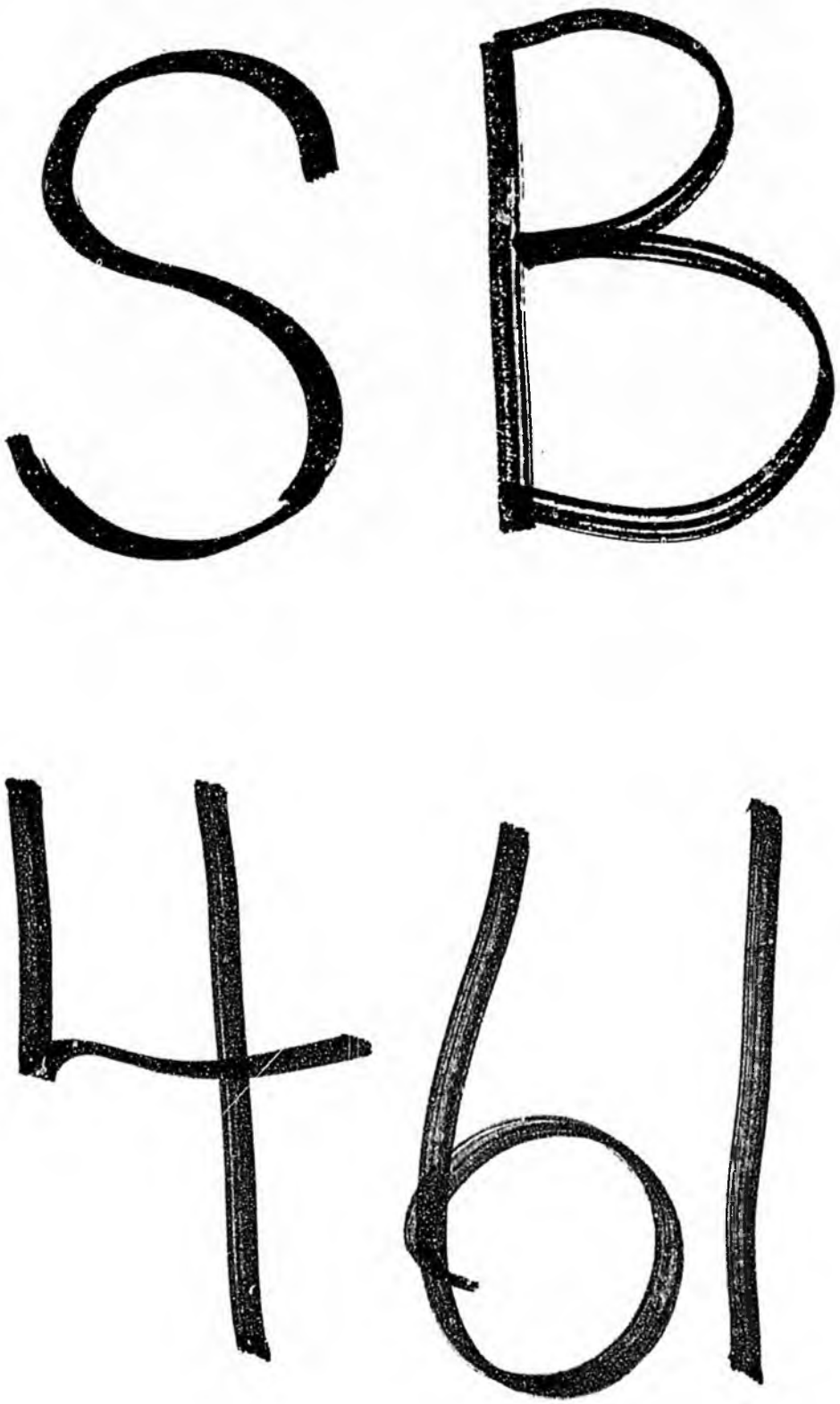
SB
461

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

POUCH Y STATE CAPITOL
JUNEAU ALASKA 99811
907-465-3800

MEMORANDUM April 28, 1988

SUBJECT: Constitutionality of CSSB 461(Judiciary)

TO: Representative H.A. "Red" Boucher

FROM: Terri Lauterbach
Assistant Revisor TML

Kathy Anders of your office has requested a legal opinion on the constitutionality of CSSB 461(Judiciary), a bill that limits the liability of hospitals in relation to the acts of nonemployees. It is my understanding from her that you have no specific doubts about the bill but that others may be concerned about its general effect.

In my opinion, the bill's effect of limiting liability is constitutional. The court decision that the bill seeks to overturn is Jackson v. Power, 743 P.2d 1376 (Alaska 1987). After an extended discussion of the statutes and regulations governing hospitals in Alaska, the court found in Jackson that the hospital could "not shield itself from liability by claiming that it is not responsible for the results of negligently performed health care when the law imposes a duty on the hospital to provide that health care." Jackson, at 1385 (emphasis added). The court also founded its decision on some public policy arguments.

The Jackson court found that the duty of the hospital to provide nonnegligent health care was a nondelegable duty because the laws of the state and public policy place that duty on the hospital. In my opinion, there is nothing unconstitutional about changing the laws of the state to limit a liability that is founded primarily on the laws of the state. And the legislature's discretion to determine matters of public policy is clear, absent constitutional constraints.

It is important to note that CSSB 461(Judiciary) does not deprive any hospital patient of a cause of action against the nonemployee who may have been negligent. Nor does

CSSB 461(Judiciary) deprive a patient of a cause of action against the hospital if it was negligent in contracting with the nonemployee. The hospital will still be liable if it negligently contracts with a person who is unfit to perform health care services and that person subsequently injures a patient.

CSSB 461(Judiciary) simply provides by law that even though the hospital is required by law to provide certain types of health care that this duty, by itself, is not enough to find the hospital liable for the negligence of its nonemployees. The legislature, by enacting CSSB 461(Judiciary), would be establishing a public policy in favor of this type of limited immunity for hospitals.

If you have more specific concerns not addressed by this memo, or if I can be of further assistance, please contact me.

TML:gc
WKG3:043

WRITTEN TESTIMONY TO THE HOUSE LABOR AND COMMERCE COMMITTEE
REGARDING SB 461

Submitted by Lawrence D. Weiss, Ph.D., M.S.
May 3, 1988

Thank you for giving me the opportunity to provide testimony concerning SB 461. First, a word about myself. I am currently the Executive Director of Alaska Health Project, a private non-profit organization devoted to public health education. For the six years prior to my coming to Alaska I conducted social research, developed and presented lectures in industrial health, and wrote professional papers relating to my teaching and administrative positions at the University of New Mexico School of Medicine. I am by training a medical sociologist.

I would like to analyze SB 461 by applying a few simple questions about the Bill's impact on health, economics, and social issues. In this way we can focus in on the essential elements of the Bill.

WILL SB 461 IMPROVE HEALTH CARE FOR ALASKANS? No. There is nothing in this Bill that indicates that health care in Alaska will improve as a result of this Bill. The fact that hospitals will lose all incentive to take an active responsibility for the provision of high quality health care will result in the decline of medical standards. Hospitals will lose their incentive to rationally organize a health care system.

WILL SB 461 RESULT IN LOWER INSURANCE RATES FOR HEALTH CARE PROVIDERS? No evidence has been presented to indicate that SB 461 will result in lower insurance rates for providers. The opposite appears to be the case. Health care providers can expect larger premiums (if they chose to purchase insurance at all) since the hospital will no longer share liability with the providers.

WILL SB 461 RESULT IN LOWER HEALTH CARE COSTS FOR CONSUMERS? No aspect of this proposed legislation will result in lower health care costs for consumers. In fact the rate of rising health care costs will likely increase as a result of this legislation. Hospital-initiated cost containment efforts will be blunted by the dismantling of the hospitals' centralized authority over increasingly autonomous franchised cost centers.

IF SB 461 WILL NOT IMPROVE THE HEALTH OF ALASKANS, WILL RAISE INSURANCE RATES FOR HEALTH CARE PROVIDERS, AND WILL RAISE COSTS FOR CONSUMERS, THEN WHAT IS THE PURPOSE OF THIS BILL? The real purpose of SB 461 is to improve the profit margins of Alaskan hospitals by shifting the costs to health care providers associated with the hospitals' share of actual and potential liabilities. While there is nothing reprehensible in attempting to increase the hospitals' profit margins, SB 461 has a number of unintended consequences that are inappropriate if not dangerous

for Alaskan health care consumers.

IS THERE A BETTER WAY FOR HOSPITALS TO REDUCE THE COSTS OF LIABILITY WITHOUT THE NEGATIVE CONSEQUENCES ASSOCIATED WITH SB 461? From the point of view of the health of Alaskans, it is clearly a more rational, humane strategy for hospitals to actively take part in the elimination of the practice of bad medicine within their walls rather than to adopt the "devil may care" policy of simple shifting entirely to providers the costs associated with the practice of bad medicine.

Another approach that simultaneously reduces the practice of bad medicine and reduces the costs of malpractice insurance for good physicians is the concept of the self insured trust fund for medical malpractice claims. This approach also potentially reduces the number of claims made on hospitals, since it encourages the practice of better medicine within their walls. Self-insured trust funds have successfully operated in the United States for more than a decade.

IN SUMMARY, I URGE DEFEAT OF SB 461. It has the potential of encouraging the practice of sloppy medicine in all Alaskan hospitals. The Bill is against the interests of every Alaskan who will need health care in the coming years. SB 461 simply shifts the costs for bad medicine. In Alaska we should strive for responsible legislation that will result in better medicine and lower costs for all.

HEALTH ASSOCIATION OF ALASKA
LIABILITY INSURANCE COSTS
1986 TO 1988

FACILITY	1986	1988
Alaska Psych Institute	N/A	N/A
Alaska Surgery Center	N/A	N/A
Alaska Treatment Center	24,270	30,760
Bartlett Memorial	275,696	587,700
Central Peninsula Hospital	66,985	91,017
Charter North Hospital	128,756	192,000
Cordova Community Hospital		
Acute	11,757	36,171
Long Term Care	7,478	23,005
Non-Reimbursable	4,006	12,324
Denali Center	18,215	7,377
Fairbanks Memorial Hospital	430,236	346,190
Geneva Woods Surgical Center	99,600	N/A
Harborview Development Center	N/A	N/A
Heritage Place	2,766	4,800
Hope Cottages	72,619	70,714
Humana Hospital-Alaska	528,671	1,486,980
Ketchikan General Hospital		
Acute	45,452	147,973
Long Term Care	19,052	62,027
Kodiak Island Hospital		
Acute	33,989	48,573
Long Term Care	10,075	14,397
Norton Sound Regional Hospital		
Acute	182,205	306,114
Long Term Care	22,312	37,486
Our Lady of Compassion Care Center	16,500	18,000
Petersburg General Hospital		
Acute	11,028	21,947
Long Term Care	9,594	19,092
Providence Hospital	658,209	944,559
St. Ann's Nursing Home	66,890	116,500
Seward General Hospital	N/A	N/A
Sitka Community Hospital	49,343	195,995
South Peninsula Hospital		
Acute	59,787	164,932
Long Term Care	14,594	40,258
Valdez Community Hospital	5,524	5,623
Valley Hospital	273,653	405,424
Wesleyan Hospital	N/A	N/A
Wrangell General Hospital		
Acute	1,512	2,698
Long Term Care	19,226	34,304
	$3,147,262	$5,377,918

Source: Medicaid Rate Commission

More Information: Harlan Knudson
Health Association of Alaska
586-1790

4/88

STATE OF ALASKA
1988 LEGISLATIVE SESSION

BILL VERSION: CSSB 461 (JUD)
PUBLISH DATE: 3/11/88 Senate

FISCAL NOTE

REQUEST:

Revision Date: 3/10/88
Title: Liability of Hospitals for the Actions of Certain Non-Employees
Sponsor: Jones, et. al.
Requestor:

Agency Affected: Health & Social Service
BRU:
Components:

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
REVENUE	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

Prepared by: Kimberly Busch Kimberly Busch
Phone: 465-3355
Division: Medical Assistance
Date: 3/11/88

(B) Approved by Commissioner: Myra M. Munson
Date: 3/11/88
Agency: Dept. of Health & Social Services

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

STATE OF ALASKA
1988 LEGISLATIVE SESSION

BILL VERSION: CSSB 461 (Jud.)
PUBLISH DATE: Senate 3/11/88

FISCAL NOTE

REQUEST:

Revision Date: March 11, 1988
Title: "An Act relating to liability of hospitals ... certain nonemployees."
Sponsor: Senate Judiciary
Requestor: Senate Judiciary

Agency Affected: Department of Law
BRU: Legal Services
Components: Operations

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND	-0-	-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

FULL-TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

Please see attached analysis.

Richard L. Pegues

Prepared by: Richard I. Pegues, Director
Phone: 465-3672
Division: Administrative Services
Date: March 11, 1988

Richard L. Pegues (FOR)

Approved by Commissioner: Grace Berg Schaible
Date: March 11, 1988
Agency: Department of Law

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

CONTINUATION of FISCAL NOTE ANALYSIS

For Bill/Resolution No. CSSB 461 (Jud.)

This bill adds a new section to AS 09.65 that sheilds hospitals from civil liability for the acts and omissions of those providing health care in a hospital who are not employees of the hospital, including physicians. Because this bill deals with the civil liability of hospitals, it will not have a direct fiscal impact on the Department of Law.

The committee substitute for this bill adds a new section that provides that the bill's provisions would apply prospectively to causes of action that accrue on or after the bill's effective date. Thus, the bill will still not have a fiscal impact on the Department of Law.

health association of alaska

319 Seward St., Juneau, Alaska 99801 • (907) 586-1790
REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

G
HFT

March 16, 1988

Representative Dave Donley, Chairman
Labor & Commerce Committee
P.O. Box v
Capitol, Room 13
Juneau, AK 99811

Dear Representative Donley:

This letter is to ask your support for SB 461, regarding the liability of hospitals for acts and omissions of non-employee physicians and other health personnel.

SB 461, corrects a ruling by the Alaska State Supreme Court that a general acute care hospital has a nondelegable duty to provide emergency room services, and therefore, the hospital is vicariously liable for the negligence of a non-employed emergency room physician.

Enclosed is a summary of SB 461. We believe very strongly that if the "Jackson v. Powers" decision is not corrected, hospitals in this state will become a "very deep pocket" for all liability actions against physicians, regardless of any fault by the hospital.

We look forward to providing additional information on the need for SB 461 during the House Labor and Commerce hearing.

Your consideration is appreciated.

Sincerely,

Harlan R. Knudson
Executive Director

P.S. The Medicaid Rate Commission reports that overall liability rates for health facilities in this state went from $3,147,000 in 1986 to $5,377,000 in 1988.

HK/cdr

Enclosure (1)

HEALTH ASSOCIATION OF ALASKA
February 1988

LEGISLATIVE SUMMARY -- SB 461, LIABILITY OF HOSPITALS FOR NON-EMPLOYED PHYSICIANS AND OTHER HEALTH PERSONNEL

By: Senators Jones, Coghill, Faiks and Kelly

On October 16, 1987, the Alaska Supreme Court ruled in Jackson v. Power (no. 3237) that a general acute care hospital has a nondelegable duty to provide emergency room services, and therefore, the hospital is vicariously liable for the negligence of an emergency room physician.

** The Jackson decision imposes liability on hospitals for the negligence of non-employee emergency room physicians solely because the hospital is required by law to provide emergency room services and is regulated in the provision of those services, without requiring the plaintiff to show that the hospital has been negligent or that it has violated any specific regulatory requirement.

** The implications of the Jackson decision extend far beyond the emergency room. Although the Jackson case dealt only with the relationship between the hospital and non-employee emergency room physicians, the rationale of the case logically extends to other non-employee physicians and health care providers. Under the common law prior to the Jackson decision a hospital was not vicariously liable for the negligence of the non-employees if the hospital itself was not negligent and had complied with all applicable statutory and regulatory requirements.

** The Jackson decision runs counter to modern trends of apportioning liability according to fault. Recent tort reforms were designed to provide some relief to public entities, which were often named as "deep pocket" defendants, even though their share of the responsibility for the injury was negligible. The Jackson case insures that municipally owned and non-profit hospitals will be named as deep pocket defendants in every case involving physicians negligence, even though the hospital was not negligent and has done everything within its power to comply with statutory and regulatory requirements. In one recent case, for example, the plaintiff dismissed all of the allegedly negligent physician defendants and went to trial solely against the corporate hospital.

** The ruling will not improve hospital and emergency room care because, by definition, the Jackson rule applies where there is no fault on the part of the hospital. Hospitals have always been liable for their own negligence, and would continue to be so liable if Jackson were legislatively repealed.

** The Jackson ruling could decrease hospital and emergency room response time if hospitals react to the ruling by requiring emergency room physicians to practice more "legal" or "defensive medicine" -- more tests, more consultations, etc. Emergency

(over)

situations are inherently risky. The legislature, for example, has granted immunity to EMTs, paramedics and ordinary citizens acting in emergency situations. These legislative choices reflect a policy decision that the need for swift action in emergency situations outweighs the policy of compensating injured plaintiffs. The Jackson decision undercuts this legislative policy.

** Hospital and Emergency room operating costs could be increased also if hospitals react to Jackson by imposing more "defensive medicine" requirements.

** Unless hospitals dramatically restructure their relationship to physicians (by requiring them to become hospital employees, for example) the net result of the Jackson decision probably will be to increase insurance costs as both hospital and doctor insure to cover the same risk.

** There is no showing that medical malpractice plaintiffs have experienced difficulty collecting their judgments. Most physicians carry adequate malpractice insurance. The addition of a "deep pocket" corporate hospital to the cast of defendants, however, will probably increase the size of jury verdicts.

** The burden of the Jackson decision will fall on municipally owned and non-profit hospitals, which are already caught in a cost squeeze from state and federal regulatory and rate requirements.

** SB 461 corrects the Supreme Court ruling by clarifying that hospitals are not liable for acts or omissions of non-employed physicians or other health professionals, solely for the reason that they must provide those services under Alaska Statue or regulations. It returns the law to where it was prior to the decision, with the hospital liable for its negligence or intentional misconduct.

** The Medicaid Rate Commission reports that health facilities malpractice insurance premiums increased from a total of $3,147,262.00 in 1986 to $5,377,918.00 for 1988. An increase of over $2 million dollars.

The passage of SB 461 will prevent an even a greater escalation of hospital liability insurance costs.

For More Information Contact:

Harlan Knudson, Executive Director
Health Association of Alaska - 586-1790

David Crosby, Attorney
Health Association of Alaska - 586-1786

Jerry Reinwand, Lobbyist
Health Association of Alaska - 586-8966

# # #

LAW OFFICES
BERNARD P. KELLY & ASSOCIATES
A PROFESSIONAL CORPORATION
310 K STREET, SUITE 506
ANCHORAGE, ALASKA 99501-2040
(907) 276-3188

BERNARD P. KELLY
PAUL COSSMAN
STEVEN PRADELL

March 14, 1988

RECEIVED
MAR 17 1987

Senator Jalmar Kerttula
Chairman, Senate Judiciary Committee
P.O. Box V
Juneau, Alaska 99811

RE: SB 461

Dear Mr. Chairman:

I oppose any passage of SB 416. This bill would insulate hospitals from any liability for the patients who are negligently injured by physicians who work in hospital emergency rooms, radiology departments, and other departments where the physicians are independent contractors with the hospital and not actual hospital employees. This would take the entire burden off hospitals for overseeing the quality control of the physicians who work in these departments in the hospital. This bill ignores the fact that hospitals are required by Alaska law to provide radiology and emergency room departments. If they must provide these departments, they should be responsible to see they are operated in a non-negligent fashion.

The only real risk management oversight that is in effect for emergency rooms and radiology departments is that of the hospital. Alaska's history of disciplining physicians for negligence and incompetence is very poor. The attached article from U.S.A. Today documents the fact that Alaska did not discipline any physicians in 1985 and disciplined only two physicians in 1986. I can assure you that there were many more cases of negligence that were successfully settled.

We need the risk management supervision of the hospitals over the physicians who work in the radiology and emergency room departments. Alaska does not have a successful record of disciplinary actions against physicians. Therefore, some other body has to provide that function. Currently hospitals provide it. Once the hospitals are freed from liability for the negligent acts of physicians in their own emergency rooms and

radiology departments, they will ease their risk management requirements, and the standard of care will drop. This is against the best interests of the citizens of Alaska, and I urge you to table or otherwise kill SB 461.

Sincerely yours,

BERNARD P. KELLY & ASSOCIATES

PAUL COSSMAN

amm

Enc.
0992m

USA TODAY 3-2-88

GRADING THE USA

Doctors improperly disciplined, health advocacy agency says

Disciplinary actions against doctors increased 17 percent in 1986, but a health advocacy agency that prepared statistics said too many slipshod physicians still go unpunished.

"The absence, in most if not all states, of the maximum effort to discipline doctors is one of the most serious threats to the health of American patients," said the report by Public Citizen's Health Research Group, founded by its director, Dr. Sidney M. Wolfe, and Ralph Nader.

The 17 percent increase from 1985 to 1986 compared with a 46 percent increase between 1984 and 1985.

Surveying data from the Federation of State Medical Boards, the organization ranked all 50 states and the District of Columbia according to the number of "serious actions" per 1,000 doctors. A serious action was revocation or suspension of a medical license, or probation.

The national average was 2.37 actions per 1,000 doctors. Georgia led with 6.94 actions per 1,000, while Wyoming was in 51st place with none.

The group found there were 1,089 serious actions across the USA in 1985 and 1,277 in 1986, the most recent year for which figures from all localities were available.

"Since there is no evidence that doctors settle in certain states depending on how competent they are, differences in the rate of doctor discipline reflect differences in how serious states are about disciplining doctors," the report said.

The group claims "until the rate of doctor discipline in this country significantly increases, there is no realistic possibility of a major decrease in the amount of medical malpractice."

Here is a state-by-state list of the number of disciplinary actions taken against doctors in 1985 and 1986 as compiled by the group. The first column lists the actual number of actions in 1985. The second column lists actual actions in 1986. The third column is the rate of actions per 1,000 doctors in the state. The fourth column is the state's rank, first being the highest number of actions.

State	Total 1985	Total 1986	Per 1,000	rank
Alabama	9	8	1.27	40
Alaska	0	2	2.76	19
Arizona	22	12	1.64	31
Arkansas	9	6	1.64	32
California	121	121	1.70	30
Colorado	14	24	3.41	10
Connecticut	4	9	0.92	46
Delaware	1	2	1.55	34
D.C.	8	9	2.36	25
Florida	55	75	2.69	20
Georgia	48	73	6.94	1
Hawaii	4	8	3.19	11
Idaho	5	4	2.93	14
Illinois	44	73	2.86	17
Indiana	39	57	6.53	2
Iowa	20	26	5.93	3
Kansas	10	7	1.57	33
Kentucky	28	22	3.56	9
Louisiana	21	13	1.54	35
Maine	4	6	2.60	22
Maryland	12	11	0.73	48
Massachusetts	22	42	2.12	28
Michigan	22	14	0.80	47
Minnesota	19	30	3.15	13
Mississippi	6	8	2.34	26
Missouri	39	38	3.80	8
Montana	0	2	1.51	36
Nebraska	0	4	1.45	38
Nevada	16	4	2.39	24
New Hampshire	1	1	0.47	50
New Jersey	76	49	2.59	23
New Mexico	2	4	1.46	37
New York	60	167	2.89	16
North Carolina	17	26	2.21	27
North Dakota	4	2	1.76	29
Ohio	39	58	2.67	21
Oklahoma	23	21	4.21	7
Oregon	25	28	4.76	6
Pennsylvania	57	27	0.95	45
Rhode Island	9	3	1.21	41
South Carolina	17	16	2.90	15
South Dakota	1	1	1.00	44
Tennessee	14	10	1.09	43
Texas	44	41	1.40	39
Utah	19	17	5.43	5
Vermont	1	1	0.68	49
Virginia	42	39	3.17	12
Washington	11	19	1.09	42
West Virginia	7	19	5.62	4
Wisconsin	9	26	2.82	18
Wyoming	1	0	0.00	51

SB 461

LAW OFFICES

L. Ames Luce

A PROFESSIONAL CORPORATION

L. AMES LUCE
DAN A. HENSLEY

1015 WEST SEVENTH AVENUE
ANCHORAGE, ALASKA 99501

TELEPHONE
(907) 276-1191

March 14, 1988

Representative Dave Donley
Labor & Commerce
Room 17, Capitol Building
Juneau, Alaska 99811

Dear Representative Donley:

I want to take a few minutes of your time to have you reflect with me upon the following situations which I hope neither you nor your family will encounter. They are, however, situations which daily confront your constituents.

> In the middle of the night you awaken with an aching pain in your right shoulder which shoots into your left arm. Your face is covered with sweat and you gasp for breath. You manage to alert your spouse and she rushes you to the hospital emergency room for what hopefully will be life saving care by the hospital emergency room physician.
>
> Your spouse notices that she has a lump in her breast and is sent by her doctor to the hospital for a mammogram to be interpreted by a hospital radiologist. Later, a biopsy is performed at the hospital and sent to hospital pathology.
>
> Your son or daughter is hospitalized and you are told that immediate surgery is necessary. Shortly before the surgery is to be performed a physician or a nurse enters the room and advises you that he will be giving anesthesia to your child. While you and your wife have chosen your surgeon, the anesthesiologist who will attend your child during the operation will have been assigned by the hospital to provide this service on its behalf.

All of these situations have several things in common. First, you, your wife, and your child as patients are looking to the "hospital" for non-negligent emergency, radiology, pathology, and anesthesiology care. You have not sought out a physician for these critical health care services, but have looked to the hospital to provide these services. Second, the hospital is "required" by state law, by its own by laws, and by national accreditation standards, to provide these critical health care services to you and your family. Third, when these critical health care services are negligently delivered and cause serious injury or death to you or members of your family, hospitals

uniformly protest that they have "no civil liability" for the harm done, because they have hired a physician who is an "independent contractor" to perform these critical health care services.

The modern hospital is no longer, as it once was, merely a sanitary wayside for the convenience of the doctor and the patient. Over 50,000 emergency room visits occur annually in our state. The modern hospital is the focal point of quality health care available to the community. This is not only true in practice but also as required by statute, hospital by laws and accreditation.

The hospitals of this state now seek exemption under SB 461 from responsibility for quality hospital health care, by statutorily providing that only the independent contractor physicians which they may hire will have any civil responsibility for the harm which might be caused by those physicians in their emergency rooms, and in their radiology, pathology, and anesthesiology departments. They seek to be "hospitals" but not to be responsible for the harm to patients occurring from the medical procedures that they are required to provide for patient care as "hospitals". Inevitably, duty without responsibility leads to the lack of quality health care.

The hospitals have sought the passage of this restrictive and unwarranted legislation because of the horrible injuries sustained to a young Fairbanks boy by the name of Brett Jackson, as the result of gross malpractice which in part occurred in the Fairbanks Memorial Hospital. In 1981, this 16 year old boy fell 40 feet from a cliff. He was rushed to Fairbanks Memorial Hospital. When he finally regained consciousness days later he learned he had lost both kidneys during his stay in the hospital. He also learned that the loss of his kidneys resulted from the failure of the emergency room physician to order a simple urine test and to perform other basic medical diagnostic procedures.

Brett Jackson was in for another surprise when he decided to file suit against the hospital for that emergency room negligence. He learned that the hospital denied any responsibility for the activities of the emergency room. He was referred to a corporation he had never heard of called Emergency Room, Inc., and was told that if he was to have any recovery it must be against that unknown corporation or the doctor that it had employed to provide emergency room coverage--a physician that Brett Jackson had never met.

In a unanimous decision, the Alaska Supreme Court, in Jackson, et al., v. Power, et al., 743 P.2d 1376 (Alaska 1987) a copy of which I have attached, held that a hospital--required by

law to have an emergency room--could not hide behind a corporation like Emergency Room, Inc. when a hospital patient is injured in the emergency department.

SB 461 would reverse that Supreme Court ruling. It would allow hospitals again to attempt to "franchise" their operations and hide behind those franchises when negligence occurs at the hospital. SB 461 would, in fact, encourage hospitals to "franchise" all of their health care services to further insulate themselves from liability for negligent acts occurring under the hospitals' very roofs. The policy issue presented by SB 461 is whether the Alaska legislature will continue, as it has in previous legislation regarding hospitals, to consider the safety of hospital patients to be of higher priority. Alaska's earliest hospital licensing laws reflect the legislative policy of "promoting safe and adequate treatment of individuals in hospitals in the interest of public health, safety and welfare." (See AS 18.20.060, enacted in 1949). The legislature has continually reaffirmed that policy.

The holding of the Alaska Supreme Court in its unanimous decision is not revolutionary. The same rule of law has been applied for decades to numerous types of quasi-public businesses which have received special protections from the government in order to further the public good. In Alaska, airlines which are granted scheduled routes may not insulate themselves from liability for the airline operation by hiring "independent contractors" as pilots to fly their planes or franchising their operations to other airlines. Common carriers, bus lines, and railroad carriers who are given special route priorities by the government may not delegate their operations to "independent contractors" and hide from liability when those contractors are negligent. Are we as hospital patients not entitled to the same protection?

If SB 461 becomes law, the Alaska legislature's long-standing commitment to quality hospital care will be impaired. Hospitals will be encouraged to "franchise" even more of their vital public services in an attempt to avoid liability for injuries to hospital patients. The passage of SB 461 and the over-ruling of Jackson v. Power would send a message to hospital

administrators that the safety of hospital patients and quality health care is no longer a high priority in the State of Alaska. I would urge you to vote against this bill.

Yours truly,

L. Ames Luce

LAL/cb

Enclosure

Brett JACKSON and Linda Estrada, Petitioners,

v.

John POWER, M.D.; Fairbanks Memorial Hospital; Lutheran Hospital and Homes Society of America, Inc.; Emergency Room, Inc.; William H. Montano, M.D.; and George Vrablick, M.D., Respondents.

No. S-1677.

Supreme Court of Alaska.

Oct. 16, 1987.

Medical malpractice action was brought against hospital. The Superior Court, Fourth Judicial District, Fairbanks, Gerald J. Van Hoomissen, J., denied patient summary judgment and petition for review was filed. The Supreme Court, Burke, J., held that: (1) hospital could not be held vicariously liable for negligence or malpractice of independent contractor/physician under enterprise liability; (2) genuine issue of material fact as to whether hospital held itself out as providing emergency care services to public precluded summary judgment for patient on apparent authority theory; and (3) general acute care hospital's duty to provide physicians for emergency room care was nondelegable.

Affirmed in part, reversed in part, and remanded.

1. Hospitals ⇐7

Doctrine of corporate negligence holds that hospital owes independent duty to its patients to use reasonable care to insure that physicians granted hospital privileges are competent, and to supervise medical treatment provided by members of its medical staff.

2. Hospitals ⇐7

Generally accepted rule is that where employment relationship exists between physician and hospital, hospital will be liable, under traditional rule of respondeat superior, for any negligence or malpractice which results in injury to hospital patient, and conversely, no liability attaches to pital when physician is independent tractor.

3. Hospitals ⇐7

Hospital could not be held vicari liable for negligence or malpractice of pendent contractor/physician, comm while treating patient in hospital's e gency room under theory of enterpris bility.

4. Hospitals ⇐7

Two factors are relevant to findin ostensible agency in hospital context cluding whether patient looks to institu rather than individual physician, for and whether hospital holds out physicia its employee.

5. Principal and Agent ⇐137(2)

Under theory of agency by estop there must be actual reliance upon re sentation of principal by person inju

6. Principal and Agent ⇐99

Traditional rules of apparent autho are applicable to hospital-independent c tractor/physician relationship.

7. Judgment ⇐181(33)

Genuine issue of material fact as whether hospital held itself out as pro ing emergency care services to public whether patient reasonably believed t physician was employed by hospital to liver emergency room service preclu summary judgment for patient in med malpractice action against hospital on th ry of apparent authority.

8. Principal and Agent ⇐159(1)

Application of apparent authority hospital/emergency room physician sit tion does not require express represen tion to patient that treating physician employee of hospital; nor is direct testi ny as to reliance required absent evide that patient knew or should have kn that treating physician was not hosp employee when treatment was rende

9. Hospitals ⇐7

Hospital licensed as general acute c hospital had duty to provide emerge

room services and part of duty was to provide physician care in emergency room.

10. Hospitals ⇐7

General acute care hospital's duty to provide physicians for emergency room care was nondelegable, and thus hospital could not shield itself from liability by claiming that it was not responsible for results of negligently performed health care when law imposed duty on hospital to provide that health care.

11. Master and Servant ⇐315

Nondelegable duty is established exception to rule that employer is not liable for negligence of independent contractors.

12. Hospitals ⇐7

Rule that general acute care hospital's duty to provide physicians for emergency room care is nondelegable does not change standard of care with which physician must comply and does not extend to situations where patient is treated by his or her own doctor in emergency room provided for convenience of doctor.

13. Hospitals ⇐7

Acute care hospital was vicariously liable as a matter of law for negligence or malpractice committed by physician on a patient who came to hospital seeking emergency room services; physician was provided by hospital as part of its nondelegable duty to provide nonnegligent physician care in emergency room.

Michael Cohn, Dan A. Hensley, L. Ames Luce, Law Offices of L. Ames Luce, Anchorage, for petitioners.

James J. Delaney, Howard A. Lazar, Delaney, Wiles, Hayes, Reitman & Brubaker, Anchorage, for respondents Fairbanks Memorial Hosp. and Lutheran Hosp. & Homes Soc.

Peter J. Maassen, Burr, Pease & Kurtz, Anchorage, for respondents John Power, M.D. and Emergency Room, Inc.

David C. Crosby, Council & Crosby, Juneau, for Health Ass'n of Alaska, amicus curiae.

Before RABINOWITZ, C.J., and BURKE, MATTHEWS and COMPTON, JJ.

OPINION

BURKE, Justice.

This case presents an issue of first impression in this state, concerning health care delivery in hospital emergency rooms. The question that we must resolve is whether a hospital may be held vicariously liable for negligent health care rendered by an emergency room physician who is not an employee of the hospital, but is, instead, an independent contractor. We hold that the hospital in this case had a non-delegable duty to provide non-negligent physician care in its emergency room and, therefore, may be liable.

I

On the evening of May 22, 1981, sixteen year old Brett Jackson was seriously injured when he fell from a cliff. Jackson was airlifted to Fairbanks Memorial Hospital (FMH). Shortly after midnight, he was received in the hospital's emergency room.

Jackson was examined by respondent John Power, M.D., one of two emergency room physicians on duty at the time. Dr. Power's examination revealed multiple lacerations and abrasions of the patient's face and scalp, multiple contusions and lacerations of the lumbar area, several broken vertebrae and gastric distension, suggesting possible internal injuries. Dr. Power ordered several tests, but did not order certain procedures that could have been used to ascertain whether there had been damage to the patient's kidneys. Jackson had, in fact, suffered damage to the renal arteries and veins which supply blood to and remove blood from the kidneys. This damage, undetected for approximately 9 to 10 hours after Jackson's arrival at FMH, ultimately caused Jackson to lose both of his kidneys.

II

Jackson and his mother, Linda Estrada, (hereinafter referred to collectively as Jack-

son) filed suit. In their complaint they alleged negligence in the diagnosis, care and treatment Jackson received at FMH. Jackson moved for partial summary judgment seeking to hold FMH vicariously liable as a matter of law for the care rendered by Dr. Power. In support of his motion, Jackson advanced three separate theories: (1) enterprise liability; (2) apparent authority; and (3) non-delegable duty.

After briefing and argument, the superior court held, as a matter of law, that FMH could not be held liable under an enterprise liability theory, and that genuine issues of material fact precluded summary judgment on the two remaining theories.[1] We subsequently granted Jackson's petition for review of the court's ruling.

III

[1] Initially, it is important to clarify the exact issue that we have been asked to resolve. Jackson has conceded, for purposes of this appeal, that Dr. Power was not an employee of FMH, but an independent contractor employed by respondent Emergency Room, Inc. (ERI), and that ERI and FMH are separate legal entities. Traditional rules of *respondeat superior* are, therefore, inapposite. Jackson also makes no claim that FMH was itself negligent in its selection, retention, or supervision of Dr. Power. Consequently, we have no occasion to consider the doctrine of corporate negligence.[2] Jackson asks us to resolve only whether a hospital should be vicariously liable, as a matter of public policy, for the negligence or malpractice[3] of an independent contractor/physician, committed while treating a patient in the hospital emergency room, under theories of (1) enterprise liability; (2) apparent authority; (3) non-delegable duty.

IV

As previously noted, this case presents this court with an issue of first impression.[4]

[2] The generally accepted rule is that where an employment relationship exists between the physician and the hospital, the hospital will be liable, under the traditional rule of *respondeat superior*, for any negligence or malpractice which results in injury to a hospital patient. *E.g., Bing v. Thunig*, 2 N.Y.2d 656, 163 N.Y.S.2d 3, 11, 143 N.E.2d 3, 9 (N.Y.1957); *Weldon v. Seminole Municipal Hospital*, 709 P.2d 1058, 1059 (Okla.1985). Conversely, no liability attaches to the hospital when the physician is an independent contractor. *E.g. Greene v. Rogers*, 147 Ill.App.3d 100, 101 Ill.Dec. 543, 547, 498 N.E.2d 867, 871 (1986); *Hill v. St. Clare's Hosp.*, 67 N.Y.2d 72, 499 N.Y.S.2d 904, 908, 490 N.E.2d 823, 827 (1986). *See generally* Comment, *The Hospital-Physician Relationship: Hospital Responsibility for Malpractice of Phy-*

1. The superior court also rejected three motions for summary judgment by various respondents seeking to have Linda Estrada's claim against them dismissed on the ground that it was time barred by the statute of limitations. None of the respondents cross-petitioned for review of that issue.

2. The doctrine of corporate negligence holds that a hospital owes an independent duty to its patients to use reasonable care to insure that physicians granted hospital privileges are competent, and to supervise the medical treatment provided by members of its medical staff. *See Tucson Medical Center v. Misevich*, 113 Ariz. 34, 545 P.2d 958, 960 (1976); *Darling v. Charleston Community Mem. Hosp.*, 33 Ill.2d 326, 211 N.E.2d 253 (1965); *Pedroza v. Bryant*, 101 Wash.2d 226, 677 P.2d 166, 170 (1984); *Johnson v. Misericordia Community Hosp.*, 99 Wis.2d 708, 301 N.W.2d 156 (1981). *See generally*, Janulis & Hornstein, *Damned If You Do, Damned If You Don't: Hospitals' Liability for Physician Malpractice*, 64 Neb.L.Rev. 689, 702–08 (1985); Note, *Hospital Corporate Liability: An Effective Solution to Controlling Private Physician Incompetence*, 32 Rutgers L.J. 342, 360–72 (1979).

3. Jackson has yet to prove that any negligence or malpractice did in fact occur. In order to resolve the issue presented here, however, we must assume negligence. We, of course, express no opinion as to the actual merits of Jackson's claim.

4. In *Baker v. Werner*, 654 P.2d 263, 267 n. (Alaska 1982), Baker appealed the trial court's rejection of his theory of vicarious liability in a wrongful death action against a physician, hospital and attending nurse. Because we upheld the jury's finding that the defendants were not negligent, we did not reach the merits of the issue, "any theory of vicarious liability [being] irrelevant." *Id.*

sicians, 50 Wash.L.Rev. 385 (1975) (hereinafter "Comment, *Hospital Responsibility*").

Jackson concedes that Dr. Power was an independent contractor; however, he asserts that Alaska's law of *respondeat superior* mandates a result different than that which would be reached under the general rule.[5] Jackson argues that our decision in *Fruit v. Schreiner*, 502 P.2d 133 (Alaska 1972), establishes that the law of "vicarious legal responsibility" in Alaska is "enterprise liability." Thus, he contends, if the enterprise impacts society and the negligent act occurred during an activity performed for the benefit or in the interest of the enterprise, the enterprise is liable.

[3] Jackson's argument proves unpersuasive. First, Jackson's interpretation of *Fruit* is flawed. A close reading of that case shows that we did not view "enterprise liability" as a separate theory of liability or a distinct cause of action. Rather, enterprise liability was seen as one of two widely accepted theories used by courts to justify imposition of vicarious liability in an established employer/employee context. *Id.* at 138–39. As was noted in *Fruit*:

> [T]he "enterprise" theory ... finds liability whenever the enterprise of the employer would have benefited by the context of the act of the *employee* but for the unfortunate injury.
>
> ....
>
> The rule of *respondeat superior* however, ... is *limited* to requiring an enterprise to bear the loss incurred as a result of the *employee's* negligence. The acts of the *employee* need be so connected to his employment as to justify requiring that the employer bear that loss.

Id. at 140–41 (emphasis added) (footnotes omitted). *See generally* Morris, *Enterprise Liability and the Actuarial Process—the Insignificance of Foresight*, 70 Yale L.J. 554 (1961).

Additionally, our decisions since *Fruit* show that we have applied the theory of *respondeat superior* only in an employer/employee context, unless one of the well established exceptions to that rule exists. *See, Parker Drilling v. O'Neill*, 674 P.2d 770, 775 (Alaska 1983); *Williams v. Alyeska Pipeline Service Co.*, 650 P.2d 343, 349 (Alaska 1982); *Hammond v. Bechtel Inc.*, 606 P.2d 1269, 1273 (Alaska 1980); *Barton v. Lund*, 563 P.2d 875, 876 (Alaska 1977); *Luth v. Rogers & Babler Construction*, 507 P.2d 761, 763–64 (Alaska 1973). Jackson's theory presents no such exception.

Finally, the cases from other jurisdictions cited by Jackson provide little support for his theory; those cases deal only with theories of apparent agency or corporate negligence. Moreover, although at least two courts appear to have implicitly indicated a willingness to recognize a theory of enterprise liability, *see Alden v. Providence Hospital*, 382 F.2d 163, 166 (D.C. Cir.1967); *Adamski v. Tacoma General Hospital*, 20 Wash.App. 98, 579 P.2d 970, 977 & n. 5 (1978), to date, no court has explicitly embraced that concept.[6]

In short, Jackson's theory of enterprise liability is not yet the law in Alaska.

V

Jackson next argues that the trial court erred in holding that genuine issues of material fact prevented it from granting summary judgment on his theory of apparent authority.

5. The trial court decided the issue of the applicability of enterprise liability as a matter of law. We scrutinize questions of law under a *de novo* or independent judgment standard of review. *Hicklin v. Orbeck*, 565 P.2d 159, 163 n. 6 (Alaska 1977), *rev'd on other grounds*, 437 U.S. 518, 98 S.Ct. 2482, 57 L.Ed.2d 397 (1978). When reviewing a question of law, it is our "duty to adopt the rule of law that is most persuasive in light of precedent, reason and policy." *Guin v. Ha*, 591 P.2d 1281, 1284 n. 6 (Alaska 1979).

6. Some commentators have suggested an enterprise tort doctrine as a basis for imposing liability for any tort occurring as part of the hospital enterprise. *See* Southwick, *Hospital Liability: Two Theories Have Been Merged*, 4 J. Legal Med. 1, 3–5 (1983); Comment, *Hospital Responsibility*, *supra* at 418–19.

Although we have recognized the doctrine of apparent authority in other contexts, *see City of Delta Junction v. Mack Trucks*, 670 P.2d 1128, 1129–30 (Alaska 1983) (national distributor and local franchise); *Perkins v. Willacy*, 431 P.2d 141, 142 (Alaska 1967) (husband and wife), this is the first time we have been asked to apply this doctrine to a hospital-independent contractor/physician relationship.

Cases from other jurisdictions show a strong trend toward liability against hospitals that permit or encourage patients to believe that independent contractor/physicians are, in fact, authorized agents of the hospitals.[7] These courts have held hospitals vicariously liable under a doctrine labeled either "ostensible" or "apparent" agency or "agency by estoppel." *See Gorubiansky v. Emory University*, 156 Ga. App. 602, 275 S.E.2d 163, 168 (1981); *Paintsville Hospital v. Rose*, 683 S.W.2d 255, 257 (Ky.1985); *Mehlman v. Powell*, 378 A.2d 1121 (Md.1977); *Grewe v. Mt. Clemens General Hospital*, 404 Mich. 240, 273 N.W.2d 429, 432–33 (1978); *Arthur v. St. Peters Hospital*, 169 N.J.Super. 575, 405 A.2d 443 (1979); *Hannola v. City of Lakewood*, 68 Ohio App.2d 61, 426 N.E.2d 1187, 1192 (1980); *Weldon*, 709 P.2d at 1060; *Themins v. Emanuel Lutheran Charity Bd.*, 54 Or.App. 901, 637 P.2d 155, 158–59 (1982); *Adamski v. Tacoma General Hospital*, 20 Wash.App. 98, 579 P.2d 970, 977 (1978); *see generally* Janulis & Hornstein, *supra* at 696–702. Although courts and commentators often use these terms interchangeably, they are not theoretically identical.

[4] The "ostensible" or "apparent" agency theory is based on Section 429 of the Restatement (Second) of Torts (1965), which provides:

> One who employs an independent contractor to perform services for another which are accepted in the reasonable belief that the services are being rendered by the employer or by his servants, subject to liability for physical harm caused by the negligence of the contractor in supplying such services, to the same extent as though the employer were supplying them himself or by his servants.

Two factors are relevant to a finding of ostensible agency: (1) whether the patient looks to the institution, rather than to an individual physician, for care; and (2) whether the hospital "holds out" the physician as its employee. *Simmons v. St. Clair Memorial Hospital*, 332 Pa.Super. 444, 481 A.2d 870, 874 (1984); *see also Irving v. Doctors Hospital of Lake Worth*, 415 So.2d 55, 60–61 (Fla.App.1982); *Smith v. St. Francis Hospital*, 676 P.2d 279, 282 (Okla.App.1984).

[5] "Agency by estoppel," in contrast, is predicated on the arguably stricter standard of the Restatement (Second) of Agency § 267 (1958). Section 267 provides:

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

Under this theory, there must be actual reliance upon the representations of the principal by the person injured. *Mehlman*, 378 A.2d at 1123.

> Thus, theoretically, there need be no causal relationship between the principal's conduct and the plaintiff's reliance to warrant a conclusion of ostensible agency; such a causal relationship and such a change of position, however, are the essence of estoppel to deny agency.

Janulis & Hornstein, *supra* at 697.

[6] Jackson, in essence, asks us to adopt a rule of ostensible agency. FMH

7. The only exception to this modern trend of which we are aware is *Greene v. Rogers*, 147 Ill.App.3d 1009, 101 Ill.Dec. 543, 498 N.E.2d 867 (1986). In *Greene*, the court specifically refused to apply apparent agency to a hospital-emergency room doctor relationship because "[t]he absence of the power to control the decision-making of the emergency room physician demands that the independent relationship between hospital and emergency room physician be recognized." *Id.* 101 Ill.Dec. at 547, 498 N.E.2d at 871. We view *Greene* as an aberration dependent upon reasoning which is not particularly persuasive.

on the other hand, requests that we follow *Greene* and refuse to apply this doctrine in the hospital-physician context or, alternatively, that we adopt a rule which is essentially estoppel by agency. Although we find nothing antithetical about applying the doctrine of apparent authority to a hospital-independent contractor/physician relationship, we perceive no reason to adopt a special rule in this area. We believe that traditional rules of apparent authority provide sufficient guidelines.

In *City of Delta Junction*, we defined the doctrine of apparent authority in Alaska as follows:

> Appa[illegible]thority to do an act is create[illegible] to third persons by written or spoken word or any other conduct of the principal which, reasonably interpreted, causes the third person to believe that the principal consents to have the act done on his behalf by the person purporting to act for him.

670 P.2d at 1130 (quoting Restatement (Second) of Agency § 27, at 103 (1958)). We went on to emphasize that it is the *principal's* conduct that gives rise to his liability and not the conduct of the alleged agent; "one dealing with an alleged agent must prove that the principal was responsible for the appearance of authority, by doing something or permitting the alleged agent to do something that led others, including the plaintiff, to believe that the agent had the authority he purported to have." *Id.* (quoting W. Seavy, *Handbook of The Law of Agency* § 8, at 13 (1964)).

Relying on *City of Delta Junction*, the trial court held that existing factual disputes required Jackson to submit his apparent authority theory to the jury. When reviewing the denial of a motion for summary judgment, we must determine whether genuine issues of material fact exist, and if not, whether the moving party is entitled to judgment as a matter of law. Alaska R.Civ.P. 56(c); *Shatting v. Dillingham City School District*, 617 P.2d 9, 11 (Alaska 1980). In reaching this decision we must draw all reasonable inferences in favor of the non-moving party and against the movant. *Id.*

Drawing all reasonable inferences in the light most favorable to FMH, the record shows the following: at the time of Jackson's accident, FMH was the only civilian hospital north of Anchorage providing emergency room services in Alaska. Two road signs in Fairbanks note the location of the hospital. However, neither of these signs specifically refer to the existence of emergency room services. The signs were not constructed or situated by FMH. In fact, FMH does no advertising at all.

From the time of its establishment in 1972, FMH has never staffed its emergency room with its own physician employees, but has always relied upon local physicians to provide that service. Prior to the formation of ERI in 1977, FMH's emergency room was serviced by three local clinics, each providing one physician on a nightly basis. After 1977, ERI provided one physician on a nightly basis who worked a 14-hour graveyard shift (6:00 p.m. to 8:00 a.m.).[8] While on duty in the emergency room, the ERI physician was "in charge" and no FMH personnel were responsible for either scheduling or monitoring the emergency room physicians. No contractual arrangement existed between FMH and ERI for the provision of emergency room physicians.

In apparent non-life threatening situations the first person an incoming patient sees at the emergency room is the admissions clerk. Immediately adjacent to the clerk's desk is a sign which indicated that physicians from ERI were working in the emergency room. Although the exact state of Jackson's awareness is not entirely clear, there is evidence suggesting that he was admitted in a conscious state.[9] Nei-

8. The clinics continued to provide an additional physician for the graveyard shift on a rotation basis.

9. Jackson testified at his deposition that he recalled being placed in the helicopter but had no recollection of being removed from it, being taken to FMH, or of meeting the doctor who treated him. On the other hand, the medical records indicate that Jackson appeared to be neurologically stable, completely oriented and gave no indication that he was unconscious or in distress. Moreover, at his deposition, Dr.

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> Thus, theoretically, there need be no causal relationship between the principal's conduct and the plaintiff's reliance to warrant a conclusion of ostensible agency; such a causal relationship and such a change of position, however, is the essence of estoppel to deny agency

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ther Jackson nor his mother selected FMH as the place of treatment nor Dr. Power as Jackson's physician.

[7, 8] From the above, a jury could conclude that FMH held itself out as providing emergency care services to the public. A jury could also find that Jackson reasonably believed that Dr. Power was employed by the hospital to deliver emergency room service. It is also possible, however, that a jury could find to the contrary.[10]

Unless the evidence allows but one inference, the question of apparent authority is one of fact for the jury. *City of Delta Junction*, 670 P.2d at 1131; *Themins*, 637 P.2d at 159; *Adamski*, 579 P.2d at 978. In the case at bar, the record is not susceptible to a single inference. Thus, the trial court properly denied summary judgment on this issue.

VI

Jackson's final point is that the trial court erred in refusing to rule, as a matter of law, that FMH, as a general acute care hospital, has a non-delegable duty to provide non-negligent physician care in its emergency room. In essence, Jackson's position is that when a hospital undertakes to operate an emergency room as an integral part of its health care enterprise, public policy dictates that it not be allowed to insulate itself from liability by shunting that responsibility onto another.

FMH, on the other hand, argues that a hospital does not have a non-delegable duty to guarantee safe treatment in its emergency room. Physicians, not hospitals, FMH asserts, have a duty to practice medicine non-negligently. Thus, according to FMH, a hospital cannot be held to have delega away a duty it never had.

The trial court ruled that "[t]here can be a non-delegable duty if there is no c tractual relationship." Since it was uncle from the evidence whether or not th was any contractual relationship betwe ERI and FMH, the court denied Jackso motion for summary judgment. Initia we note the trial court's erroneous char terization of the issue. By holding t there can be no "non-delegable duty there is no contractual relationship," t court confused the question of the exi ence of a duty with the issue of whether duty is non-delegable. The flaw in t reasoning is self-evident. As FMH poir out, a party cannot be held to have deleg ed away a duty it never had. Thus, t threshold question is whether FMH had duty to provide emergency room ca Only if it did, is it necessary to determi what that duty entailed.

[9] FMH is licensed as a "general acu care hospital."[11] As such, it is required comply with state regulations designed promote "safe and adequate treatment individuals in hospitals in the interest public health, safety and welfare." AS 1 20.060. These regulations provided, at t time of Jackson's accident, that an acu care hospital *shall* "insure that a physici is available to respond to an emergency all times." Former 7 AAC 12.110(c)(2) Thus, at a minimum, the law imposed duty on FMH to provide emergency ca physicians on a 24-hour basis.

FMH, however, voluntarily assumed much broader duty. At the time of Jac son's accident, FMH was accredited by t

Power testified that "Jackson was talking" and "completely oriented."

10. In this regard, we agree with the weight of authority that application of apparent authority in the hospital/emergency room physician situation does not require an express representation to the patient that the treating physician is an employee of the hospital. Nor is direct testimony as to reliance required absent evidence that the patient knew or should have known that the treating physician was not a hospital employee when the treatment was rendered. *See* cases cited *supra* p. 1380.

11. A general acute care hospital is a "facil which provides hospitalization for inpatie medical care of acute illness or injury and c stetric care." 7 AAC 12.100.

12. In 1983, this regulation was amended to p vide that "[a] general acute care hospital *m* provide ... [among other services not relev here] emergency care services." 7 AAC 12.: (emphasis added).

Joint Committee on the Accreditation of Hospitals (JCAH).[13] In order to receive and maintain accreditation,[14] FMH had to comply with the JCAH's standards promulgated in the *Accreditations Manual For Hospitals, Emergency Services.* Standard I mandates that all accredited hospitals implement a well defined plan for emergency care based on community need and the capability of the hospital. The JCAH standards also mandate, among other things, that: (1) FMH's emergency room be directed by a physician member of the active medical staff (Standard II); (2) FMH's emergency room be integrated with other units and departments of the hospital (Standard III); (3) that emergency care be guided by written policies and procedures; and (4) that the quality of care be continually reviewed, evaluated and assured through establishment of quality control mechanisms (Standard V).

Additionally, FMH's own bylaws provided for the establishment and maintenance of an emergency room. Article X, section 1(d)(1)(b) of FMH's Medical Bylaws provides for an emergency room as one of the services of the hospital. Article XI, section 3(e) provides for the creation of an emergency room committee which is required among other things to:

(a) formulate rules and regulations for the continuous coverage of the emergency room; and

(b) supervise the clinical work in that department.

[10] Based upon the above, it cannot seriously be questioned that FMH had a duty to provide emergency room services and that part of that duty was to provide physician care in its emergency room. Having so determined, we must next ascertain whether FMH's duty to provide physician care in the emergency room is non-delegable. That is, we must determine whether, having assumed the duty to staff an emergency room, FMH should be allowed to avoid responsibility for the care rendered therein by claiming that the physicians it provides are not its employees. We conclude that it cannot.

[11] A non-delegable duty is an established exception to the rule that an employer is not liable for the negligence of an independent contractor. W. Keeton, D. Dobbs, R. Keeton, D. Owen, *Prosser and Keeton on The Law of Torts*, § 71 at 511-12 (5th ed. 1984). According to the late Professor Prosser, such a duty "may be imposed by statute, by contract, by franchise or by charter, or by the common law." *Id.* Among the duties considered non-delegable are the following:

> [T]he duty of a carrier to transport its passengers in safety, of a railroad to fence its tracks properly or to maintain safe crossings, and of a municipality to keep its streets in repair; the duty to afford lateral support to adjoining land, to refrain from obstructing or endangering the public highway, to keep premises reasonably safe for business visitors, to provide employees with a safe place to work; the duty of a landlord to maintain common passageways, to make repairs according to covenant, or to use proper

13. The JCAH was formed in the early 1950's by the American College of Surgeons, the American College of Physicians, the American Hospital Association, and the American Medical Association. Its purpose was to establish minimum hospital standards for patient care. For details of the program, see Dornette, *The Legal Impact on Voluntary Standards in Civil Actions Against the Health Care Provider*, N.Y.L.Sch.L.Rev. 925, 925-28 (1977); Holbrook & Dunn, *Medical Malpractice Litigation: The Discoverability and Use of Hospitals' Quality Assurance Committee Records*, 16 Washburn L.J. 54, 57 (1976).

14. Hospitals voluntarily seek accreditation for financial and professional prestige reasons. First, accreditation by the JCAH means the hospital qualifies to participate in the federal Medicare and Medicaid programs. Accreditation by JCAH is deemed substantial compliance with the Medicare conditions of participation. 42 U.S.C. § 1395bb (1982); 42 C.F.R. § 405.1901(d) (1986). *See generally,* Dornette, *supra* n. 13 at 927, Holbrook & Dunn, *supra* n. 13, at 58. Second, JCAH accreditation is often a prerequisite to obtaining approval of internship and residency programs. *See generally, American Medical Association Directory of Accredited Residencies* J (1975-76), *quoted in* Dornette, *supra* n. 13, at 928. Finally, the institution's reputation and standing in the community is affected by whether it receives JCAH accreditation. *See* Holbrook & Dunn, *supra* n. 13.

care in making them, and no doubt others.

Id. (footnotes omitted). However:

> 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.*

Id. at 512 (emphasis added). *Accord, Alaska Airlines v. Sweat*, 568 P.2d 916, 925–26 (Alaska 1977).

Our principal decision on non-delegable duty is *Swe[illegible]*, 568 P.2d 916. In that case, Sweat sued Alaska Airlines for injuries sustained in an air crash while traveling aboard a Chitina Air Service plane. *Id.* at 922. Chitina had been engaged under a contract with Alaska Airlines to service a portion of Alaska Airlines' regularly scheduled routes. *Id.* at 921, 922. Alaska Airlines contended that Chitina was an independent contractor and therefore it was not liable for Chitina's negligence. *Id.* at 923. The trial court found Alaska Airlines vicariously liable based on Restatement (Second) of Torts § 428. *Id.* On appeal, we affirmed the trial court's decision on the alternative ground that Alaska Airlines owed a common law nondelegable duty of safety to its passengers. *Id.* at 925. We reasoned:

> We believe that the responsibility of a common carrier for the safety of its passengers is so important that the carrier should not be permitted to transfer it to another. A scheduled common carrier such as Alaska is given a monopoly or semi-monopoly primarily for the purpose of furnishing safe and reliable scheduled air transportation. It should not be permitted to barter away its responsibility to the traveling public by means of contracts with other carriers. If this were permissible, an air carrier could avoid liability by engaging in independent contracts for furnishing food, maintenance of its planes and conceivably even for supplying crews. Regardless of whether such contracts may be permitted by regulatory authorities, the traveling public is entitled to look for protection to the certificated carrier responsible for the scheduled route.

Id. at 926.

We have little trouble concluding that patients, such as Jackson, receiving treatment at a hospital emergency room are as deserving of protection as the airline passengers in *Sweat*. Likewise, the importance to the community of a hospital's duty to provide emergency room physicians [illegible] vals the importance of the common-carriers' duty for the safety of its passengers. We also find a close parallel between the regulatory scheme of airlines and hospitals. Undoubtedly, the operation of a hospital is one of the most regulated activities in the state. Besides the license,[15] and certificate of need,[16] requirements mentioned above, a hospital must comply with state regulations promulgated to control its activities. AS 18.20.070, 7 AAC 12.610; adopt a state approved risk management program "to minimize the risk of injury to patients," AS 18.20.075; and undergo "annual inspections and investigations" of its facilities, AS 18.20.080. Failure to comply with these statutory requirements can lead to suspension or revocation of the hospital's license. AS 18.20.050.

The hospital regulatory scheme and the purpose underlying it (to "provide for the development, establishment, and enforcement of standards for the care and treatment of hospital patients that promote safe and adequate treatment" AS 18.20.010, along with the statutory definition of a hospital, (an institution devoted primarily to providing diagnosis, treatment or care for individuals, AS 18.20.130(3)), manifests the legislature's recognition that it is the hospital as an institution which bears ultimate responsibility for complying with the mandates of the law. It is the hospital that is required to ensure compliance with the regulations and thus, relevant to the instant case, it is the hospital that bears final

15. *See* AS 18.20.020.

16. *See* AS 18.07.031.

countability for the provision of physicians for emergency room care. We, therefore, hold that a general acute care hospital's duty to provide physicians for emergency room care is non-delegable. Thus, a hospital such as FMH may not shield itself from liability by claiming that it is not responsible for the results of negligently performed health care when the law imposes a duty on the hospital to provide that health care.

We are persuaded that the circumstances under which emergency room care is provided in a modern hospital mandates the rule we adopt today. Not only is this rule consonant with the public perception of the hospital as a multifaceted health care facility responsible for the quality of medical care and treatment rendered, it also treats tort liability in the medical arena in a manner that is consistent with the commercialization of American medicine. Finally, we simply cannot fathom why liability should depend upon the technical employment status of the emergency room physician who treats the patient. It is the hospital's duty to provide the physician, which it may do through any means at its disposal. The means employed, however, will not change the fact that the hospital will be responsible for the care rendered by physicians it has a duty to provide.

[12] This holding is necessarily limited. We do not change the standard of care with which a physician must comply, nor do we extend the duty which we find non-delegable beyond its natural scope. Our holding does not extend to situations where the patient is treated by his or her own doctor in an emergency room provided for the convenience of the doctor. Such situations are beyond the scope of the duty assumed by an acute care hospital. Rather our holding is limited to those situations where a patient comes to the hospital, as an institution, seeking emergency room services and is treated by a physician provided by the hospital. In such situations, the hospital shall be vicariously liable for damages proximately caused by a physician's negligence or malpractice.

[13] In the instant case, Jackson came to FMH as an institution seeking emergency room services. Dr. Power was a physician FMH had a non-delegable duty to provide. FMH is, therefore, vicariously liable as a matter of law for any negligence or malpractice that Dr. Power may have committed. Accordingly, the trial court's ruling on this issue must be reversed. Jackson is entitled to partial summary judgment on the issue of FMH's vicarious liability.

VII

For the reasons outlined above, the trial court's denial of summary judgment on Jackson's theories of enterprise liability and apparent authority are AFFIRMED. However because we hold that FMH has a non-delegable duty to provide non-negligent physician care in its emergency room, the trial court's denial of summary judgment on the theory of non-delegable duty, is REVERSED and REMANDED with instructions to enter partial summary judgment on the issue of FMH vicarious liability in favor of Jackson.

AFFIRMED in part; REVERSED in part; and REMANDED.

MOORE, J., not participating.

SB461

ROBERT ALBERTS, M.D., M.P.H., A.P.C.
3340 PROVIDENCE DRIVE, SUITE 461
ANCHORAGE, ALASKA 99508

(907) 561-6600

April 21, 1988

RECEIVED
APR 25 1987

The Honorable Dave Donley
Alaska House of Representatives
P.O. Box V
Juneau, Alaska 99811

Dear Representative Donley,

I would like to thank you for allowing me some time in your heavy schedule last week. It was enlightening to listen to your concerns about the effect of S.B. 461 if this bill were to be enacted. One problem professional people have is that they often become myopic in the way they look at the world and don't understand why other people don't see the world the same way. Physicians are no exception.

Unfortunately a certain segment of medicine is becoming commercialized, with the purpose of providing a financial return for stock holders. I understand your concern about that industry not being willing to accept liability. We cannot have it both ways. My concern however is what the effect of not passing S.B. 461 (if needed in an amended form) would have on the nonprofit and small community hospitals. Making these hospitals liable when no malpractice can be traced to the institution or the employees would be like suing the court when a trial lawyer were to make a serious mistake while pleading his case in the court room.

Although the relationship between the private physician and the traditional community hospital such as Providence Hospital is unique the comparison with the relationship between the trail lawyer and the court may help to clarify my concern.

If S.B. 461 were not passed into law I am afraid that the health care of our patients would suffer by creating an adversary climate between the physicians and the hospitals on which we depend for inpatient care. Already I have observed the disastrous impact on the trust relationship between the two parties when Providence Hospital, being vicariously sued, in turn was advised to cross-claim one of its physicians. The quality of health care depends to a great extent on a close working relationship among all the health care providers. For the sake of our patients, we cannot afford to have this relationship further disturbed.

I foresee still another problem. The increased exposure as the deep pocket could effectively put the nonprofit and community hospitals out of business due to further significant increases in the already skyrocketing insurance rates.

For these reasons I strongly urge you to bring S.B. 461 out of committee for consideration by the full House.

Sincerely,

Robert Alberts, M.D., M.P.H.

RA/dp

ALASKA STATE LEGISLATURE

Home Address
3813 Denali Street
Ketchikan, AK 99901
907-225-9082

While in Juneau
P.O. Box V
Juneau, AK 99811
907-465-3743

Senator Lloyd Jones

MEMORANDUM

TO: Representative Dave Donley, Chair
House Labor & Commerce Committee

FROM: Senator Lloyd Jones

RE: Senate Bill 461

I respectfully request that Senate Bill 461 be scheduled for a hearing.

So I may contact the people who would like to testify on this important piece of legislation, could you have staff contact Jim Lottsfeldt (465-3743) of my office if you plan on hearing this bill.

Lastly, Jerry Reinwand and David Crosby are representing one of the groups (Alaska Health Association) who are supporting this bill. Staff may wish to contact them for back-up or questions.

Thank you.

L&C / HES / JUD

SB 461 AND THE ALASKA SUPREME COURT OPINION IN JACKSON V. POWER

INTRODUCTION

In 1981, 16 year old Brett Jackson fell 40 feet from a cliff and suffered severe injuries. He was rushed to Fairbanks Memorial Hospital. When he finally regained consciousness he learned he had lost both kidneys during his stay in the hospital. He also learned that the loss of his kidneys was probably the result of failure of the emergency room physician to order certain kidney function tests.

Brett Jackson was in for another surprise when he decided to file suit against the hospital for that emergency room negligence. He learned that the hospital denied any responsibility for the activities of the emergency room. He was referred to a corporation he had never heard of called Emergency Room, Inc., and was told that if he was to have any recovery it must be against that unknown corporation.

In a unanimous decision, the Alaska Supreme Court, in Jackson, et al., v. Power, et al., 743 P.2d 1376 (Alaska 1987) rectified this gross inequity. The court held that a hospital--required by law to have an emergency room--could not hide behind a corporation like Emergency Room, Inc. when a hospital patient is injured in the emergency department.

SB 461 would reverse that Supreme Court ruling. It would allow hospitals again to attempt to "franchise" their

operations and hide behind those franchises when negligence occurs at the hospital. SB 461 would, in fact, encourage hospitals to create new "franchises" to further insulate the hospital from liability for negligent acts occurring under the hospital's very roof.

THE PUBLIC POLICY OF THE STATE OF ALASKA MUST BE TO PROTECT THE SAFETY OF HOSPITAL PATIENTS

The policy issue presented by SB 461 is whether the Alaska legislature will continue, as it has in previous legislation regarding hospitals, to consider the safety of hospital patients to be of highest priority.

Alaska's earliest hospital licensing laws reflect the legislative policy of "promoting safe and adequate treatment of individuals in hospitals in the interest of public health, safety and welfare." (See AS 18.20.060, enacted in 1949). The legislature has continually reaffirmed that policy. In 1976, the requirement for an internal risk management program was instituted. (AS 18.20.075). Important amendments to the certificate of need program were adopted in 1983. The rule in Jackson v. Power merely reiterates that important commitment to the public health and safety. The rule recognizes that when hospitals are finally held accountable for activities occurring under the hospital's own roof, a hospital will have full incentive to take whatever measures are necessary to ensure that patients are not injured during their hospital stay.

The Alaska legislature, by its certificate of need

program (AS 18.07.031), has given hospitals special protection from competition in order to allow hospitals to devote energy to providing safe medical treatment to patients, rather than engaging in "bidding wars" and other competitive activities. In fact, this statute has been used in legal proceedings to prevent the establishment of an additional hospital in Anchorage.

However, in exchange for this protection from competition, Alaska law has required semi-monopoly hospitals to provide certain basic services to the public, including emergency room treatment, radiology, pathology, anesthesiology and the like. In Jackson v. Power, the Alaska Supreme Court merely reasoned that if a hospital is granted special legislative treatment it must bear full responsibility for the operations carried out under that special protective legislation.

The civil liability rule adopted by the Alaska Supreme Court in its unanimous decision is not revolutionary. The same rule has been applied for decades to numerous types of quasi-public businesses which have received special protections from the government in order to further the public good. In Alaska, airlines which are granted scheduled routes may not insulate themselves from liability for operation of those routes by franchising those operations to other airlines. Common carriers such as trucking lines, bus lines and railroad carriers who are given special route priorities by the government may not delegate their operations to "independent contractors" and hide from liability when those contractors are negligent.

If SB 461 becomes law, the Alaska legislature's commitment to quality hospital care will be reversed. Hospitals will be encouraged to "franchise" even more of their vital public services in an attempt to avoid liability for injuries to hospital patients. The passage of SB 461 and the overruling of Jackson v. Power would send a message to the public, and to hospital administrators, that the safety of hospital patients is no longer a high priority in the State of Alaska.

THERE IS NO EVIDENCE THAT INSURANCE RATES WILL INCREASE AS A RESULT OF THE RULE IN JACKSON V. POWER

Although claims have been made that the Supreme Court ruling will drastically increase hospital insurance premiums, no evidence has been presented to support those claims. The same contention was made before the Alaska Supreme Court, again with no evidence to support that argument. In fact, one commentator who has addressed the issue has suggested that "if the hospital, all its employees, and all physicians admitted to membership on the medical staff" are "insured by the same insurance carrier, . . . the costs and the excessive length of the litigation process" would be greatly reduced. Southwick 4, Journal of Legal Medicine, 1 (1983).

The costs to the consumer of medical treatment should not increase under the Jackson v. Power rule. If, for example, a "franchised" emergency room is presently carrying adequate insurance, then the burden of paying the costs of that insurance will merely shift from the "franchise" to the hospital. However,

the total overall insurance costs for the emergency room operation, and thus the costs to the public, should remain the same. These costs may even be reduced if, in carrying out its obligation under Jackson v. Power, a hospital undertakes a greater role in requiring quality medical treatment in the emergency room, and therefor reduces the risk factor for those operations. The Jackson v. Power rule merely places the primary responsibility for providing that insurance coverage upon the hospital, rather than leaving that important decision to a less regulated franchise.

THE JACKSON V. POWER RULE AND RURAL HOSPITALS

The Jackson v. Power rule applies to those services which a hospital is required to provide to the public by law, by its own national accreditation process and by its own bylaws. If a rural hospital is not required by law, accreditation, or its own bylaws to provide such services, then the reasoning in Jackson v. Power may not apply to that rural hospital. If, on the other hand, a rural hospital is required to provide such services, the sound public policy reasoning behind the rule should apply to that hospital. Safe, quality health care is just as important for the rural residents of this state as it is for urban residents.

CONCLUSION

In mind's dim memory are the days when hospitals served merely as sanitary waysides where individual physicians practiced their professions. The modern day hospital is a fully-integrated

commercial enterprise which provides essential services to the public. In Jackson v. Power the Alaska Supreme Court recognized this modern day fact. The passage of SB 461 would result in a step backward in time, to the detriment of the citizens of our state.