Co. v. Alexander, 84 Ga. App. 207, 65 S.E.2d 694 (1951); Weiss v. Kling, 96 Ga. App. 618, 101 S.E.2d 178 (1957).

40. Mduba v. Benedictine Hosp., 52 A.D.2d 450, 384 N.Y.S.2d 527 (1976). *See also* Overstreet v. Doctors Hosp., 142 Ga. App. 895, 237 S.E.2d 213 (1977), wherein the court affirmed summary judgment for defendant on similar facts. Although the hospital had adopted rules governing emergency room procedures and had imposed restrictions on the outside practice of doctors employed by its director of emergency room services, the court found no employer-employee relationship. *But see* Hodges v. Doctors Hosp., 141 Ga. App. 649, 234 S.E.2d 116 (1977) (jury may infer a contract where physician had arrangement with hospital to "cover" the emergency room).

41. ACCREDITATION MANUAL FOR HOSPITALS (1981).

42. *Id.* at 28-29.

43. *Id.* at 29-30.

44. *Id.* at 26.

through the establishment of quality control mechanisms.[45] In *Darling v. Charleston Community Memorial Hospital,*[46] the Illinois Supreme Court held that the standards adopted by professional non-government organizations such as the JCAH are admissible evidence to provide a basis for defining the standard of care that the hospital and its personnel must practice.

In *Mduba v. Benedictine Hospital,*[47] the Appellate Division of the New York Supreme Court found a hospital responsible for the decedent's death as a result of the emergency room contract physician's negligent failure to administer blood in time to prevent irreversible shock. The court stated:

> While conducting the operations of the Emergency Room, the doctor was to do so in accordance with the rules and regulations of defendant hospital's governing board. Thus, under the contract, the doctor was not only bound to achieve a certain result, i.e., direct and supervise the Emergency Room, but was controlled by the defendant hospital as to the means or manner of achieving this result. Since the hospital controlled the manner in which the doctor operated the emergency room, Dr. Bitash [contract physician] was not an independent contractor but an employee of the defendant hospital.[48]

The contract doctor performs services which are an "inherent function of the hospital, a function without which the hospital could not properly achieve its purpose."[49] A significant relationship exists between the contract physician and the hospital.[50] The following factors support this significant

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45. *Id.* at 33-34.

46. 33 Ill. 2d 326, 331, 211 N.E.2d 253, 256-57 (1965), *cert. denied,* 383 U.S. 946 (1966). Other courts have also held that standards sponsored by professional non-government organizations are admissible on the issue of the appropriate standard of care for doctors. In Stone v. Proctor, 259 N.C. 633, 131 S.E.2d 297 (1963), the standards of electroshock treatment prepared by the American Psychiatric Association were admissible as evidence of the requisite standard of care. *See also* Steeves v. United States, 294 F.Supp. 446 (D. S.C. 1968) where the court relied on the AMA Principles of Medical Ethics and AHA Standards of Hospital Accreditation.

47. 52 A.D.2d 450, 384 N.Y.S.2d 527 (1976).

48. *Id.* at 452-53, 384 N.Y.S.2d at 529 *citing* Matter of Morton, 284 N.Y. 167, 30 N.E.2d 369 (1940).

49. Beeck v. Tucson Gen. Hosp., 18 Ariz. App. 165, 170, 500 P.2d 1153, 1158 (1972).

50. Adamski v. Tacoma Gen. Hosp., 20 Wash. App. 98, 108, 579 P.2d 970, 975 (1978). *But see* Johnson v. St. Bernard Hosp., 79 Ill. App. 3d 709, 399 N.E.2d 198 (1979).

relationship: (1) contract physicians have guaranteed salaries;[51] (2) the hospital bills for the physician's services;[52] (3) the physician did not engage in private practice;[53] (4) the hospital owned the equipment used by the physician;[54] (5) the hospital furnished all supporting technicians involved in patient care;[55] (6) the patient had no choice in selecting the physician, the hospital making the choice for the patient.[56] Note that these significant factors are identical to the relationship a staff physician has to the hospital. As previously mentioned, a staff physician's negligence is imputed to the hospital through the master-servant doctrine.

B. *Ostensible Agency*

Ostensible agency originated in the law of agency. In *Seneris v. Haas*,[57] the California Supreme Court held that a hospital can be liable for the conduct of a nonemployee if a patient could reasonably believe that such a person was an employee of the hospital and the hospital had done nothing to dispel that belief. This ostensible agency theory has been described in the Restatement of Agency as follows:

> One who represents that another is his servant or agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such.[58]

Liability is imposed under an estoppel theory, rather than under a contract theory.[59] The courts must decide whether an actual agency between the employer and the non-employee

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51. Beeck v. Tucson Gen. Hosp., 18 Ariz. App. 165, 500 P.2d 1153 (1972); Overstreet v. Doctors Hosp., 142 Ga. App. 895, 237 S.E.2d 213 (1977); Mduba v. Benedictine Hosp., 52 A.D.2d 450, 384 N.Y.S.2d 527 (1976).

52. Beeck v. Tucson Gen. Hosp., 18 Ariz. App. 165, 500 P.2d 1153 (1972); Rucker v. High Point Hosp., Inc., 20 N.C. App. 650, 202 S.E.2d 610 (1974).

53. Beeck v. Tucson Gen. Hosp., 18 Ariz. App. 165, 500 P.2d 1153 (1972); Rucker v. High Point Hosp., Inc., 20 N.C. App. 650, 202 S.E.2d 610 (1974).

54. Beeck v. Tucson Gen. Hosp., 18 Ariz. App. 165, 500 P.2d 1153 (1972).

55. *Id.*

56. *Id.*

57. 45 Cal. 2d 811, 291 P.2d 915 (1955).

58. RESTATEMENT (SECOND) OF AGENCY § 267 (1958).

59. Arthur v. St. Peters Hosp., 169 N.J. Super. 575, 580, 405 A.2d 443, 446 (1979).

appears likely.[60] The test is subjective: has the principal (hospital) through its voluntary act placed the nonemployee (contract physician) in such a situation that a person of ordinary prudence, acquainted with the nature of the particular business, is justified in presuming that such nonemployee has the principal's authority to perform the particular act?[61]

There are certain presumptions held by the courts. First, the hospital is involved in the business of providing health care services. A patient is admitted to the hospital for no reason other than to receive this care.[62] Second, the determination of whether to admit a given patient to the hospital through the emergency room is frequently made by doctors and staff acting on behalf of the hospital.[63] Third, the changing role of the hospital in our society has resulted in the patient looking to the institution, rather than the individual physician, to provide health care. The Superior Court of New Jersey took judicial notice of the public's reasonable expectation of emergency room physicians, stating, "[P]eople who seek medical help through emergency room facilities of modern-day hospitals are unaware of the status of the various professionals working there."[64] The patient has no duty to inquire of each person who treats him whether he is an employee or independent contractor of the hospital.[65] It is absurd to require a patient to ask such a question when he is suffering excruciating pain.

Some courts justify a finding of ostensible agency when a hospital "holds out" to the public that the contract physician is its employee.[66] The courts have relied on the following to support their rulings: (1) the public is not informed of the independent status of the contracting physician,[67] (2) all drugs and equipment supplied to the contracting physician came

60. *Id.*

61. *Id.*

62. Mehlman v. Powell, 281 Md. 269, 274, 378 A.2d 1121, 1124 (1977).

63. *See* Methodist Hospital v. Ball, 50 Tenn. App. 460, 362 S.W.2d 475 (1961).

64. Arthur v. St. Peters Hosp., 169 N.J. Super. at 583, 405 A.2d at 447.

65. Grewe v. Mount Clemens Gen. Hosp., 404 Mich. 240, 273 N.W.2d 429 (1978).

66. Brown v. Moore, 247 F.2d 711 (3d Cir. 1957); Howard v. Park, 37 Mich. App. 496, 497, 195 N.W.2d 39, 40 (1972); Lundberg v. Bay View Hosp., 175 Ohio St. 133, 137, 191 N.E.2d 821, 823 (1965); Adamski v. Tacoma Gen. Hosp., 20 Wash. App. 98, 115, 579 P.2d 970, 978-79 (1978).

67. Adamski v. Tacoma Gen. Hosp., 20 Wash. App. 98, 115, 579 P.2d 970, 979 (1978).

from the hospital,[68] (3) medical treatment took place inside the hospital,[69] (4) the hospital chose the contracting physician,[70] (5) the patient was given written instruction advising him to return for further treatment to the emergency room if he could not contact his personal physician,[71] (6) the hospital bill for the contracting physician's services contained the logo of the hospital.[72] The application of ostensible agency to the hospital and physician relationship continues to be strongly supported by case law.[73]

C. *Corporate Negligence*

Hospital liability for corporate negligence originated in 1965 in the Illinois Supreme Court case of *Darling v. Charleston Community Memorial Hospital.*[74] Corporate negligence differs from respondeat superior and ostensible agency in that the duty of care generates from the hospital and is owed directly to the patient. Consequently, the hospital is liable for negligent acts of physicians who are employees as well as independent contractors.[75]

In *Darling*, the Illinois Supreme Court held the hospital liable for the malpractice of an independent contractor physician who improperly applied a cast to a patient's leg. The court determined that the hospital had a duty to supervise its physicians and the care they provided. This case introduced the concept of the hospital's responsibility for medical treatment, compelling hospitals to become more directly involved

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68. Seneris v. Haas, 45 Cal. 2d 811, 291 P.2d 915 (1955); Quintal v. Laurel Grove Hosp., 62 Cal. 2d 154, 397 P.2d 161, 41 Cal. Rptr. 577 (1964).

69. Howard v. Park, 37 Mich. App. 496, 195 N.W.2d 39 (1972).

70. *Id.*

71. Adamski v. Tacoma Gen. Hosp., 20 Wash. App. 98, 115, 579 P.2d 970, 979 (1978).

72. Arthur v. St. Peters Hosp., 169 N.J. Super. at 578, 405 A.2d at 446.

73. *See, e.g.*, Seneris v. Haas, 45 Cal. 2d 811, 291 P.2d 915 (1955); Mehlman v. Powell, 281 Md. 269, 378 A.2d 1121 (1977); Grewe v. Mount Clemens Hosp., 404 Mich. 240, 273 N.W.2d 429 (1978); Howard v. Park, 37 Mich. App. 496, 195 N.W.2d 39 (1972); Mduba v. Benedictine Hosp., 52 A.D.2d 450, 384 N.Y.S.2d 527 (1976); Lundberg v. Bay View Hosp., 175 Ohio St. 133, 191 N.E.2d 821 (1965); Adamski v. Tacoma Gen. Hosp., 20 Wash. App. 98, 579 P.2d 970 (1978). *But see* Johnson v. St. Bernard Hosp., 79 Ill. App. 3d 709, 399 N.E.2d 198 (1979).

74. 33 Ill. 2d 326, 211 N.E.2d 253 (1965).

75. *See generally* Note, *The Hospital's Responsibility for its Medical Staff: Prospects for Corporate Negligence in California*, 8 PAC. L.J. 141 (1977).

in patient care over the ensuing fifteen years.[76]

Subsequent cases have recognized the hospital's affirmative duty in insuring that only competent physicians are selected and remain on the medical staff. The hospital must act with due care in selecting members of the medical staff. In *Corleto v. Shore Memorial Hospital*,[77] the New Jersey Superior Court held a hospital could be liable "because of the wrongful act in placing an incompetent [physician] in a position to do harm."[78] The court argued that such a ruling will cause the level of medical care to rise within the state and benefit the public as a result.[79]

The Georgia Supreme Court, in *Mitchell County Authority v. Joiner*,[80] concluded that a hospital may incur liability if it accepts an incompetent physician on its staff, even though it relied on the hospital's medical staff or the state's licensure process to determine competence.[81] The hospital could not abdicate its responsibility for staff selection, even though Georgia law permitted the medical staff to perform this function.[82] These cases show that a hospital cannot limit its liability by delegating its selection of contract physicians to a professional corporation. The JCAH has imposed liability for selection of contract physicians on the hospital since these physicians are members of the hospital staff.[83] All appointments made by the professional corporation of incompetent physicians will be imputed to the hospital.

Finally, hospitals have been found liable under the corporate negligence theory for failing to assure the continued competence of its medical staff. In *Purcell v. Zimbelman*,[84] the Arizona Court of Appeals upheld a jury verdict stating that a

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76. J. KING, THE LAW OF MEDICAL MALPRACTICE, 315-17 (1977) (discussing Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965).

77. 138 N.J. Super. 302, 350 A.2d 534 (1975).

78. *Id.* at 307, 350 A.2d at 537.

79. *Id.* at 311, 350 A.2d at 539.

80. 229 Ga. 140, 189 S.E.2d 412 (1972).

81. *Id.* at 142-43, 189 S.E.2d at 414.

82. Joiner v. Mitchell County Hosp. Auth., 125 Ga. App. 1, 2-3, 186 S.E.2d 307, 308 (1971).

83. *See supra* note 44 and accompanying text.

84. 18 Ariz. App. 75, 500 P.2d 335 (1972). The plaintiff, injured as a result of an inappropriate operation, sued both his independently retained physician and the hospital. He alleged that the hospital had a duty to limit use of its facilities to professionally competent staff doctors employing acceptable medical procedures. *Id.* at 80, 500 P.2d at 340.

hospital had been negligent in failing to review a physician's competence after two previous malpractice suits had been filed which involved similar surgical procedures.[85] In *Gonzales v. Nork*,[86] the Superior Court for Sacramento County found a hospital liable for failing to adequately review the performance of its staff. In that case a physician performed at least thirty-five unnecessary operations to support his drug habit. It is clear from this analysis of case law and from the guidelines of JCAH[87] that a hospital must constantly monitor the qualifications and performance of its medical staff, including those of contract physicians.[88]

III. CONCLUSION

Case law demonstrates that a hospital will not be held vicariously liable for its nonhospital-based staff physicians' malpractice. The institution shares no economic or other relationship with the physician sufficient to show the existence of a master-servant relationship.[89] A physician employed by the hospital is considered a servant under the doctrine of respondeat superior. A physician so employed participates in an economic relationship with the hospital as a regularly salaried employee, and hospital control is implied by the existence of a formal employment relationship.[90] A contract physician shares an economic relationship with the hospital by receiving a fixed salary, but his formal employment contract is with a professional corporation, not the hospital. The courts are divided as to whether this physician should be regarded as an independent contractor or an employee of the hospital. The author submits that, regardless of the physician's status, the hospital will be responsible for the contract physician's malpractice

85. *Id.* at 83-84, 500 P.2d at 343-44.

86. No. 228566 (Super. Ct. of Sacramento Co., Nov. 27, 1973), *rev'd*, 60 Cal. App. 3d 728, 131 Cal. Rptr. 717 (1976). Although the *Nork* decision was not binding upon the hospital, it has nonetheless received widespread attention from the hospital industry. *See, e.g.*, Hedgepeth, *Trial Court Finds Hospital "Strict Liable" For Physician Negligence*, 3 HOSP. MED. STAFF 8 (1974).

87. *See supra* notes 41-45 and accompanying text.

88. *See generally* Note, *Torts—Medical-Malpractice—Hospital May Be Held Liable for Permitting Incompetent Independent to Operate*, 8 RUT.-CAM. L. REV. 177 (1976).

89. *See supra* notes 22-26 and accompanying text.

90. *See supra* notes 19-21 and accompanying text.

under respondeat superior,[91] ostensible agency,[92] or corporate negligence theories.[93]

What can a hospital do to limit its liability? Some courts have held that a contract between the hospital and the emergency room physician will destroy a master-servant relationship.[94] The hospital can exculpate itself from respondeat superior by stating that the hospital will not "exercise any control over the means employed by the [director] in the performance of his departmental services,"[95] and that the director of the emergency room, in turn, will be solely responsible for the "results of the services being consistent with the existing standards of his profession."[96] The hospital can exercise a limited surveillance over the emergency room services in order to monitor the quality of hospital care but must exert very little control over the manner of patient treatment.[97]

Under the ostensible agency concept, however, the contract between the hospital and a contract physician will not limit the institution's liability. Ostensible agency is a subjective standard and a patient will be unaware of the contract that existed between the two parties. In *Mduba v. Benedictine Hospital*[98] the court found that a patient was not bound by the secret limitations of such a contract. Notice must be given to the patient of the contract physician's nonemployee status at the first instance the patient appears in the emergency room. This can be accomplished by signs posted on walls and applicable treatment consent forms providing this information. In addition, the physician should wear a uniform different from other hospital professionals and wear a badge stating with which professional corporation he is associated. The physician's prescription pads should also indicate his nonemployee status.

A hospital can take preventive steps to eliminate possible corporate negligence judgments by an active role in the selection of contract physicians and by monitoring their compe-

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91. *See supra* notes 30-35 and accompanying text.
92. *See supra* notes 57-73 and accompanying text.
93. *See supra* notes 74-88 and accompanying text.
94. Overstreet v. Doctors Hosp., 142 Ga. App. 895, 237 S.E.2d 213 (1977); Pogue v. Hosp. Auth., 120 Ga. App. 230, 170 S.E.2d 52 (1969).
95. Overstreet v. Doctors Hosp., 142 Ga. App. at 896, 237 S.E.2d at 214.
96. *Id.*
97. *Id.*
98. 52 A.D. 450, 452, 384 N.Y.S.2d 527, 529 (1976).

tence. This can be accomplished by applying the same quality assurance controls to contract physicians as applied to staff physicians. Only in this way can the hospital safeguard patient care and protect itself from corporate liability.