

Case Comments

Hospital Liability for Physician Malpractice: The Impact of *Hannola v. City of Lakewood*

I. INTRODUCTION

The medical malpractice liability relationship between hospitals, physicians, and patients in Ohio underwent extensive surgery in *Hannola v. City of Lakewood*.¹ In *Hannola*, the Court of Appeals for Cuyahoga County cut away traditional boundaries of *respondeat superior*, diagnosed agency by estoppel as a new theory of hospital liability, and transplanted a higher independent duty of hospitals for physician malpractice in emergency rooms.²

This Case Comment addresses the impact of the *Hannola* decision on the medical malpractice liability relationship between hospitals, physicians, and patients in Ohio. The analysis will focus on the three theories of hospital liability recognized by the *Hannola* court: *respondeat superior*, agency by estoppel, and independent duty. The appropriateness of these alternative theories will be discussed in relationship to past Ohio Supreme Court decisions and present hospital-physician-patient relationships.

In *Hannola*, Liisa Hannola, as executrix of her decedent husband's estate, sued Lakewood Hospital, the city of Lakewood, Milton J. MacKay M.D., and the West Shore Medical Care Foundation (West Shore), alleging that Paavo Hannola died as a result of medical malpractice in the emergency room.³ The hospital and the city both claimed that the hospital emergency room was operated by West Shore under contract with the hospital and, therefore, any acts of malpractice were the acts of independent contractors.⁴ Specifically, the defendants argued the following:

That physicians practice medicine; that the hospital *did not control* and had no right to control the care and treatment provided to Paavo Hannola by Dr. MacKay; and that Dr. MacKay and West Shore Medical Care Foundation, which hired the physicians for the hospital emergency room, were *independent contractors* for whose acts the hospital was not liable.⁵

The trial court granted the defendants' motion for summary judgment for Lakewood Hospital and the city of Lakewood, based on the arguments that the hospital did not practice medicine and did not undertake to treat Paavo Hannola.⁶

Two issues were raised by Liisa Hannola on appeal. First, did the trial court err in granting summary judgment when material facts were at issue as to whether Lakewood Hospital and the city of Lakewood *controlled* or had the right to control

1. 68 Ohio App. 2d 61, 426 N.E.2d 1187 (1980).

2. *Id.* at 61, 69, 426 N.E.2d at 1188, 1192.

3. *Id.* at 62, 426 N.E.2d at 1188. The specific events that occurred in the emergency room are not recited in the record.

4. *Hannola v. City of Lakewood*, 68 Ohio App. 2d 61, 62, 426 N.E.2d 1187, 1188 (1980). *See infra* note 9.

5. *Id.* (emphasis added).

6. *Id.* at 62-63, 426 N.E.2d at 1188.

Dr. MacKay and West Shore, and when there was a clear issue as to the hospital's *independent duty* to Hannola to prevent the physician's malpractice.⁷ Second, did the trial court err in granting summary judgment when an issue of material fact existed as to whether Liisa and Paavo Hannola were *induced to rely* on the appearance that Dr. MacKay was an agent of Lakewood Hospital.⁸

In response to these two issues, the *Hannola* court stated that “[t]he essential question for our consideration is whether a hospital may insulate itself by contractual arrangement from liability for acts of medical malpractice committed in an emergency room upon its premises.”⁹ The court stated that a hospital may not so insulate itself¹⁰ and held that the trial court erred in granting the defendants’ motion for summary judgment.¹¹

Concerning the first issue, the court held that Liisa Hannola presented “enough facts to raise an issue as to whether Dr. MacKay was under the control of the hospital to justify the imposition of liability upon the hospital under the doctrine of *respondeat superior*.”¹² The court also explained that hospitals have a duty to prevent physician malpractice, at least to the extent that the hospital establishes procedures for the granting of staff privileges and for the review of those privileges.¹³ The court further admonished that “a hospital may well have [a] more specific and precise *independent duty* in the emergency room than in other parts of the hospital to monitor the treatment procedures and medical care provided patients.”¹⁴

Regarding the second issue, whether Liisa Hannola relied on Dr. MacKay’s appearance as an agent of the hospital, the court held that there existed issues of material fact.¹⁵ The court specifically held that:

when an institution purporting to be a full-service hospital makes emergency room treatment available to serve the public, the hospital will be *estopped to deny* that the physicians and other medical personnel on duty providing treatment are its agents. Regardless of any contractual arrangements with so-called independent contractors, the hospital will be liable to the injured patient for the acts of malpractice committed in its emergency room, assuming proximate cause and damage are present.¹⁶

In summary, the *Hannola* court recognized hospital liability for physician malpractice under three theories: the traditional *respondeat superior* doctrine and the

7. *Id.* at 63, 426 N.E.2d at 1189.

8. *Id.*

9. *Id.* The contractual relationship was described by the *Hannola* court as follows: Lakewood Hospital had an agreement with West Shore Medical Care Foundation whereby the Foundation hired physicians and provided all the services of physicians for the emergency room of the hospital. The agreement also contained a provision that the hospital shall not be liable for injury or damages to any person by reason of any acts or omissions of physicians employed by the Foundation. . . . The Foundation billed patients directly for professional services rendered by physicians employed by the Foundation.

Id. at 64, 426 N.E.2d at 1189.

10. *Id.* at 66, 426 N.E.2d at 1190.

11. *Id.* at 70, 426 N.E.2d at 1193.

12. *Id.* at 69, 426 N.E.2d at 1192.

13. *Id.*

14. *Id.* (emphasis added).

15. *Id.* at 67, 426 N.E.2d at 1191.

16. *Id.* at 65–66, 67, 426 N.E.2d at 1190 (emphasis added).

new theories of agency by estoppel and independent duty.¹⁷ Because of this expansive approach, the *Hannola* decision removes important barriers to hospital liability for physician malpractice.

II. RESPONDEAT SUPERIOR

The maxim *respondeat superior* means "let the master answer."¹⁸ Under the doctrine of *respondeat superior*, the terms master, servant, and independent contractor are carefully defined:

A master is a principal who employs an agent to perform service in his affairs and who controls or has the right to control the physical conduct of the other in the performance of the service.

A servant is an agent employed by a master to perform service in his affairs and whose physical conduct in the performance of the service is controlled or is subject to the right to control by the master.

An independent contractor is a person who contracts with another to do something for him but who is not controlled by the other nor subject to the other's right to control with respect to his physical conduct in the performance of the undertaking. He may or may not be an agent.¹⁹

In certain circumstances, a master is liable for the wrongful acts of his servant; a principal is liable for the wrongful acts of his agent.²⁰ This section of the Case Comment discusses the history of the application of the *respondeat superior* doctrine to hospital liability in Ohio.

The *Hannola* court was not the first Ohio court to consider the applicability of the *respondeat superior* doctrine to hospitals. In 1911, the Ohio Supreme Court in *Taylor v. Protestant Hospital Association*²¹ refused to extend the rule of *respondeat superior* to hold a nonprofit hospital liable for the alleged negligence of an operating room nurse who, despite a duty to account for sponges, left a sponge in a patient's body.²² The court explained as follows:

to extend the rule [of *respondeat superior*] to masters different from others and who do not come within its reason . . . is not justified. Public policy should and does encourage

17. *Id.* at 65-66, 69, 426 N.E.2d at 1190, 1192.

18. BLACK'S LAW DICTIONARY 1179 (5th ed. 1979).

19. RESTATEMENT (SECOND) OF AGENCY § 2 (1958).

20. RESTATEMENT (SECOND) OF AGENCY § 219 (1958).

§ 219 When Master is Liable for Torts of His Servants

(1) A master is subject to liability for the torts of his servants committed while acting in the scope of their employment.

(2) A master is not subject to liability for the torts of his servants acting outside the scope of their employment, unless:

(a) the master intended the conduct or the consequences, or

(b) the master was negligent or reckless, or

(c) the conduct violated a non-delegable duty of the master, or

(d) the servant purported to act or to speak on behalf of the principal and there was reliance upon apparent authority, or he was aided in accomplishing the tort by the existence of the agency relation.

Id. See *infra* note 47.

21. 85 Ohio St. 90, 96 N.E. 1089 (1911).

22. *Id.* at 91, 103, 96 N.E. at 1089, 1092.

enterprises with the aims and purposes of defendant [non-profit hospital] and requires that they should be exempted from the operation of the rule.²³

Throughout the years after the *Taylor v. Protestant Hospital Association* decision, the rule granting full immunity to charitable hospitals became a rule of partial immunity. In 1922, the court in *Taylor v. Flower Deaconess Home and Hospital*,²⁴ allowed recovery against a non-profit hospital for negligence in failing to use ordinary care in selecting its servants.²⁵ In 1930, the court in *Sisters of Charity of Cincinnati v. Duvelius*,²⁶ allowed recovery against a non-profit hospital for a hospital elevator operator's negligence to an individual who was not a patient.²⁷ Finally, in 1956, the Ohio Supreme Court in *Avellone v. St. John's Hospital*²⁸ held that "a corporation not for profit, which has as its purpose the maintenance and operation of a hospital, is, under the doctrine of *respondeat superior* . . . liable for the torts of its servants . . ." ²⁹ The *Avellone* decision marked the end of the concept of charitable immunity for non-profit hospitals in Ohio.³⁰

The *Avellone* case involved the alleged negligence of a hospital in allowing a patient to twice fall out of bed.³¹ According to the *Avellone* court the prior justifications for hospital immunity were premised upon public policy reasons which were no longer relevant:

What we do find with regard to this aspect [public policy] is that the availability of liability insurance and the existing power to purchase it with hospital funds, coupled with the increased base of remuneration for services rendered and the efficient businesslike management of modern hospitals, certainly tend to negate the argument that to hold the hospital amenable, under the doctrine of *respondeat superior*, to damages for injuries to patients caused by the negligence of its servants would be such a detriment as to defeat the charitable purpose for which it was organized and incorporated.³²

In concluding that a non-profit corporation, which has as its purpose the maintenance and operation of a hospital, is liable for the torts of its servants under the doctrine of *respondeat superior*, the *Avellone* court cautioned: "[W]e are not deciding that persons working in a hospital, such as doctors and nurses, under circumstances where

23. *Id.* at 103, 96 N.E. at 1092.

24. 104 Ohio St. 61, 135 N.E. 287 (1922).

25. *Id.* at 74, 135 N.E. at 291. The court stated that "every principle of justice requires that they [the hospital] use care in the development and maintenance of the property and in the selection of servants who have the oversight of patients." *Id.* at 73-74, 135 N.E. at 291.

26. 123 Ohio St. 52, 173 N.E. 737 (1930).

27. *Id.* at 57-61, 173 N.E. 739-40. The injured non-patient was a nurse employed by a patient.

28. 165 Ohio St. 467, 135 N.E.2d 410 (1956).

29. *Id.* at 477, 135 N.E.2d at 417.

30. The concept of charitable immunity of non-profit hospitals in Ohio was judicially recognized in *Taylor v. Protestant Hosp. Ass'n.*, 85 Ohio St. 90, 103, 96 N.E. 1089, 1092 (1911). The rule for immunity of charitable associations was first recognized in the United States in *McDonald v. Massachusetts Gen. Hosp.*, 120 Mass. 432 (1876). For a discussion regarding the U.S. adoption of charitable immunity, an English concept, that had been reversed in England prior to its adoption in the U.S. see *Directors of Georgetown College v. Hughes*, 130 F.2d 810 (D.C. Cir. 1942).

31. 165 Ohio St. 467, 135 N.E.2d 410, 410-11 (1956).

32. *Id.* at 475, 135 N.E.2d at 415. The *Avellone* court stated that the discussion did not address imposing liability where none previously existed, but rather, addressed the public policy that in the past allowed non-profit hospital immunity from a pre-existent liability under *respondeat superior*. *Id.*

the hospital has no authority or right of control over them, can bind the hospital by their negligent actions."³³

In 1960, the Ohio Supreme Court once more addressed the issue of the applicability of the doctrine of *respondeat superior* to hospitals in *Klema v. St. Elizabeth's Hospital of Youngstown*,³⁴ but this time in relationship to *physician* malpractice. The *Klema* court reaffirmed the *Avellone* decision that non-profit corporations could be found liable for the negligence of employees under the doctrine of *respondeat superior*.³⁵ Specifically, the court held that a defendant hospital may be held liable for the negligent acts of an anesthesiologist employed by the hospital as a resident physician.³⁶

Although the *Klema* court emphasized that hospitals could be liable for the malpractice of such a physician, it specifically reserved the same question that was unresolved in *Avellone*: Whether "persons working in a hospital, such as doctors and nurses, under circumstances where the hospital has no authority or right of control over them, can bind the hospital by their negligent actions."³⁷ The *Klema* court, however, did elucidate a test for determining a hospital's liability under the doctrine of *respondeat superior*:

The test should be, simply, was the act done in the scope and course of the employee's duties. Obviously, such a test will, so far as a hospital is concerned, relieve from, or subject to, liability in exactly the same manner and according to the same rules as any other employer is relieved or subjected.³⁸

Thus, the *Klema* and *Avellone* decisions provided the background for the *Hannola* court's expansion of liability under the *respondeat superior* doctrine.³⁹ In applying the doctrine, the *Hannola* court first distinguished the relationship of principal and agent, or master and servant, from the relationship of employer and independent contractor by the following test:

Did the employer retain control of, or the right to control, the mode and manner of doing the work contracted for? If he did, the relationship is that of principal and agent or master and servant. If he did not but is interested merely in the ultimate result to be accomplished, the relationship is that of employer and independent contractor.⁴⁰

33. *Id.* at 478, 135 N.E.2d at 417.

34. 170 Ohio St. 519, 166 N.E.2d 765 (1960).

35. *Id.* at 519, 525, 166 N.E.2d at 766-67, 770.

36. *Id.* at 520, 525-27, 166 N.E.2d at 767, 770-71. In *Klema*, the plaintiff brought a wrongful death action against the defendant hospital alleging negligence on the part of the anesthesiologist for inadequately administering anesthesia to the patient. *Id.* at 519-20, 166 N.E.2d at 767. The decedent was admitted to the hospital for the purpose of undergoing an operation for a perirectal abscess and subsequently died four days after the operation. *Id.* The anesthesiologist was not licensed to practice medicine in Ohio but was licensed to practice medicine in Italy. He was first employed by the defendant hospital as an intern and then as a resident in anesthesia on the staff of the defendant hospital. The court noted the following:

[S]ince the anesthetist was not licensed as a physician in Ohio . . . it would be possible to consider him as any other nonmedical employee. . . . However, . . . we prefer to consider the anesthetist as if he were a physician licensed to practice medicine in Ohio and on the staff of the hospital as a resident physician.

Id. at 520, 135 N.E.2d at 767.

37. *Id.* at 525-26, 166 N.E.2d at 770 (quoting *Avellone v. St. John's Hospital*, 165 Ohio St. 467, 478, 135 N.E.2d 410, 417 (1956)).

38. *Klema v. St. Elizabeth's Hosp. of Youngstown*, 170 Ohio St. 519, 527, 166 N.E.2d 765, 771 (1960).

39. *Hannola v. City of Lakewood*, 68 Ohio App. 2d 61, 68-69, 426 N.E.2d 1187, 1192 (1980).

40. *Id.* at 67-68, 426 N.E.2d at 1191 (emphasis added) (quoting *Council v. Douglas*, 163 Ohio St. 292, 295, 126 N.E.2d 597, 599 (1955)).

The *Hannola* court then rejected the defendants' argument for a narrow interpretation of control focused on authority over diagnosis and treatment of patients, and accepted plaintiff's broader interpretation of control focused on authority over personnel management and patient care policies.⁴¹

Applying this broad interpretation of control to the agreement between the hospital and West Shore, the court concluded that the hospital did have the right to control the mode and manner of the work performed in the emergency room. For example, the court specifically pointed to a provision in the agreement requiring that physicians employed by West Shore must apply for and obtain appointment as members of the medical staff of Lakewood Hospital.⁴² The staff privileges of the West Shore physicians were revocable for cause on recommendation of the medical staff of the hospital, subject to the appeals procedure in the bylaws of the medical staff.⁴³ The court viewed the hospital's power to dismiss the physicians for cause as similar to an employer's right to fire an employee.⁴⁴ Assuming *arguendo* that dismissing a physician and firing an employee are similar, this does not logically lead to the court's conclusion that the hospital had a right to control the mode and manner of the physician's work in the emergency room.

The court also viewed another provision in the agreement as creating a factual question concerning the hospital's control over Dr. MacKay. This provision provided that the board of trustees of West Shore, with the approval of the executive committee of the medical staff, the administration, and the board of trustees of the hospital, may establish matters of policy regarding patient care.⁴⁵ After noting these provisions, the *Hannola* court in essence held that staff privileges revocable by the hospital and the cooperative agreement, in which the trustees of West Shore could establish matters of patient care policy subject to approval of the hospital, raised a factual question of control justifying liability under *respondeat superior*.⁴⁶

The *Hannola* decision indicates the court's willingness to expand the doctrine of *respondeat superior* by simply redefining control. Specifically, the doctrine was expanded to include non-employee physicians with staff privileges, a group that traditionally has been considered independent contractors as opposed to servants.⁴⁷ The court's broad interpretation of the control necessary to demonstrate the existence of a *respondeat superior* relationship as control of personnel and patient care policy reflects an attempt by the court to use a means to reach an end. The end reached is hospital liability for non-employee physicians. The means is a rearranging of the law to fit the intended result.

41. *Hannola v. City of Lakewood*, 68 Ohio App. 2d 61, 68, 426 N.E.2d 1187, 1192 (1980).

42. *Id.* at 68-69, 426 N.E.2d at 1192.

43. *Id.* at 69, 426 N.E.2d at 1192.

44. *Id.*

45. *Id.*

46. *Id.*

47. See RESTATEMENT (SECOND) OF AGENCY § 223 (1958). The Restatement of Agency acknowledges that employed house physicians or interns may be considered servants of the hospital in certain circumstances, but indicates that a physician employed by a hospital is not normally considered a servant. *Id.* See *supra* notes 19-20 and accompanying text.

The power to grant and revoke staff privileges does not, as the *Hannola* court suggests, establish that an employer-employee relationship has been created.⁴⁸ The court assumes too much when it suggests that staff privileges give hospitals control over physicians in a manner sufficient to justify liability under the doctrine of *respondeat superior*. Physicians who are members of a medical staff have "delimited clinical privileges that allow them to provide patient care services *independently* within the scope of their clinical privileges."⁴⁹ Moreover, "[t]he hospital provides that each patient's general medical condition is the *responsibility of a qualified physician* member of the medical staff."⁵⁰ The hospital does not have overall responsibility: "The medical staff . . . has *overall* responsibility for the quality of the professional services provided by individuals with clinical privileges."⁵¹ Thus, physicians control the development and delivery of the patient's medical care based on their independent knowledge and professional responsibility.

Furthermore, staff privileges that attempt to control, influence, or alter a physician's plan of care would be an unauthorized practice of medicine under state law.⁵² A patient should be fearful of hospitals that violate state law by purporting to control physicians and thereby practice medicine without authorization.

It is equally difficult to find support for the court's opinion that a hospital can control a physician based on an agreement in which a third party may assist in establishing matters of policy subject to approval by the hospital. This type of collaboration is not unique. The development of an institutional policy regarding patient care requires input from health care professionals; otherwise, the policy would not adequately or accurately reflect patient needs. Therefore, it is a common practice of hospitals to use input from health care professionals in developing patient care policy.⁵³ This cooperative effort does not indicate control of the physician by the

48. See *infra* note 71 and accompanying text. The granting of staff privileges is part of the hospital's accreditation process.

49. JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS, 1986 101 (1985) (emphasis added). See *infra* note 71.

50. JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS, 1986 xvi (1985) (emphasis added). See *infra* note 71.

51. JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS, 1986 101 (1985) (emphasis added). See *infra* note 71.

52. OHIO REV. CODE ANN. § 4731.41 (Page 1977).

No person shall practice medicine or surgery, or any of its branches without a certificate from the state medical board; no person shall advertise or announce himself as a practitioner of medicine or surgery, or any of its branches, without a certificate from the board; no person not being licensed shall open or conduct an office or other place for such practice without a certificate from the board; no person shall conduct an office in the name of some person who has a certificate to practice medicine or surgery, or any of its branches; and no person shall practice medicine or surgery, or any of its branches, after a certificate has been revoked, or, if suspended, during the time of such suspension.

Id.

53. For example, at Riverside Methodist Hospital in Columbus, Ohio, there are *interdepartmental* standard policies and procedures related to patient care. In addition, there are *departmental* policies and procedures related to patient care. The following discussion is a generalized overview of the policy and procedure process. The *interdepartmental* standard policies and procedures are developed, revised, and reviewed through a process in which appropriate departments (those departments affected by the policies and procedures) provide input. The input from the departments may include all levels of hospital personnel as well as input from both employee and non-employee physicians depending on the nature of the policy or procedure and the need for the input. This input receives final review by a committee of vice presidents. The *departmental* policies and procedures are developed within departments, but also utilize input from other departments and physicians as needed.

hospital, but rather, reflects a collaborative, interdisciplinary approach to patient care policy.

III. AGENCY BY ESTOPPEL

As if cutting away at the doctrine of *respondeat superior* is not enough, the *Hannola* court diagnoses agency by estoppel, creating a new theory of hospital liability for physician malpractice in Ohio.⁵⁴ Prior to *Hannola*, the doctrine of agency by estoppel had not been applied to the hospital-physician relationship. The Ohio Supreme Court had, however, previously applied the doctrine to commercial settings.⁵⁵ In one commercial case, the supreme court explained that “[t]he doctrine of agency by estoppel . . . rests upon the theory that one has been led to rely upon the appearance of agency to his detriment. It is not applicable where there is no showing of induced reliance upon an ostensible agency.”⁵⁶

Having recognized agency by estoppel in commercial cases,⁵⁷ the *Hannola* court concluded too easily that the doctrine of agency by estoppel can be applied to hospitals and physicians in an emergency room setting:⁵⁸

By calling itself a “hospital” and by being a full-service hospital including an emergency room as part of its facilities, an institution makes a special statement to the public when it opens its emergency room to provide emergency care for people. In essence, an *agency by estoppel* is established by creating an effect: that is, the *appearance* that the hospital’s agents, not independent contractors, will provide medical care to those who enter the hospital. The patient *relies* upon this as a fact and he believes he is entering a full-service hospital.⁵⁹

It is clear that a finding of agency by estoppel must rest on a determination of whether the injured party *relied* on the appearance that the physician was an agent of the hospital.⁶⁰

The *Hannola* court concluded that there were issues of material fact about whether the Hannolas relied on Dr. MacKay’s appearance as an agent of the hospital.⁶¹ Specifically, the *Hannola* court identified the following circumstances as pertinent in estopping the hospital from denying that Dr. MacKay, the emergency

Because of the profound impact on patient care, nursing policies and procedures will be used as an example of how *departmental* policies and procedures involve physician input. Nursing policies and procedures are developed, revised, and reviewed by committees comprised of all levels of nursing personnel. Based on the content of the policy, the Associate Manager of Policy and Procedure in the Nursing Department routes the work of the committee to individuals with specialty expertise to obtain their input. These individuals might include nurse specialists, physicians, legal counsel, committees comprised of nurses and physicians, the medical council, and others. After this input is received, the policy and procedure is reviewed by a director’s council comprised of nursing directors and a hospital vice president to be either accepted and issued or returned for more input. Telephone interview with Ms. Ilene Hand, R.N., Associate Manager of Policy and Procedure, Nursing Department, Riverside Methodist Hospital (Feb. 7, 1986).

54. *Hannola v. City of Lakewood*, 68 Ohio App. 2d 61, 65, 426 N.E.2d 1187, 1190 (1980).

55. *Rubbo v. Hughes Provision Co.*, 138 Ohio St. 178, 34 N.E.2d 202–03 (1941); *Johnson v. Wagner Provision Co.*, 141 Ohio St. 584, 49 N.E.2d 925 (1943).

56. *Johnson v. Wagner Provision Co.*, 141 Ohio St. 584, 584, 49 N.E.2d 925, 926 (1943).

57. *Id.* at 584, 49 N.E.2d at 925. *Rubbo v. Hughes Provision Co.*, 138 Ohio St. 178, 34 N.E.2d 202 (1941).

58. *Hannola v. City of Lakewood*, 68 Ohio App. 2d 61, 65–66, 426 N.E.2d 1187, 1190 (1980).

59. *Id.* at 64–65, 426 N.E.2d at 1190 (emphasis added).

60. *Id.* See *infra* note 65.

61. *Id.* at 67, 426 N.E.2d at 1191.

room physician who treated Paavo Hannola in the hospital emergency room, was an agent of the hospital: Hannola did not choose to go to the West Shore Medical Foundation; Liisa Hannola took Paavo to the emergency room for emergency treatment relying on Lakewood Hospital holding itself out as a hospital; and Liisa took Paavo to Lakewood, relying on the hospital's excellent reputation.⁶²

The court's conclusions that these facts were sufficient to estop the hospital from denying that Dr. MacKay was an agent of the hospital is based on too great an assumption of knowledge regarding the hospital-physician-patient relationship. For example, there is no empirical support for the statement that merely because a hospital labels itself a hospital and is a full-service hospital with an emergency room, that the public believes that the physicians who work within the hospital facilities are the hospital's agents rather than independent contractors.

The *Hannola* court further suggests that it is necessary to estop hospitals from denying liability for physician malpractice in an emergency room setting because a patient in an emergency situation does not always have a meaningful choice of going elsewhere for treatment.⁶³ However, in an emergency situation as identified in *Hannola*, where no meaningful choice exists, no reliance exists, thereby precluding the application of the agency by estoppel doctrine. Similarly, in situations where the choice of hospital is made by emergency squad personnel, no reliance and no agency by estoppel exists because the patient or family is not making a choice based on reliance.⁶⁴ Without reliance, there is no agency by estoppel.⁶⁵

Even in those situations in which patients do exercise a meaningful choice, courts should not automatically apply the doctrine of agency by estoppel to create hospital liability because individuals choose hospitals for a variety of reasons. For example, one study has demonstrated that for life-threatening problems, thirty-two percent of individuals select a hospital based on which hospital is closest in terms of both geographic distance and traffic patterns.⁶⁶ Twenty-two percent select a hospital based on prior experience.⁶⁷ In those situations in which the choice is made based on geographic distance and traffic patterns, neither reliance nor agency by estoppel exists. In situations in which the choice is made on prior experience, the prior

62. *Id.* at 66, 426 N.E.2d at 1191. Additional facts, as stated by the court, were as follows: Lakewood Hospital held itself out as a full-service hospital that included emergency room facilities; the public did not know and was not effectively informed that the emergency room facilities were operated by an independent contractor and were no longer considered as part of the hospital. *Id.* at 64, 426 N.E.2d at 1190. (The record does not explain why Hannola had no choice).

63. *Id.* at 65, 66, 426 N.E.2d at 1190.

64. For example, the unwritten policy of the City of Columbus, Fire Division regarding the squad and medic units is as follows: In general, take patients to the nearest hospital; take heart patients with stable condition to the hospital where their personal cardiologist admits patients; take dialysis patients to any hospital with a dialysis unit; take children to Childrens Hospital; take patients with burns to Ohio State University Hospitals. Interview with Ms. Susie Barnes, R.N., Emergency Medical Technician Paramedic Instructor, City of Columbus, Division of Fire (Jan. 13, 1986).

65. *Johnson v. Wagner Provision Co.*, 141 Ohio St. 584, 584, 49 N.E.2d 925, 926 (1943).

The doctrine of agency by estoppel, as it might be invoked by a plaintiff in a tort action, rests upon the theory that one has been led to rely upon the appearance of agency to his detriment. *It is not applicable where there is no showing of induced reliance upon an ostensible agency.*

Id. (emphasis added).

66. Confidential COMMUNITY ATTITUDE SURVEY conducted by a metropolitan Columbus hospital (September 10, 1985).

67. *Id.*

experience could include the patient's relationship with particular physicians as well as with the hospital and, thus, the court could not automatically attribute the choice to reliance on the hospital.

In general, the *Hannola* court glosses over the importance of physician influence in choosing a hospital. Statistically, the physician selects the hospital in over half of all cases (51%), with another twelve percent of hospital selection based on joint decisions between the patient and physician.⁶⁸ Conversely, hospitals have little influence over an individual's reasons for selecting a physician. In one study, the three most frequently mentioned reasons for selecting a physician were as follows: recommended by a friend or relative (40.6%); recommended by another physician (14.5%); and convenience of location (6.5%).⁶⁹ Among the least mentioned reasons were: recommended by hospital (1.1%) and treated by member of hospital staff (1.2%).⁷⁰

The rationale of the *Hannola* court thus contradicts the past experience of patients and discredits the patient-physician relationship. Many patients have relationships with physicians that predate their emergency room admissions and are aware that physicians use hospitals to admit patients when more than outpatient care is required. There is no data to support that the use of an emergency room facility can alter common understanding of the physician as an independent professional.

It is equally unclear that the granting of staff privileges can change this common understanding. The Joint Commission on Accreditation of Hospitals (J.C.A.H.) *requires* that a hospital have a medical staff.⁷¹ Physicians often have staff privileges at several hospitals. This does not mean that their patients view them as employed by these hospitals. In fact, whether a physician with staff privileges is employed by the hospital, or is employed by a third party under a contractual basis with the hospital, has little medical relevance to a patient. The bottom line is that patients rely on the expertise of the physician, not on the status of the physician's employment. Hospitals should not pay the penalty of liability for physician malpractice merely because they follow established procedures for accreditation.⁷²

However, in furtherance of the court's conclusions that agency by estoppel is created by a hospital representing itself as a hospital and by being a full-service hospital with emergency room services, the *Hannola* court states that "sound public policy demands that the full-service hospital not be permitted to contractually insulate

68. *Id.*

69. R. BLACKWELL & W. TALARZYK, *CONSUMER ATTITUDES TOWARD HEALTH CARE AND MEDICAL MALPRACTICE* 30 (1977).

70. *Id.*

71. Hospitals seeking accreditation by the Joint Commission on Accreditation of Hospitals (JCAH) must meet certain eligibility requirements in order to apply for a JCAH accreditation survey. These eligibility requirements include the following:

The hospital has a governing body, *medical staff*, and a nursing service.

The hospital provides that each individual who has been granted clinical privileges by the governing body practices only within the scope of privileges granted.

The hospital provides that each patient's general medical condition is the *responsibility of a qualified physician* member of the medical staff.

JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, *ACCREDITATION MANUAL FOR HOSPITALS*, 1986 XV, xvi (1985) (emphasis added).

72. *See supra* note 71.

itself from liability for acts of medical malpractice committed in its emergency room.”⁷³ The reasons given by the court are that an emergency room is an integral part of a full-service hospital, that hospitals should not pretend emergency rooms are separate entities, and that emergencies are a time of high emotion in which patients frequently have no chance to choose a hospital.⁷⁴ Thus, this sound public policy is merely a repetition of the court’s reasons for concluding that agency by estoppel should be established.⁷⁵

The *Hannola* court explains that its analysis is consistent with public expectations regarding emergency treatment, and relies on the following excerpt from a law review article for support:

The image of modern hospitals as centers of medical practice of the highest quality is understandably cultivated by the hospitals themselves. . . . [The hospital presents itself] . . . as a unified institution vital to community health, rather than as a mere physical shell in which private physicians practice their profession.

. . . Public outrage, and possibly even an effect on admissions at a typical hospital, 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. The public assumes, correctly or not, that the hospital exerts some measure of control over the medical activities taking place there.⁷⁶

The wisdom of assuming that the public would be outraged because a hospital regards all staff doctors as completely independent must be questioned. The assumption could just as easily be set forth that the public would be outraged that hospitals regarded staff doctors as under the hospital control. For example, a possible concern might be that a hospital, in an effort to reduce costs, would try to prevent a physician from implementing the best medical treatment plan.

As if creating an agency by estoppel doctrine for hospital liability is not severe enough, the *Hannola* court states that the creation of agency by estoppel in the hospital setting is “somewhat different” from creation in commercial settings.⁷⁷ The court explains that in commercial settings public advertisements disclaiming agency might insulate unwilling principals because people might act differently with the knowledge that there was no actual agency.⁷⁸ The implication is that similar public advertisements disclaiming agency would not insulate hospitals. Thus, the *Hannola* court implies that it will allow a hospital no method of escaping from this restrictive and potentially destructive doctrine.⁷⁹

The court justifies this “somewhat different” application of the doctrine by stating that in a hospital setting in which a patient seeks medical treatment “without a meaningful choice,” the patient “will turn to his local hospital to provide it

73. *Hannola v. City of Lakewood*, 68 Ohio App. 2d 61, 65, 426 N.E.2d 1187, 1190 (1980).

74. *Id.* at 65, 426 N.E.2d at 1190.

75. See *supra* notes 48–63 and accompanying text.

76. *Hannola v. City of Lakewood*, 68 Ohio App. 2d 61, 66, 426 N.E.2d 1187, 1190–91 (1980) (quoting Leonard, *Independent Duty Of A Hospital To Prevent Physicians' Malpractice*, 15 ARIZ. L. REV. 953, 967 (1973)).

77. *Hannola v. City of Lakewood*, 68 Ohio App. 2d 61, 65, 426 N.E.2d 1187, 1190 (1980).

78. *Id.*

79. *Id.*

regardless of prior notice that the physicians are independent contractors. The patient thinks of 'Lakewood Hospital' in his time of need, not the West Shore Medical Care Foundation."⁸⁰ However, in a situation in which a patient has no meaningful choice, he cannot logically be said to "think" of Lakewood and cannot be said to rely when no choice in fact exists.

The *Hannola* court appears eager to relentlessly apply the doctrine of agency by estoppel to hospitals, even though it might financially destroy hospitals. From 1970 to 1984, medical malpractice payments by hospital insurance companies skyrocketed by 9000 percent from \$211,000 to \$18,000,000.⁸¹ The amount of the average award escalated 900 percent from \$4,100 in 1970 to \$35,000 in 1984.⁸² As recently as 1981 there were no claims for more than \$1,000,000, but since 1982 there has been an increase in the number of claims greater than \$1,000,000.⁸³ In 1985 there was even a \$5,000,000 claim.⁸⁴ Correspondingly, premiums for malpractice insurance have increased across the country. During the 1960's, premiums rose 950 percent for surgeons, 541 percent for other physicians, and 262 percent for hospitals.⁸⁵

Perhaps the *Hannola* court's relentless application of the doctrine of agency by estoppel to hospitals reflects a desire to tap a deeper pocket. Hospitals, however, do not necessarily have deeper pockets. Hospitals cannot buy insurance at better rates than physicians.⁸⁶ More importantly, hospitals are unable to obtain insurance coverage for non-employee staff physicians, physicians under contract, and fee for service physicians.⁸⁷ Thus, the court is holding hospitals liable for situations in which the hospitals cannot protect themselves.

These staggering statistics require a more well-reasoned opinion by the court than proffered for holding hospitals liable under the doctrine of agency by estoppel. Additionally, the erroneous assumption of knowledge regarding the hospital-physician-patient relationship should not be the basis for establishing a new theory of hospital liability.

80. *Id.*

81. Data obtained from a closed claim survey conducted by the Ohio Hospital Association. The survey represents information from member hospitals of the Hospital Association, whose membership includes about 90% of the hospitals in Ohio. The increase in the number of claims has only doubled, and therefore, cannot account for the 9000% increase in the amount of payments. Telephone interview with Mr. Richard Sites, J.D., M.S., Director of Risk Management, Ohio Hospital Association (Jan. 22, 1986).

82. *Id.*

83. *Id.*

84. *Id.*

85. R. BLACKWELL & W. TALARZYK, *supra* note 69, at 20.

86. Telephone interview with Mr. Richard Sites, J.D., M.S., Director of Risk Management, Ohio Hospital Association (Jan. 22, 1986). Two insurance companies write insurance for hospitals in Ohio: Ohio Hospital Insurance Company; St. Paul Fire and Marine Insurance. *Id.*

87. In general, premiums are based on the number of hospital beds and the number of outpatient visits with credits or debits based on loss experience. In order to include employed physicians, hospitals must additionally pay 10-15% of the premium rate. Employed physicians are considered to be physicians on the payroll subject to standard payroll deductions. Any staff physicians, physicians under contract, and fee for service physicians are not covered. Despite this non-coverage, courts may require hospitals to pay if physician coverage is not considered to be adequate. Information on specific premium rates was not obtainable. Telephone interview with Ms. Karen McDonald, Senior Supervisor, Underwriting Department, Ohio Hospital Insurance Company, Columbus, Ohio (Jan. 22, 1986).

IV. INDEPENDENT DUTY

The *Hannola* court recognized, as a third theory of hospital liability, that a hospital has an independent duty to prevent physician malpractice.⁸⁸ Prior to *Hannola*, there had been no reference to this new duty by any Ohio or federal court.

The *Hannola* court cited two out-of-state cases⁸⁹ to support the proposition that “[a] hospital clearly does have a duty to prevent a physician’s malpractice at least to the extent that it establishes procedures for the granting of staff privileges and for the review of these privileges.”⁹⁰ An analysis of these two cases, however, does not support the court’s broad holding that hospitals have an independent duty to prevent physician malpractice.

In *Mitchell County Hospital Authority v. Joiner*,⁹¹ the plaintiff sought to hold the hospital liable under the “doctrine of independent negligence in permitting the alleged negligent physician to practice his profession in the hospital, when his incompetency [was] known.”⁹² In *Purcell v. Zimbelman*⁹³ the plaintiff’s theory against the hospital was as follows:

[T]he hospital had a duty to the public to allow the use of its facilities only by such independent staff doctors as are *professionally competent* and who treat their patients in full accordance with accepted and established medical practices, and that the hospital breached its duty when it failed to take any action against [Dr.] Purcell when it *knew, or should have known*, that he lacked the skill to treat the condition in question.⁹⁴

The *Mitchell* and *Purcell* cases refer to a hospital’s duty to protect the public from physician malpractice when the *incompetence of the physician is known or should be known by the hospital*.⁹⁵ This narrow duty must be distinguished from the overly broad duty to prevent physician malpractice created by the *Hannola* court. Incompetency indicates a lack of ability, legal qualification, or fitness to discharge a required duty.⁹⁶ Malpractice indicates professional misconduct or unreasonable lack of skill.⁹⁷ Since professional misconduct may be different from lack of skill or ability, malpractice cannot automatically be equated with incompetence.

The record in the *Mitchell* case does not reveal what incompetency the hospital was alleged to have known.⁹⁸ The *Mitchell* court did specifically state that “[i]f the physician was incompetent and the [Hospital] Authority *knew*, or from information in its possession such *incompetency was apparent*, then it cannot be said that the

88. *Hannola v. City of Lakewood*, 68 Ohio App. 2d 61, 69, 426 N.E.2d 1187, 1192 (1980).

89. *Purcell v. Zimbelman*, 18 Ariz. App. 75, 500 P.2d 335 (1972); *Mitchell County Hosp. Auth. v. Joiner*, 229 Ga. 140, 189 S.E.2d 412 (1972).

90. *Hannola v. City of Lakewood*, 68 Ohio App. 2d 61, 69, 426 N.E.2d 1187, 1192 (1980).

91. 229 Ga. 140, 189 S.E.2d 412 (1972).

92. *Id.* at 141, 189 S.E.2d at 413.

93. 18 Ariz. App. 75, 500 P.2d 335 (1972).

94. *Id.* at 80, 500 P.2d at 340 (emphasis added).

95. *Mitchell County Hosp. Auth. v. Joiner*, 229 Ga. 140, 141, 189 S.E.2d 412, 414 (1972); *Purcell v. Zimbelman*, 18 Ariz. App. 75, 80, 500 P.2d 335, 340 (1972).

96. BLACK’S LAW DICTIONARY 688 (5th ed. 1979).

97. *Id.* at 864.

98. *Mitchell County Hosp. Auth. v. Joiner*, 229 Ga. 140, 141–43, 189 S.E.2d 412, 413–14 (1972).

[Hospital] Authority acted in good faith and with reasonable care in permitting the physician to become a member of its staff.”⁹⁹

In *Purcell*, the physician defendant had a record of past lawsuits for medical malpractice, several of which involved the same procedure that allegedly killed the decedent.¹⁰⁰ The *Purcell* court held that the prior lawsuits were admissible evidence to prove that the hospital had notice of the general competency of Dr. Purcell to continue as a staff member of the hospital.¹⁰¹

In summary, the *Mitchell* and *Purcell* cases involved staff physicians and the allegations that the hospitals knew or should have known of the incompetence of the physicians.¹⁰² By contrast, the *Hannola* case involved a physician hired by a third party and no allegations by the plaintiff that the physician was incompetent or that the hospital knew or should have known of his incompetence.¹⁰³

The basis of an independent duty of hospitals, if it is to be recognized at all, is the duty to protect patients from *incompetent* physicians. The duty is not, as the *Hannola* court suggests, a broad duty to protect patients from physician malpractice.¹⁰⁴

The *Hannola* court compounds its mistake by attempting to establish an even higher independent duty for medical malpractice in emergency rooms.¹⁰⁵ The only rationale given by the *Hannola* court for establishing this higher duty is “the unique nature of an emergency room and the public’s lack of meaningful choice in a dire medical emergency”¹⁰⁶

A court should not create a broad independent duty of hospitals to protect against physician malpractice as casually as the court does in the *Hannola* case.¹⁰⁷ The duty in *Hannola* is based on an erroneous reading of the common law of other jurisdictions¹⁰⁸ and on an overzealous attitude regarding hospital liability for emergency room physicians.

V. THE *HANNOLA* COURT’S DISREGARD OF THE OHIO SUPREME COURT *COOPER* DECISION

In its haste to create new avenues of hospital liability for physician malpractice, the *Hannola* court dismissed, in a footnote,¹⁰⁹ *Cooper v. Sisters of Charity*,¹¹⁰ a prior Ohio Supreme Court case ruling that is relevant to the issue at hand. In *Cooper*, the plaintiff brought a malpractice action against the following defendants: The Sisters of Charity of Cincinnati, Inc., doing business as Good Samaritan Hospital; the Emer-

99. *Id.* at 143, 189 S.E.2d at 414 (emphasis added).

100. *Purcell v. Zimbelman*, 18 Ariz. App. 75, 83–85, 500 P.2d 335, 343–45 (1972).

101. *Id.* at 84, 500 P.2d at 344.

102. *Mitchell County Hosp. Auth. v. Joiner*, 229 Ga. 140, 141, 189 S.E.2d 412, 414 (1972); *Purcell v. Zimbelman*, 18 Ariz. App. 75, 80, 500 P.2d 335, 340 (1972).

103. *Hannola v. City of Lakewood*, 68 Ohio App. 2d 61, 62, 426 N.E.2d 1187, 1188 (1980).

104. *Id.* at 69, 426 N.E.2d at 1192 (1980).

105. *Id.*

106. *Id.*

107. *Id.*

108. *Id.* See *Mitchell County Hosp. Auth. v. Joiner*, 229 Ga. 140, 141, 189 S.E.2d 412, 414 (1972). See *Purcell v. Zimbelman*, 18 Ariz. App. 75, 80, 500 P.2d 335, 340 (1972). See *supra* notes 91–104 and accompanying text.

109. *Hannola v. City of Lakewood*, 68 Ohio App. 2d 61, 69–70 n.2, 426 N.E.2d 1187, 1192–93 n.2 (1980).

110. 27 Ohio St. 2d 242, 272 N.E.2d 97 (1971).

gency Professional Service Group, a third party that had entered into an agreement with the Good Samaritan Hospital to run its emergency room at the hospital; Richard Weber, that group's director; and Dr. Hansen, the physician who treated the decedent in the emergency room.¹¹¹ The supreme court, affirming the judgment of both the trial court and the court of appeals, granted defendants' motion for a directed verdict on the basis that the evidence of proximate cause was insufficient to submit to the jury.¹¹² More importantly, the supreme court affirmed the trial court's finding that the Sisters of Charity would not be liable for any negligence of Dr. Hansen because he was an employee of the Emergency Professional Service Group and was not under the "control" of the hospital.¹¹³ In affirming the trial court's decision, the supreme court stated that "the practice of medicine by a licensed physician in a hospital is not sufficient to create an agency by estoppel. . . . Nowhere is 'induced reliance' [present] . . . as [is] required . . . to establish such a relationship."¹¹⁴

The *Hannola* court distinguished the *Cooper* case by a procedural comparison: the *Cooper* case reached the Ohio Supreme Court on the granting of a motion for a directed verdict. *Hannola* came to the court of appeals on the improper granting of a pretrial motion for summary judgment wherein there remained significant issues of fact to be determined on the questions of control, induced reliance, and the hospital's independent duty of care.¹¹⁵

The *Hannola* court also stated that the *Cooper* court had not considered the relevant public policy issues:

These public policy issues include the hospital's special independent duty in the emergency room on its premises and the problem of the full-service hospital and patients' induced reliance on the reputation of the hospital with an emergency room on the premises. *Of course, we fully agree that the mere practice of medicine by a licensed physician in a hospital is not sufficient to create an agency by estoppel.*¹¹⁶

The *Hannola* court's decision provides two contradictory messages. "[T]he mere practice of medicine by a licensed physician in a hospital is not sufficient to create an agency by estoppel."¹¹⁷ However, the presence of an agreement with the hospital to collaborate on patient care policy and the granting of staff privileges, both of which apply to virtually all physicians who care for patients within hospitals, will be sufficient to raise an issue about whether a hospital has enough control over a physician to justify imposition of liability upon the hospital.¹¹⁸ The Ohio Supreme Court overruled a motion to certify the record in *Hannola*.¹¹⁹ Subsequently, the parties reached a settlement.¹²⁰

111. *Id.* at 245, 246, 272 N.E.2d at 100, 101.

112. *Id.* at 254, 272 N.E.2d at 104-105.

113. *Id.*

114. *Id.*

115. *Hannola v. City of Lakewood*, 68 Ohio App. 2d 61, 70 n.2, 426 N.E.2d 1187, 1193 n.2 (1980).

116. *Id.* (emphasis added).

117. *Id.*

118. *Id.* at 69, 426 N.E.2d at 1192.

119. *Id.* at 61 n.1, 426 N.E.2d at 1187 n.1.

120. West Shore paid the plaintiff. The hospital did not pay. Telephone interview with Mr. Patrick J. Murphy, J.D., Jacobson, Maynard, Tuschman, Kalur, Co. L.P.A., Cleveland, Ohio (Jan. 31, 1986). Mr. Murphy was a defense attorney

VI. POST-*HANNOLA* DECISIONS

By invoking an “anything goes” attitude, the *Hannola* court has opened the door for imposing liability on hospitals for physician malpractice in virtually every possible circumstance. In 1984, in *Stratso v. Song*,¹²¹ despite a trial court finding as a matter of law that the anesthesiologists were independent contractors hired by a third party, the Franklin County Court of Appeals of Ohio held that the evidence permitted a jury to find the hospital liable for the alleged malpractice under either of two theories: agency by estoppel or the existence of a non-delegable duty.¹²²

Regarding the first theory, the *Stratso* court remarked that agency by estoppel is ordinarily a factual issue to be proved by evidence of induced reliance.¹²³ “In the medical-malpractice context, a physician’s negligence is imputed to the hospital where the patient relies, to his detriment, upon demonstrable indications that the physician is an employee of the hospital.”¹²⁴

According to the *Stratso* court, ample evidence existed of induced reliance and of actual reliance on the representations by the hospital that it would provide the service of anesthesia.¹²⁵ Specifically, the court stated that the patient did not have the same opportunity to solicit information about the anesthesiologists’ qualifications and reputation as he would in choosing a surgeon or physician in private practice.¹²⁶ The patient relied on the hospital to provide all operating-room services, other than surgery, but including anesthesia.¹²⁷ The “hospital . . . contracted with the physician group to provide that service (anesthesia) which it, the hospital, had at least impliedly represented it would provide to the patient.”¹²⁸ The court stated that from the patient’s perspective the hospital and the anesthesiologist were not separate.¹²⁹

in the *Hannola* case. At the time of the case he was an attorney with Weston, Hurd, Fallon, Paisley & Howley, Cleveland, Ohio.

121. 17 Ohio App. 3d 39, 477 N.E.2d 1176 (1984).

122. *Id.* at 45, 477 N.E.2d at 1184–85.

The evidence indicated that the anesthesiologists involved in Frances Stratso’s care were employed by Allied Anesthesia Services, Inc., a physician corporation providing one hundred percent anesthesia coverage to defendant hospital pursuant to a contract with the hospital. Concerning the relationship between the hospitals and the employees of Allied Anesthesia Services, Dr. Hamelberg, Director of Critical Care at St. Anthony, testified that: the hospital provides a job description for the Chief of Anesthesia Services; the Chief of Anesthesia Services is responsible for implementation of the standards of the Joint Commission for the Accreditation of Hospitals as they relate to anesthesia services; the Chief of Anesthesia Services develops policies and procedures for anesthesia services; the other physician anesthesiologists work under the Chief of Anesthesia Services; the Chief of Anesthesia Services is responsible to the Chief of Staff and the administration of St. Anthony Hospital and reports to the Director of Critical Care, who is responsible for seeing that the Chief of Anesthesia Services carries out his responsibilities; the hospital provides a job description for all physician anesthesiologists; the physician anesthesiologists are expected to meet the demands of the surgery schedule at the hospital; the job description requires a physician anesthesiologist to make pre-operative and post-operative rounds and to be present at all times in the operating room; the physician anesthesiologist supervises nurse anesthetists; and the physician anesthesiologist is jointly responsible to the Chief of Staff and to the administration of St. Anthony Hospital.

Id.

123. *Id.* at 47, 477 N.E.2d at 1186.

124. *Id.*

125. *Id.* at 47–48, 477 N.E.2d at 1186–87.

126. *Id.* at 46, 477 N.E.2d at 1185.

127. *Id.* at 48, 477 N.E.2d at 1187.

128. *Id.*

129. *Id.* at 46, 477 N.E.2d at 1185.

The court, however, may be making an erroneous assumption by stating that a patient relies on a hospital to provide anesthesia. Indeed, it may be more true that patients merely rely on the anesthesiologist, not the hospital, to provide anesthesia. A patient is told that a physician will administer the anesthesia, and indeed, it will be the anesthesiologist and not the hospital who makes a visit to the patient prior to surgery. In addition, it is the physician and not the hospital who administers the anesthesia to the patient. The court should not make hasty assumptions when more empirical facts are needed to determine whether patients rely on a hospital's *agent* to administer anesthesia.

Regarding the theory of a non-delegable duty, the court's rationale is unclear. The *Stratso* court reiterates the rule of *Richman Brothers Co. v. Miller*:¹³⁰

Where danger to others is likely to attend the doing of certain work unless care is observed, the person having it to do is under a duty to see that it is done with reasonable care, and cannot, by the employment of an independent contractor, relieve himself from liability for injuries resulting to others from the negligence of the contractor or his servants.¹³¹

Then, without further explanation, the court states that reasonable minds could conclude that the hospital was liable for the negligence of the anesthesiologist and the nurse anesthetist under the doctrine of *respondeat superior*.¹³²

One year prior to *Stratso*, in another post-*Hannola* decision, *Smith v. Timken Mercy Medical Center*,¹³³ a different result was reached by an appellate court. The Court of Appeals for Stark County addressed the alternate claims of whether an express principal-agent relationship existed between the defendant hospital and three physicians, or whether the hospital was liable under an agency by estoppel theory.¹³⁴ The *Smith* court did not find *respondeat superior* or agency by estoppel to apply.¹³⁵

In *Smith*, the decedent was admitted to the defendant hospital as a patient of co-defendant Dr. Williams for diagnosis and treatment.¹³⁶ During hospitalization, the patient was also treated by defendants Dr. Alasyali and Dr. Gesenhues.¹³⁷ All three physicians had staff privileges and were governed by the hospital's constitution, bylaws, policies, rules, and regulations.¹³⁸ The plaintiff claimed that the hospital had a right to exercise control over these doctors with staff privileges because of the Timken Mercy Medical Staff Constitution.¹³⁹ The plaintiff alleged that the negligence of the defendants in diagnosis, care, and treatment resulted directly and proximately in the decedent's death.¹⁴⁰

130. 131 Ohio St. 424, 3 N.E.2d 360 (1936).

131. *Stratso v. Song*, 17 Ohio App. 3d 39, 48, 477 N.E.2d 1176, 1187 (1984) (quoting *Richman Brothers Co. v. Miller*, 131 Ohio St. 424, 424, 3 N.E.2d 360, 360 (1936)).

132. *Stratso v. Song*, 17 Ohio App. 3d 39, 48, 477 N.E.2d 1176, 1188 (1984).

133. *Smith v. Timken Mercy Medical Center*, No. CA-6006, slip op. at 1 (Ohio Ct. App. Feb. 8, 1983).

134. *Id.* at 2-3.

135. *Id.* at 4-5.

136. *Id.* at 3.

137. *Id.*

138. *Id.*

139. *Id.* at 3-4.

140. *Id.* at 2.

[Plaintiff] argues that the hospital Board of Trustees has the final say on whether the physician is to be appointed or reappointed to the staff and that the Board controls whether the doctor shall have reduced, suspended, or

The *Smith* court, however, held that the hospital's constitution did not justify "impos[ing] upon the hospital and the doctors admitted to practice there a relationship of *respondeat superior* as relates to the diagnosis and treatment of medical conditions of patients admitted to the hospital by the doctor."¹⁴¹ Regarding the alternate claim of agency by estoppel, the court did not find evidence to "support the conclusion that the hospital held itself out to plaintiff's decedent as the provider of such medical care, or by its conduct is somehow estopped from denying its responsibility as a principal."¹⁴²

The *Smith* court held that the case falls clearly within the holding in *Cooper v. Sisters of Charity* that the practice of medicine is not enough to create an agency by estoppel without a showing of induced reliance by the plaintiff.¹⁴³ The court further elaborated that the Timken Mercy Medical Center did not do anything to create an impression in the patient's mind that the doctor was the hospital's agent.¹⁴⁴ The *Smith* court stated that *Hannola* was distinguishable.¹⁴⁵ According to the *Smith* court, the *Hannola* case did not present an issue of *respondeat superior*, but instead was decided on ostensible agency (agency by estoppel) in which the hospital "held itself out" to a patient who voluntarily appeared at the hospital and relied on the hospital's reputation.¹⁴⁶

In a more recent case, *Funk v. Hancock*,¹⁴⁷ the Court of Appeals, Twelfth Appellate District, Fayette County, addressed the question of hospital liability for the alleged malpractice of a physician called in as a consultant by the emergency room physician. In *Funk*, the decedent was brought to the emergency room of the defendant, Fayette County Memorial Hospital, by his mother for treatment of an injury to his left arm.¹⁴⁸ The decedent was treated by an emergency room physician who diagnosed a fracture of the left forearm and who then called co-defendant Dr. Hancock for consultation regarding the setting of the arm.¹⁴⁹ Dr. Hancock was a staff physician on call at the emergency room.¹⁵⁰ The mother sued the hospital and Dr. Hancock for medical malpractice as a result of "improper casting of a compound fracture without debridement and appropriate follow-up observations and care."¹⁵¹

terminated privileges; that the staff must comply with lawful standards, policies, and rules of the hospital; that staff are governed by the principles of ethics promulgated by the staff and conforming to the Code of Catholic Medical Ethics; that the staff provide for continuous care of patients and refrain from delegating the responsibility for diagnosis or care to one not qualified to undertake the responsibility.

Id. at 3-4.

141. *Id.* at 4.

142. *Id.*

143. *Id.* *Cooper v. Sisters of Charity*, 27 Ohio St. 2d 242, 272 N.E.2d 97 (1971).

144. *Smith v. Timken Mercy Medical Center*, No. CA-6006, slip op. at 5 (Ohio Ct. App. Feb. 8, 1983).

145. *Id.* at 5.

146. *Id.*

147. 26 Ohio App. 3d 107, 498 N.E.2d 490 (1985).

148. *Id.* at 107, 489 N.E.2d at 491.

149. *Id.*

150. *Id.*

151. *Id.* at 107-108, 498 N.E.2d at 490-92. "Debridement" is defined as removal of all foreign material and aseptic excision of all contaminated and devitalized tissue. B. MILLER & C. KEANE, ENCYCLOPEDIA AND DICTIONARY OF MEDICINE AND NURSING 295 (1983).

The plaintiff's claims of hospital liability were premised on the legal theories of joint venture, actual agency, and agency by estoppel.¹⁵² The court dismissed the plaintiff's allegation of joint venture because the hospital and physicians did not have a contract to carry out a single business adventure for their joint profit.¹⁵³ The court directed its attention to plaintiff's agency by estoppel argument "without discounting the more remote possibility that an actual agency relationship might be proved to exist as between Dr. Hancock and the hospital."¹⁵⁴ The court stated:

Although the *Cooper* and *Hannola* decisions reach opposite results as to whether the respective hospitals involved should be relieved of further participation in suits against them, both decisions reflect the same underlying philosophy: agency by estoppel is applicable to cases involving physicians practicing in hospital emergency rooms, and if a hospital's actions are such that emergency room patrons are encouraged to rely on a presumed agency relationship between a treating physician and the hospital, the hospital may in fact be estopped from denying such relationship.¹⁵⁵

The court concluded that the evidence raised sufficient questions concerning the hospital relationship to preclude the hospital's motion for summary judgment.¹⁵⁶

A review of *Hannola* and post-*Hannola* decisions reveals the depth of the new expansion in hospital liability for physician malpractice. Hospitals have now been held liable for malpractice of emergency room physicians hired by third parties under theories of *respondeat superior*, agency by estoppel, and independent duty;¹⁵⁷ for malpractice of anesthesiologists hired by third parties under theories of agency by estoppel and non-delegable duty;¹⁵⁸ and for malpractice of staff physicians on call for consultation in hospital emergency rooms.¹⁵⁹ The trend however, is not without opposition. One appellate court has held that merely because a physician has staff privileges and is governed by a hospital constitution, no justification exists for imposing a relationship of *respondeat superior* or for creating a relationship of agency by estoppel.¹⁶⁰ Perhaps this confusion concerning the appropriate theories for hospital liability in Ohio, and their proper application, will encourage the Ohio Supreme Court to certify the record of future cases addressing these issues.

VII. CONCLUSION

The *Hannola* court's extensive surgery on the medical malpractice liability relationship of hospitals, physicians, and patients in Ohio has set an unprecedented standard for expanding hospital liability for physician malpractice. Since *Hannola*, hospitals are liable for what they do not and cannot control, namely, the independent

152. *Funk v. Hancock*, 26 Ohio App. 3d 107, 109, 498 N.E.2d 490, 493 (1985).

153. *Id.*

154. *Id.* at 110, 498 N.E.2d at 494.

155. *Id.* at 111-12, 498 N.E.2d at 495.

156. *Id.* at 112, 498 N.E.2d at 495.

157. *Hannola v. City of Lakewood*, 68 Ohio App. 2d 61, 65-66, 69, 426 N.E.2d 1188, 1190, 1192 (1980).

158. *Stratso v. Song*, 17 Ohio App. 3d 39, 45, 477 N.E.2d 1176, 1185 (1984).

159. *Funk v. Hancock*, 26 Ohio App. 3d 107, 498 N.E.2d 490 (1985).

160. *Smith v. Timken Mercy Medical Center*, No. CA-6006, slip op. at 4 (Ohio Ct. App. Feb. 8, 1983).

medical decisions and actions of physicians that result in malpractice.¹⁶¹ As a result, a serious postoperative complication has occurred. The courts have given hospitals the authority to practice medicine—a role the law disallows.¹⁶²

The cutting away of the traditional boundaries of *respondeat superior*, the transplantation of an independent duty, and the diagnosis of agency by estoppel all hold hospitals liable for physician malpractice. Physicians shoulder the responsibility for sound patient care within their private offices and should be given the dignity of doing so within the hospital environment. This responsibility is demonstrated by their level of care, commitment to the continuing education requirement,¹⁶³ and the financial burden of carrying malpractice insurance.¹⁶⁴

161. *Stratso v. Song*, 17 Ohio App. 3d 39, 45, 477 N.E.2d 1176, 1185 (1984); *Funk v. Hancock*, 26 Ohio App. 3d 107, 498 N.E.2d 490 (1985).

162. See *supra* note 52 and accompanying text.

163. Physicians must complete 100 hours of continuing medical education every two years. OHIO REV. CODE ANN. § 4731.281 (Page Supp. 1986).

164. The Physicians Insurance Company of Ohio (PICO) is the company that underwrites the Ohio State Medical Association Medical Professional Liability Plan. This plan is available to Ohio physicians who are licensed by the Ohio State Medical Board; are members of the Ohio State Medical Association; practice the majority of time in Ohio; and meet the Plan's underwriting requirements. The physicians are divided into general risk classifications and the rates increase accordingly with the risk. The following table demonstrates that even at group rates the financial burden of malpractice insurance is high. Residents and first and second year practitioners do receive discounts. Physicians Insurance Company of Ohio Brochure for Ohio State Medical Association (August 1985) (available from Ohio State Law Journal).

	<u>Primary</u>	<u>Excess</u>
	<u>\$100,000/300,000</u>	<u>\$1.2 million</u>
Class I	\$1,967	\$1,103
Class II	3,546	1,989
Class III	6,150	3,449
Class IV	10,819	6,450
Class V	12,982	7,740
Class VI	17,310	10,319
	<u>Primary</u>	<u>Excess</u>
	<u>\$200,000/600,000</u>	<u>\$1.2 million</u>
Class I	\$2,404	\$918
Class II	4,334	1,655
Class III	7,517	2,870
Class IV	13,096	5,090
Class V	15,715	6,107
Class VI	20,954	8,143

Claims Made Rates available upon request. Higher excess limits available with underlying \$200,000/\$600,000 primary limit.

General Risk Classifications:

Class I

The following specialists who perform no surgery:

Family/General Practice
Allergy
Cardiovascular Disease
Dermatology
Gastroenterology
Internal Medicine
Psychiatry
Gynecology

Occupational Medicine
Ophthalmology
Otorhinolaryngology
Pathology
Pediatrics
Pulmonary Diseases
Radiology (Diagnostic)

(Some minor surgical techniques performed in the office may be included in this classification.)

Class II

Specialists (see Class I list) performing minor surgery or surgical assistance on their own patients.

Class III

Surgical specialists in the following (as well as physicians who perform surgical assistance on other than their own patients):

Patients injured through malpractice deserve redress, and redress is available.¹⁶⁵ But in attempting to hold hospitals liable for medical malpractice, the courts appear to be establishing liability merely because insurance is available to hospitals.¹⁶⁶ Patients deserve the very best of care. Physicians are the professionals to whom patients entrust their care. The very best of care is not furthered by holding hospitals liable for physicians' independent actions which remain beyond a hospital's control.

Ruth Bope Dangel

Emergency Medicine
Radiology, with X-ray therapy

Class IV

The following specialists in:

Anesthesiology
Otorhinolaryngology Surgery

Class V

Surgical Specialists in:

Obstetrics and Gynecology
Plastic

Class VI

Surgical Specialists in:

Cardiovascular Disease

Neurology

Orthopedics

(This is only a partial listing.)

Id.

Endocrinology
Ophthalmology
Urology

General Surgery
Gynecological Surgery

Hand
Head and Neck

Thoracic
Vascular
Trauma

165. See *supra* note 164, which addresses medical malpractice coverage.

166. The Ohio Supreme Court has expressed disdain for establishing hospital liability merely on the basis of the presence of insurance. "We emphatically state that we are not imposing liability heretofore nonexistent merely because it may be indemnified by insurance." *Avellone v. St. John's Hosp.*, 165 Ohio St. 467, 475, 135 N.E.2d 410, 415 (1956). In addition, the prejudicial impact in a courtroom of evidence regarding a defendant's liability insurance is a legitimate concern. Thus, "[e]vidence that a person was or was not insured against liability is not admissible upon the issue of whether he acted negligently or otherwise wrongfully." OHIO R. EVID. 411.

