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Theories for Imposing Liability Upon Hospitals for Medical Malpractice: Ostensible Agency and Corporate Liability

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NOTE
THEORIES FOR IMPOSING LIABILITY UPON HOSPITALS FOR MEDICAL MALPRACTICE: OSTENSIBLE AGENCY AND CORPORATE LIABILITY

A medical malpractice action against a hospital, once considered an imprudent undertaking, is now recognized as a legitimate cause of action. Today, hospitals may be held liable for the negligent actions of their employees under several legal theories. The following Note discusses these theories and the particular situations to which they apply.

I. INTRODUCTION ........................................... 561

II. HISTORICAL TREATMENT .................................. 563
   A. Respondeat Superior .................................... 564
   B. Charitable Immunity .................................... 566

III. PRESENT STATUS OF LIABILITY THEORIES ................. 568
   A. Respondeat Superior ..................................... 569
   B. Ostensible Agency and Corporate Liability ............ 572
      1. Ostensible Agency ................................... 573
      2. Corporate Liability .................................. 576

IV. CONCLUSION ............................................... 581

I. INTRODUCTION

Services provided by contemporary hospitals differ significantly from those rendered by hospitals of the past. Today's hospitals are larger and more complex that ever before and operate as highly integrated systems utilizing a team approach to medical care. Typically, many persons

1. The changing nature of hospitals was noted in the landmark case of Bing v. Thunig, 2 N.Y.2d 656, 666, 143 N.E.2d 3, 8, 163 N.Y.S.2d 3, 11 (1957): 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.

   Id.

2. See Ybarra v. Spangard, 25 Cal. 2d 486, 491, 154 P.2d 687, 691 (1944). The modern hospital has become a community health center designed to provide patient care of the highest quality. Moore v. Board of Trustees of Carson-Tahoe Hosp., 88 Nev. 207, 211, 495 P.2d 605, 608 (1972); cf. Angel, Professionals and Unionization, 66 MINN. L. REV. 383, 411-12 (1982) (“Recent developments in the health care industry have derogated the role of the individual practitioner, while promoting the growth and expansion of hospitals. As health care became hospital-based, and the number of medical specialties increased, hospitals changed from small, local, charitable institutions to major industries.”) Id. (footnote omitted)).

561
care for a patient. Consequently, patients expect that treatment will be rendered by the hospital staff as a well-coordinated and efficient unit. As the larger hospitals treat more patients, the potential for negligence by hospital personnel increases. A patient commencing a malpractice action will probably sue the hospital in addition to the treating physician since in all likelihood many hospital employees participated in the patient’s treatment. Patients commence malpractice actions against hospitals with increasing frequency, and with increasing frequency courts impose vicarious liability upon those institutions for their employees’ negligence. The issue is no longer whether the patient has a right to sue

3. Comment, The Hospital’s Responsibility for its Medical Staff: Prospects for Corporate Negligence in California, 8 PAC. L.J. 141, 149-50 (1977) (citing Ybarra, 25 Cal. 2d at 491, 154 P.2d at 690 (“We have no doubt that in a modern hospital a patient is quite likely to come under the care of a number of persons in different types of contractual and other relationships with each other”)).


5. Although five million medical complications occur annually in the United States, only 34,000 claims are brought against doctors. Patients are apparently unaware that the complications they experience may have resulted from malpractice, even though this is the case at least one half of the time. See J. EISBERG, MEDICAL MALPRACTICE LITIGATION: ART AND SCIENCE 8 (1982).


7. An increase in the incidence of medical malpractice claims closely follows recent significant advances in medicine. Wasmuth, Definition and Scope of Malpractice Problem—A National Overview in EXPLORING THE MEDICAL MALPRACTICE DILEMMA 1, 2 (C. Wecht ed. 1972). Few claims were filed prior to 1940. Id. at 1. The number of claims reported nationwide to a major malpractice insurer doubled between 1974 and 1983, although the number of persons insured only rose by approximately 25%. Telephone interview with Jack Rowlig, Physicians and Surgeons Underwriting Officer for St. Paul Fire and Marine Insurance Company, in St. Paul, Minnesota (Mar. 5, 1984). Interestingly, the number of claims filed against physicians and surgeons in Minnesota has risen by approximately 10% in the past ten years, while the number of insureds has dropped by approximately 25%. Id.

The public now expects hospitals to provide high quality medical care. In view of their patients’ reliance, hospitals must assume an increased responsibility toward their patients. See Swan, Hospital Liability for Corporate Negligence, 1984 MED. TRIAL TECH. Q. 275, 282.

Most patients file malpractice claims as a result of poor communication with the physician or a bad result from medical treatment. See A. HOLDER, MEDICAL MALPRACTICE LAW 407 (1975). A plaintiff in a malpractice action must prove that “it was more probable that [injury] resulted from some negligence for which defendant was responsible than from something for which he was not responsible.” Plutshack v. University of Minn. Hosp., 316 N.W.2d 1, 7 (Minn. 1982) (quoting Silver v. Redleaf, 292 Minn. 463, 465, 195 N.W.2d 271, 273 (1972) (footnotes omitted)). If a patient has not paid his bill because of dissatisfaction with his treatment, attempts at fee collection by the hospital frequently result in the patient filing a malpractice claim. A. HOLDER, supra, at 408.

8. See Payne, Recent Developments Affecting a Hospital’s Liability for Negligence of Physicians, 18 S. TEX. L.J. 389, 390 (1977). It is estimated that 75 to 80% of all medical malpractice claims arise in hospitals. Note, Hospital Corporate Liability: An Effective Solution to
HOSPITALS' MEDICAL MALPRACTICE LIABILITY

the hospital, but whether the claim against the institution has any merit.

The changing nature of hospitals has not gone unnoticed by the courts. These changes have precipitated a reevaluation of the traditional legal analysis regarding hospitals' liability for the negligence of their personnel. There has been a recognition that the traditional rule of nonliability of hospitals is no longer appropriate. In light of this changing philosophy, new theories have been formulated which predicate liability upon hospitals for employee negligence.

This Note examines the reasons why courts have moved away from the traditional rule of nonliability of hospitals, and presents current legal theories that attempt to justify imposing a duty of care upon hospitals. The discussion focuses on how courts use the doctrines of respondeat superior, ostensible agency, and corporate liability to hold hospitals accountable. While these theories have a long history in tort law, their application in the context of medical malpractice is novel.

II. HISTORICAL TREATMENT

A major change has occurred in the relationship between doctors, staff, and hospitals. In the past, hospitals were similar to modern nursing homes; they housed and fed the ill while doctors and nurses rendered


9. C. Kramer, The Negligent Doctor 39 (1968). The legal analysis at the turn of the century often focused on how the hospital was classified: a nonprofit hospital could not be liable, even for administrative negligence. Public policy determined that protecting "the dispenser of public benevolence" was more important than protecting the patient. Id. at 36.


11. See Note, supra note 4, at 953 n.1; see also supra note 1.

12. See Note, supra note 4, at 953. The author noted, "In recent years, courts and legislatures throughout the country have come to realize that the traditional legal analyses of these relationships accord with neither contemporary realities nor societal needs. The result has been increased recognition of a duty owed by hospitals to their patients with respect to the quality of medical care offered, even in the absence of a master-servant relationship between the physician and the hospital." Id. at 953-54.

13. See Bing, 2 N.Y.2d at 667, 143 N.E.2d at 7, 163 N.Y.S.2d at 9-10 ("The rule of nonliability is out of tune with life about us, at variance with modern-day needs and with concepts of justice and fair dealing").

medical care.\textsuperscript{15} The hospital personnel consisted of two factions.\textsuperscript{16} The hospital management provided and supervised hospital services, including the financial and housekeeping chores,\textsuperscript{17} while the medical staff rendered strictly medical services.\textsuperscript{18} In light of these responsibilities, physicians were not originally employed by hospitals.\textsuperscript{19} They contracted independently with hospitals, arranging to use hospital facilities for their patients when necessary.\textsuperscript{20} Since these professionals were not hospital employees, hospitals were traditionally found not liable for their negligence.\textsuperscript{21}

\textbf{A. Respondeat Superior}

The doctrine of respondeat superior, which holds an employer liable for tortious acts committed by his employee within the scope of employment,\textsuperscript{22} was not imposed upon early hospitals because the unusual nature of the hospital-independent contractor relationship, as compared with a typical employer-employee relationship, allowed many exceptions to the general rule.\textsuperscript{23} For example, many courts took the position that

\begin{flushright}
\textsuperscript{15} In contrast, "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." \textit{Bing}, 2 N.Y.2d at 664, 143 N.E.2d at 7, 163 N.Y.S.2d at 9.

\textsuperscript{16} \textit{But see Galatz, Hospital Liability: The Institution, The Physician, The Staff, TRIAL, May 1984, at 64, 65 (it is now recognized that a hospital is not comprised of two separate bodies).}

\textsuperscript{17} \textit{See J. ORLIKOFF, W. FIFER, M.D. \& H. GREELEY, MALPRACTICE PREVENTION AND LIABILITY CONTROL FOR HOSPITALS 5, 6 (1981) (quoting Southwick, The Hospital as an Institution: Expanding Responsibilities Change its Relationship with the Staff Physician, 9 CAL. W.L. REV. 429, 431 (1973)).} \textit{Holbrook \& Dunn, Medical Malpractice Litigation: The Discoverability and Use of Hospitals' Quality Assurance Committee Records, 16 WASHBURN L.J. 54, 55 (1976).} Traditionally, medical services were rendered by physicians who volunteered their services. Only chiefs of service were paid. In contrast, modern hospitals pay chiefs of service, associate and assistant chiefs, and attending physicians for their services. \textit{See Angel, supra note 2, at 413.}

\textsuperscript{18} \textit{See generally Horty \& Mulholland, The Legal Status of the Hospital Medical Staff, 22 ST. LOUIS U.L.J. 485, 487-88 (1978).}

\textsuperscript{19} \textit{Holbrook \& Dunn, supra note 17, at 55.}

\textsuperscript{20} \textit{Id.}

\textsuperscript{21} \textit{Id.}

\textsuperscript{22} The typical employer-employee relationship is subject to the doctrine of respondeat superior. \textit{See Note, supra note 4, at 956.} This doctrine insures payment to the injured person and puts society on notice that individuals are expected to exercise reasonable care in the workplace. \textit{See Bing, 2 N.Y.2d at 666, 143 N.E.2d at 8, 163 N.Y.S.2d at 10-11.} Liability can be avoided, however, if the hospital can demonstrate that the negligent party was not its employee. \textit{See Swan, supra note 7, at 276.} The legal analysis behind this doctrine focuses on whether the master had the right to control the servant's activities at the time the act or omission occurred. \textit{See Note, supra note 4, at 956.} Some jurisdictions tend to focus less on a mechanical application of the rule than on the actual relationship between the parties. \textit{See id. at 957.}

\textsuperscript{23} \textit{Note, supra note 4, at 957.} As with the employer-employee relationship, it is nec-
the doctrine of respondeat superior was inapplicable if the physician was required to exercise his professional discretion. Courts rationalized that the medical profession requires such a high level of skill and specialization that a hospital administrator could not easily control a physician's discretionary acts. Thus, courts refused to impose respondeat superior liability even upon salaried physicians.

Courts also refused to impose respondeat superior liability if the negligent act or omission was administrative rather than medical. A hospital's function, it was reasoned, was to supply professionals who undertook responsibility for the treatment they rendered. The hospital's role was not to heal or attempt to heal patients through the agency of others. In Minnesota, courts applied the doctrine of respondeat superior when physicians or nurses performed administrative acts, but not when they rendered medical treatment. As a general practice, hospital employees performed administrative functions for which the hospital would be held liable. In contrast, physicians and nurses who were independent con-

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25. See Runyan, 157 Ark. 481, 228 S.W. 397; Rosane, 112 Colo. 363, 149 P.2d 372; Schloendorff, 211 N.Y. 125, 105 N.E. 92.

26. Note, supra note 4, at 957. In Rosane, 112 Colo. at 366, 149 P.2d at 374, the court stated, "The relation between doctor and patient is personal. That a hospital employs doctors on its staff does not make it liable for the discharge of their professional duty since it is powerless . . . to command or forbid any act by them in the practice of their profession." Id. One commentator concluded, "[The determination of the existence of a master-servant relationship turned from a case-by-case contractual analysis into the simple proposition that the physician was always an 'independent contractor' simply using hospital facilities, and never an employee." Note, supra note 4, at 957 (emphasis in original) (footnotes omitted).

27. Payne, supra note 8, at 396. The Minnesota Supreme Court attempted to explain the distinction between administrative and medical acts in Swigerd v. City of Ortonville, 246 Minn. 339, 75 N.W.2d 217 (1956). The court stated, "The decision that the heat-lamp treatment should be given was a nonadministrative or medical act of . . . the attending physician, but the execution, and the manner of implementing that decision, was merely administrative and did not call for specialized medical skill." Id. at 346, 75 N.W.2d at 222. But see Bing, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (expressly overruling the medical-administrative acts distinction).

28. C. Kramer, supra note 9, at 37-38.

29. Id.

30. Swigerd, 246 Minn. at 345, 75 N.W.2d at 222. The court adopted the liability for administrative acts rule, stating "the hospital is liable for the negligence [in] administrative or clerical acts, which acts, though constituting a part of a patient's prescribed medical treatment, do not require the application of the specialized technique or understanding of a skilled physician or surgeon." Id. (emphasis in original).

31. Id. The Swigerd court distinguished Mesedahl v. St. Luke's Hosp. Ass'n, 194 Minn. 198, 259 N.W. 819 (1935), in which the court found that a hospital retained the right of control over allegedly negligent nurses.
tractors performed medical acts involving the exercise of discretion.\textsuperscript{32} Since respondeat superior liability did not apply to the hospital-independent contractor relationship, courts would not hold hospitals liable for the performance of discretionary medical acts.\textsuperscript{33}

Distinguishing between the types of acts created the most difficulty for courts applying the rule.\textsuperscript{34} Courts finally determined that distinctions could not consistently be identified.\textsuperscript{35} Courts abandoned the theory because no legitimate reason existed for continuing to exempt hospitals from a responsibility imposed upon other institutions.\textsuperscript{36} Thus, hospitals became subject to the "scope of employment" standard applicable in assessing liability to employers for the negligence of their employees.\textsuperscript{37}

\textbf{B. Charitable Immunity}

Hospitals were also exempted from respondeat superior liability because they were considered to be charitable institutions, unaccountable for the quality of services provided.\textsuperscript{38} The premise of this rule was the charitable immunity doctrine, which is based on two theories.

The "trust fund" theory held that trust funds donated to a charitable hospital could not be used to pay tort claims.\textsuperscript{39} To do so would not only

\begin{itemize}
  \item \textsuperscript{32} Payne, \textit{supra} note 8, at 396.
  \item \textsuperscript{33} \textit{Id.}; see McKelvey v. Barber, 381 S.W.2d 59 (Tex. 1964) (doctor seeking to avoid malpractice liability alleged that he was the agent of the patient's employer but court refused to give effect to any presumption of a master-servant relationship). Some courts will establish a business relationship when facts demonstrate great injury to the plaintiff and gross negligence by the physician. See Edwards v. West Tex. Hosp., 89 S.W.2d 801 (Tex. Civ. App. 1935) (doctor removed one twin successfully in a cesarean section, but his failure to remove other twin resulted in the mother's death due to fetal decomposition).
  \item \textsuperscript{34} Comment, \textit{supra} note 3, at 143.
  \item \textsuperscript{35} \textit{Id.} The difficulties facing the courts in applying the administrative-medical distinction were addressed in Bing.
  \begin{itemize}
    \item Placing an improperly capped hot water bottle on a patient's body is administrative . . . while keeping a hot water bottle too long on a patient's body is medical. . . . Administering blood, by means of a transfusion, to the wrong patient is administrative . . . while administering the wrong blood to the right patient is medical. . . . Employing an improperly sterilized needle for a hypodermic injection is administrative . . . while improperly administering a hypodermic injection is medical.
  \end{itemize}
  \item \textsuperscript{2} N.Y.2d at 660-61, 143 N.E.2d at 4-5, 163 N.Y.S.2d at 6.
  \item \textsuperscript{36} \textit{Id.} at 662, 143 N.E.2d at 5, 163 N.Y.S.2d at 7. The court noted that the special skills of other employees, e.g., airline pilots, locomotive engineers, and chemists, has not exempted them from application of respondeat superior. Furthermore, since public hospitals were held accountable for the negligence of their employees, private hospitals should be treated similarly. \textit{Id.} at 662, 143 N.E.2d at 6, 163 N.Y.S.2d at 8.
  \item \textsuperscript{37} \textit{Id.}
  \item \textsuperscript{38} Note, \textit{supra} note 4, at 954.
  \item \textsuperscript{39} W.P. KEETON, D. DOBBS, R. KEETON & D. OWEN, PROSSER AND KEETON ON THE LAW OF TORTS § 133, at 1070 (5th ed. 1984) [hereinafter cited as PROSSER & KEETON]; see Perry v. House of Refuge, 63 Md. 20 (1885); McDonald v. Massachusetts Gen. Hosp., 120 Mass. 432 (1876).
\end{itemize}
hospitals' medical malpractice liability

have violated donors' intentions, but might also have discouraged donors from making additional contributions to charities if they knew their gifts could be used to pay tort claims. Public policy required that in a dispute between the dispenser of public benevolence and the unfortunate victim of negligence, the former should be protected, even at the expense of the latter.

Another theory, the "implied waiver" theory, provided that charity recipients waived their rights to recover damages because their medical services were rendered gratuitously. Inherent in the waiver theory was the notion that a good samaritan who renders care at no charge was not obligated to exercise the same degree of care and skill as his colleagues.

The charitable immunity doctrine, though short-lived in England, was adopted in the United States in the mid-1800's and retained vitality for nearly a century. The doctrine, after numerous exceptions, qualifications, and requirements, was finally scrutinized and rejected by a federal court in 1942. The doctrine was abolished because it was not needed to protect hospitals' economic well-being.


41. PROSSER & KEETON, supra note 39, § 133, at 1070. There was also a concern that a large judgment against a charitable hospital would destroy the hospital. Nevertheless, with the availability of malpractice insurance, modern hospitals are generally not faced with this concern. See Bing, 2 N.Y.2d at 664, 143 N.E.2d at 7, 163 N.Y.S.2d at 9.

42. C. KRAMER, supra note 9, at 36. Under the so-called "public policy theory," courts held that societal interests would be best served if charitable hospitals were not subject to lawsuits. Most commentators disfavor this theory. Connors & Boniuk, Hospital Liability: Treatment of the Institution, 1984 MED. TRIAL TECH. Q. 393, 396.


44. PROSSER & KEETON, supra note 39, § 133, at 1070.

45. See Feoffees of Heriot's Hosp. v. Ross, 8 Eng. Rep. 1508 (1846) (adopting charitable immunity); Mersey Docks & Harbour Bd. of Trustees v. Gibbs, 1 L.R.-E. & I. App. 93 (1866) (repudiating the charitable immunity doctrine of Feoffees); see also PROSSER & KEETON, supra note 39, § 133 (discussing the development and application of charitable immunity).

46. See Perry, 63 Md. 20; McDonald, 120 Mass. 432. Apparently, both courts were unaware that the English decision creating the immunity had been overruled in 1866. The most famous case upholding the immunity rule is Schloendorff v. Society of the New York Hospital, 211 N.Y. 125, 105 N.E. 92 (1914). The Schloendorff court based the charitable immunity on both the implied waiver and respondent superior theories. Id. at 128-29, 105 N.E. at 93.

47. In recent years only two or three states have retained full immunity in the absence of legislation to the contrary. Other states have retained immunity, subject to certain exceptions or limitations. The doctrine of complete immunity has virtually been discarded by American courts. See PROSSER & KEETON, supra note 39, § 133, at 1070-71.

48. See President of Georgetown College v. Hughes, 130 F.2d 810 (D.C. Cir. 1942).

not depend upon volunteer work and donations for their existence.50 They are well insulated from financial failure by liability insurance.51 Furthermore, policy considerations deem it unfair to permit a patient to be subjected to careless treatment and left uncompensated because the hospital is owned by a governmental52 or charitable organization.53 Such immunity from liability could be interpreted as providing a license for hospitals to tolerate carelessness by their employees. The vast majority of jurisdictions now adhere to the rule that hospitals do not enjoy charitable immunity. Thus, with the abolition of the charitable immunity theory and the resurgence of respondeat superior, the once impenetrable fortress of immunity surrounding hospitals began to crumble.

III. PRESENT STATUS OF THE LIABILITY THEORIES

The nature of the modern hospital as an institution of care imposes an obligation on the hospital to protect its patients from negligent treatment. The hospital's function changed significantly during the twentieth century; the hospital became more than a provider of bed and board for

HOSPITALS’ MEDICAL MALPRACTICE LIABILITY

the patients of its physicians. Hospitals assumed extensive educational and research responsibilities and began to furnish technical and specialist services to their patients and physicians. Modern hospitals generally regulate their own staffs and take an active role in supplying the patients’ medical treatment. Physicians who use hospital facilities must comply with hospital regulations and submit their work to staff review. Hospital employees now include interns, residents, staff nurses, anesthesiologists, radiologists, pathologists, and paramedical personnel. Hospitals may be liable for the negligence of these specialists, even though they are not technically hospital employees, if the specialists operate under a concession arrangement or monopolize a particular department of the hospital.

A. Respondeat Superior

Sound policy reasons now exist for holding hospitals accountable under respondeat superior. Patients enter hospitals in anticipation of receiving treatment which will improve their mental or physical condition. They expect that to some degree the hospital will control the

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55. See supra note 15.
56. See Angel, supra note 2, at 411-14.
57. Payne, supra note 8, at 389.
58. Id. at 390. "[I]t has become generally accepted in most jurisdictions that the employer (the hospital) is liable to a third person (the patient) for any injury which results proximately from the tortious conduct of the employee acting within the scope of his employment, even though that employee is a physician." Id.
59. A. HOLDER, supra note 7, at 211. The Minnesota Supreme Court made the following observation about hospital employees:

It does not seem reasonable to us to characterize a resident doctor such as Dr. Finkelnberg as an independent contractor while he performs the routine hospital functions for which he is hired. ... [R]esidents are assigned to supervise the interns in providing the details of medical service, physical examinations, and the necessary treatment with which they are charged; to assist the interns when their capabilities are not sufficiently advanced so that they can do the service themselves; and to report to the attending staff the progress and effects of the treatment.

Moeller v. Hauser, 237 Minn. 368, 379, 54 N.W.2d 639, 645-46 (1952). The court continued:

The relationship of a resident to the hospital is not unlike that of an interne or nurse. All three groups are specially and highly trained. All three are engaged in supplying the element of trained medical care which distinguishes a hospital from a hotel. Under these circumstances, we must hold that a resident doctor in a hospital who receives his compensation from the hospital while providing medical care as a part of a regular hospital routine is a servant of the hospital so as to make the hospital liable for his negligence under the doctrine of respondeat superior.

Id. at 379, 54 N.W.2d at 646.
60. C. KRAMER, MEDICAL MALPRACTICE 24 (1965).
61. Note, supra note 4, at 958.
62. Id. at 953.
activities which occur there.\textsuperscript{63} Patients have faith in health care providers and anticipate that they will benefit from a stay in a hospital.\textsuperscript{64} If a patient does not receive the anticipated level of treatment, and is adversely affected by the care provided, he should be compensated for his injuries. Individuals should be permitted a basis for recovery for injuries sustained because of the negligence of hospital personnel. The modern trend interprets the law in favor of the sick and injured who seek care and protection from doctors and other hospital personnel.\textsuperscript{65}

Most courts now apply the doctrine of respondeat superior to the hospital-patient situation, although with limitations.\textsuperscript{66} In Minnesota, courts apply respondeat superior to impose liability on hospitals for the negligence of their employees and on doctors for the negligence of their nurses.\textsuperscript{67}

\textsuperscript{63} Id. at 967. The author noted, “Public outrage, and possibly even an effect on admissions . . . would surely follow a public announcement by the hospital that it regards all staff doctors as completely independent professionals, conducts no supervision of their performance and takes no interest in their competence.” Id.

\textsuperscript{64} A malpractice victim is not injured by a stranger, as in an auto accident, but is hurt by a particular physician or hospital selected by the victim to render treatment. Comment, The Hospital-Physician Relationship: Hospital Responsibility for Malpractice of Physicians, 50 WASH. L. REV. 385, 393-94 (1975).


\textsuperscript{66} Note, supra note 4, at 958.

\textsuperscript{67} See, e.g., Synnott v. Midway Hosp., 287 Minn. 270, 178 N.W.2d 211 (1970) (injury caused by x-ray technician’s negligence imputed to hospital under doctrine of respondeat superior); Quick v. Benedictine Sisters Hosp. Ass’n, 257 Minn. 470, 102 N.W.2d 36 (1960) (knowledge of nurses and attendants was knowledge of hospital; neglect of hospital personnel constituted neglect of hospital); Swigerd v. City of Ortonville, 246 Minn. 339, 75 N.W.2d 217 (1956) (hospital liable for patient’s death from burns caused by heat lamp fire); St. Paul Mercury-Indem. Co. v. St. Joseph’s Hosp., 212 Minn. 558, 4 N.W.2d 637 (1942) (hospital nurses are employees of doctor while assisting doctor during operation, making doctor liable for nurses’ acts during operation).

If a nurse is assigned to assist a surgeon during an operation, the surgeon assumes full responsibility for any negligent acts which occur during the surgery. Swigerd, 246 Minn. at 342, 75 N.W.2d at 220 (refining borrowed-servant rule); see also Synnott, 287 Minn. at 274, 178 N.W.2d at 213 (citing Swigerd). The physician who directly supervises the nurse’s treatment of a patient is also personally responsible for her actions. Swigerd, 246 Minn. at 342, 75 N.W.2d at 220. The physician’s liability ends and the hospital’s responsibility begins when the nurse begins to administer routine nursing care. Id. at 345, 75 N.W.2d at 222.

The hospital’s liability extends to the nurse who negligently performs routine nursing functions “constituting a part of the patient’s prescribed treatment.” Id. The acts must be those which do not require application of a physician’s specialized skill or specific instructions on how to perform duties. See id. Usually, routine acts are those which a physician assumes will be performed in a doctor’s absence as part of the nurse’s daily activities. Id. at 346, 75 N.W.2d at 222.

Nurses have an additional duty to convey crucial information regarding changes in a patient’s condition to their supervisors or to the supervising physicians. Sandhofer v. Abbott-Northwestern Hosp., 283 N.W.2d 362 (Minn. 1979). Sandhofer was treated by two doctors at Abbott-Northwestern for a fractured wrist. He alleged that defendants’ negli-
In ascertaining whether the hospital rightfully controls the employee, courts look to "the nature of the acts performed, and the custom as to the control ordinarily exercised in the performance of similar acts."68 This approach embodies the administrative-medical act analysis that has been abandoned in some jurisdictions.69 It is difficult to apply this analysis, because the controlling party is often unidentifiable. Hospital administrators exercise control over hospital departments.70 Hospital administrators, however, cannot and would not try to exercise control over a physician's decisions, even if the physician were salaried.71 The right of control test is an unrealistic means of viewing the operation of modern hospitals; therefore, Minnesota should formulate an alternative standard.

California has adopted one potential solution.72 California courts first examine the hospital-patient relationship, focusing on whether the patient sought treatment from the hospital.73 Then the hospital-physician relationship is examined by querying whether the hospital pays the negligence occurred during the five-day period between the application and removal of a plaster cast on his right arm. During that period, his hand became blue and swollen due to lack of circulation. The resulting necrotic condition required amputation of his arm several months later. Id. at 364-65.

The evidence at trial showed that the charge nurse and doctors were not warned of significant changes in plaintiff's condition, although they expected to be notified. See id. at 367. The lower court found that there was sufficient evidence to support a verdict of negligence against both the physicians and the hospital. See id. The supreme court affirmed the trial court's decision because the evidence established that the standard of care recognized by the medical community would require the nurses to notify the doctors of significant and observable changes in the plaintiff's condition. Id. at 367.

Regardless of whether information is conveyed to management personnel, if the hospital fails to take preventive measures and the patient is subsequently injured due to the mental or physical incapacities resulting from the patient's condition or treatment, the hospital will be liable to the patient for resulting injuries on the basis of respondeat superior. In Quick, the court held that the hospital's responsibility extended to protecting the patient from foreseeable dangers due to his incapacity. The court held that the knowledge and neglect of the hospital personnel was imputed to the hospital under the doctrine of respondeat superior. 257 Minn. at 480, 120 N.W.2d at 44. 68. Swigerd, 246 Minn. at 345, 75 N.W.2d at 222 (citing Frenkle v. Twedt, 234 Minn. 42, 48, 47 N.W.2d 482, 487 (1951). 69. St. Paul-Mercer Indem. Co., 212 Minn. at 560, 4 N.W.2d at 639; accord Synott, 287 Minn. at 274, 178 N.W.2d at 213. 70. See Comment, supra note 64, at 392-93. 71. Id. at 392 & n.49. "[I]t would be a violation of most state medical practices acts for the directors to attempt to exercise such control." Id. at 392; see also Grewe v. Mount Clemens Gen. Hosp., 404 Mich. 240, 252, 273 N.W.2d 429, 433 (1978) ("The relationship between a given physician and a hospital may well be that of an independent contractor performing services for, but not subject to, the direct control of the hospital"); Pbarra, 25 Cal. 2d at 492, 154 P.2d at 690 (during hospital stay various agencies and instrumentalities exercise control). 72. See Brown v. La Societe Francaise de Bienfaisance Mutuelle, 138 Cal. 475, 71 P. 516 (1903); see also Comment, supra note 64, at 393-96 (discussing Brown). 73. Brown, 138 Cal. at 476, 71 P. at 516.
gent physician a salary. By focusing on these factors, courts avoid the
difficult task of determining who had the right to control the tortfeasor
when the negligence occurred. Courts can also more accurately deter-
mine where responsibility for malpractice lies and decide whether the
hospital should share in the liability.

B. Ostensible Agency and Corporate Liability

Courts have reevaluated the hospital-physician relationship in an at-
ttempt to formulate new legal theories which would further the public
policy behind respondeat superior and avoid the problems inherent in
the doctrine. If a patient fails to prove the existence of a master-ser-
vant relationship between the hospital and the physician which would
form the basis of the institution’s liability, the hospital may still be liable
under the theories of ostensible agency and corporate liability. While
these theories approach the liability issue from different perspectives,
they share the same purpose and achieve the same result. Both are

74. Id.
75. See Comment, supra note 64, at 393.
76. See id. In discussing the current viability of the respondeat superior doctrine, one
author has stated:

When applying the doctrine of respondeat superior to the hospital-physician rel-
ationship it is important to recognize that the traditional right of control test is
unworkable. Central to the control test is the master's right of physical control
over the details of the servant's work. The lay board of directors or lay adminis-
trators of hospitals obviously do not exercise any control over the medical treat-
ment rendered by physicians. Moreover, it would be a violation of most
state medical practices acts for directors to attempt to exercise such control.
Thus, although courts still frame the issue in terms of the right of control, they
necessarily ignore it whenever they hold a hospital liable for the malpractice of a
physician.

Id. at 392 (footnote omitted).
77. Payne, supra note 8, at 398-99. The doctrine of ostensible agency involves a “hold-
ing out” to a patient by the hospital that the medical treatment will be adminstered by a
physician employed by the hospital. Id. at 399. If a hospital makes such a representation,
it may be liable under respondeat superior for the negligence of a physician within its
employ even if the physician would otherwise be regarded as an independent contractor.
It is the patient’s reasonable impressions, not the legal arrangement between the physician
and the hospital, which are controlling under the ostensible agency doctrine. Id.; see How-
doctrine to hold medical center and its owner liable for negligence of surgeon
recommended).

78. Comment, supra note 3, at 142-45. The Washington Supreme Court has stated:
The doctrine of corporate negligence reflects the public's perception of the modern
hospital as a multifaceted health care facility responsible for the quality of
medical care and treatment rendered. The community hospital has evolved into
a corporate institution, assuming 'the role of a comprehensive health center ulti-
"http://open.mitchellhamline.edu/wmlr/vol11/iss2/9"
intended to impose a duty on hospitals directly to their patients.\textsuperscript{80} Both are applied when the duty would otherwise be avoided because of the independent contractor status of the physician.\textsuperscript{81} Both result in the consistent imposition of liability upon hospitals when the negligent acts or omissions of their employees injure their patients.\textsuperscript{82}

\section{Ostensible Agency}

An ostensible agency relationship is created when a principal erroneously leads a third party to believe that another is the principal's agent.\textsuperscript{83} A third party must prove three elements to recover against a principal for the ostensible agent's negligence:\textsuperscript{84} the person dealing with the agent must reasonably believe in the agent's authority;\textsuperscript{85} the principal's act or omission must have generated such a belief;\textsuperscript{86} and the third person who
relies on the agent's authority must not be negligent. If an aggrieved party can prove that the hospital represented that he would be treated by a physician-employee, the hospital may be held liable even if the physician was actually an independent contractor of the hospital.

While the Minnesota Supreme Court has not been confronted with the specific issue of whether a hospital may be held liable under the ostensible agency theory, courts in other jurisdictions have addressed the issue. Those courts have examined whether the patient looked to the hospital for treatment of his condition or merely viewed the hospital as the situs where his physician would render treatment. They have also queried whether the hospital provided the physician or whether the patient and physician had a preexisting relationship. A patient entering a hospital for treatment typically relies on the hospital to cure him, not the doctor acting on his own responsibility. Finally, courts have considered whether factors were present which should have alerted the patient that the physician was not an employee. If a patient has notice

87. Payne, supra note 8, at 399.
88. Id.; see supra note 77.
89. Payne, supra note 8, at 398-99; see, e.g., Wilson v. Stilwill, 411 Mich. 587, 610, 309 N.W.2d 898, 906 (1981) (court rejected plaintiff's ostensible agency argument because patient had an independent relationship with the physician prior to admission to the hospital); Grewe, 404 Mich. at 250, 273 N.W.2d at 433 (hospitals generally not held vicariously liable, but agency by estoppel can be found where hospital represents an independent physician as its employee); Howard, 37 Mich. App. at 499, 195 N.W.2d at 40 (the doctrine of ostensible agency is well recognized in Michigan).
90. See Grewe, 404 Mich. at 250, 273 N.W.2d at 433.
91. See id. at 250, 273 N.W.2d at 433.
92. Id. at 250, 273 N.W.2d at 433 (citations omitted).
93. In Seneris v. Haas, 45 Cal. 2d 811, 828-30, 291 P.2d 915, 926-27 (1955), the plaintiff alleged that Dr. Haas negligently allowed Dr. West to administer the anesthetic, and
that an employer-employee relationship does not exist, then he cannot rely on that relationship.94

Sound policy reasons exist for allowing patients to recover under the ostensible agency theory, but practical application of the theory arguably imposes an unfair burden on hospitals. Hospitals must give timely notice of any independent contractor relationships so that patients cannot mistakenly rely on the existence of an employer-employee relationship.95 The patient has no duty to inquire whether his attending physician is an employee or independent contractor, particularly in emergency situations.96 One court implied that the hospital has the burden of advising the patient when the employer-employee relationship does not exist.97 The patient's reasonable impressions will be given more weight than the actual legal arrangement between the doctor and the hospital.98

Despite the problems confronting hospitals, the theory is fair in light of patients' expectations and perceptions of hospital operation. For example, emergency room treatment has become more specialized99 and more frequently utilized than in the past. Once a hospital establishes an emergency room, the public relies on the availability of adequate medical care.100 The public assumes that hospitals are supervising their staffs

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The Senerit court held that the trial court erred in taking the agency issue from the jury, stating:

There is nothing in the record to show that plaintiff should have been on notice that defendant West was not an employee of defendant hospital and it cannot be seriously contended that she was obligated to inquire whether each person who attended her in said hospital was an employee or an independent contractor.

Id. at 832, 291 P.2d at 927.

94. See Howard, 37 Mich. App. at 500-01, 195 N.W.2d at 41 (citing several sources stating that ostensible agency applies only where a patient reasonably relies on a hospital's representation of agency).

95. See generally Payne, supra note 8, at 398-99.

96. Id. at 393; see Howard, 37 Mich. App. at 501, 195 N.W.2d at 41-42.


98. See supra note 77, supra note 88 and accompanying text.

99. See Payne, supra note 8, at 393.

100. See Galatz, supra note 16, at 66-67; see also Horty & Mulholland, supra note 18, at 490:

The area of the hospital in which the impact of the consumer movement has been felt most acutely is the emergency room. Many consumers, especially in urban areas, regard the emergency room as just another doctors' office, and go there expecting treatment for every ailment, no matter how inconsequential. Then, if the medical care they receive does not measure up to their expectations, the hospital may be sued, even where the problem was the fault of the attending physician. The hospital can no longer assert the defense that it is not responsible
and exerting the appropriate measure of control over their activities. In view of these expectations, hospitals are held responsible for adequately and safely staffing emergency rooms and providing the related administrative functions. Despite the notice requirement imposed on hospitals, ostensible agency is a viable theory upon which to hold hospitals liable for the malpractice of persons practicing medicine on their premises.

The ostensible agency theory deserves consideration by the Minnesota courts. The theory creates an agency relationship which did not previously exist and holds hospitals vicariously liable for the malpractice of independent contractors. Unlike respondeat superior, no control determination is necessary. The patient's reliance and the hospital's failure to communicate the absence of the employer-employee relationship will provide sufficient bases on which to apply the theory.

2. Corporate Liability

The corporate liability theory is premised on the notion that a hospital owes a duty directly to its patients to render quality medical care and to protect its patients' safety. The hospital fulfills its duty by acting affirmatively to protect its patients from incompetent or negligent treatment. The breach of this independent duty by any hospital personnel

for the care rendered by that physician, even if that physician was an independent contractor and not an employee of the hospital.

101. See Payne, supra note 8, at 393 (noting that control over doctors' performances in an emergency room may not alter the status of the independent contractor).

102. Letourneau, supra note 65, at 52-53.

103. Note, supra note 4, at 967.

104. Swan, supra note 7, at 318. In a medical malpractice suit, the plaintiff must introduce evidence of the standard of care recognized by the medical community and the defendant's deviation from that accepted standard. Typically, this evidence is presented through expert testimony. Sandhofer v. Abbott-Northwestern Hosp., 283 N.W.2d 362, 364, 368-69 (Minn. 1979). Additionally, the plaintiff must establish that departure from that standard was a direct cause of his injury. Plutshack v. University of Minn. Hosp., 316 N.W.2d 1, 5 (Minn. 1982).

105. Letourneau, supra note 65, at 52. The theory has been characterized as being both broader and narrower than respondeat superior; broader because liability can be imposed on the hospital regardless of whether the tortfeasor was actually an employee, and narrower because the hospital may not be held liable if it fulfilled its duty. Swan, supra note 7, at 318.

106. The Washington Supreme Court recently adopted the theory of corporate negligence in Pedroza v. Bryant, 101 Wash. 2d 226, 677 P.2d 166 (1984). The specific issue in Pedroza was whether a hospital could be held liable under the theory of corporate negligence for its action in granting staff privileges to a non-employee physician who allegedly committed malpractice while in private practice off the hospital premises. Id. at 227, 677 P.2d at 167. The court held that the theory is limited to individuals who are treated as patients within the hospital. Id. at 237, 677 P.2d at 172. The court noted that it was embracing a theory adopted by nearly every jurisdiction which had addressed the issue in the past 15 years. Id. at 233, 677 P.2d at 170.
results in corporate or hospital liability.\textsuperscript{107} While a hospital is not an insurer,\textsuperscript{108} it must exercise reasonable care for the protection and well-being of its patients.\textsuperscript{109} The measure of a hospital's duty is that degree of care, skill, and diligence used by other hospitals in the community.\textsuperscript{110}

Courts impose corporate liability because patients are entitled to expect quality treatment from modern hospitals, which generally have extremely sophisticated equipment and highly trained personnel.\textsuperscript{111}
Hospitals, like other businesses, must provide quality services or be responsible to the consumer for the consequences. The policy reasons for imposing corporate liability are virtually identical to those for imposing ostensible agency.\textsuperscript{112} Courts in Minnesota and in other jurisdictions have utilized corporate liability in order to impose numerous duties.\textsuperscript{113} Statutes, case law, and malpractice suits had been filed against Dr. Salinsky prior to his appointment to the Misericordia staff. \textit{Id.} at 743, 301 N.W.2d at 174.

The medical staff coordinator testified that she failed to investigate Salinsky’s application because she believed he had been on the hospital staff prior to her employment at the hospital, even though the application was not marked approved until four months after she commenced employment. \textit{Id.} at 714, 301 N.W.2d at 160.

\textsuperscript{112} The Minnesota Supreme Court has noted:

\begin{quote}
A patient enters a hospital in reliance upon the reasonable assumption that its trained staff of nurses, its responsible supervision, and its special equipment will insure him a higher standard of care in administering to his needs as his physician may prescribe. If this assumption were not justifiable, the patient might just as well stay at home during his illness. Clearly, a hospital has a greater responsibility for the welfare of its patients than merely to maintain a pool of trained nurses from which the various attending physicians may select their assistants.
\end{quote}

\textsuperscript{113} \textit{See}, e.g., Crumley v. Memorial Hosp., Inc., 509 F. Supp. 531 (E.D. Tenn. 1979) (duty to select staff with care, duty to remove incompetent staff members); Elam v. College Park Hosp., 132 Cal. App. 3d 332, 183 Cal. Rptr. 156 (1982) (duty to establish specific policies of safe medical practice); Rum River Lumber Co. v. State, 282 N.W.2d 882 (Minn. 1979) (duty to control patient’s conduct where hospital knew of patient’s dangerous propensities and had authority to control conduct). The court never made reference to the doctrine of corporate liability in the \textit{Rum River} case. The court rejected the defendant’s argument that the jury should have been given Minnesota Jury Instruction Guide II (Minn. Jig II), 434 G-S, and agreed with the plaintiff that the proper instruction was Minn. Jig II, 112-G. Minn. Jig II, 434 G-S states:

\begin{quote}
A hospital must exercise reasonable care for the protection and well being of its patients.

In determining whether the hospital exercised reasonable care you may consider, among other things:

1. What facts the hospital knew or in the exercise of reasonable care should have known concerning the physical and mental state of (plaintiff) (decedent) (person who injured (plaintiff) (decedent)).

2. In determining whether the hospital acted reasonably you may also consider the level of training and experience of its employees in regard to the type of treatment being given to (plaintiff) (decedent) and whether such employees were or should have been equipped to anticipate and take adequate precautions for the safety of (plaintiff) (decedent). In this regard you may consider whether the hospital held itself out to the (public) (admitting doctors) as being equipped to treat and care for a patient requiring that form of treatment and care.
\end{quote}

\textit{4 J. HETLAND & O. ADAMSON, MINNESOTA PRACTICE} 342 (2d ed. 1974).

The trial court in \textit{Rum River} paraphrased Minn. Jig II, 112-G as follows:

Now a hospital to which a patient suffering from a mental illness or disease is committed by the court is responsible for an injury caused by the patient if the hospital is negligent with respect to defendant’s duty to control the patient.

In order to find the hospital negligent you must find the hospital failed to exercise reasonable control over the patient. Factors to be considered in determining whether negligence exists are (a) Did the hospital know or should it have
regulations of associations governing hospital accreditation impose these duties.\footnote{114} Medical profession customs,\footnote{115} hospital bylaws,\footnote{116} and professional organization requirements\footnote{117} may be used as evidence of the standards which hospitals are expected to uphold. The duties include requiring a hospital to carefully select and supervise its physicians.\footnote{118} The hospital cannot shirk its duty by claiming that the staff, rather than

\begin{itemize}
  \item known of characteristics, habits and prior conduct of the patient similar to that which resulted in the injury; 
  \item Did the hospital know or should it have known of the need to control the patient in the particular instance; and 
  \item Did the hospital have an ability to control the patient and an opportunity to do so. 
\end{itemize}

282 N.W.2d at 884. It should be noted that Minn. Jig II, 112-G deals with parental liability for torts of their children. \textit{4} J. HETLAND & O. ADAMSON, \textit{supra}, at 90. Obviously, Minn. Jig II, 434 G-S addresses the liability issue in terms of an ostensible agency theory, i.e., whether the hospital held itself out to the public, whereas Minn. Jig II, 112-G uses a negligence test to assess the hospital's liability. Interestingly, the Minn. Jig. II authors cite as authority for Minn. Jig II, 434 G-S cases which approach the hospital liability issue from the respondeat superior perspective. The fact that the instruction uses an ostensible agency analysis but cites respondeat superior cases for authority illustrates how much the theories overlap.

114. For example, the American Osteopathic Association has basic accreditation requirements which state that the governing authorities of a hospital owe a duty to the community to select professionally competent physicians as staff members. Pecell v. Zimbelman, 18 Ariz. App. 75, 81, 500 P.2d 335, 341 (1972).

115. The plaintiff in \textit{Purcell} sued a doctor who had been a defendant in four previous malpractice actions, two of which involved the same type of operation as the plaintiff had undergone. \textit{Purcell}, 18 Ariz. App. at 83, 500 P.2d at 343. The plaintiff alleged that by failing to take any action against Dr. Purcell or to recommend that the board of trustees take some action, the hospital breached its duty to ensure that only professionally competent doctors who follow accepted medical practices will be allowed to use the facilities. \textit{Id}. The court agreed. \textit{Id}. In imposing liability upon the hospital, the court cited custom in the medical profession, the hospital bylaws, and requirements of the American Osteopathic Association as evidence of the duty which the hospital violated. \textit{Id}. at 80-81, 500 P.2d at 340-41. The court stated that it was customary for hospitals nationwide to establish and operate review committees to regulate physicians' staff privileges and to ensure that only qualified doctors receive privileges. \textit{Id}. at 81, 500 P.2d at 341. A member of the hospital's board of trustees testified that the hospital was aware of the custom among hospitals of monitoring performance of staff doctors and restricting or suspending their privileges if necessary. \textit{Id}. He said that the hospital subscribed to this custom and attempted to follow it. \textit{Id}.

116. \textit{Id}. 

117. \textit{See Note, supra note 8, at 369}.

118. Johnson, 99 Wis. 2d at 724-25, 301 N.W.2d at 164-65; \textit{see also Tuscon Medical Center, Inc. v. Misevich, 113 Ariz. 34, 36, 545 P.2d 958, 960 (1976) (hospitals have the duty to supervise the competence of their doctors); Johnson v. St. Bernard Hosp., 79 Ill. App. 3d 709, 714-15, 399 N.E.2d 198, 203 (1979) (plaintiff failed to allege that hospital failed to properly select or supervise physician); Ferguson v. Gonyaw, 64 Mich. App. 685, 697, 236 N.W.2d 543, 550 (1975) (it is a primary function of a hospital to screen its staff to insure only competent physicians are allowed to practice in the hospital); Bost v. Riley, 44 N.C. App. 638, 647, 262 S.E.2d 391, 396 (1980) (hospital must make reasonable effort to monitor and oversee treatment of patients); Payne, \textit{supra} note 8, at 391-401. Payne suggests that hospitals owe four duties to the patient:

\begin{enumerate}
  \item to use reasonable care in the maintenance of buildings and grounds for the protection of the hospital's invitees;
\end{enumerate}
the institution, was expected to fulfill the duty.\(^ {119} \)

An institution can suffer serious repercussions from inadequately screening a physician's employment application and hiring an unqualified doctor who subsequently commits malpractice. It is the hospital’s duty to investigate an applicant’s qualifications for employment to prevent the appointment of unqualified physicians. Failure to fulfill this duty makes harm to patients reasonable and foreseeable.\(^ {120} \) The hospital must obtain and assess the appropriate information and exercise reasonable care in investigating the applicant’s credentials.\(^ {121} \) It must follow certain minimum procedures in assessing an applicant’s qualifications.\(^ {122} \) The hospital should require him to complete the application.\(^ {123} \) The employer should verify all statements, particularly those pertaining to medical education, training, and experience.\(^ {124} \) The hospital should also elicit comments from the applicant’s colleagues, especially those who are not given as references.\(^ {125} \) The hospital should consult persons familiar with the physician’s education, training, experience, and health who can

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(2) to exercise reasonable care to furnish the patient supplies and equipment free from defects;
(3) to select its employees with reasonable care; and
(4) to oversee the qualifications of persons who practice medicine within its walls.

Id. at 399-400.

119. Mitchell County Hosp. Auth. v. Joiner, 229 Ga. 140, 189 S.E.2d 412 (1972). In the lower court, the plaintiff alleged that the hospital was negligent in failing to examine a doctor’s professional qualifications, background, and character. Joiner v. Mitchell County Hosp. Auth., 125 Ga. App. 1, 186 S.E.2d 307, 308 (1971). The hospital attempted to avoid liability by claiming that screening of applicants was conducted by the medical staff, which is composed of its staff doctors. Id. The Georgia Supreme Court rejected this defense on the basis that the staff members were agents of the hospital and that any negligence in selecting new staff members would be imputed to the hospital. Mitchell County Hosp., 229 Ga. at 142-43, 189 S.E.2d at 414.

120. Johnson, 99 Wis. 2d at 723, 301 N.W.2d at 164.

[The issue of whether [the hospital] should be held to a duty of care in the granting of medical staff privileges depends upon whether it is foreseeable that a hospital’s failure to properly investigate and verify the accuracy of an applicant’s statements dealing with his training, experience and qualifications as well as to weigh and pass judgment on the applicant would present an unreasonable risk of harm to its patients. The failure of a hospital to scrutinize the credentials of its medical staff applicants could foreseeably result in the appointment of unqualified physicians and surgeons to its staff. Thus, the granting of staff privileges to these doctors would undoubtedly create an unreasonable risk of harm or injury to their patients. Therefore, the failure to investigate a medical staff applicant’s qualifications for the privileges requested gives rise to a foreseeable risk of unreasonable harm and ... a hospital has a duty to exercise due care in the selection of its medical staff.

Id.

121. See id. at 744, 301 N.W.2d at 174-75.

122. See id. The hospital may delegate this responsibility to a committee. Id. Such delegation, however, does not relieve the hospital of its duty. Id.

123. Id.

124. Id.

125. Id.
make a reasonable assessment of the candidate.\textsuperscript{126}

Once a hospital has selected its employees, it must ensure that the employees exercise due care in treating patients and in using hospital equipment.\textsuperscript{127} Hospitals must protect their patients from physicians' malpractice by staying abreast of the treatment being administered.\textsuperscript{128} Thus, responsibility for most routine administrative acts will be imputed to a hospital if performed negligently.

\section*{IV. Conclusion}

The law of medical malpractice is clearly evolving to the point where hospitals are no longer immune from liability for the negligence of their physicians and other employees. The concept of charitable immunity is extinct\textsuperscript{129} and the administrative-medical act distinction has been rejected.\textsuperscript{130} Most importantly, reasons once asserted for exempting hosp-
tals from liability for the acts of physicians who were independent contractors are now outweighed by stronger policy considerations.\textsuperscript{131}

Patients put themselves into the hands of doctors and other hospital personnel expecting to receive quality health care. Whether they are faced with major or minor health problems, patients do not anticipate malpractice when they enter modern hospitals possessing state-of-the-art equipment.\textsuperscript{132} While the basic goal of both hospitals and physicians is to provide quality health care in an efficient manner,\textsuperscript{133} mistakes will inevitably be made. In such situations, the question becomes, "Who will pay?"\textsuperscript{134} Absent an independent duty owed by the hospital to the patient, the patient's only recourse may be against a doctor.\textsuperscript{135} If a malpractice case involves excessive damages, the physician's insurance alone may be insufficient.\textsuperscript{136} Larger verdicts may be awarded to patients by including the hospital as a defendant because of the increased availability of funds.\textsuperscript{137}

Since modern hospitals are run like businesses, it is reasonable to require them to insure against malpractice by all their personnel, including doctors.\textsuperscript{138} Payment of insurance premiums by hospitals can be negotiated along with other terms of employment and can be absorbed as a cost of doing business.\textsuperscript{139} If hospitals become more directly involved in malpractice liability, they will undoubtedly develop a greater interest in

\textsuperscript{131} Id. at 396; Swan, supra note 7, at 324. A significant consideration is that hospital administrators are thought to be in an ideal position to control their staff physicians since they are always present at the scene of the physician's activities. Swan, supra note 7, at 324. The hospital can formulate procedures to carefully review applications and to evaluate physicians once they are hired. Hospitals can create their own review panels which would be more qualified to conduct the evaluations than outsider review panels. Hospitals can implement quality control measures such as revocations or suspensions of hospital privileges or restrictions on use of the facilities. \textit{Id.}

\textsuperscript{132} See Note, supra note 8, at 389.

\textsuperscript{133} Moore v. Board of Trustees of Carson-Tahoe Hosp., 88 Nev. 207, 211, 495 P.2d 605, 608 (1972).

\textsuperscript{134} Payne, supra note 8, at 389.

\textsuperscript{135} Note, supra note 4, at 960.

\textsuperscript{136} Payne, supra note 8, at 389. If a patient suffers substantial injuries, the physician's malpractice insurance alone may be inadequate compensation. \textit{Id.} "Including the hospital as a defendant increases the funds available to the plaintiff for recovering damages, thus allowing larger verdicts. This makes the question of vicarious liability very important." \textit{Id.}

\textsuperscript{137} Id. The public's increased reliance upon hospitals also justifies imposition of liability for corporate negligence under appropriate circumstances. See Pedroza, 101 Wash. 2d at 230, 677 P.2d at 169 (theory of corporate negligence adopted in Washington, although plaintiff did not prevail because malpractice acts of defendant "occurred entirely outside the hospital").

\textsuperscript{138} Cf. Note, supra note 4, at 965-66.

\textsuperscript{139} See Wasmuth, supra note 7, at 2.
monitoring the quality of care being provided.\textsuperscript{140}

Since the doctrine of respondeat superior is premised on the right to control employees' activities, it has limited application to hospitals. The doctrine is easily applied to the performance of traditional, nonspecialized functions by nursing and other personnel, but not to the performance of nontraditional responsibilities, particularly non-employees' discretionary acts. Respondeat superior is a viable foundation for imposing liability upon hospitals, where the hospital has no control over the tortfeasor in an employer-employee relationship. In those limited circumstances, respondeat superior should be applied to hold the hospital accountable to patients who are the victims of malpractice.

In those cases where respondeat superior is an unworkable theory of recovery, one or more alternative theories may be available to facilitate the same result. Courts in some jurisdictions have openly acknowledged and adopted the doctrines of ostensible agency and corporate liability as substitutes for the doctrine of respondeat superior. While the Minnesota Supreme Court has not addressed these concepts in such terms, it has clearly recognized the duties owed by hospitals to their patients. Minnesota should follow the lead established by other jurisdictions and embrace the concepts of ostensible agency and corporate liability as foundations upon which to hold hospitals accountable for the negligence of all their personnel.

\textsuperscript{140} Cf. Note, supra note 4, at 965-66. One court has noted that the best way to minimize liability insurance expenses is to avoid corporate negligence. See Pedroza, 101 Wash. 2d at 232, 677 P.2d at 170.