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Apparent Authority: Minnesota Finally Rejects Categorical Exemption for Independent Contractors in Hospital Emergency Rooms and Signifies Potential for Nondelegable Duty Doctrine—Popovich v. Allina Health Sys., 946 N.W.2D 885 (MINN. 2020).

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APPARENT AUTHORITY: MINNESOTA FINALLY REJECTS CATEGORICAL EXEMPTION FOR INDEPENDENT CONTRACTORS IN HOSPITAL EMERGENCY ROOMS AND SIGNIFIES POTENTIAL FOR NONDELEGABLE DUTY DOCTRINE—POPOVICH V. ALLINA HEALTH SYS., 946 N.W.2D 885 (MINN. 2020).

Dana Ohman

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I. INTRODUCTION

Minnesota recently joined the majority of states that apply the vicarious liability doctrine of apparent authority to hospitals for the negligence of independent contractor physicians in emergency rooms.[1] In *Popovich v. Allina Health Systems*, the Minnesota Supreme Court clarified previous decisions involving vicarious liability in emergency rooms, stating that the previous holdings conflated the two underlying doctrines of respondeat superior and apparent authority.[2] The court rejected an exclusive exemption for hospitals from the widely applied doctrine of apparent authority.[3]

This Case Note proceeds in three parts. First, it reviews the concurrent evolution of hospitals and accompanying public perception in the United States, along with the development of vicarious liability theories both generally and in Minnesota.[4] Second, the Note outlines *Popovich*, discusses the court's analysis and holdings, and reviews the dissent.[5] Third, the Note concludes that the decision comports with the current health care climate, explores the possible effects of the relaxed apparent authority standard, and analyzes *Popovich*'s influence, including the potential for consideration of a nondelegable duty standard in Minnesota.[6]

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[1] Popovich v. Allina Health Sys., 946 N.W.2d 885, 895 (Minn. 2020).
[2] *Id.* at 891–92.
[3] *Id.* at 892–93.
[4] *See infra* Part II.
[5] *See infra* Part III.
[6] *See infra* Part IV.

II. HISTORY

The gradual transformation of hospitals in the United States is a testament to the commitment to caring for patients regardless of ability to pay in unison with advancing medical technology and related costs.[7] The modernization of hospitals into large corporations led to diminished forbearance from pursuit of legal remedies by patients injured by physician negligence.[8] As hospitals developed, their immunity dissolved, and courts applied vicarious liability theories against hospitals for physician negligence.[9] Beginning with respondeat superior, courts later included agency theories of agency by estoppel, apparent agency, and eventually, nondelegable duty.[10] Minnesota courts followed this general trajectory but were slower to apply apparent authority than many other states.[11]

A. *Evolution of Hospitals and Their Public Perception in the United States*

Before the rise of hospitals in the modern context, personal physicians medically treated patients in their homes, if they could afford such care.[12] Those who could not afford in-house visits from personal physicians sought charitable medical care at almshouses,[13] which were seen as a last resort and often contained dire conditions.[14] Over time, almshouses slowly evolved into hospitals.[15] Starting with the first hospital founded in the United States in the mid-eighteenth century, hospitals initially remained charitable and focused on educational medicine, stemming from the experimental background of

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[7] Hadley Hamilton, Note, Boren *Ex. Rel.* Boren v. Weeks *and the Extension of Apparent Agency Liability to Tennessee Hospitals for the Negligence of Independent Contractor Physicians: Does the Fine Print Really Matter Anymore?*, 29 TEMP. J. SCI. TECH. & ENV'T L. 257, 260–61 (2010).

[8] *Id.* at 262.

[9] *Id.*

[10] *Id.* at 262–66; Martin C. McWilliams, Jr. & Hamilton E. Russell, III, *Hospital Liability for Torts of Independent Contractor Physicians*, 47 S.C. L. REV. 431, 438–57 (1996).

[11] *See infra* Part II.C & Part III.

[12] Hamilton, *supra* note 7, at 260 (citing Steven R. Owens, Note, Pamperin v. Trinity Memorial Hospital *and the Evolution of Hospital Liability: Wisconsin Adopts Apparent Agency*, 1990 WIS. L. REV. 1129, 1131–34 (1990)).

[13] *Id.* Almshouses were facilities supported by public and private donations that served to care for indigent patients who had no means to receive medical care in their own home. *Id.* at n.23 (citing Ruth E. Malone, *Whither the Almshouse? Overutilization and the Role of the Emergency Department*, 23 HEALTH POL. POL'Y & L. 795, 798 (1998)).

[14] *Id.* (citing JOINT COMM'N, HEALTH CARE AT THE CROSSROADS: GUIDING PRINCIPLES FOR THE DEVELOPMENT OF HOSPITALS FOR THE FUTURE 6 (2008)). Physicians often evaluated treatments by testing them on almshouse patients. *Id.* (citing Owens, *supra* note 12, at 1131).

[15] *Id.* (citing Owens, *supra* note 12, at 1131).

almshouses.[16]

Hospitals began modernizing in the late nineteenth century as medical science advanced.[17] These developments provided hospitals with revolutionary equipment and techniques not readily accessible to private physicians.[18] Coupled with technological and surgical innovations, the evolution of transportation solidified hospitals' accessibility and appeal to the public for sophisticated, effective medical care.[19] Modern hospitals have become dynamic facilities capable of providing comprehensive medical treatment, shifting steadily away from their charitable roots to providing premium medical care.[20] But this advanced level of care comes with a steep price tag.[21]

In step with the technological and methodological developments, hospitals came to rely on paying clients to fund medical advancements and for many, eventually turn a profit.[22] Hospitals began to compete with one another for these patrons, touting their sophisticated services and equipment to sway potential patients into choosing their medical care facilities.[23] Now high-volume businesses, modern hospitals spend a sizeable portion of their budgets on advertising to attract prospective clients not only

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[16] *Id.* at 260–61 (citing JOINT COMM'N, *supra* note 14, at 6) ("Over the next century, hospitals became more closely aligned with medical education but still carried the air of 'medical experimentation' that had been so closely associated with almshouses.").

[17] *Id.* at 261 (citing Owens, *supra* note 12, at 1133).

[18] *Id.* (citing Owens, *supra* note 12, at 1134).

[19] *Id.* (citing Owens, *supra* note 12, at 1131, 1133) ("Railroads and automobiles provided the public with a greater ability to travel than ever before. The hospital became a way for these travelers to receive medical care if they happened to fall ill away from their homes and their private doctors.").

[20] *Id.* (citing JOINT COMM'N, *supra* note 14, at 6); *see infra* note 23 (noting the correlation between advertising and public perception).

[21] Owens, *supra* note 12, at 1134 ("This new technology was expensive, and hospital trustees increasingly placed more emphasis on attracting paying customers.").

[22] *See id.*; *see also* Hamilton, *supra* note 7, at 262–63 ("Advancing technology caused hospitals [to] depend more on paying customers to help finance their activities. . . . [H]ospitals continued to evolve into large for-profit institutions"); Howard Levin, Note, *Hospital Vicarious Liability for Negligence by Independent Contractor Physicians: A New Rule for New Times*, 2005 U. ILL. L. REV. 1291, 1294–95 (2005) ("The modern health care industry continues to distance itself from its charitable past and has experienced a significant conversion from not-for-profit health care to for-profit hospital businesses.").

[23] *See* McWilliams & Russell, *supra* note 10, at 436 ("[T]he most important driver in the shift in public perception has been hospitals' marketing of themselves."); *see also* Edwin L. Barnes, Jr., *Victims of Their Own Success? South Carolina Hospitals Now Have an Absolute, Nondelegable Duty to Provide Competent Emergency Room Care*, 50 S.C. L. REV. 1063, 1064 (1999); Ryan Montefusco, *Hospital Liability for the Right Reasons: A Non-Delegable Duty to Provide Support Services*, 42 SETON HALL L. REV. 1337, 1337–38 (2012) (noting the undertaking of hospitals to distinguish themselves "has been marked by increased self-advertising and overall commercialization of the industry").

for their specialized and elective services but also for emergency treatment.[24]

These advertisements often boast of state-of-the-art equipment and highly sought-after physicians and, as intended, induce potential patients to rely on their marketing claims and choose their facilities in times of need instead of other potential medical providers.[25] Nearly all modern hospitals have long since abandoned their charitable roots and evolved into conglomerates and brands, treating those who rely on their services as consumers instead of patients.[26]

Because the overarching messages of these advertising campaigns aggrandize hospitals' resources and treatment capabilities, the public has come to expect a certain level of care.[27] The messaging not only promises exceptional treatment but also describes hospitals as teams of exceedingly capable professionals who work together to provide the utmost care.[28] These

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[24] Simmons v. Tuomey Reg'l Med. Ctr., 533 S.E.2d 312, 316–17 (S.C. 2000) ("Like any business dependent upon attracting individual people as customers, hospitals in the aggregate spend billions to advertise their facilities and services in a variety of media, from newspapers and billboards to television and the Internet."); Kashishian v. Port, 481 N.W.2d 277, 282 (Wis. 1992) ("[H]ospitals increasingly hold themselves out to the public in expensive advertising campaigns as offering and rendering quality health care services. . . . Modern hospitals have spent billions of dollars marketing themselves, nurturing the image with the consuming public that they are full-care modern health facilities."); *see infra* note 209 (citing examples of current Minnesota hospital websites).

[25] *Kashishian*, 481 N.W.2d at 282 ("All of these expenditures have but one purpose: to persuade those in need of medical services to obtain those services at a specific hospital. In essence, hospitals have become big business, competing with each other for health care dollars."); Clark v. Southview Hosp. & Fam. Health Ctr., 628 N.E.2d 46, 53 (Ohio 1994) ("As an industry, hospitals spend enormous amounts of money advertising in an effort to compete with each other for the health care dollar, thereby inducing the public to rely on them in their time of medical need."); Hamilton, *supra* note 7, at 257–58 ("The modern hospital typically advertises itself as a multifaceted institution providing the public with the best available healthcare through a vast array of specialty physicians and services.").

[26] Hamilton, *supra* note 7, at 257 ("Since their inception in the eighteenth century, hospitals have evolved from charitable institutions providing care for the poor to large streamlined corporations providing cutting edge medical care to those who can afford it. Hospitals have become big business.").

[27] *Id.* at 293 (citing Owens, *supra* note 12, at 1129) ("Often the advertisement portrays the particular hospital as providing superlative care in some or all areas of medicine. These modern advertising campaigns strive to portray a facility as a sort of brand name supplier of medical care."); *Simmons*, 533 S.E.2d at 321–22 ("Patients make those decisions based primarily on the reputation of the hospital, which it often has aggressively promoted, and not on the reputation of individual emergency room physicians."); *Clark*, 628 N.E.2d at 53 ("Public policy dictates that the public has every right to assume and expect that the hospital is the medical provider it purports to be.").

[28] *See supra* note 25 (quoting Hamilton, *supra* note 7, at 257–58); *see also* Note, *Theories for Imposing Liability Upon Hospitals for Medical Malpractice: Ostensible Agency and Corporate Liability*, 11 WM. MITCHELL L. REV. 561, 561–62 (1985) ("Today's hospitals are larger and more complex tha[n] ever before and operate as highly integrated systems utilizing a team approach to medical care. Typically, many persons care for a patient. Consequently, patients expect that treatment will be rendered by the hospital staff as a well-coordinated and efficient unit.") (citations omitted).

portrayals lead reasonable community members to see hospitals not simply as buildings housing equipment and providers, but as interwoven organizations providing comprehensive care.[29]

B. Emergence of Vicarious Liability in Emergency Rooms

As hospitals evolved, so did their liability to patients for accidents and incorrect diagnoses and treatments.[30] First, courts held hospitals liable for employee physician negligence under respondeat superior.[31] Then, under agency theory, courts found hospitals liable for negligent independent contractor physicians.[32]

1. Respondeat Superior Supplants Charitable Immunity

When hospitals first emerged as the still-charitable offspring of almshouses, judicial precedent generally protected hospitals from any negligence liability using the doctrine of charitable immunity.[33] As hospitals advanced in step with developments in medical technology, two concurrent dependencies surfaced: hospitals became dependent on paying customers, and society became dependent on hospitals for comprehensive medical care.[34] Charitable immunity could no longer shield hospitals from liability as hospitals cared for increasing numbers of patients from the middle and upper classes who paid for their own medical care.[35]

Without charitable immunity, hospitals were held liable for their employees' negligent actions under the doctrine of respondeat superior, a

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[29] "The simple fact of the matter is that '[t]he modern hospital has evolved into a corporate institution assuming "the role of a comprehensive health center ultimately responsible for arranging and coordinating total health care."' Gone are the days when hospitals were simply buildings where doctors came to treat patients." R. Edwin Lamberth, *Establishing Hospital Liability for Physician Negligence*, 21 ALA. ASS'N JUST. J. 33, 33 (2001) (quoting J. Douglas Peters, *Hospital Malpractice: Ten Theories of Direct Liability*, 12 J. L. MED. & ETHICS 254, 254 (1984)). *See* Hamilton, *supra* note 7, at 258 ("By holding itself out as providing all manner of medical care to the public, the modern hospital has blurred the line between simply being a building where physicians practice medicine and being the entity providing that actual medical care.").

[30] Hamilton, *supra* note 7, at 258 ("Modern jurisprudence is also evolving to keep pace with the evolution of hospitals. Where hospitals were once shielded from liability on the basis of charitable immunity they now find themselves on the frontline of increasing liability to the patients they serve.").

[31] *Id.* at 262–63.

[32] *Id.* at 263–66.

[33] *Id.* at 261–62 (citing Owens, *supra* note 12, at 1132–33); Elizabeth Isbey, Note, Diggs v. Novant Health, Inc. *and the Emergence of Hospital Liability for Negligent Independent-Contractor Physicians in North Carolina*, 43 WAKE FOREST L. REV. 1127, 1131 (2008).

[34] Hamilton, *supra* note 7, at 262 (citing Owens, *supra* note 12, at 1134). Hospitals began to rely on paying customers to finance the newest technology and equipment. *Id.*

[35] *Id.*

well-known principle of vicarious liability.[36] Because respondeat superior requires an employer-employee relationship, courts initially refused to hold hospitals vicariously liable for negligent independent contractors.[37]

2. Brief Categorization of Agency Theories Applied to Hospitals

As hospitals evolved, courts eventually used agency principles to hold hospitals liable even when the physicians were not technically employees.[38] The two most common agency theories in the United States are agency by estoppel and apparent agency.[39] Although sometimes mistakenly used interchangeably, these two theories are founded in separate principles.[40] While there is some deviation in the standards used, these theories have been widely applied to hospital emergency rooms for decades.[41] A third theory emerging more recently in hospital liability is the more stringent nondelegable duty doctrine.[42]

a. Agency by Estoppel

Rooted in agency principles, agency by estoppel is an equitable doctrine requiring that a plaintiff justifiably relied to his detriment on the care of a negligent independent contractor who was held out by a hospital as an agent.[43] The doctrine is applied to prevent a party from taking advantage of another party who reasonably relied on the first party's actions.[44] When applied to hospital liability, plaintiffs usually must establish:

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[36] *Id.* (citing Levin, *supra* note 22, at 1294–95). "An employer is subject to liability for torts committed while acting within the scope of their employment." RESTATEMENT (THIRD) OF AGENCY § 2.04 (Am. L. Inst. 2006). Rationales behind the theory of respondeat superior include that it incentivizes employers to prevent accidents, assures monetary compensation for the injured party, and equitably distributes the financial losses among the parties who directly benefit from the activity that caused the accident. Hamilton, *supra* note 7, at 263 (citing Rhett B. Franklin, Comment, *Pouring New Wine into an Old Bottle: A Recommendation for Determining Liability of an Employer Under Respondeat Superior*, 39 S.D. L. REV. 570, 577 (1994)).

[37] Hamilton, *supra* note 7, at 263 (citing Isbey, *supra* note 33, at 1131).

[38] *Id.*

[39] *Id.* (citing Levin, *supra* note 22, at 1295).

[40] *Id.*; *see* Isbey, *supra* note 33, at 1136 n.50 ("Many courts fail to distinguish between these two theories and instead rely on a combination of the different requirements of each doctrine."); Levin, *supra* note 22, at 1295 ("These doctrines of liability have significant substantive differences. Commentators criticize state courts for using these names interchangeably and confusing the underlying legal theories which are based on either agency or tort law.").

[41] Popovich v. Allina Health Sys., 946 N.W.2d 885, 893 n.8 (Minn. 2020).

[42] McWilliams & Russell, *supra* note 10, at 452.

[43] Hamilton, *supra* note 7, at 263–64 (citing RESTATEMENT (SECOND) OF AGENCY § 267, cmt. a (Am. L. Inst. 1958)). The mere belief that the physician was an employee is not enough to create liability in the hospital. *Id.* The plaintiff's detrimental reliance must be reasonable. *Id.* at 264 n.62 (citing Owens, *supra* note 12, at 1142 n.58).

[44] Isbey, *supra* note 33, at 1135–36.

(1) the hospital held out the negligent physician as an agent or employee; and (2) the plaintiff reasonably relied on the hospital's representation.[45]

The element setting this theory apart is the stricter reliance requirement, often referred to as detrimental reliance.[46] The patient must show reliance on the hospital holding itself out as the employer of the physician and that treatment would have been refused if the patient knew the physician was not an employee.[47] The patient must also show the reliance was justified or reasonable.[48] Some state courts even require the patient to show the hospital acted in bad faith in its misrepresentations.[49] While many states applied this doctrine at one time, or still do, other states apply the more accessible theory of apparent or ostensible agency.[50]

b. Apparent or Ostensible Agency

Apparent agency (otherwise referred to as apparent authority in Minnesota) is a tort-based doctrine with nearly the same elements as agency by estoppel but does not require the plaintiff to establish the more stringent element of detrimental reliance.[51] In the hospital setting, a plaintiff must prove the medical services were accepted based on the belief that the hospital or its employees were providing those services.[52]

Here, the patient's reliance on the hospital's representation of the relationship must still be reasonable, but the patient typically does not need to prove the services would have been refused if the patient had known the physician was an independent contractor.[53] There have been discrepancies

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[45] Hamilton, *supra* note 7, at 264 (citing RESTATEMENT (SECOND) OF AGENCY § 267).

[46] *Id.* (citing Owens, *supra* note 12, at 1142 n.58); Isbey, *supra* note 33, at 1136–37 ("[U]nlike apparent agency, agency by estoppel requires both reliance and a change in position by the patient based on the representations of the hospital as the alleged employer of the independent contractor.").

[47] Isbey, *supra* note 33, at 1137.

[48] *Id.*; *see, e.g.,* Mehlman v. Powell, 378 A.2d 1121, 1123–24 (Md. 1977) (discussing examples of both reasonable and unjustified reliance).

[49] Isbey, *supra* note 33, at 1137. Usually, bad faith misrepresentation must be proven by showing a misrepresentation of fact by the hospital or silence where the hospital knows the patient will misconstrue it. McWilliams & Russell, *supra* note 10, at 448.

[50] *See* Simmons v. Tuomey Reg'l Med. Ctr., 533 S.E.2d 312, 322–23 (S.C. 2000) (citing cases relying on section 429 of the Restatement (Second) of Torts); *see also* Isbey, *supra* note 33, at 1133 ("Courts look at a variety of factors in determining whether the hospital held itself out as employing one of these types of physicians. This is a low standard, designed to assist the patient in proving the apparent agency relationship existed between the hospital and the physician.").

[51] Hamilton, *supra* note 7, at 264 (citing RESTATEMENT (SECOND) OF TORTS § 429 (Am. L. Inst. 1965)). Apparent agency is also referred to as apparent authority in Minnesota. Popovich v. Allina Health Sys., 946 N.W.2d 885, 890 n.4 (Minn. 2020).

[52] Hamilton, *supra* note 7, at 264–65 (citing RESTATEMENT (SECOND) OF TORTS § 429).

[53] Isbey, *supra* note 33, at 1137 (stating that section 429 of the Restatement (Second) of Torts only requires the patient to "show that the hospital held itself out as a provider of medical care," as opposed to the requirements of section 267).

among the courts as to whether the patient's reliance should be measured on an objective or subjective basis.[54] The holding out element is generally less stringent under this theory as well;[55] a hospital's advertisements may be enough to show it held its physicians out as employees.[56] Even further, some jurisdictions held patients could properly assume emergency room physicians were employees of the hospital unless notice was provided to the contrary.[57]

Over the years, courts increasingly lowered the requirements of apparent agency in favor of patients seeking to hold hospitals liable for independent contractor physicians.[58] This idea is seen where at least one court agreed with the proposition that patients have the right, absent notice to the contrary, to assume emergency room treatments are being rendered by hospital employees and that the hospital will be held responsible for any negligence in that treatment.[59] Such interpretations of apparent agency pushed the doctrine closer to a nondelegable duty standard.[60]

c. Nondelegable Duty

A few courts bypassed agency by estoppel and apparent agency and

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[54] Levin, *supra* note 22, at 1291–92 ("[C]ourts in Illinois imposed divergent reliance standards. . . . As a result, vicarious liability of hospitals under the doctrine of apparent authority has developed into a confusing and unpredictable area of law in Illinois. Other states have also struggled with the reliance requirement of independent contractor vicarious liability for hospitals.").

[55] Isbey, *supra* note 33, at 1133 ("This is a low standard, designed to assist the patient. . . . Typically, if the hospital held itself out to the patient such that the patient would look to the hospital and not to the individual independent-contractor physician for care, then a court would find this condition satisfied.").

[56] *See* Pamperin v. Trinity Mem'l Hosp., 423 N.W.2d 848, 856 (Wis. 1988) (noting many courts found that by providing emergency room care to patients who were not advised they were being treated by the hospital's agent, hospitals create an appearance that the hospital's employees will provide care as opposed to an independent contractor).

[57] *See id.* at 856–57 (making its own rule after citing Mduba v. Benedictine Hosp., 52 A.D.2d 450, 453 (1976)) ("[I]f Pamperin proves that Trinity held itself out as a provider of emergency room care without informing Pamperin that the care was provided by independent contractors, Pamperin has satisfied the first requirement for proving liability under the doctrine of apparent authority.").

[58] *See* Isbey, *supra* note 33, at 1133–34 (stating the first factor "can be satisfied merely by demonstrating that the hospital held itself out as a complete provider of medical care to the public," and the second factor "presumes the patient's actual reliance when he enters the hospital and comes under the care of a physician whom he believes to be an employee of the hospital.").

[59] *See* McWilliams & Russell, *supra* note 10, at 460 (discussing Fulton v. Quinn, C.A. 89C-AU-36, 1993 WL 19674 (Del. Super. Ct. Jan. 12, 1993) (mem.)).

[60] Simmons v. Tuomey Reg'l Med. Ctr., 533 S.E.2d 312, 320–21 (S.C. 2000) ("Most courts applying the apparent agency doctrine in the emergency room setting have relaxed those requirements substantially in order to hold the hospital liable. . . . Consequently, we believe the better solution, grounded primarily in public policy reasons . . . is to impose a nondelegable duty on hospitals.").

applied a nondelegable duty theory, holding hospitals responsible for the care provided by their emergency room physicians, regardless of their employment arrangements.[61] This vicarious liability theory imposes liability on the delegating party regardless of fault.[62] One policy behind this doctrine is that certain responsibilities to the community are too important to allow a party to transfer liability.[63] In practice, the nondelegable piece is liability; a hospital may delegate its duty to an independent contractor, but the hospital will remain liable to any third party for negligence of the delegatee.[64] Some courts found hospitals owe patients a direct and nondelegable duty to provide non-negligent care in their emergency rooms.[65]

This liability stems from statutes, regulations, contracts, and common law.[66] A common law nondelegable duty typically arises out of an "inherently dangerous activit[y]."[67] Although emergency room care is not widely considered inherently dangerous, some argue for that designation.[68] However, because it is not commonly viewed as dangerous, this application is less likely in the hospital setting.[69]

The most common bases for this type of liability are statutory or contractual.[70] Many states have statutes and regulations that impose a minimum standard of care on health care providers.[71] This minimum standard of care has been used in some cases to impose a nondelegable duty

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[61] *See* McWilliams & Russell, *supra* note 10, at 454; *see also Simmons*, 533 S.E.2d at 318–19 (implementing nondelegable duty doctrine in hospitals and referencing other states who already do so).

[62] McWilliams & Russell, *supra* note 10, at 453.

[63] Barnes, *supra* note 23, at 1069 (citing W. Page Keeton, Dan B. Dobbs, Robert E. Keeton & David G. Owen, Prosser and Keeton on the Law of Torts § 69, at § 71, at 511–12 (5th ed. 1984)) ("It is difficult to suggest any criterion by which the non-delegable character of such duties may be determined, other than the conclusion of the courts that the responsibility is so important to the community that the employer should not be permitted to transfer it to another.").

[64] McWilliams & Russell, *supra* note 10, at 452.

[65] *See Simmons*, 533 S.E.2d at 318–19 ("Alaska, Florida, and New York courts have applied the nondelegable duty doctrine to care provided by a hospital's emergency room physicians.").

[66] McWilliams & Russell, *supra* note 10, at 453 (citing Keeton, *supra* note 63, at § 71, at 511).

[67] *Id.* at 453 n.117.

[68] *Id.* at 456–57 n.141.

[69] *Id.*

[70] David G. Wirtes, Jr. & George M. Dent, III, *Hospitals', Surgical Centers', and Clinics' Vicarious Liability for Acts and Omissions of Doctors, CRNAs, Physician's Assistants, and Nurses*, 31 ALA. ASS'N JUST. J. 44, 48–49 (2012).

[71] *See e.g., id.* at 49 ("A hospital's nondelegable duty to provide competent medical care may arise from one or more of the following: (1) regulations imposed upon all hospitals which are recipients of federal funding under Medicare/Medicaid; (2) the fact that the hospital voluntarily undertook to provide emergency medical care to the patient; and (3) *the fact that the Alabama Legislature has imposed a minimum standard of care upon all health care providers who operate in this State pursuant to Ala. Code § 65584(a) (1975).*") (emphasis added).

on hospitals to provide a certain level of care.[72] On a contractual basis, hospitals may be subject to a nondelegable duty expressly based on certain admittance or authorization forms to provide treatment, as well as impliedly based on voluntarily undertaking to provide medical services.[73]

While the nondelegable duty theory has been around since at least the early nineteenth century in other contexts,[74] most courts have been reluctant so far to take the extra step toward what would practically be strict liability of hospitals for negligent physicians, especially in emergency rooms.[75] However, the courts that decided to impose a nondelegable duty on hospitals bolstered these decisions with strong public policy arguments that could eventually sway more courts into joining in this application.[76] Although apparent agency is the current theory applicable to hospitals with independent contractors in most states, including the recent addition of Minnesota,[77] several states have taken the liability a step further, finding hospitals have a nondelegable duty to provide a minimum standard of care in emergency rooms.[78]

C. *Vicarious Liability in Minnesota*

Vicarious liability has been applied in Minnesota since at least the late nineteenth century.[79] With the court's latest decision in *Popovich*, Minnesota now recognizes two pertinent theories of vicarious liability relating to hospitals: respondeat superior and apparent authority.[80] Throughout its application of apparent authority, Minnesota kept its

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[72] *See* Wax v. Tenet Health Sys. Hosps., Inc., 955 So. 2d 1, 9 (Fla. Dist. Ct. App. 2007) ("We conclude that because the statute and regulation impose this duty for non-negligent anesthesia services on all surgical hospitals, it is important enough that as between the hospital and its patient it should be deemed non-delegable without the patient's express consent.").

[73] *See, e.g.*, *id.* at 9–11. Here, the patient only consented to administering anesthesia services under the admission form, and the language in the form could not be "construed to stand as an agreement to discharge the hospital from its primary statutory and contractual duty of providing non-negligent anesthesia services." *Id.* Had negligence been addressed in the provision, "the Hospital would be liable as a matter of law." *Id.* at 11.

[74] *See* McWilliams & Russell, *supra* note 10, at 452–53.

[75] *See* Wirtes & Dent, *supra* note 70, at 49 ("A hospital that provides a full service emergency medical facility that is open to the public has a duty to provide such services within the standard of care.").

[76] *See* McWilliams & Russell, *supra* note 10, at 452–55; *see, e.g.*, *supra* notes 60, 63, and accompanying text (referencing policy arguments); *infra* Part IV.B.2. & Part IV.C.2 (addressing the ways these policy arguments could sway additional courts).

[77] Popovich v. Allina Health Sys., 946 N.W.2d 885, 892–93 n.8 (Minn. 2020).

[78] *See supra* note 76.

[79] *See* Rait v. New Eng. Furniture & Carpet Co., 66 Minn. 76, 78, 68 N.W. 729, 730 (1896); Gahagan v. Aerometer Co., 67 Minn. 252, 255, 69 N.W. 914, 915 (1897).

[80] *Popovich*, 946 N.W.2d at 890. The Minnesota Supreme Court uses the terms apparent authority and apparent agency interchangeably. *Id.* at 890 n.4.

reliance standard fairly consistent.[81]

1. *Respondeat Superior and Apparent Authority*

Respondeat superior holds an employer vicariously liable for its employee's negligence while working.[82] Apparent authority holds a principal vicariously liable for holding an agent out "as having authority" or "knowingly" allowing the agent to act for the principal when the agent is negligent.[83] In addition to the requirement of holding an agent out as having authority, Minnesota courts also established a second requirement of reliance.[84] Ultimately, the principal's conduct, rather than the agent's, provides proof of apparent authority.[85]

Minnesota courts have long applied the theory of respondeat superior to hold hospitals vicariously liable for negligent employees.[86] Minnesota precedent requires an employer to retain a chain of control over an employee's actions.[87] The court pointed out the notable difference between respondeat superior and apparent authority: the latter does not require an element of control.[88] Under apparent authority in Minnesota, a principal does not need to have control over a non-employee to be held vicariously liable for the non-employee's negligence.[89] Before *Popovich*, the Minnesota

[81] *See infra* Part II.C.2 (outlining marginal variations to the reliance standard).

[82] *Popovich*, 946 N.W.2d at 890 (citing Schneider v. Buckman, 433 N.W.2d 98, 101 (Minn. 1988)).

[83] *Id.* at 890–91 (quoting Hockemeyer v. Pooler, 268 Minn. 551, 562, 130 N.W.2d 367, 375 (1964) ("The principal must have held the agent out as having authority, or must have knowingly permitted the agent to act on its behalf; furthermore, the party dealing with the agent must have actual knowledge that the agent was held out by the principal as having such authority or had been permitted by the principal to act on its behalf; and the proof of the agent's apparent authority must be found in the conduct of the principal, not the agent.").

[84] *Popovich*, 946 N.W.2d at 895. The argument behind the reliance element is when a person interacts with an agent, that person must reasonably and diligently attempt to verify whether the agent has authority to act as requested or intended in the interaction. *See* Truck Crane Serv. Co. v. Barr-Nelson, Inc., 329 N.W.2d 824, 827 (Minn. 1983).

[85] *Popovich*, 946 N.W.2d at 891 (citing *Hockemeyer* at 562, 130 N.W.2d at 375).

[86] *Id.* This was already a well-established principle in Minnesota by 1942. *See* St. Paul-Mercury Indem. Co. v. St. Joseph's Hosp., 212 Minn. 558, 559–60, 4 N.W.2d 637, 638 (1942).

[87] *Popovich*, 946 N.W.2d at 891; *see St. Paul-Mercury Indem. Co.*, 212 Minn. at 558–61, 4 N.W.2d at 638–39; Moeller v. Hauser, 237 Minn. 368, 375–82, 54 N.W.2d 639, 644–46 (1952) (affirming the rule requiring a continuous chain of control).

[88] *Popovich*, 946 N.W.2d at 891 (citing RESTATEMENT (SECOND) OF AGENCY § 2.03 cmt. a, c (Am. L. Inst. 1958)).

[89] *Id.* Control was not necessary as long as the principal "held the non-employee out as having authority or knowingly permitted the non-employee to assume authority." *Id.* (citing RESTATEMENT (THIRD) OF AGENCY § 2.03 cmt. c (Am. L. Inst. 2006)). "'Apparent authority holds a principal accountable for the results of third-party beliefs about an actor's authority to act as an agent when the belief is reasonable and is traceable to a manifestation of the

Supreme Court had not yet considered whether apparent authority applied to hospitals for the negligence of emergency room non-employees.[90]

2. Variations in Minnesota's Apparent Authority Reliance Requirement

The doctrine of apparent authority has been applied in Minnesota since at least the mid-1960s.[91] Under this theory, a business may be held vicariously liable for a non-employee's negligence, even if the business has no control over the non-employee, if the business holds out the non-employee as having authority or knowingly permits the non-employee to assume authority.[92] The element of control necessary to respondeat superior is irrelevant to a finding of apparent authority.[93] A plaintiff seeking to hold a business liable under an apparent authority theory must prove two elements: holding out and reliance.[94]

While holding out is still a required element, the *Popovich* decision focuses heavily on the reliance standard;[95] this Note will follow suit. The Minnesota Supreme Court established the standard for apparent authority in *Hockemeyer v. Pooler*, providing in relevant part that "the party dealing with the agent must have actual knowledge that the agent was held out by the principal as having such authority or had been permitted by the principal to act on its behalf."[96] This "actual knowledge" reliance standard was cited in other early cases applying apparent authority in Minnesota.[97]

The courts in these early cases interpreted reliance to require a plaintiff

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principal.'" *Id.* (quoting RESTATEMENT (THIRD) OF AGENCY § 2.03 cmt. c). Non-employee and independent contractor are meant to be used interchangeably throughout this Note, and non-employee is used here specifically in relation to the Minnesota courts' use of the term. *See, e.g.*, *id.* (using the term non-employee).

[90] *Id.* at 890. Although the Minnesota Court of Appeals considered vicarious liability against a hospital for the alleged malpractice of a non-employee in a hospital's emergency room in its *McElwain* decision, the court did not specifically refer to either respondeat superior or apparent authority when it decided the hospital could not be held vicariously liable. *Id.* at 891 (referring to McElwain v. Van Beek, 447 N.W.2d 442 (Minn. Ct. App. 1989)). *See* Kramer v. St. Cloud Hosp., No. A11-1187, 2012 WL 360415, at *13–14 (Minn. Ct. App. Feb. 6, 2012) (Minge, J., concurring in part and dissenting in part) (noting *McElwain* addressed vicarious liability, but "no reported Minnesota court decision has addressed the issue of the apparent authority of a hospital for the actions of a separately employed physician").

[91] *See* Hockemeyer v. Pooler, 268 Minn. 551, 562, 130 N.W.2d 367, 375 (1964); Lindstrom v. Minn. Liquid Fertilizer Co., 264 Minn. 485, 119 N.W.2d 855 (1963).

[92] *Popovich*, 946 N.W.2d at 891.

[93] *Id.* at 891–92.

[94] *Id.* at 895 (citing *Hockemeyer*, 268 Minn. at 562, 130 N.W.2d at 375; Foley v. Allard, 427 N.W.2d 647, 653 (Minn. 1988)).

[95] *See id.* at 895–97.

[96] *Hockemeyer*, 268 Minn. at 562, 130 N.W.2d at 375.

[97] Foley v. Allard, 427 N.W.2d 647, 653 (Minn. 1988) (citing *Hockemeyer*, 268 Minn. at 562, 130 N.W.2d at 375); Truck Crane Serv. Co. v. Barr-Nelson, Inc., 329 N.W.2d 824, 826 (Minn. 1983) (citing *Hockemeyer*, 268 Minn. at 562, 130 N.W.2d at 375).

to be aware of the principal's representations of authority.[98] While Minnesota courts have interpreted the reliance or knowledge element with slight variation depending on the circumstances,[99] they have never applied a "but-for" test to establish reliance.[100] A "but-for" reliance would mean a plaintiff must show the services of the non-employee would not have been accepted had the plaintiff known the non-employee was not an actual agent of the business.[101] This precedent becomes imperative in the court's application of apparent authority to hospital emergency room dynamics in *Popovich.*[102]

III. THE *POPOVICH* DECISION

Alla Popovich brought a medical malpractice action on behalf of her husband, Aleksandr Popovich ("Popovich"), against Allina Health System as the owner and operator of two hospitals where Popovich received allegedly negligent emergency room medical care.[103] First, an outline of the facts provides context for the decision.[104] Then, the court provides reasoning and analysis relating to precedent.[105] Finally, the dissent discusses the logical progression from the court's applied standard.[106]

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[98] *See Truck Crane Serv. Co.*, 329 N.W.2d at 827 (quoting Duluth Herald & News Trib. v. Plymouth Optical Co., 286 Minn. 495, 498–99, 176 N.W.2d 552, 555 (1970)) ("Apparent authority 'exists only as to those third persons who learn of the manifestation from words or conduct for which the principal is responsible.'").

[99] *See id.* at 826–27 n.1 (discussing the circumstances of the present matter as compared to a distinguishable set of circumstances in a previous matter).

[100] *Popovich*, 946 N.W.2d at 895, n.16 ("Our precedent does not describe an actual reliance standard whereby a plaintiff must show that certain actions would not have been taken but for the appearance of an agent's authority.").

[101] *See id.* at 895 ("Actual reliance, as explained by Allina, would mean that a plaintiff's claim fails unless the plaintiff can show that the patient would not have accepted care had the patient known that the personnel in the emergency room were not actually agents or employees of the hospital."). "The Ohio Supreme Court initially adopted the type of 'but for' reliance standard that Allina asks us to apply here." *Id.* at 896 (citing Albain v. Flower Hosp., 553 N.E.2d 1038, 1049–50 (1990)).

[102] *See id.* at 895–97.

[103] *Id.* at 888. Alla Popovich is Aleksandr Popovich's wife and guardian ad litem. *Id.* Allina Health System owns and operates both Unity Hospital and Mercy Hospital. *Id.*

[104] *See infra* Part III.A.

[105] *See infra* Part III.B.

[106] *See infra* Part III.C.

A. *Facts and Procedural Posture*

On February 9, 2016, Popovich went to Unity Hospital's emergency room with dizziness and trouble breathing.[107] A physician ordered a CT scan of Popovich's head, and Popovich returned home after about two hours.[108] Later that morning, Popovich became unresponsive and went to Mercy Hospital's emergency room where a physician ordered a second CT scan.[109] A radiologist reviewed both CT scans and noted increased swelling in Popovich's brain since the first CT scan.[110] Popovich was later transferred to Abbott Northwestern Hospital for further care.[111] Doctors at Abbott found Popovich suffered a stroke, which left him with irreversible brain damage.[112]

Popovich sued Allina and several other parties, alleging he would not have suffered such debilitating injuries if the emergency room doctors and first radiologist had diagnosed and treated his stroke symptoms earlier.[113] The doctors and radiologists in the Unity and Mercy Hospital emergency rooms were not employees of the hospitals but were instead employees of Emergency Physicians Professional Association ("EPPA").[114] EPPA provided doctors for emergency rooms in Allina's facilities under contract.[115] The complaint against Allina asserted Allina was vicariously liable for its non-employee radiologist and doctors under the doctrine of apparent authority.[116]

Allina moved to dismiss the complaint, arguing the complaint did not state a proper claim because Minnesota did not allow suits against hospitals for independent contractor negligence.[117] Relying on the Minnesota Court of Appeals' decision in *McElwain v. Van Beek*,[118] the district court granted

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[107] *Popovich*, 946 N.W.2d at 888.
[108] *Id.* The CT scan was reviewed by a radiologist. *Id.*
[109] *Id.* at 889.
[110] *Id.*
[111] *Id.*
[112] *Id.* Popovich's official diagnosis was "dissection of the left proximal vertebral artery with thrombus." *Id.* Popovich's permanent symptoms included the inability to walk without assistance, very little use of his right arm and leg, and severe cognitive impairments, including speech. *Id.* Popovich will need nursing care for the remainder of his life for his permanent disabilities. *Id.*
[113] *Id.*
[114] *Id.*
[115] *Id.* Suburban Radiologic Consultants employed the radiologists, who were provided to Allina emergency rooms under a similar contract arrangement as EPPA. *Id.*
[116] *Id.*
[117] *Id.* Allina moved to dismiss under Minn. R. Civ. P. 12.02(e) for "failure to state a claim upon which relief can be granted." *Id.*
[118] 447 N.W.2d 442, 446 (Minn. Ct. App. 1989); *see infra* Part III.B.1 (explaining how the Minnesota Supreme Court later clarified the *McElwain* decision).

Allina's motion.[119] Popovich appealed to the Minnesota Court of Appeals, which affirmed the district court's dismissal in a divided decision.[120] The court of appeals agreed with the district court that *McElwain* barred Popovich's vicarious liability claim against Allina.[121] The dissent argued *McElwain* had not properly established a rule regarding apparent authority—contrary to the majority's conclusion.[122] The Minnesota Supreme Court granted Popovich's petition for review.[123]

B. The Minnesota Supreme Court's Decision

The Minnesota Supreme Court reversed the court of appeals' decision and remanded to the district court, holding a plaintiff may state a claim under the theory of apparent authority against a hospital for the negligence of emergency room independent contractors.[124] The court briefly reviewed vicarious liability precedent in Minnesota, noting the differences between the two vicarious liability theories of respondeat superior and apparent authority, then began its full analysis.[125] First, the court explained how the court of appeals' *McElwain* decision conflated the two theories.[126] Next, the court reasoned why hospitals should not be exempt from apparent authority.[127] Lastly, the court outlined the legal standard for applying apparent authority to hospitals for negligent independent contractor physicians.[128]

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[119] *Popovich*, 946 N.W.2d at 889–90.
[120] *Id.* at 890 (citing Popovich v. Allina Health Sys. (*Popovich Appeal*), No. A18-1987, 2019 WL 3000755, at *1 (Minn. Ct. App. July 8, 2019), *aff'g* No. 27-CV-18-10905, 2018 WL 9785370 (Minn. Dist. Ct. 2018), *rev'd*, 946 N.W.2d 885 (Minn. 2020)).
[121] *Id.* (citing *Popovich Appeal*, 2019 WL 3000755, at *3).
[122] *Id.* (citing *Popovich Appeal*, 2019 WL 3000755, at *6 (Ross, J., dissenting)) ("Minnesota has never properly established any rule categorically immunizing hospitals from vicarious liability premised on the tortfeasor's apparent authority to act for the institution.").
[123] *Id.*
[124] *Id.* at 898. On remand, Popovich settled with Allina. *See* Findings of Fact and Ord. Dismissing Defendant Allina Health Sys. Without Prejudice at 2, Popovich v. Allina Health Sys., No. 27-CV-18-10905, (Minn. Dist. Ct. dismissed Oct. 4, 2021). In the settlement, Allina agreed Popovich could re-assert a claim against Allina in the future. *Id.* ("Allina has agreed that Plaintiffs may re-assert their Apparent Authority Claim against Allina if Plaintiffs obtain a jury verdict and subsequent judgment in their favor against the remaining Defendants and are not able to collect the total amount of the judgment from the remaining Defendants or their liability insurers.").
[125] *Popovich*, 946 N.W.2d at 890–91; *see supra* Part II.C.1 (reviewing precedent in more detail).
[126] *Popovich*, 946 N.W.2d at 892 (stating control is irrelevant to an apparent authority claim); *see infra* Part III.B.1.
[127] *See infra* Part III.B.2.
[128] *See infra* Part III.B.3.

1. McElwain's Conflation of Vicarious Liability Theories

In *McElwain v. Van Beek*,[129] an emergency room visitor sued a physician and medical center for injuries she suffered when she fainted while her brother received emergency treatment.[130] In relevant part, the Minnesota Court of Appeals decided only that the lower court did not err in dismissing the plaintiff's action against the medical center.[131] The court stated an earlier decision in *Moeller v. Hauser*[132] stood for the proposition that "[i]n Minnesota, a hospital can *only* be held vicariously liable for a physician's acts if the physician is an employee of the hospital."[133] However, this was not a proposition the court made in *Moeller*.[134] Instead, the court stated, "It is well established in this state that a hospital, private or charitable, is liable to a patient for the torts of its employes [sic] under the doctrine of Respondeat superior."[135] The *Moeller* court did not propose that respondeat superior was the *only* theory of vicarious liability that could hold a hospital liable to patients for the negligence of physicians.[136]

The *McElwain* decision did not spend much time on the issue of the medical center's liability, disposing of the issue quickly by misstating what *Moeller* stood for.[137] The court found that because the physician was an independent contractor, the medical center was relieved of any liability.[138] The court failed to consider other theories of vicarious liability in its cursory dismissal based on respondeat superior.[139] By this time, Minnesota courts had been applying the theory of apparent authority to many other

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[129] 447 N.W.2d 442 (Minn. Ct. App. 1989).
[130] *Id.* at 444.
[131] *Id.* at 447. The court did not believe the medical center had independent liability and noted the appellant's complaint did not allege independent liability against the medical center. *Id.* The court also noted that without a cause of action for independent liability, the medical center could not be found liable if the physician is not liable. *Id.*
[132] 237 Minn. 368, 54 N.W.2d 639 (1952).
[133] *McElwain*, 447 N.W.2d at 446 (emphasis added) (citing *Moeller*, 237 Minn. at 378–79, 54 N.W.2d at 645–46). In *Moeller*, a father sued a hospital and its doctors for an injury to his son's foot, sustained while his son was being treated at the hospital. *Moeller*, 237 Minn. at 370–71, 54 N.W.2d at 641.
[134] *See Moeller*, 237 Minn. 368, 54 N.W.2d 639.
[135] *Id.* at 645 (citing St. Paul-Mercury Indem. Co. v. St. Joseph's Hosp., 212 Minn. 558, 4 N.W.2d 637 (Minn. 1942)).
[136] *See Moeller*, 237 Minn. 368, 54 N.W. 2d 639; *see also* Popovich v. Allina Health Sys., 946 N.W.2d 885, 891 (Minn. 2020) (discussing the *McElwain* court's improper use of *Moeller* to support its proposition that an employment relationship is necessary for vicarious liability).
[137] *See McElwain*, 447 N.W.2d at 446; *supra* notes 132–34 and accompanying text.
[138] *McElwain*, 447 N.W.2d at 446.
[139] *See id.* at 446–47.

circumstances,[140] and the *McElwain* court missed an opportunity to address its potential applicability to hospitals in that case.[141]

2. Apparent Authority Applies to Hospitals

Next, the court analyzed, as a matter of first impression, whether hospitals should be exempt from vicarious liability for the negligence of independent contractors under the theory of apparent authority.[142] First, the court rejected Allina's policy argument that "patients already have sufficient remedies for medical malpractice"[143] and offered its own policy argument: apparent authority prevents "secret limitations" from being placed on "liability to third persons" for an agent's acts or omissions.[144] The court also suggested methods for hospitals to address additional risks.[145]

Furthermore, the court noted the public is often unaware of hospitals' arrangements with emergency room physicians, stating that allowing hospitals to evade vicarious liability because of these undetected independent contractor agreements would contradict the purpose of apparent authority.[146] The court found no reason to grant an exemption to hospitals and held plaintiffs may assert apparent authority claims for

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[140] *See supra* Part II.C (noting application of apparent authority in Minnesota started in the 1960s).

[141] *Popovich*, 946 N.W.2d at 891 (referring to *McElwain*, 447 N.W.2d 442) ("The court of appeals conflated the two theories of vicarious liability and cited *Moeller* for a holding we never made—that an employment relationship between a hospital and physician is a necessary condition for vicarious liability. *McElwain*'s reliance on *Moeller* as support for this proposition was therefore incorrect.").

[142] *Id.* at 890–95.

[143] *Id.* at 892 ("The existence of other remedies does not justify granting a hospitals-only exemption from the general rule of vicarious liability based on apparent authority.").

[144] *Id.* at 894 (quoting Lindstrom v. Minn. Liquid Fertilizer Co., 264 Minn. 485, 496, 119 N.W.2d 855, 862 (1963)).

[145] *Id.* at 893–94. Hospitals can monitor the care provided in their facilities and allocate risks through their independent contractor agreements (likely through indemnification clauses). *Id.*

> Nonemployee physicians providing medical services in the hospital have a contractual relationship with the hospital. As such, the parties are free to make any agreement they wish between themselves. In addition to its common law right to indemnification when held vicariously liable, the hospital can provide in its nonemployee physician contracts that the physician will defend, indemnify and hold the hospital harmless from all claims and liabilities resulting from the physician's negligence.

Id. at 894 n.11 (quoting John Dwight Ingram, *Liability of Medical Institutions for the Negligence of Independent Contractors Practicing on Their Premises*, 10 J. CONTEMP. HEALTH L. & POL'Y 221, 229 (1993)).

[146] *Id.* at 894 ("It would be contrary to the fundamental purpose of the apparent authority doctrine to allow hospital systems to escape vicarious liability for the negligence of independent contractors working in emergency rooms through these little-known contractual relationships, even as hospitals reap both reputational and financial benefits.").

vicarious liability against hospitals for non-employees' negligent acts.[147]

3. Legal Standard for Applying Apparent Authority to Emergency Rooms

Finally, after confirming apparent authority doctrine encompassed hospitals, the court debated which legal standard applies to cases alleging medical malpractice by non-employees in hospital emergency rooms.[148] The court began by distinguishing apparent authority from actual authority.[149] Then, it provided the two requirements for an apparent authority claim: (1) the principal "held the agent out as having authority" or "knowingly permitted the agent to act on its behalf,"[150] and (2) the plaintiff was aware of the principal's representations of the agent's authority and relied on them.[151] The court ultimately modified this standard to apply to apparent authority claims against hospitals for emergency room independent contractors.[152]

As to the first requirement, the court noted the focus should be on the hospitals' representations to the public because modern health care facilities are run like businesses, and hospitals competitively advertise so the public will choose them for their medical needs.[153] The court dedicated the remainder of its analysis on the reliance requirement.[154] Allina argued for an actual reliance standard,[155] but the court asserted precedent in other apparent authority matters did not use actual reliance.[156] Instead, it decided to explore other jurisdictions for guidance in hospital emergency room settings.[157] The Ohio Supreme Court had an initial standard of actual or "but-for" reliance, which the court found too strict.[158] Consequently, it was rejected in favor of a standard requiring only that a patient look to a hospital to provide medical care instead of an individual physician.[159]

[147] *Id.* at 894–95.
[148] *Id.* at 895.
[149] *Id.* (quoting Tullis v. Federated Mut. Ins. Co., 570 N.W.2d 309, 313 (Minn. 1997)) ("Apparent authority 'is not actual authority; rather it is authority which the principal holds the agent out as possessing or knowingly permits the agent to assume.'").
[150] *Id.* (quoting Hockemeyer v. Pooler, 268 Minn. 551, 562, 130 N.W.2d 367, 375 (1964)).
[151] *Id.*
[152] *See id.* at 898.
[153] *Id.* at 897.
[154] *See id.* at 895–97.
[155] *Id.* at 895. According to Allina, actual reliance would mean a plaintiff must show he would not have accepted care if he had known the physicians were not employees. *Id.*
[156] *Id.*
[157] *Id.* at 896.
[158] *Id.*
[159] *Id.* The court rejected *Albain*'s "but for" standard because it "force[d] the emergency patient to demonstrate that she would have chosen to risk further complications or death rather than be treated by a physician of whose independence she had been unaware." *Id.* *See* Albain v. Flower Hosp., 553 N.E.2d 1038, 1049–50 (Ohio 1990); Clark v. Southview Hosp. & Fam. Health Ctr., 628 N.E.2d 46, 50 (Ohio 1994) (showing the short time between *Albain*'s "but-for" reliance standard to *Clark*'s lower standard).

Pointing to Ohio's relatively quick abandonment of "but-for" reliance, the Minnesota Supreme Court declined actual reliance for Minnesota's standard.[160] The court argued the reliance element should focus on the patient's beliefs and determine whether the patient relied on the hospital to select a physician to perform the necessary medical care.[161] The final rule adopted by the court required two elements to bring a claim for vicarious liability under the theory of apparent authority against a hospital for a negligent emergency room independent contractor.[162] A plaintiff must show: "(1) the hospital held itself out as a provider of emergency medical care; and (2) the patient looked to the hospital, rather than a specific doctor, for care and relied on the hospital to select the personnel to provide services."[163]

C. Dissent Likens Application of Majority's Decision to Strict Liability

In his dissent, Justice G. Barry Anderson categorized the issue in *Popovich* as "a pure question of public policy."[164] According to Justice Anderson, the new rule issued by the majority was "inconsistent with the longstanding common law of Minnesota," and the rule's reliance requirement is "unworkable."[165] Justice Anderson wrote medical facilities and hospitals were not comparable to other Minnesota businesses, and therefore, apparent authority should not be extended to health care.[166] The dissent suggested that since the state and national legislatures heavily regulate hospitals but had not prohibited independent contractor physicians, the court should not use the common law to expand hospital liability.[167]

Justice Anderson argued the reliance requirement fit poorly in the hospital setting.[168] Accordingly, he said, apparent authority should not be imposed on hospitals.[169] The dissent noted application of apparent authority primarily hinges on the reliance element.[170] While Justice Anderson conceded emergency room patients may believe the hospital provides services or considers physicians employees, actual reliance should be

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[160] *Popovich*, 946 N.W.2d at 896–97.
[161] *Id.* at 898.
[162] *Id.*
[163] *Id.*
[164] *Id.* at 899 (Anderson, J., dissenting).
[165] *Id.*
[166] *Id.* at 900. Justice Anderson framed the rule as extending apparent authority to hospitals in contrast with the majority's argument that declining to apply the rule to medical care would be an exception to an otherwise indiscriminately applied principle. *Id.*
[167] *Popovich*, 946 N.W.2d at 900 (Anderson, J., dissenting).
[168] *Id.* at 901.
[169] *Id.*
[170] *Id.* "[A]uthority by holding out is of no importance until a third party relies thereon." *Id.* (quoting Schlick v. Berg, 205 Minn. 465, 468, 286 N.W. 356, 358 (1939)).

required if apparent authority was applied to hospitals.[171] The dissent posited the subjective nature of the majority's reliance requirement, coupled with a loose understanding of what it means for a hospital to hold itself out, would leave hospitals with no effective way to disprove a patient's beliefs—effectively making the application one of "strict liability or a close relative of strict liability."[172]

Justice Anderson may not be entirely off base. The application of apparent authority to hospitals, as outlined by the majority, leaves little room for hospitals to mitigate liability.[173] It remains to be seen whether the majority's suggestions for risk minimization to hospitals will be effective.[174] If the court's new rule is as close to strict liability as the dissent argues, the leap to a nondelegable duty standard may be more of a small step.[175]

IV. ANALYSIS

Although delayed, the Minnesota Supreme Court finally applied apparent authority to hospitals through its *Popovich* decision.[176] The court's application falls in line with other states, tying its reasoning to modern hospital advertising.[177] The court's virtually unrestricted standard shows the court intends unobstructed vicarious liability for hospitals, so long as the patient can prove the underlying negligence.[178] Because of this potential liability, hospitals will look for ways to minimize their burden.[179]

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[171] *Id.* Under this type of reliance, patients would need to prove they would choose a different hospital whose physicians were employees if the patients were informed the hospital physicians were independent contractors. *Id.* This is similar to the rule proposed by Allina. *See id.* at 895.

[172] *Popovich*, 946 N.W.2d at 901 (Anderson, J., dissenting). Justice Anderson goes on to point out the meaninglessness of the rule once hospitals inevitably implement measures such as disclosures and notices suggested by the majority to minimize liability. *Id.* at 902–03.

[173] *See infra* Part IV.B.1 (discussing the accessibility of the relaxed standard).

[174] *See Popovich*, 946 N.W.2d at 893–94 (discussing ways in which hospitals could minimize or reallocate liability for independent contractor physicians); *see also infra* Part IV.C.2 (arguing the Minnesota Supreme Court is moving towards a nondelegable duty standard).

[175] *See Popovich*, 946 N.W.2d at 901 (Anderson, J., dissenting); *see also infra* Part IV.B.2 (outlining a possible progression toward nondelegable duty).

[176] *See Popovich*, 946 N.W.2d 885.

[177] *Id.* at 897–98; *see* Kashishian v. Port, 481 N.W.2d 277, 282 (Wis. 1992) ("The development in the law of the doctrine of apparent authority is based on a number of rationales . . . [including] the recognition that hospitals increasingly hold themselves out to the public in expensive advertising campaigns as offering and rendering quality health care services."); Clark v. Southview Hosp. & Fam. Health Ctr., 628 N.E.2d 46, 53 (Ohio 1994) (reasoning hospitals have large advertising budgets that induce the public to rely on the hospital's services in a competitive market); Hamilton, *supra* note 7, at 257–58.

[178] *See Popovich*, 946 N.W.2d at 895–98; *infra* Part IV.B (detailing how the relaxed standard opens accessibility to patients looking to hold hospitals accountable).

[179] *See Popovich*, 946 N.W.2d at 893–94; *infra* Part IV.C.1 (summarizing potential methods to limit liability).

Meanwhile, public policy moves vicarious liability theory toward nondelegable duty doctrine.[180]

A. *Evolution of Hospitals Lends Itself to the Application of Apparent Authority*

Given the transition of hospitals from charitable to profitable facilities and the development and application of apparent authority to other areas of Minnesota law, the Minnesota Supreme Court rightly applied apparent authority to hospitals.[181] With a majority of other states already applying apparent authority to hospitals, Minnesota was due to make this decision.[182] As framed by the majority, deciding not to apply apparent authority to hospitals would have been an unprecedented categorical exemption counteracting the doctrine's very purpose.[183] Both Allina and Justice Anderson attempted to frame the issue as a deserved exception, but the arguments failed to persuade the majority.[184]

The public's perception of hospitals and emergency rooms played a large role in applying apparent authority in hospitals, and much of that perception is driven by hospitals themselves through advertising.[185] Modern hospital emergency rooms provide care for patients regardless of class or ability to pay.[186] Even so, hospitals rely on paying customers to fund the latest technology and treatments in competition with other hospitals and advertise their amenities to attract those customers.[187] The public, in turn, relies on those advertisements and expects hospitals to provide exceptional care, especially in emergency situations.[188]

As hospitals cultivate financial benefits and grow their reputations

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[180] *See infra* Part IV.B.2.
[181] *Popovich*, 946 N.W.2d at 890–92; *see supra* Part II.
[182] *Popovich*, 946 N.W.2d at 892–93, 893 n.8.
[183] *Id.* at 892–94. Neither the majority nor the dissent provides any example of another similar categorical exemption to provide a comparison, implying the hospital exemption would be the only such exemption from apparent authority. *See id.* at 899–903 (Anderson, J., dissenting).
[184] *Id.* at 892–94 (majority opinion); *see id.* at 899–903 (Anderson, J., dissenting).
[185] *Id.* at 894 (majority opinion); *see* McWilliams & Russell, *supra* note 10, at 436 (stating hospital advertising is the most important driver in the shift of public perception of hospitals as acceptable litigation targets); Barnes, *supra* note 23, at 1064 ("[H]ospitals have become victims of their own success as they have actively solicited business and marketed themselves as multifaceted health care providers.").
[186] Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (2020).
[187] *See* Hamilton, *supra* note 7, at 262 (citing Owens, *supra* note 12, at 1134); *see also supra* Part II.A (summarizing the evolution of hospitals and their public perception in the United States).
[188] *Popovich*, 946 N.W.2d at 897–98; *see supra* notes 24–25 and accompanying text (discussing hospital advertising habits and subsequent public reliance).

through their advertisements and services, patients remain largely unaware of independent contractor arrangements that could leave them without adequate recourse to obtain payment for injuries resulting from physician negligence.[189] As large, profitable facilities, hospitals can—and should—shoulder a portion of the financial burden of negligence claims against independent contractors in their emergency rooms, since hospitals rely on the income from the regular use of these services.[190] Holding hospitals financially responsible for accidents caused by negligent physicians, regardless of employment status, may compel hospitals to implement more oversight and higher standards of care.[191] Otherwise, hospitals risk financial and reputational losses.[192]

B. Juxtaposed Legal Standards Broaden Accountability While Maintaining Underlying Medical Malpractice Doctrine

Although the *Popovich* court was persuasive in applying apparent authority, the derived legal standard will likely need clarification in the future.[193] Because the standard is so lenient, patients will easily include hospitals in medical malpractice suits going forward.[194]

The Minnesota Supreme Court spent little time analyzing what it means for a hospital to hold itself out or how a hospital might update its advertisements to prevent public misunderstanding as to its physicians.[195] Similarly, although the court attempted to bypass perceived issues with "but-for" reliance, based on Ohio's relatively swift rule change, the standard adopted may be too broad to be meaningful.[196] Under the current subjective standard, most anyone can and will claim they relied on the hospital to select the physician when seeking care in an emergency room and easily meet the criteria for the reliance element.[197]

Holding a hospital accountable for a negligent physician may be the new normal under Minnesota's new apparent authority rule, putting nondelegable duty easily within reach.[198] However, while the elements to involve hospitals under apparent authority may be easily proven, patients still face a rigorous standard in proving medical malpractice against

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[189] *Popovich*, 946 N.W.2d at 897–98; *see id.* at n.20–21 (explaining patients often look to hospitals, and not specific physicians, to provide care).

[190] *Id.* at 894; *see* McWilliams & Russell, *supra* note 10, at 436.

[191] *Popovich*, 946 N.W.2d at 893–94.

[192] *Id.*

[193] *Id.* at 902 (Anderson, J., dissenting).

[194] *See supra* Part III.C (discussing the leniency of the apparent authority standard chosen by the *Popovich* majority).

[195] *Popovich*, 946 N.W.2d at 897–98.

[196] *See id.* at 896–97. *But see id.* at 902 (Anderson, J., dissenting) (questioning the majority's reliance on Ohio's "unworkable" standard).

[197] *Id.* at 898 (majority opinion); *Id.* at 902 (Anderson, J., dissenting).

[198] *See id.* at 901–02 (Anderson, J., dissenting).

physicians.[199]

1. *Relaxed Agency Standard Indicates Strong Will to Hold Hospitals Accountable*

As the dissent pointed out, the majority's rule leaves little room for hospitals to avoid liability under current circumstances.[200] Each element's broad parameters make hospital vicarious liability accessible to most patients who receive negligent treatment from emergency room physicians.[201] First, advertising alone can fulfill Minnesota's holding out requirement.[202] Then, the second element of reliance is subjective, making it nearly irrefutable.[203]

a. *Typical Advertising Fulfills Holding Out Requirement*

The first element requires courts to review a hospital's actions, as the principal, to decide whether the hospital held itself out to the community as providing emergency treatment from "qualified medical personnel."[204] The court's formulation of this element is consistent with the element's construction in other jurisdictions, focusing heavily on hospitals' advertisements and representations to their local communities.[205] Based on current advertising habits for most hospitals in Minnesota and around the country, this element is essentially a forgone conclusion.[206]

The court notes in *Popovich* that "Allina, like other hospital systems,

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[199] *See infra* Part IV.B.3 (outlining applicability of underlying medical malpractice standard).

[200] *See Popovich*, 946 N.W.2d at 901 (Anderson, J., dissenting) ("Under the court's rule, the hospital is liable simply because it has independent contractors working in the emergency room located in the physical building owned by the hospital; that is, based simply on the fact that the hospital provides the space in which the nonemployee physician exercises independent medical judgment."). *But see infra* Part IV.C.1 (summarizing ways hospitals may try to minimize liability in the wake of *Popovich*); *Popovich*, 946 N.W.2d at 893–94 (pointing out methods for hospitals to address risks).

[201] *Popovich*, 946 N.W.2d at 901 (Anderson, J., dissenting)*; see* Simmons v. Tuomey Reg'l Med. Ctr., 533 S.E.2d 312, 320–21 (S.C. 2000) (stating application is not limited to emergency rooms).

[202] *See infra* Part IV.B.1.a.

[203] *See infra* Part IV.B.1.b.

[204] *Popovich,* 946 N.W.2d at 897 ("Focusing the fact-finder's analysis on the hospital's representations to the public is consistent with the ways in which the practice of medicine and the business of health care have changed significantly in the modern age.").

[205] *Id.* at 987–98 (referencing Eads v. Borman, 277 P.3d 503, 512 (Or. 2012); Clark v. Southview Hosp. & Fam. Health Ctr., 628 N.E.2d 46, 53 (Ohio 1994); and Sword v. NKC Hosps., Inc., 714 N.E.2d 142, 151 (Ind. 1999)).

[206] *See Popovich*, 946 N.W.2d at 897 (explaining modern hospitals operate like businesses and compete with each other through advertising); *infra* note 209 (citing current advertising in the Twin Cities area).

advertised the quality of its care to the public,"[207] and that those statements to the public were similar to advertisements and other generalized conduct found by other courts to satisfy the holding out element.[208] Allina's advertisements are no different than any other regional hospital system's advertisements.[209] In fact, any advertisement that offers emergency room care will meet this requirement if it fails to advise the physicians are not employees.[210] Since hospital system advertisements generally do not explicitly delineate the relationships between hospitals and their physicians, most advertisements will allow patients to easily prove the holding out element.[211] This leaves only the second element of reliance, which is also readily met due to its subjective nature.[212]

b. *Subjective Reliance Easily Met, Not Easily Refuted*

Though the court spent slightly more time discussing the reliance element, the element is only marginally less predetermined than the holding out element. Reliance is determined by the patient showing awareness of the hospital's representations of authority.[213] This awareness then manifests itself in the patient's subjective beliefs; patients only need to show they "looked to the hospital, rather than to a particular doctor, to provide care."[214] Since most patients seeking emergency room care rely on the hospital to

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[207] *Popovich*, 946 N.W.2d at 897. The court then quotes Allina's specific advertisements: referring to "[o]ur board-certified emergency medicine physicians and skilled, caring nurses," and that both hospitals "had a fully-staffed emergency department, capable of providing emergency services twenty-four hours a day, 365 days a year." *Id.* at 897–98.

[208] *Id.* at 898 (referencing *Sword*, 714 N.E.2d at 151 (stating a representation also may be "general and implied")); *see* Pamperin v. Trinity Mem'l Hosp., 423 N.W.2d 848, 856 (Wis. 1988) (noting hospitals create the appearance that employees will provide care by failing to advise patients otherwise).

[209] *See, e.g.*, *Emergency Services*, NORTH MEM'L HEALTH, https://northmemorial.com/specialty/emergency/ [https://perma.cc/FE93-AFNB] ("We have the sharpest skills and finest resources to treat you immediately. . . . [W]e coordinate care and share physicians and resources for consistently exceptional results. Together, we treat more than 100,000 customers a year . . . . Our multidisciplinary team works with you to get you back to your multilayered, yet very singular life, stat."); *Emergency Center*, REGIONS HOSPITAL, https://www.healthpartners.com/care/hospitals/regions/specialties/emergency-center/ [https://perma.cc/3FBG-86W4] ("We provide renowned specialty care for burns, heart conditions and much more. . . . We are led by board-certified emergency doctors and specialists that are ready to help you 24/7. You'll be surrounded by a team of people, working together to quickly get you the care you need.").

[210] *See supra* notes 200, 208, and accompanying text (simply providing emergency care (without advertising) can create the appearance of agency if the hospital does not advise patients they are being treated by a non-employee).

[211] *See Popovich*, 946 N.W.2d at 901 (Anderson, J., dissenting).

[212] *See infra* Part IV.B.1.b.

[213] *Popovich*, 946 N.W.2d at 895.

[214] *Id.* at 898 ("Specifically, the fact-finder should determine if the plaintiff relied on the hospital to select the physician . . . to provide the necessary services.").

select and provide physicians and other medical professionals,[215] reliance is also proven with relative ease.[216] Because the standard is subjective, hospitals will have a hard time disproving patients' reliance on the hospitals' representations.[217] While the "but-for" reliance discussed in the majority's opinion was deemed "'virtually impossible' to meet,"[218] the subjective rule adopted may be too obliging to provide any discernable difference between apparent authority and strict liability.[219]

1. Nondelegable Duty: A Logical Progression

Minnesota's apparent authority rule, as it stands, means hospitals will almost certainly be held vicariously liable if their independent contractor emergency room physicians are found negligent.[220] By instituting a rule with such accessible elements, the court tacitly moved toward a nondelegable duty standard.[221]

The nondelegable duty standard is supported by public policy arguments shared by apparent authority proponents—simply taken a step further.[222] In imposing a nondelegable duty on hospitals, the Supreme Court of South Carolina noted the underlying point in many cases is "expecting a patient in an emergency situation to debate or comprehend the meaning and extent of any representations by the hospital—which likely would be based on an opinion gradually formed over the years and not on any single representation—imposes an unfair and improper burden on the patient."[223]

Additionally, imposing a nondelegable duty often depends on the underlying activity's societal importance.[224] The Alaska Supreme Court used this reasoning to hold that hospital emergency room patients are as

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[215] *Id.*

[216] *Id.* at 902 (Anderson, J. dissenting) ("[A] hospital will have no ability to disprove the subjective element of the test, and a plaintiff need do little more than identify the hospital to establish hospital liability.").

[217] *Id.*

[218] *Id.* at 896 (majority opinion) (quoting Clark v. Southview Hosp. & Family Health Ctr., 628 N.E.2d 46, 50 (Ohio 1994)).

[219] *See supra* text accompanying note 172.

[220] *Popovich*, 946 N.W.2d at 901 (Anderson, J. dissenting); *see supra* note 200.

[221] *See Popovich*, 946 N.W.2d at 901 (Anderson, J. dissenting) (comparing the standard to strict liability).

[222] *See supra* Part II.B.2.c (discussing nondelegable duty doctrine and its policy reasoning).

[223] Simmons v. Tuomey Reg'l Med. Ctr., 533 S.E.2d 312, 321 (S.C. 2000) ("Given the fundamental shift in the role that a hospital plays in our health care system, the commercialization of American medicine, and the public perception of the unity of a hospital and its emergency room, we hold that a hospital owes a nondelegable duty to render competent service to its emergency room patients.").

[224] Montefusco, *supra* note 23, at 1361–62 (noting that accepted nondelegable duties in other areas of law "are considered so important to the community that the responsibility for their execution cannot be transferred to another entity" and that "[c]ourts should extend the doctrine of nondelegable duty to hospital operations for the same reason.").

deserving of protection as common carrier passengers, where common carriers have a nondelegable duty to ensure passenger safety.[225] Public perception of hospitals drives much of the nondelegable duty discussion.[226]

Further, patients experiencing an emergency generally do not have the time to bypass the closest emergency room to find one staffed by employees.[227] Under these circumstances, the nondelegable duty standard has strong supporting policy arguments that parallel the arguments used to apply apparent authority.[228] Therefore, the doctrine is in line with apparent authority.[229]

2. *Strict Standard for Prima Facie Medical Malpractice Cases Buffers Impact of Broadened Hospital Vicarious Liability*

Although the new apparent authority standard applied to hospitals will be fairly easy for patients to prove, the underlying medical malpractice and negligence cases retain their stringent requirements.[230] As a practical matter, while Minnesota's apparent authority standard likely needs clarification, plaintiffs must prove a prima facie case for negligence or medical malpractice against the physicians themselves before hospitals can be held vicariously liable.[231] The new apparent authority standard may make it easier for plaintiffs to include hospitals in their claims, but this underlying standard

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[225] Jackson v. Power, 743 P.2d 1376, 1384 (Alaska 1987), *overturned due to legislative action*. *Jackson* was only partially overturned. *See infra* note 265 (noting that *Jackson* was superseded in part by ALASKA STAT. § 09.65.096 (2000)).

[226] *See supra* Part II.B.2.c (discussing the public policy shaping nondelegable duty doctrine in hospitals); *see also* Alison Chen, *Hospital Liability: Nondelegable Duty in Hospital Emergency Rooms* - Simmons v. Tuomey Regional Medical Center, 24 AM. J.L. & MED. 135, 136 (1998) ("Imposing a nondelegable duty on hospitals therefore is consonant with the public's perception of the unity of hospitals' services.").

[227] Chen, *supra* note 226, at 136 (citing Simmons v. Tuomey Reg'l Med. Ctr., 498 S.E.2d 408 (S.C. Ct. App. 1998), *aff'd as modified*, 533 S.E.2d 312 (S.C. 2000)).

[228] *Compare* Hannola v. City of Lakewood, 426 N.E.2d 1187, 1190 (Ohio Ct. App. 1980), *cert. denied*, 611 A.2d 657 (N.J. 1992) ("Given the relationship of the emergency room to the full-service hospital, and the crisis circumstances under which people seek emergency treatment, public policy requires that the hospital not be able to artificially screen itself from liability for malpractice in the emergency room."), *with* Popovich v. Allina Health Sys., 946 N.W.2d 885, 894 (Minn. 2020).

[229] *See supra* note 228.

[230] *See* McElwain v. Van Beek, 447 N.W.2d 442, 447 (Minn. Ct. App. 1989); St. Paul-Mercury Indem. Co. v. St. Joseph's Hosp., 212 Minn. 558, 559, 4 N.W.2d 637, 638 (1942); *see also* Owens, *supra* note 12, at 1144 (describing how apparent agency could become much more difficult to apply because it is grounded in plaintiff's reliance upon the apparent relationship because the "court must not only determine if there was malpractice, but also whether there was reasonable reliance on the part of the plaintiff.").

[231] *See McElwain*, 447 N.W.2d at 447 ("Appellant's case was premised on showing the physician had committed medical malpractice. . . . Thus, it follows that if the physician is not liable as a matter of law the medical center cannot be found liable.").

will continue to help prevent frivolous lawsuits.[232] Ultimately, hospitals will only be held vicariously liable if a prima facie case is first established.[233]

B. *Popovich's Impact: A Look at Conceivable Hospital and Judicial Responses*

Although Minnesota is relatively late in applying apparent authority in hospital emergency rooms, the Minnesota Supreme Court used strong public policy arguments to support its decision.[234] It made the rule purposely lenient—making it easily accessible to most patients.[235] The court reviewed how other states revised their applications of apparent authority to hospitals and used those already-updated rules as the basis for Minnesota's rule.[236] Consequently, hospitals will be eager to implement measures to limit potential liability from apparent authority in the wake of *Popovich*.[237] While hospitals consider how to minimize liability, United States public policy becomes more receptive to nondelegable duty for hospital care.[238]

1. *Hospitals' Attempts to Minimize Liability*

In response to potential apparent authority liability, hospitals could update advertising or implement additional notices and disclaimers. Aside from implementing policies to monitor hospital facility care, the *Popovich* court specifically suggested that hospitals allocate risk by updating their agreements with independent contractors.[239]

a. *Advertising, Notices, and Disclaimers*

First, hospitals may update their disclaimers and signs in the emergency rooms. Even so, it is unlikely they will deviate from their advertising to widely inform the public of their independent contractor relationships with their physicians because those arrangements do not fit with the all-inclusive care typically advertised.[240] That kind of information could prompt risk-conscious patients to choose to seek care elsewhere or

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[232] *Popovich*, 946 N.W.2d at 890 (stating the merits of the medical malpractice claims were not before the court—implying they would need to be considered on remand).
[233] *See id.*; *see also McElwain*, 447 N.W.2d at 447 (noting that patients must first prove the physician was liable).
[234] *Popovich*, 946 N.W.2d at 894.
[235] *See id.*; *see also id.* at 901 (Anderson J., dissenting) (stating it is relatively easy to see the reliance and the resulting damages in apparent authority claims).
[236] *Id.* at 896–97 (majority opinion) (discussing Ohio cases).
[237] *Id.* at 893–94 n.11; *see infra* Part IV.C.1 (discussing which measures might be used).
[238] *See infra* Part IV.C.2.
[239] *Popovich*, 946 N.W.2d at 893–94.
[240] *Id.* at 897–98; *see* McWilliams & Russell, *supra* note 10, at 436 (noting public perception has been hospitals' marketing themselves as full-service healthcare providers).

avoid that hospital in an emergency.[241] Moreover, if widely known because of advertising, losing numerous patients could be crippling.[242] Instead, hospitals will likely opt for notices inside the emergency room and disclaimers in their paperwork, since many patients—especially those truly in an emergency situation—will be less likely to leave once there.[243]

Nevertheless, case law from other jurisdictions shows even disclaimers and notices must meet certain criteria to insulate hospitals from liability.[244] Generally, notices in emergency rooms must be prominently displayed and of a certain size to be effective.[245] Additionally, any disclaimers in admittance paperwork must be in a standard size font (i.e., not in a paragraph with substantially smaller font than the rest of the document) and not otherwise obscured.[246] It is not enough to hide the disclaimer in an inconspicuous paragraph of an admission form.[247] The point is to legitimately notify patients

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[241] *See supra* notes 23–29 and accompanying text (describing advertising habits and the intentions behind them).

[242] *See* McWilliams & Russell, *supra* note 10, at 436 (noting how maintaining pace with other hospitals and reliance on patient monetary support necessitated advertising).

[243] Isbey, *supra* note 33, at 1147 ("[I]t is likely that by the time the patient enters the hospital, he is unable or unwilling to leave the hospital simply because this employment relationship is missing, even if he is completely aware of it.").

[244] Williams v. Tissier, 165 N.E.3d 885, 895 (Ill. App. Ct. 2019), *appeal denied*, 144 N.E.3d 1209 (Ill. 2020); Adam Alstott, *Hospital Liability for Negligence of Independent Contractor Physicians Under Principles of Apparent Agency*, 25 J. LEGAL MED. 485, 499–500 (2004) (citing ALASKA STAT. § 09.65.096(a) (2003)) ("Alaska explicitly allows hospitals to escape liability in emergency room contexts if the patient is afforded notice of the physician's independent contractor status. . . . Nonetheless, the hospital is not exonerated if it did not exercise reasonable care in granting the negligent physician privileges."). *But see* Clark v. Southview Hosp. & Fam. Health Ctr., 628 N.E.2d 46, 54 n.1 (Ohio 1994) (noting that in order to be effective, notices "must come at a meaningful time" and that notifying patients in consent forms provided upon admission or on signs posted in emergency rooms would not necessarily insulate hospitals from liability, especially for patients suffering medical emergencies).

[245] *See Tissier*, 165 N.E.3d at 895 (noting that "[i]n determining the effect of an independent contractor disclosure in a consent form, reviewing courts have considered the precise language and the location of the disclosure"); *see also* Sword v. NKC Hosps., Inc., 714 N.E.2d 142, 151 (Ind. 1999) (acknowledging the central question is *how* the hospital provided notice to the patient that the treating physician was an independent contractor and not an employee of the hospital).

[246] *See Sword*, 714 N.E.2d at 151. But at least one court found even bold typeface may not be meaningful notice. *See* Hamilton, *supra* note 7, at 259 ("[T]he court looked to the case law of other states to delineate what constitutes meaningful notice. Boren held as a matter of law that a disclaimer written in boldfaced type and signed by the patient did not constitute meaningful notice."); *Tissier*, 165 N.E.3d at 895 ("[T]here could be situations in which a patient has signed a consent form containing a disclaimer regarding an employment or agency relationship, but additional facts may exist that would create a triable issue of fact as to whether a hospital held a physician out as its agent.").

[247] Boren *ex rel.* Boren v. Weeks, 251 S.W.3d 426, 437 (Tenn. 2008) ("While the hospital included a disclaimer in the consent form, we cannot say as a matter of law that the disclaimer

and allow them to decide for themselves whether they still accept treatment from the hospital's independent contractor physicians, knowing the hospital will not be vicariously liable for the physicians' negligence.[248]

These requirements show a propensity toward disallowing hospitals to evade liability without properly informing unsuspecting patients.[249] Some courts already decided the notices must not only meet specific criteria as to size and location, but they must be provided at an opportune time.[250] Therefore, hospitals walk a fine line between properly informing patients (before they seek treatment) and risking that informed patients will not accept treatment under those arrangements or avoid the hospital entirely.[251]

On the other hand, the very same paperwork used by hospitals to attempt to disclaim liability for independent contractor physicians may also be what ultimately holds them to a nondelegable duty standard.[252] Courts in other jurisdictions found that these hospital forms may create a nondelegable duty to provide a certain level of care.[253] With this in mind, the more effective approach for hospitals to shield themselves from independent contractor physician negligence is through their contracts with

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provided the Borens with adequate notice under the circumstances."). The *Boren* court pointed to a Georgia Court of Appeals decision in its analysis. *Id.* at 436–37 (quoting Cooper v. Binion, 598 S.E.2d 6, 11–12 (2004)) ("The acknowledgment in the admitting form was one of thirteen paragraphs in a two-page document signed by [plaintiff's] wife, and nothing indicates that the hospital called attention to the acknowledgment.").

[248] *Clark*, 628 N.E.2d at 54; *see Tissier*, 165 N.E.3d at 895 ("The existence of a signed consent form containing a clear, concise, and unambiguous 'independent contractor' disclaimer is an important fact to consider in evaluating the 'holding out' element, but it is not dispositive."); *Sword*, 714 N.E.2d at 152 ("Under some circumstances, such as in the case of a medical emergency, however, written notice may not suffice if the patient had an inadequate opportunity to make an informed choice.").

[249] *See* Mary Dameron Stuart, Simmons v. Tuomey Regional Medical Center*: The New South Carolina Rule on Hospital Liability for Malpractice of Emergency Room Physicians*, 52 S.C. L. REV. 975, 985, 987–88 (2001) (stating that "[w]hile it is clear that simply posting signs and having consent forms signed will not be sufficient," courts have not provided enough guidance as to what notice would be sufficient). "Because imposing the ostensible-agency doctrine could result in broader attempts by hospitals to inform their patients and thus avoid liability, some courts have decided to take the full leap and impose an absolute nondelegable duty on the hospital." *Id.*

[250] *Clark*, 628 N.E.2d at 54; Simmons v. Tuomey Reg'l Med. Ctr., 533 S.E.2d 312, 320 (S.C. 2000) (referencing *Clark*).

[251] *See supra* notes 240–50 and accompanying text.

[252] *See* Pope v. Winter Park Healthcare Grp., Ltd., 939 So. 2d 185, 187 (Fla. Dist. Ct. App. 2006) ("[I]t is undisputed that an express contract exists between the Popes and Winter Park Hospital, and we have concluded that an issue remains unresolved concerning the scope of the express contractual undertaking which may have given rise to a duty to provide non-negligent neonatal care to baby Tyler.").

[253] *See id.* ("[W]e agree that Florida law does not currently recognize an implied nondelegable duty on the part of a hospital to provide competent medical care to its patients. Florida law does recognize, however, that such a duty can be undertaken pursuant to an express contract.").

those physicians.[254]

b. *Indemnification Clauses in Independent Contractor Contracts*

Indemnification clauses in hospital contracts with independent contractor physicians will likely be the most effective means for hospitals to divert liability.[255] These clauses mean the physicians will indemnify the hospital and be financially responsible for all negligence claims against the physicians.[256] To ensure maximum effectiveness, hospitals should require physicians to hold individual liability insurance. This should include a minimum amount of coverage high enough to guarantee coverage for high-cost claims, naming the hospital as an additional insured.[257] Under these arrangements, patients will still receive adequate payment for any damages or injuries resulting from physician negligence, but the cost will be borne by the negligent actor, with little cost shouldered by the hospital.[258]

As hospitals attempt to minimize apparent authority liability, some courts already found certain duties to be nondelegable, especially concerning emergency room treatment, indicating a potential trend.[259] The Minnesota Supreme Court's sympathetic legal standard for plaintiffs here may suggest Minnesota is open to the possibility of a nondelegable duty theory.[260] Thus, these indemnification clauses will be indispensable to hospitals.[261]

2. *Courts' Budding Receptiveness Toward Nondelegable Duty Doctrine*

The Minnesota Supreme Court did not consider a nondelegable duty theory in *Popovich*, but the theory could be on the horizon, depending on how the law, public policy, and emergency room medical care continue to evolve.[262] For now, the Minnesota Supreme Court appears to endorse

[254] Ingram, *supra* note 145, at 229.
[255] *Id.*
[256] *Id.*
[257] *Id.* These arrangements can be made in a number of cost-effective ways. *Id.* at 229 n.57 ("In some cases it might be more effective for the hospital to obtain insurance for itself and all its physicians on a group basis. The cost of this insurance could then be allocated to the physician as part of the overall contractual arrangement.").
[258] *Id.* at 229. "The only ultimate cost to the hospital would be the occasional case where the physician's insurance and personal assets were insufficient to pay a negligence claim." *Id.* at 230 n.61.
[259] McWilliams & Russell, *supra* note 10, at 454.
[260] *See* Popovich v. Allina Health Sys., 946 N.W.2d 885, 897–98 (Minn. 2020); *see also supra* Part IV.B.1 (summarizing the lenient standard and its proximity to the nondelegable duty doctrine).
[261] *See Popovich,* 946 N.W.2d at 897–98; *supra* Part IV.B.1 (leaving indemnification clauses as the only means left for hospitals to avoid liability if their duty is nondelegable).
[262] *See Popovich*, 946 N.W.2d at 885*; see also* McWilliams & Russell, *supra* note 10, at 456–

methods available to hospitals to avoid liability.[263] Even still, the majority's reasoning and leniency suggest the court could easily find public policy reasons to disallow avoidance in the future.[264]

Although at least two states expressly reject the application of nondelegable duty to hospitals, at least four states already apply the doctrine.[265] Public perception, and therefore public policy, bends toward viewing hospitals as multifaceted medical teams who provide essential, often life-saving, services that amount to a public safety concern.[266] Emergency rooms are inherently high-risk—patients' lives hang in the balance, relying on the physicians to save them from the very real possibility of death.[267] Perhaps independent contractor arrangements—or the delegation of duty—should be reserved for lower risk areas in the practice of medicine where patients have more control over who provides their treatment and where patients are not reliant on treatment in life-or-death situations.[268]

If Minnesota moves to a nondelegable duty standard in the future, it will likely be achieved via legislative or administrative regulation updates because that is the most concrete avenue currently recognized by the courts.[269] It will be interesting to see whether the Minnesota Legislature or

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57 (discussing public policy perceptions and the debate over whether medical practice is inherently dangerous).

[263] *Popovich*, 946 N.W.2d at 893–94.

[264] *See generally id.* (using public policy arguments throughout the decision and pointing to policy arguments from other jurisdictions).

[265] Simmons v. Tuomey Reg'l Med. Ctr., 533 S.E.2d 312, 318–19 (S.C. 2000). "Texas and Missouri courts have rejected the nondelegable duty doctrine in connection with care provided by emergency room physicians." *Id.* at 319 (citing Baptist Mem'l Hosp. Sys. v. Sampson, 969 S.W.2d 945, 949 (Tex. 1998); Kelly v. St. Luke's Hosp. of Kansas City, 826 S.W.2d 391 (Mo. Ct. App. 1992)). The *Simmons* court noted Alaska, Florida, and New York had all applied a nondelegable duty to hospitals for emergency room care and applied the doctrine itself. *Id.* (citing Jackson v. Power, 743 P.2d 1376, 1385 (Alaska 1987); *superseded in part by* ALASKA STAT. § 09.65.096 (2000); Irving v. Drs. Hosp. of Lake Worth, Inc., 415 So.2d 55, 59 (Fla. Dist. Ct. App. 1982); Martell v. St. Charles Hosp., 523 N.Y.S.2d 342, 351 (N.Y. Sup. Ct. 1987)).

[266] Chen, *supra* note 226, at 136 (citing Simmons v. Tuomey Reg'l Med. Ctr., 498 S.E.2d 408 (S.C. Ct. App. 1998), *aff'd as modified*, 533 S.E.2d 312 (S.C. 2000)) ("*As hospitals [] increasingly provide immediate, around-the-clock medical care, emergency rooms become of vital import to public safety*. . . . [P]atients seeking emergency assistance generally cannot choose to pass by the nearest emergency room in hopes of finding a hospital whose emergency services are staffed by employees rather than independent contractors.") (emphasis added).

[267] *See* McWilliams & Russell, *supra* note 10, at 457 (quoting Beeck v. Tuscon Gen. Hosp., 500 P.2d 1153, 1157 (Ariz. Ct. App. 1972)).

[268] *See Popovich*, 946 N.W.2d at 898; *see also* McWilliams & Russell, *supra* note 10, at 454–57 (identifying cases where courts suggest that high-risk medical procedures should be nondelegable).

[269] *See* James W. Gustafson, Jr. & Thomas D. Masterson, *Suing the Hospital When Superdoc Falls*, 38 TRIAL 20, 23 (May 2002) ("[P]laintiff attorneys should carefully review the state

the Minnesota Department of Health reacts to *Popovich* and whether any residual effects from the decision push Minnesota toward nondelegable duty for hospitals. Any reactions by these state departments will likely be met with lobbying from opposing groups: patient advocates and hospital systems. Even if there are no legislative or administrative updates, the Minnesota Supreme Court has shown a willingness to review hospital liability to patients in light of public policy updates.[270] Thus, the court could find a compelling reason to use common law to find a contractual basis to impose a nondelegable duty standard in hospital emergency rooms in the not-so-distant future.

V. CONCLUSION

The Minnesota Supreme Court joined a majority of other states in applying the vicarious liability doctrine of apparent authority to hospitals for negligent non-employee physicians in emergency rooms.[271] The *Popovich* decision follows the general trend throughout the United States of holding hospitals vicariously liable for the negligence of emergency room physicians, regardless of employment status.[272] As noted by the dissent, the court's adopted legal standard lands very close to strict liability for hospitals if their physicians are found negligent.[273]

Notwithstanding the Minnesota Supreme Court's lenient legal standard for plaintiffs, the court suggests hospitals can manage the added risks through indemnification clauses in independent contractor agreements and providing notice through advertisements, signs, and disclosures.[274] As the law develops in this area and medical advancements continue, hospitals will have a vested interest in updating their contracts with independent contractor physicians and attempting to change public perceptions regarding emergency rooms and the physicians therein.[275] As hospitals find new ways to avoid liability, it remains to be seen whether public policy will shift away from holding hospitals liable or progress toward a nondelegable duty for hospitals to provide non-negligent care, especially in emergency rooms.

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licensing statutes and regulations applicable to the hospital. . . . state licensing statutes and regulations often set forth minimum standards for operating hospitals and surgical centers."); *see also* Stuart, *supra* note 249, at 979 (stating that South Carolina statutes evidence a public policy encouraging hospital liability for emergency room torts). "[I]f the regulations are considered together, they provide support for the public policy that hospitals have a duty to afford competent care to patients in their emergency room facilities." *Id.*

[270] *See Popovich*, 946 N.W.2d at 894 (discussing public policy).

[271] *Id.* at 898.

[272] *See supra* Part II.B; *see also* Hamilton, *supra* note 7, at 263–66 (explaining how agency by estoppel and apparent agency are used to hold hospitals vicariously liable for the negligent actions of non-employee physicians).

[273] *Popovich*, 946 N.W.2d at 901 (Anderson, J., dissenting).

[274] *Id.* at 893–94 n.11 (majority opinion).

[275] *See supra* Part IV.C.1 (outlining possible hospital updates).