

HOSPITAL VICARIOUS LIABILITY FOR NEGLIGENCE BY INDEPENDENT CONTRACTOR PHYSICIANS: A NEW RULE FOR NEW TIMES

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The contractual relationship between a treating physician and the hospital where treatment takes place is a factor in determining whether a patient can hold the hospital liable for medical malpractice occurring on the hospital's premises. Under the doctrine of respondeat superior, a hospital is vicariously liable only if an agent or employee of the hospital commits malpractice. Historically, physicians were agents or employees of the hospitals where they provided treatment. Therefore, patients could hold hospitals responsible for malpractice committed on the hospitals' premises. However, under common law, hospitals were immune from liability caused by the negligence of independent contractors.

Due to dramatic changes in the health care industry, hospitals started providing a wide array of medical services through independent contractor physicians. Relying on their common-law immunity, hospitals were able to benefit from relationships with independent contractor physicians while avoiding any risk of liability for medical malpractice committed by those same physicians on hospital premises. Recognizing the ability of hospitals to exploit their common-law immunity, courts across the nation began holding hospitals responsible for the negligence of independent contractor physicians.

In Gilbert v. Sycamore Municipal Hospital, the Illinois Supreme Court abrogated hospital immunity to vicarious liability of independent contractor physicians. The Gilbert court held that hospitals could be held liable for the actions of independent contractor physicians under the doctrine of apparent authority. However, the court's decision failed to adequately set forth the requirements for apparent authority liability. In particular, the court failed to sufficiently define the required element of reliance and did not address the situational differences between emergency room and non-emergency room treatment.

After Gilbert, courts in Illinois imposed divergent reliance standards, including detrimental and assumed reliance. Furthermore, courts applied different and contradictory interpretations of those 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.

The author proposes a comprehensive, hospital-specific vicarious liability rule for independent contractor physician negligence. The rule accounts for both emergency room and non-emergency room situations, as well as situations where a patient relies on a third-party for treatment decisions. The rule is based on traditional agency by estoppel principles and diverges from those principles only where required by the public policy concerns giving rise to the abrogation of hospital common-law immunity to independent contractor vicarious liability. In short, the author proposes that non-emergency room patients have a heavy burden to establish the reliance requirement for liability, while emergency room patients are relieved of the burden to show reliance.

I. INTRODUCTION

When a typical patient seeks treatment for an injury at a hospital emergency room, the last thing on the patient's mind is the business relationship between the hospital and the treating physicians. The physician-hospital relationship is an important factor, however, in a patient's ability to hold a hospital liable if treatment goes awry and the patient is harmed by medical malpractice.¹

Traditionally, emergency room physicians providing hospital treatment were employees of the hospital.² Under the longstanding common-law doctrine of respondeat superior, a hospital could be held vicariously liable only if a negligent physician was an employee or agent of the hospital.³ Hospitals were immune from medical malpractice claims when a negligent physician was an independent contractor.⁴ Due to changes in the health care industry, however, modern hospitals typically provide emergency room, surgery, and out-patient treatment through independ-

1. See *Gilbert v. Sycamore Mun. Hosp.*, 622 N.E.2d 788, 792-96 (Ill. 1993) (discussing vicarious liability when the physician is an employee of the hospital and apparent authority liability when the physician is an independent contractor).

2. Randell C. Ogg, *Epidural Abscess: The Missed Diagnosis, A Correct Initial Diagnosis and Immediate Treatment Are Essential to Prevent This Spinal Infection From Causing Paralysis*, TRIAL, Sept. 1999, at 75, 77 (1999) ("Traditionally, radiologists and ER physicians were hospital employees, and traditional principles of respondeat superior applied if the hospital was named as a defendant. If discovery revealed negligence by these doctors, the negligence would be imputed to the hospital . . .").

3. Colleen Moran, Note, *Clark v. Southview Hospital: Ohio Follows the Nationwide Trend of Using Agency by Estoppel to Impose Strict Liability on Hospitals*, 9 J.L. & HEALTH 319, 321 (1994); see also W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 69, at 499-500 (5th ed. 1984). See generally Dane Getz, Comment, *The Doctrine of Apparent Authority in Illinois Medical Malpractice Cases: An Argument for its Application*, 18 S. ILL. U. L.J. 195, 195-96 (1993); Bradford C. Kendall, Note, *The Ostensible Agency Doctrine: In Search of The Deep Pocket?*, 57 UMKC L. REV. 917, 917-20; Martin C. McWilliams, Jr. & Hamilton E. Russell, III, *Hospital Liability for Torts of Independent Contractor Physicians*, 47 S.C. L. REV. 431, 434-38 (1996).

4. KEETON ET AL., *supra* note 3, § 71; Getz, *supra* note 3, at 198-200; Kendall, *supra* note 3, at 917-20; McWilliams, *supra* note 3, at 434-38; Moran, *supra* note 3, at 321.

ent contractor physicians.⁵ Concerned that hospitals were benefiting from their association with independent contractor physicians but sharing no responsibility when these physicians were negligent, courts across the nation began stripping hospitals of their common-law immunity from the negligent acts of non-employee physicians.⁶

By the mid-1980s, Illinois courts were split on the matter. Some courts held that hospitals could be found liable for independent contractor negligence under the theory of apparent authority.⁷ Other courts refused to extend independent contractor liability to hospitals.⁸ In *Gilbert v. Sycamore Municipal Hospital*,⁹ the Illinois Supreme Court abrogated hospitals' common-law immunity for independent contractor negligence and held that hospitals could be found liable under the doctrine of apparent authority.¹⁰

Although *Gilbert* ended one controversy regarding the applicability of apparent authority to hospitals, it created another in regards to the requirements to prove liability under the doctrine. As a result of its rationale, sources cited, and ambiguous statements, *Gilbert* supports contradictory interpretations of the element of reliance. Some post-*Gilbert* courts endorse a detrimental reliance requirement,¹¹ while others promote an assumed reliance requirement.¹² Furthermore, courts that appear to support the same type of reliance requirements adopt substantially different approaches.¹³ Confusion regarding reliance requirements has a number of adverse consequences: the inability of courts to discern and apply the law in a predictable manner, the use of erroneous language and reason-

5. See Ogg, *supra* note 2, at 77 ("Today, more and more hospitals are employing outside services as independent contractors to staff the emergency, radiology, and other departments. The hospital may not be vicariously liable for the independent contractors' negligence."); see also Steven R. Owens, Note, Pamperin v. Trinity Memorial Hospital and the Evolution of Hospital Liability: Wisconsin Adopts Apparent Agency, 1990 WIS. L. REV. 1129, 1130 n.4 (1990) ("A 1983 survey found that 61% of formally organized emergency departments in hospitals were staffed by physicians on contract, while 28% relied upon rotation of doctors appointed to the medical staff. About 11% of the departments reported other arrangements. . . ." (citations and internal quotations omitted)).

6. *Brown v. Coastal Emergency Serv., Inc.*, 354 S.E.2d 632, 637 (Ga. Ct. App. 1987); *Hardy v. Brantley*, 471 So. 2d 358, 371 (Miss. 1985); *Arthur v. St. Peters Hosp.*, 405 A.2d 443, 447 (N.J. Sup. Ct. 1979); *Pamperin v. Trinity Mem'l Hosp.*, 423 N.W.2d 848, 855 (Wis. 1988).

7. See Getz, *supra* note 3, at 205-08 (discussing the progression of the split among Illinois appellate courts regarding the application of apparent authority liability to hospitals); see also *N. Trust Co. v. St. Francis Hosp.*, 522 N.E.2d 699, 704 (Ill. App. Ct. 1988); *Sztorc v. Nw. Hosp.*, 496 N.E.2d 1200, 1201-02 (Ill. App. Ct. 1986).

8. Getz, *supra* note 3, at 205-08; see also *Johnson v. Sumner*, 513 N.E.2d 149, 151 (Ill. App. Ct. 1987); *Greene v. Rogers*, 498 N.E.2d 867, 871-72 (Ill. App. Ct. 1986).

9. 622 N.E.2d 788 (Ill. 1993).

10. *Id.* at 795.

11. See, e.g., *James v. Ingalls Mem'l Hosp.*, 701 N.E.2d 207, 211 (Ill. App. Ct. 1998) (promoting a traditional detrimental reliance standard based on a hospital-physician relationship).

12. See, e.g., *Scardina v. Alexian Bros. Med. Ctr.*, 719 N.E.2d 1150, 1152 (Ill. App. Ct. 1999).

13. See, e.g., *Chi. Title & Trust Co. v. Sisters of St. Mary*, 637 N.E.2d 543, 546 (Ill. App. Ct. 1994) (promoting a detrimental reliance standard based on hospital reputation, rather than a hospital-physician relationship).

ing to support ambiguous and confusing precedent, and the hindering of effective advocacy due to the unsettled state of the law.¹⁴

In an effort to promote clear and principled reliance requirements, this note proposes a new, hospital-specific variation of apparent authority liability that directly addresses the public policy concerns giving rise to the abrogation of common-law hospital immunity to independent contractor negligence. The proposed rule is comprehensive, encompassing requirements for both non-emergency room and emergency room situations. Additionally, the new rule addresses situations where a patient harmed by malpractice relies on a third party for treatment decisions.¹⁵

Before developing the proposed rule, Part II examines the common-law legal foundations for vicarious independent contractor liability under traditional tort and agency theories. Part III analyzes *Gilbert* in an attempt to decipher its precedential significance for the reliance element. Part IV examines the various reliance requirements developed by the Illinois courts and legislature after *Gilbert*. Part V exposes the inadequacy of existing doctrines to address the public policy concerns identified in *Gilbert*, and discusses the need for a new hospital-specific doctrine. Part VI examines the procedural and substantive policy issues relating to the creation of a new hospital-specific rule. Finally, the new rule is proposed in Part VII. Although this note focuses on Illinois law, confusion regarding vicarious hospital liability is a nationwide problem. Therefore, the legal issues discussed and the solution proposed are applicable to states across the nation.¹⁶

II. BACKGROUND AND LEGAL FOUNDATIONS FOR HOSPITAL VICARIOUS LIABILITY FOR INDEPENDENT CONTRACTOR PHYSICIAN NEGLIGENCE

Until the mid-nineteenth century, hospitals were generally charitable institutions, providing medical services to the lowest classes of society, without regard to a patient's ability to pay.¹⁷ Those who could afford medical treatment were usually treated at home by their doctors.¹⁸ However, the days of house calls and philanthropic health care are over. The modern health care industry continues to distance itself from its charitable past and has experienced a significant conversion from not-for-profit

14. Getz, *supra* note 3, at 212.

15. The issue of third-party reliance typically arises when a patient is unable to make choices governing her treatment due to serious injury, and therefore relies on a third party to make treatment decisions.

16. See, e.g., Kendall, *supra* note 3 (discussing ostensible agency in Missouri); McWilliams, *supra* note 3 (discussing hospital liability in South Carolina); Moran, *supra* note 3 (discussing agency by estoppel in Ohio); Owens, *supra* note 5 (discussing apparent agency in Wisconsin).

17. Owens, *supra* note 5, at 1131; Introduction: A Guide for Communities Considering Hospital Conversion in the Carolinas, <http://www.hpolicy.duke.edu/cyberexchange/conversion/gchap1.html> (last visited Jan. 18, 2005).

18. Owens, *supra* note 5, at 1131.

health care to for-profit hospital businesses.¹⁹ Significant changes in health law have accompanied the business-related changes in the hospital industry.²⁰ One important legal change is an increase in hospital liability for physician medical malpractice.²¹ The gradual erosion of the immunity traditionally afforded nonprofit hospitals, and the emergence of new types of negligence claims, which apply to both nonprofit and for-profit hospitals, have contributed to the increase in hospital liability.²² One relatively new type of hospital liability is vicarious liability for medical malpractice of independent contractor physicians, or VIC liability.²³

Many states now allow claims for VIC liability under theories of apparent agency, ostensible authority, agency by estoppel, and apparent authority.²⁴ These doctrines of liability have significant substantive differences.²⁵ Commentators criticize state courts for using these names interchangeably and confusing the underlying legal theories which are based on either agency or tort law.²⁶ Such confusion has a pernicious effect on the law.

The purpose of this section is to develop a framework for analyzing VIC liability, to define clear and accurate terms, and to establish the traditional elements of VIC liability. Technically speaking, VIC liability can be based on two distinct, but similar, legal theories with different requirements: tort doctrine and agency doctrine.²⁷ For purposes of this note, the tort doctrine will be referred to as “apparent agency” and the agency doctrine will be referred to as “agency by estoppel.”²⁸

19. Guide for Communities, *supra* note 17 (discussing the conversion of 147 not-for-profit hospitals between 1980 to 1993, and rapid acceleration of conversion demonstrated by 206 hospitals converting to for-profit status between 1994 and 1997).

20. For a complete history of hospital liability, see Getz, *supra* note 3, at 198–209; Moran, *supra* note 3, at 320–21; Owens, *supra* note 5, at 1131–39; Jacklyn M. Penna, Case Note, *Hospital Liability for Physicians’ Negligence: Gilbert v. Frank (Sycamore Municipal Hospital)*, 2 J. PHARMACY & LAW 407, 407–10 (1993).

21. Owens, *supra* note 5, at 1131–39; Penna, *supra* note 20, at 407–10.

22. See Moran, *supra* note 3, at 320–21 (discussing the shift from charitable immunity to vicarious liability, and then to apparent agency); see also Getz, *supra* note 3, at 198–204 (discussing the traditional liability of noncharitable and charitable hospitals).

23. See *supra* notes 20–22 and accompanying text. VIC is an acronym introduced in this note to represent vicarious independent contractor. The reason for introducing this new terminology is that many states have mislabeled and confused the various forms of vicarious liability that are applied to hospitals and a generic term is needed.

24. See Moran, *supra* note 3, at 321–22 (discussing the many flavors of vicarious hospital liability applied throughout the country).

25. See Getz, *supra* note 3, at 210–12; Moran, *supra* note 3, at 336.

26. See Getz, *supra* note 3, at 196 (stating “the doctrine of apparent authority is greatly misunderstood”); Moran, *supra* note 3, at 336 (“Courts across the nation have failed to recognize the distinction between [a]gency [and] [t]orts.”).

27. RESTATEMENT (SECOND) OF AGENCY § 267 (1958); RESTATEMENT (SECOND) OF TORTS § 429 (1965).

28. See WARREN A. SEAVEY, HANDBOOK OF THE LAW OF AGENCY § 8(D)–(E), at 13–15 (1964) (differentiating between apparent agency and estoppel); Getz, *supra* note 3, at 210–11 (describing the agency theory as agency by estoppel and the tort theory as ostensible agency or apparent agency); Moran, *supra* note 3, at 321–23 (describing the two theories of “agency by estoppel”: the agency theory requiring estoppel and the tort theory requiring apparent agency). Note that neither section 267

A. Tort Doctrine: Apparent Agency

The apparent agency doctrine of VIC liability is based on section 429 of the *Restatement (Second) of Torts*, which is entitled, “Negligence in Doing Work Which is Accepted in Reliance on the Employers’ Doing the Work Himself.”²⁹ Section 429 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, is 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.³⁰

Comment (a) of section 429 provides:

[It] is not necessary that the person who is injured ha[s] himself accepted the services in the belief that they are being rendered by the employer of the contractor. *It is equally applicable where the services are rendered to the injured person because a third person believes that they are being rendered by the employer* of the contractor as when the injured person shares in services which a third person accepts in such belief, or when they are furnished him under an arrangement which a third person makes under such belief.³¹

In terms of medical malpractice, the tort based doctrine of apparent agency requires: (1) a hospital’s “holding out” (i.e., representing a physician as an agent of the hospital); and (2) a plaintiff’s reasonable belief that the physician is an agent or employee of the hospital at the time of treatment.³²

B. Agency Doctrine: Agency by Estoppel

The agency by estoppel doctrine of VIC liability is based on section 267 of the *Restatement (Second) of Agency*, which is entitled, “Reliance Upon Care or Skill of Apparent Servant or Other Agent.”³³ Section 267 provides:

of the *Restatement of Agency* nor section 429 of the *Restatement of Torts* use any of the terminology used by commentators or courts: apparent authority, apparent agency, ostensible agency, or agency by estoppel.

29. RESTATEMENT (SECOND) OF TORTS § 429 (1965).

30. *Id.* (emphasis added).

31. *Id.* § 429 cmt. a (emphasis added). This *Restatement* comment is the basis for third-party reliance (e.g., if the plaintiff suing a hospital for VIC liability was unconscious and relied on someone else to take the plaintiff to the hospital).

32. See Getz, *supra* note 3, at 211 (“Two factors are relevant to a finding of ostensible [apparent agency]: (1) whether the patient looks to the institution, rather than the individual physician, for care; and (2) whether the hospital ‘holds out’ the physician as its employee.”); Moran, *supra* note 3, at 322 (“[Section] 429 . . . requires a showing that the plaintiff accepted the independent contractor’s services under the reasonable belief that the care was being provided by the employer (hospital) or by servants (physicians) of the employer.”).

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

One who represents that another is his servant or other agent and thereby *causes a third person justifiably to rely* upon the care or skill of such apparent agent is subject to the 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.³⁴

Comment (a) of section 267 provides:

The mere fact that acts are done by one whom the injured party believes to be the defendant's servant is not sufficient to cause the apparent master to be liable. *There must be such reliance upon the manifestation as exposes the plaintiff to the negligent conduct.*³⁵

The emphasized portions of the preceding passages represent an essential requirement of agency by estoppel: a change in the plaintiff's position as a result of justifiable reliance on the representation of agency.³⁶ This change in position is often referred to as "detrimental reliance."³⁷ One definition of detrimental reliance is a change of position for the worse caused by a reliance on representations of another.³⁸ Another way of explaining the requirement of detrimental reliance for agency by estoppel is that "the plaintiff [must] prove that, *had it not been for the hospital's representations*, he or she would have chosen another procedure, physician or hospital."³⁹

In terms of medical malpractice, a claim for agency by estoppel requires a plaintiff to establish: (1) a holding out by the hospital which makes the allegedly negligent independent contractor physician appear like an agent of the hospital; and (2) the plaintiff must *justifiably rely* upon the skill or care of the apparent agent *to his detriment*.⁴⁰

34. *Id.* (emphasis added).

35. *Id.* § 267 cmt. a (emphasis added).

36. See SEAVEY, *supra* note 28, at 14 ("Conduct which causes a third person to believe that the agent is authorized and hence creates apparent authority to those who act upon it, usually operates to cause the principal to be liable to those who have changed their position in reliance."); Getz, *supra* note 3, at 211 ("[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." (citations omitted)); Moran, *supra* note 3, at 323 (stating that Agency section 267 requires establishment of estoppel).

37. See Getz, *supra* note 3, at 211 ("Both apparent agency and agency by estoppel require [justifiable reliance] . . . Only agency by estoppel, however, requires . . . [the] element of detrimental reliance."); Moran, *supra* note 3, at 323 ("Where Agency section 267 is applied, a plaintiff will bear the onus of demonstrating . . . she relied on this belief to her detriment.").

38. Getz, *supra* note 3, at 210 ("Detrimental reliance is defined as a plaintiff's reliance on any hospital actions or representations which suggest an agency relationship exists between the institution and the negligent physician and which subsequently *induce* that plaintiff to change his or her position for the worse based on those representations." (emphasis added)). Black's Law Dictionary defines detrimental reliance as "[r]eliance by one party on the acts or representations of another, causing a worsening of the first party's position. Detrimental reliance may serve as a substitute for consideration and thus make a promise enforceable as contract." BLACK'S LAW DICTIONARY 1293 (7th ed. 1999).

39. Getz, *supra* note 3, at 211-12 (citing Diane M. Janulis & Alan D. Hornstien, *Damned If You Do, Damned if You Don't: Hospital Liability for Physicians' Medical Malpractice*, 64 NEB. L. REV. 689, 696-97 (1985) and RESTATEMENT (SECOND) OF AGENCY § 8 (1958)) (emphasis added).

40. See Getz, *supra* note 3, at 211; Moran, *supra* note 3, at 322.

In essence, the requirements for agency by estoppel are a superset of those for apparent agency.⁴¹ Agency by estoppel and apparent agency have three overlapping requirements for medical malpractice: (1) holding out by the hospital; (2) a plaintiff's justifiable reliance on the holding out; and (3) negligent conduct by an independent contractor physician.⁴² Only agency by estoppel has the additional element of detrimental reliance.⁴³

C. Justifiable and Detrimental Reliance Are Not Mutually Exclusive

Some post-*Gilbert* cases adopt the position that the reliance requirement for VIC liability is either detrimental or justifiable reliance.⁴⁴ In other words, contrary to the previous discussion promoting a detrimental reliance standard which encompasses justifiable reliance, some cases endorse the mutual exclusivity of justifiable and detrimental reliance. Such a position, however, is contrary to the plain meaning of the *Restatements* of Torts and Agency and Illinois law.

In *Zeitz v. Village of Glenview*,⁴⁵ the court set out the elements of the estoppel doctrine against a municipality which include, "a landowner 'must establish . . . that it *substantially changed its position* as a result of its *justifiable reliance*'" on the affirmative act of a municipality.⁴⁶ The court held that the plaintiff failed "to establish detrimental justifiable reliance."⁴⁷ The court set forth both a justifiable reliance and detrimental reliance requirement in order to establish liability under the doctrine of estoppel. *Zeitz* demonstrates that Illinois courts have recognized and applied terminology that is consistent with the *Restatement*-based doctrines of agency by estoppel and apparent agency. Therefore, the terminology and analytical foundations developed in this section are consistent with Illinois law, and are appropriate to apply to the subsequent analysis of Illinois VIC liability cases.

41. See *Getz*, *supra* note 3, at 211–12 (showing that agency by estoppel has four elements, three of which are the elements required to prove apparent agency.); see also *SEAVEY*, *supra* note 28, § 8, at 14 ("[E]stoppel is frequently present when there is apparent authority . . ."). Note that Seavey seems to equate "apparent authority" with "apparent agency." *Id.* at 13–14; see also *Moran*, *supra* note 3, at 323 ("[T]he critical distinction between these two *Restatement* sections is that Agency § 267 requires establishment of an estoppel, while Torts § 429 does not and, instead, only requires a showing of an apparent agency."). Estoppel is defined as "[a]n affirmative defense alleging good-faith reliance on a misleading representation and an injury or detrimental change in position resulting from that reliance." *BLACK'S LAW DICTIONARY* 570 (7th ed. 1999).

42. *Getz*, *supra* note 3, at 212.

43. *Id.*; see also *supra* notes 37–39 and accompanying text.

44. See, e.g., *Chi. Title & Trust Co. v. Sisters of St. Mary*, 637 N.E.2d 543, 546 (Ill. App. Ct. 1994) ("*Gilbert* clearly established that the rule in Illinois regarding the reliance element necessary to support action under the apparent agency theory should be predicated on justifiable, not detrimental reliance.").

45. 304 Ill. App. 3d 586 (1999).

46. *Id.* at 594 (emphasis added) (citations omitted).

47. *Id.*

III. ANALYSIS OF THE *GILBERT* OPINION: THE END OF ONE CONTROVERSY, THE BEGINNING OF ANOTHER

In an effort to determine *Gilbert*'s legal requirements for the reliance element, this Part examines the relevant portions of that opinion. Additionally, this section extracts the prevailing common-law principles and public policies that form the basis of the proposed hospital-specific VIC liability rule. The Part is divided into a number of subsections that discuss and analyze the following: (A) an overview of the *Gilbert* opinion; (B) *Gilbert*'s rationale for abrogating the common law hospital immunity to VIC liability; (C) the elements of apparent authority and *Gilbert*'s explicit treatment of the reliance element; (D) reliance requirements of secondary sources and cases relied upon by *Gilbert*; (E) pre-*Gilbert* precedent and legal basis for hospital VIC liability in Illinois; and (F) plausible interpretations of *Gilbert*'s reliance requirement.

A. Overview of *Gilbert*

In *Gilbert*, the plaintiff's husband arrived by ambulance at an emergency room, complaining of chest pains.⁴⁸ The patient signed a form that authorized emergency room treatment by "physicians and employees of the hospital."⁴⁹ The doctor provided by the hospital administered a number of tests that did not reveal any sign of heart disease or heart problems.⁵⁰ The doctor then prescribed pain medication and discharged the plaintiff from the hospital.⁵¹ Later that evening, the plaintiff died from heart disease.⁵² The plaintiff's estate brought an action against both the emergency room doctor and the hospital.⁵³ The circuit court hearing the case granted summary judgment on behalf of the hospital because the doctor was neither an agent nor an employee of the hospital.⁵⁴ The judgment was affirmed on appeal.⁵⁵

At the time of *Gilbert*, Illinois appellate courts disagreed on whether or not hospital VIC liability was applicable to medical malpractice.⁵⁶ The appellate court in *Gilbert* acknowledged *Northern Trust Co. v. Saint Francis Hospital*⁵⁷ and *Sztorc v. Northwest Hospital*,⁵⁸ as well as other states' opinions that recognized hospital VIC liability under the

48. *Gilbert v. Sycamore Mun. Hosp.*, 622 N.E.2d 788, 791 (Ill. 1993).

49. *Id.* Note that the form was ambiguous as to whether the physicians were employees of the hospital.

50. *Id.* at 792.

51. *Id.*

52. *Id.*

53. *Id.*

54. *Id.*

55. *Id.*

56. *Id.* at 792-93; see also *supra* notes 7-8 and accompanying text.

57. 522 N.E.2d 699 (Ill. App. Ct. 1988).

58. 496 N.E.2d 1200 (Ill. App. Ct. 1986).

doctrine of apparent agency.⁵⁹ However, the appellate court relied on *Johnson v. Sumner*⁶⁰ and *Greene v. Rogers*⁶¹ in rejecting VIC liability for hospitals.⁶²

The *Gilbert* appellate court's rationale for rejecting the doctrine of apparent agency was that such a doctrine fails to account for the unique nature of hospital-physician and physician-patient relationships, especially in emergency situations.⁶³ The court noted that physicians control and direct patient treatment in emergency rooms, and such control by hospital staff or hospital administrators is unrealistic when split-second decisions are required.⁶⁴ Based on this lack of hospital control and the "fundamental precept of tort law that the tortfeasor be liable to the injured party for damages resulting only from his or her conduct," the appellate court concluded that a hospital can only be held vicariously liable if the physician is an actual agent or employee of the hospital.⁶⁵

Upon hearing the case, the Supreme Court of Illinois established the claim of "apparent authority," under which a hospital could be held liable for the negligent acts of an independent contractor.⁶⁶ The court reversed summary judgment and remanded the case to the circuit court for further factual hearings on the elements of apparent authority.⁶⁷

B. *Gilbert's Rationale for Creating Hospital VIC Liability in Illinois*

The Illinois Supreme Court criticized the *Johnson* and *Greene* decisions, as well as the appellate court's reasoning, for overlooking three realities of modern hospital care.⁶⁸ First, the court discussed the general business practices of modern hospitals. Relying on the Wisconsin Supreme Court's observation about hospital business practices in *Kashishian v. Port*,⁶⁹ *Gilbert* recognized that the typical modern hospital utilizes expensive advertising campaigns to induce patients to select it for treatment by creating the image that it provides complete and quality care.⁷⁰

59. *Gilbert*, 622 N.E.2d at 793 (discussing *Gilbert v. Frank*, 599 N.E.2d 143, 146-48 (Ill. App. Ct. 1992)).

60. 513 N.E.2d 149 (Ill. App. Ct. 1987).

61. 498 N.E.2d 867 (Ill. App. Ct. 1986).

62. *Gilbert*, 622 N.E.2d at 793.

63. *Id.*

64. *Id.*

65. *Id.* (discussing the rationale of the appellate opinion that cited *Johnson* and *Greene*).

66. *Id.* at 792, 794.

67. *Id.* at 796, 798.

68. *Id.* at 793.

69. 481 N.W.2d 277 (Wis. 1992).

70. *Gilbert*, 622 N.E.2d at 793 (citing *Kashishian*, 481 N.W.2d at 277 ("[H]ospitals increasingly hold themselves out to the public in expensive advertising campaigns as offering and rendering quality health services. One need only pick up a daily newspaper to see full and half-page advertisements extolling the medical virtues of an individual hospital and the quality health care that the hospital is prepared to deliver in any number of medical areas. Modern hospitals have spent billions of dollars marketing themselves, nurturing the image with the consuming public that they are full-care modern

Second, *Gilbert* relied on the Mississippi Supreme Court's observation in *Hardy v. Brantley* regarding the importance of emergency rooms to hospital profits.⁷¹ The *Hardy* court stated that hospital profits are dependent on the performance of the emergency room.⁷² The court set forth the public policy that if hospitals profit from quality emergency care, they should be liable when the emergency room care is below acceptable levels.⁷³

Third, the *Gilbert* court relied on the New Jersey Supreme Court's observation in *Arthur v. Saint Peters Hospital*⁷⁴ that patients generally do not understand the business relationship between physicians and the hospitals in which emergency room services are provided.⁷⁵ Additionally, the court relied on a Georgia appellate court decision, *Brown v. Coastal Emergency Services*,⁷⁶ which disapproved of the hidden relationship between hospitals and independent contractor physicians.⁷⁷

The *Gilbert* court concluded that a hospital cannot always escape medical malpractice liability for care provided on its grounds simply because the administrator is an independent contractor.⁷⁸ Furthermore, the court reasoned that the existence of liability depends on how the physician was held out to the public and the public's perception of the physician-hospital relationship.⁷⁹ The court agreed with the conclusions of *Kashishian*: the fact that providers of emergency room care are independent contractors, unbeknownst to the patient, should not prohibit a

health facilities. *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." (emphasis added)).

71. *Id.* at 793-94 (citing *Hardy v. Brantley*, 471 So. 2d 358, 371 (Miss. 1985)).

72. *Id.* at 793 ("If [emergency room physicians] do their job well, the hospital succeeds in its chosen mission, profiting financially and otherwise from the quality of emergency care so delivered. On such facts, anomaly would attend the hospital's escape from liability where the quality of care so delivered was below minimally acceptable standards." (citing *Hardy*, 471 So. 2d at 371)).

73. *Id.*

74. 405 A.2d 443 (N.J. Super. Ct. 1979).

75. *Gilbert*, 622 N.E.2d at 794 ("[G]enerally people who seek medical help through the emergency room facilities of modern-day hospitals are unaware of the status of the various professionals working there. *Absent a situation where the patient is directed by his own physician* or where the patient makes an independent selection as to which physicians he will use while there, it is the *reputation of the hospital itself upon which he would rely*. Also, unless the patient is in some manner put on notice of the independent status of the professionals with whom it might be expected to come into contact, it would be natural for him to assume that these people are employees of the hospital.") (emphasis added) (citing *Arthur*, 405 A.2d at 447)).

76. 354 S.E.2d 632, 637 (Ga. Ct. App. 1987).

77. *Gilbert*, 622 N.E.2d at 794 ("Such appearances [referring to the absence of patient knowledge that ER physicians are typically not actual agents of the hospital] speak much louder than the words of whatever private contractual arrangements the physicians and the hospital may have entered into, unbeknownst to the public, in an attempt to insulate the hospital from liability for the negligence, if any, of the physicians." (citing *Brown v. Coastal Emergency Servs., Inc.* 354 S.E.2d 632, 637 (Ga. Ct. App. 1987)).

78. *Id.*

79. *Id.*

patient from holding a hospital liable for their negligence.⁸⁰ *Gilbert* clarified that such liability only applies if the treating physician is the “apparent or ostensible agent of the hospital. If a patient knows, or should have known, that the treating physician is an independent contractor, then the hospital will not be liable.”⁸¹

In summary, the underlying rationale for extending VIC liability to hospitals is explicitly tied to emergency room treatment: because hospitals attract patients to their profitable emergency rooms based on advertised associations with physicians, hospitals should share liability when those physicians are negligent. Additionally, the cases cited by *Gilbert* focused on the reliance of a patient on a hospital’s reputation.⁸² This focus supports, from a public policy standpoint, VIC liability in non-emergency room situations as well. However, the opinions relied on in *Gilbert* only identified emergency rooms as hospital profit centers. Therefore, the public policy justifications for non-emergency room hospital VIC liability are less compelling. The financial incentive to induce a patient to select a hospital for non-emergency room treatment is apparently less than the incentive to induce a patient to select a hospital for emergency room treatment. Furthermore, the public may realize that physicians providing non-emergency services are not employees of the hospital.

80. *Id.* (“Consistent with this concept of the modern-day hospital facilities, a patient who is unaware that the person providing treatment is not the employee or agent of the hospital should have a right to look to the hospital in seeking compensation for any negligence in providing emergency room care. The fact that, unbeknownst to the patient, the physician was an independent contractor should not prohibit a patient from seeking compensation from the hospital which offers the emergency room care.” (citing *Kashishian v. Port*, 481 N.W.2d 277, 282 (Wis. 1992)).

81. *Id.*

82. *Pamperin v. Trinity Mem’l Hosp.*, 423 N.W.2d 848, 857 (Wis. 1988) (“Courts have uniformly recognized that, except when the patient enters a hospital intending to receive care from a specific physician while in the hospital, it is the reputation of the hospital itself upon which a patient relies.”); *Brown*, 354 S.E.2d at 637 (“By furnishing the attending physician, the hospital is in effect holding him out as its own and calling upon the patient to accept his services based on its own reputation rather than the physician’s However, there being no suggestion in the record that Mr. Brown relied in any way upon Coastal’s reputation or, indeed, that he even knew of that company’s existence, there is no basis upon which Coastal may be held liable under the apparent agency doctrine.”); *Hardy v. Brentley*, 471 So. 2d 358, 370 (Miss. 1985) (“The basic rationale of these cases is that, unless there is some reason for a patient to believe that the treating physician in a hospital is an independent contractor, it is natural for him to assume that he can rely upon the reputation of the hospital as opposed to any doctor, which is the reason he goes there in the first place.”); *Arthur v. St. Peters Hosp.*, 405 A.2d 443, 447 (N.J. Super. Ct. 1979) (“It is the reputation of the hospital itself upon which he would rely.”). *But see Pamperin*, 423 N.W.2d at 860 (Steinmetz, J., dissenting) (“The majority improperly focuses, as did the courts in the cases cited by the majority, on whether the plaintiff relied on the reputation of the hospital. This focus is misplaced; under the doctrine of apparent authority, which is basically a theory of agency by estoppel, the question is whether a patient reasonably relied on the apparent agency relationship, not whether reliance was placed on the reputation of the hospital.” (citations omitted)).

C. Gilbert's *Elements of Apparent Authority and Explicit Treatment of Reliance*

The Illinois Supreme Court adopted the *Pamperin v. Trinity Memorial Hospital* language for the three elements of apparent authority:

(1) the hospital, or its agent, *acted in a manner that would lead a reasonable person to conclude that the individual* who was alleged to be negligent *was an employee or agent of the hospital*; (2) where the acts of the agent create the appearance of authority, the plaintiff must also prove that the hospital had knowledge of and acquiesced in them; and (3) the *plaintiff acted in reliance upon the conduct of the hospital* or its agent, consistent with ordinary care and prudence.⁸³

Although hospital VIC liability under *Gilbert* consists of three elements, liability under the Illinois doctrine of apparent authority has only two requirements: holding out (i.e., making representations that support an agency relationship between the hospital and physician) and reliance.⁸⁴

Based on *Pamperin*, the *Gilbert* court stated that the first element, holding out, does not require an express statement by a hospital that the negligent physician is a hospital agent.⁸⁵ The “element is satisfied if the hospital holds itself out as a provider of *emergency room care* without informing the patient that the care is provided by independent contractors.”⁸⁶ When discussing the reliance requirement, *Gilbert* cited *Pamperin* once again, and stated “the element of *justifiable reliance* . . . is satisfied if the plaintiff *relies* upon the hospital to provide complete *emergency room care*, rather than upon a specific physician.”⁸⁷ This statement is ambiguous and can lead to considerable confusion. An advocate of VIC liability under the agency by estoppel doctrine will view the scope of this statement to be limited to describing justifiable reliance, without disturbing the detrimental reliance requirement. After all, *Gilbert* did not refer to the reliance requirement as the element of justifiable reliance when the elements were set forth, supporting an interpretation that the reliance requirement is broader than mere justifiable reliance.⁸⁸ How-

83. *Gilbert*, 622 N.E.2d at 795 (quoting *Pamperin*, 423 N.W.2d at 855–56) (emphasis added).

84. *Id.* at 795–96. *Gilbert*'s first and second elements represent two different ways of establishing the holding out requirement: (1) holding out by the hospital, or (2) an alternative means of establishing holding out, allowing for an apparent agency relationship when the principal itself has not held out the apparent relationship, but instead has permitted the apparent agent to hold out the relationship.

85. *Id.* at 796 (citing *Pamperin*, 423 N.W.2d at 56–57).

86. *Id.* (emphasis added). Therefore, a hospital has the burden to inform patients that a physician is an independent contractor, but can escape liability if the patient is notified of the hospital-physician relationship.

87. *Id.* at 796 (emphasis added) (citing *Pamperin*, 423 N.W.2d at 857).

88. *Id.* at 795 (setting forth the reliance element as “the plaintiff acted in reliance upon the conduct of the hospital”). Prior to this statement, *Gilbert* had not referred to the reliance requirement as “justifiable reliance.” *Pamperin* never referred to any “element of justifiable reliance,” nor explicitly set forth a reliance on the hospital standard. However, *Pamperin* discussed a “justifiable belief” in relation to the holding out element, rather than the reliance element. See *Pamperin*, 423 N.W.2d at 856. The court observed:

ever, an advocate of VIC liability under apparent agency will view this statement as a clear indication that *Gilbert* defined the reliance requirement as justifiable reliance, precluding any need to show detrimental reliance.

Furthermore, the statement does not define a clear test for the so-called element of justifiable reliance.⁸⁹ Instead, it begs the question: What does a plaintiff need to show to prove she relied upon the hospital to provide complete emergency room care? *Gilbert* appears to answer this question by quoting *Pamperin*.⁹⁰ Essentially, *Pamperin* provides that (1) if a person voluntarily enters a hospital without a specific physician in mind, she is assumed to be seeking care from the hospital itself; and (2) anyone who seeks care from the hospital itself is accepting care from the hospital in reliance upon the fact that complete emergency room care will be provided by the hospital through its staff.⁹¹ Following this line of reasoning, a plaintiff will meet her burden of showing justifiable reliance merely by accepting care from an emergency room. This *assumed* justifiable reliance standard undercuts the actual justifiable reliance requirement of both agency by estoppel and apparent agency. Under this interpretation, courts can assume that when a plaintiff accepts care from an emergency room, her belief in the agency relationship is inherently reasonable based on the general public's perception that emergency room physicians are hospital employees.⁹² Therefore, under an assumed reliance standard, reliance is automatically justifiable.

In view of the requirement for justifiable reliance in both agency by estoppel and apparent agency, *Gilbert* fails to disclose which doctrine is applicable to hospital VIC liability in Illinois. What seems clear, and in

The cases from other jurisdictions indicate that the first element of apparent authority—acts by the hospital or agent *justifying belief in an agency relationship*—can be proven without an express representation by the hospital that the individual alleged to be negligent is an employee. Many courts have concluded that a hospital, by providing emergency room care and by failing to advise patients that they were being treated by the hospital's agent and not its employee, has created an appearance that the hospital's agents, not independent contractors, will provide medical care to those who enter the hospital. . . . "[P]atients entering the hospital through the emergency room, could *properly assume* that the treating doctors and staff of the hospital were acting on behalf of the hospital"

Id. (emphasis added) (citations omitted).

89. The statement is also circular, providing that justifiable reliance is satisfied if the plaintiff shows reliance.

90. *Gilbert*, 622 N.E.2d at 796 ("[T]he critical distinction is whether the plaintiff is seeking care from the hospital itself or whether the plaintiff is looking to the hospital merely as a place for his or her personal physician to provide medical care. Except for one who seeks care from a specific physician, if a person voluntarily enters a hospital without objecting to his or her admission to the hospital, then that person is seeking care from the hospital itself. An individual who seeks care from a hospital itself, as opposed to care from his or her personal physician, accepts care from the hospital in reliance upon the fact that complete emergency room care—from blood testing to radiological readings to the endless medical support services—will be provided by the hospital through its staff." (citing *Pamperin*, 423 N.W.2d at 857)).

91. *Id.*

92. See *supra* notes 68–82 and accompanying text (discussing public perception and promoting the view that because of the way hospitals hold themselves out to the public, it is reasonable for emergency room patients to believe that physicians are employees of the hospital).

line with the more compelling rationale for promoting hospital VIC liability, is that the element of justifiable reliance is explicitly applicable to emergency room situations.⁹³

D. Treatment of Reliance by Secondary Sources and the Brown Cases Cited by Gilbert

The *Gilbert* court's first meaningful reference to secondary sources came after stating that "Illinois has long recognized the doctrine of apparent authority."⁹⁴ The specific sections of the secondary sources cited do not address reliance and merely distinguish between the types of agency (actual and ostensible) and define the circumstances under which ostensible agency can exist.⁹⁵ Although the court did not explicitly reference other sections of these two secondary sources, both sources cited require the element of detrimental reliance, in addition to justifiable reliance, to impose liability under apparent authority.⁹⁶

Gilbert subsequently made a specific statement about reliance: "[I]t is settled that an apparent agency gives rise to tort liability where the injury would not have occurred but for the injured parties' justifiable reliance on the apparent agency."⁹⁷ This explicit statement, discussing "but for" causation leading to injury, supports requiring detrimental reliance

93. *Pamperin* only extended hospital VIC liability to emergency room cases. 423 N.W.2d at 853–55.

94. *Gilbert*, 622 N.E.2d at 795 (citing 2A C.J.S. AGENCY §§ 19, 20 (1972) and 1 FLOYD R. MECHEM, LAW OF AGENCY §§ 56, 57 (2d ed. 1914)). The court previously acknowledged that other state courts relied upon section 429 of the *Restatement of Torts*, and section 267 of the *Restatement of Agency*, or both. *Id.* However, the court did not express any explicit preference between the two doctrines when initially mentioned.

95. Both sets of sections cited establish two types of agency relationships, and distinguished actual agency from apparent and ostensible agency. See 2A C.J.S. AGENCY §§ 19, 20 (1972); MECHEM, *supra* note 94, at §§ 56–57; see, e.g., 2A C.J.S. AGENCY § 20 (1972) ("[Agents] are ostensible agents if the principal, intentionally or through want of ordinary care, induces others to believe they are his agents, although they have been given no authority. . . . [A]n apparent agent is a person who, whether or not authorized, reasonably appears to third persons, because of the manifestations of another, to be authorized to act as agent for such other.").

96. See 2A C.J.S. AGENCY § 160 (1972) ("The elements essential to apparent authority are acts or conduct of the principal, reliance thereon by a third person, and a change of a position by him to his detriment; and, save as modified by statute, all three must concur to create such authority."). Note that sections 140–42 of C.J.S. AGENCY (2003) set forth similar requirements. Mechem also discusses apparent authority. MECHEM, *supra* note 94, at §§ 720–26. ("When, however, the authority is . . . sought to be deduced from . . . acquiescence or holding out, the principle of estoppel or something akin to it at least, must be invoked . . ."); *id.* at § 722.

Inasmuch as the whole doctrine of powers by estoppel rests upon the theory that the other party has been led to rely upon the appearances to his threatened detriment, it is obvious that the doctrine can apply only in those cases in which this element of reliance was present. It can therefore only apply to cases in which . . . some change of position has occurred, in reliance upon the appearance of authority.
Id. at §§ 724, 729.

97. *Gilbert*, 622 N.E.2d at 795 (emphasis added) (citing *Brown v. Coastal Emergency Servs.*, 354 S.E.2d 632, 637 (Ga. Ct. App. 1987)); RESTATEMENT (SECOND) OF AGENCY § 267 (1958); SEAVEY, *supra* note 28, at § 90.

in order to establish apparent authority liability.⁹⁸ The sources cited for this statement also require detrimental reliance.⁹⁹ In summary, *Gilbert's* “but for” causation statement and secondary sources cited strongly support a requirement of detrimental reliance for the doctrine of apparent authority.

E. Gilbert's Discussion of Precedence and Legal Basis for Hospital VIC Liability in Illinois

According to *Gilbert*, legal precedent for hospital VIC liability in Illinois was sufficiently established prior to the *Gilbert* case, and the court proclaimed that it did “not deem it necessary at this time to adopt a special rule in this area . . . Illinois case law sufficiently recognizes the realities of modern hospital care and defines the limits of a hospital's liability.”¹⁰⁰ If one takes such a statement at face value, then an examination of the Illinois hospital VIC liability cases cited by *Gilbert* is highly relevant to determining the requirements for establishing the reliance element.

Two Illinois cases cited by *Gilbert* supported hospital VIC liability.¹⁰¹ In *Sztorc v. Northwestern Hospital*,¹⁰² the court supported hospital VIC liability under “apparent agency” with the requirement of detrimental reliance.¹⁰³ *Sztorc* was a non-emergency room case that involved the negligence of a radiologist who administered radiation treatment.¹⁰⁴ *Gil-*

98. See *supra* notes 33–39 and accompanying text discussing causation and definitions of detrimental reliance.

99. See SEAVEY, *supra* note 28, at § 90 (“A person harmed by the tortious conduct of an ‘apparent servant’ of another, is entitled to an action against the other, if he relied upon the apparent relation of master and servant. . . . An apparent servant of another is one whom the other has caused third persons to believe to be his servant. . . . The rules of causation apply, so that the belief by the injured person in the relation of master and principal must have been one of the causes of harm . . . it is part of the plaintiff's case to prove some element of reasonable reliance.” (emphasis added)); see also *Richmond County Hosp. Auth. v. Brown*, 361 S.E.2d 164, 165 (“It was alleged that the emergency room was operated jointly by University Hospital and Coastal and that Isiah Brown went to the emergency room rather than to a private doctor because he was led to believe that he would receive better care.” (emphasis added)); *Brown*, 354 S.E.2d at 636 (“[T]he doctrine of apparent agency is predicated on principles of estoppel . . . there would appear to be no question that an apparent agency relationship may also give rise to tort liability where it can be shown that the injury would not have occurred but for the injured party's justifiable reliance on the apparent agency.” (emphasis added)); *supra* notes 33–39 and accompanying text (discussing the detrimental reliance requirement of section 267 of the *Restatement (Second) of Agency*). Although the *Georgia* cases confused the terms “apparent agency,” “apparent authority,” and “agency by estoppel,” the *Brown* and *Richmond* courts ultimately applied a detrimental reliance test.

100. *Gilbert*, 622 N.E.2d at 795.

101. *Id.* at 793.

102. 496 N.E.2d 1200 (Ill. App. Ct. 1986).

103. *Id.* at 1202 (“[W]e believe that a factual determination remains to be made as to whether plaintiff would have acted differently had she known of the contractual relationship between the hospital and the treating physicians in the radiology department.” (emphasis added)); see also *Getz*, *supra* note 3, at 206 (discussing the court's requirement of detrimental reliance).

104. *Sztorc*, 496 N.E.2d at 1202. *Sztorc* provides support for expanding hospital VIC liability to non-emergency room situations.

bert also cited *Northern Trust Co. v. Saint Francis Hospital*.¹⁰⁵ This case involved emergency room treatment and upheld the application of hospital VIC liability.¹⁰⁶ The *Northern Trust* court explicitly rejected the plaintiff's claim that "apparent agency" does not require detrimental reliance.¹⁰⁷ The court went on to say that "[t]he doctrine of apparent agency is based on the doctrine of equitable estoppel . . . there is no practical difference between them," and detrimental reliance is required.¹⁰⁸

Gilbert also discussed two cases that rejected hospital VIC liability.¹⁰⁹ In *Greene v. Rogers*,¹¹⁰ the court rejected the applicability of apparent agency in an emergency room situation.¹¹¹ The *Greene* court then analyzed the facts of the case under the "doctrine of estoppel [which] requires that the injured party rely to his detriment on the representations made by the parties sought to be estopped."¹¹² The court stated that under the doctrine of estoppel, "negligence of the treating physician in the treatment of the patient can not be imputed to the hospital unless the physician is an [actual] agent of the hospital."¹¹³ The court also stated, however, that the doctrine of estoppel did not apply to the *Greene* case, even if the physician was an agent, because there was no proof of detrimental reliance.¹¹⁴ The *Greene* court had a unique interpretation of the doctrine of estoppel, reasoning that it only applies when an actual agency relationship exists between the physician and hospital.¹¹⁵ However, while the court rejected hospital VIC liability, it promoted a detrimental reliance requirement for VIC liability, if such liability existed.¹¹⁶

The *Gilbert* court also cited *Johnson v. Sumner*,¹¹⁷ another emergency room VIC liability case. Relying on *Greene*, the *Johnson* court reaffirmed its rejection of hospital VIC liability.¹¹⁸ The *Johnson* court did not revisit reliance. *Gilbert* did not cite to three other pre-*Gilbert* cases

105. 522 N.E.2d 699 (Ill. App. Ct. 1988).

106. *Id.* at 704-05.

107. *Id.* at 704.

108. *Id.*; see also Getz, *supra* note 3, at 207-08 ("Ironically, after citing Illinois commercial cases which seem to impliedly recognize a distinction between the theories, the court held that there was no difference between" apparent agency and agency by estoppel.). Note that the court relied upon 3 AM. JUR. 2D AGENCY § 80 (1986) in requiring detrimental reliance.

109. *Gilbert v. Sycamore Mun. Hosp.*, 622 N.E.2d 788, 793 (Ill. 1993).

110. 498 N.E.2d 867 (Ill. App. Ct. 1986).

111. *Id.* at 871-72 ("The doctrine of apparent agency is generally thought of as a contract theory of recovery. . . . Other state courts, however, have carved an apparent agency . . . exception in tort actions for medical malpractice . . . Illinois courts have yet to recognize the exception and will not do so in this case.")

112. *Id.* at 872; see also Getz, *supra* note 3, at 206-07.

113. *Greene*, 498 N.E.2d at 871.

114. *Id.* at 871 ("We find no express agency relationship between [the doctor] and [the hospital]."); *id.* at 872 (stating that estoppel does not apply to the case "regardless of whether [the doctor] was an agent of the hospital" because there was no detrimental reliance.)

115. See Getz, *supra* note 3, at 207 (stating that "the court's language indicated it felt apparent agency and equitable estoppel were two entirely different theories").

116. See *supra* note 114 and accompanying text.

117. 513 N.E.2d 149 (Ill. App. Ct. 1987).

118. *Id.* at 151.

that supported hospital VIC liability.¹¹⁹ Two of these three cases supporting hospital VIC liability required detrimental reliance, and one rejected the requirement for detrimental reliance.¹²⁰

In summary, both *Sztorc* and *Northern Trust*, the pre-*Gilbert* cases that supported hospital VIC liability, required detrimental reliance. So did two of the three cases promoting VIC liability that were not cited by *Gilbert*. Furthermore, in *Greene*, which rejected hospital VIC liability, the court implied that even if it were to hold hospitals liable for acts of independent contractor physicians, detrimental reliance would be required.¹²¹ Therefore, at the time of *Gilbert*, the majority of courts, recognizing the realities of modern hospital care, defined the limits of hospital liability with a detrimental reliance requirement. The pre-*Gilbert* courts made no distinction between emergency and non-emergency room situations in defining reliance requirements.

F. *Plausible Interpretations of Gilbert's Reliance Requirement*

The precise holding of *Gilbert* that a hospital may be vicariously liable under the doctrine of apparent authority, taken on its face, appears to be generally applicable to hospitals.¹²² In light of the most compelling arguments for abrogating hospital VIC liability immunity, based on emergency room profitability and the public perception of the relationship between emergency room physicians and hospitals, one can question whether *Gilbert* sought to endorse hospital VIC liability beyond emergency room malpractice.¹²³ *Gilbert* failed to provide a clear precedent for

119. In *Gasbarra v. St. James Hosp.*, 406 N.E.2d 544 (Ill. App. Ct. 1980), the court considered hospital VIC liability for emergency room negligence under the doctrine of equitable estoppel. The court required both justifiable reliance and detrimental reliance in order to establish VIC liability. *Id.* at 551–52; *see also Getz, supra* note 3, at 204–05. In *Uhr v. Lutheran General Hosp.*, 589 N.E.2d 723 (Ill. App. Ct. 1992), the court drew no distinction between apparent authority and equitable estoppel, rejected the requirement of detrimental reliance, and found a hospital liable for the negligence of a non-emergency room physician. The hospital appealed the decision and the Illinois Supreme Court granted certiorari. The Supreme Court, however, vacated its decision after it determined that the parties had settled immediately before the lower court's decision. *See also Getz, supra* note 3, at 208–09. The remaining hospital VIC liability case was *Raglin v. HMO, Inc.*, 595 N.E.2d 153 (Ill. App. Ct. 1992), where the court applied the doctrine of apparent authority and required detrimental reliance. *Getz, supra* note 3, at 209.

120. *See supra* note 119.

121. *See supra* notes 109–13 and accompanying text.

122. *Gilbert v. Sycamore Mun. Hosp.*, 622 N.E.2d 788, 793 (Ill. 1993); *see also supra* note 81 and accompanying text (discussing the rationale for abrogating the common-law hospital immunity to VIC liability and its application to non-emergency room situations).

123. Most of the cases relied upon by *Gilbert* applied to emergency rooms situations. In *Kashishian*, however, the Wisconsin Supreme Court removed the emergency room limitations for VIC liability from its previous holding in *Pamperin*, and stated that “the doctrine of apparent authority can be a basis for a malpractice action against a hospital beyond the emergency room context in instances in which the elements necessary to prove apparent authority exist.” *Kashishian v. Port*, 481 N.W.2d 277, 278 (Wis. 1992); *see also id.* at 281 (discussing that *Pamperin* expressly limited its holding to the emergency room, although it did not foreclose expansion of VIC liability to non-emergency room cases). To support this expansion, *Kashishian* cited the pre-*Gilbert* Illinois case, *Sztorc v. Northwest*

satisfying the reliance requirement under the doctrine of apparent authority for emergency room situations. In addition, *Gilbert* failed to indicate whether the reliance requirement for emergency room situations, whatever that may be, was also applicable to non-emergency room situations. Of the possible interpretations of *Gilbert*, three seem most plausible.

The first interpretation is one of universal detrimental reliance.¹²⁴ Applying a canon of construction borrowed from principles of statutory interpretation, different parts of a body of work should be interpreted to avoid internal inconsistencies such that the parts make up a coherent whole.¹²⁵ *Gilbert*'s discussion of justifiable reliance can be read as merely alleviating a plaintiff's burden to show that reliance on emergency room physicians is justifiable.¹²⁶ If the "element of justifiable reliance" language is interpreted to completely relieve the plaintiff's reliance burden, then the language is inconsistent with the preceding "but for" causation language and authorities cited that require detrimental reliance. Under this first interpretation, the justifiable reliance element described in *Gilbert* is only one of the two reliance elements required to show agency by estoppel liability. Generally, a plaintiff must show both justifiable and detrimental reliance.¹²⁷ However, in the special case of emergency room treatment, justifiable reliance is assumed, and the plaintiff need only show detrimental reliance. Therefore, the detrimental reliance standard based on *Gilbert*'s but-for causation statement, pre-*Gilbert* case law, secondary sources, and the majority of cases relied upon, coexists with the assumed justifiable reliance in emergency room situations.

The second interpretation is a conditional detrimental reliance standard. This conditional standard dictates that assumed justifiable reliance satisfies the overall reliance requirement in emergency room situations, and in non-emergency room situations, detrimental and justifiable reliance are required. In general, detrimental reliance is required based on *Gilbert*'s but-for causation statement, pre-*Gilbert* case law, secondary sources and the majority of cases relied upon. However, in the special case of emergency room treatment, the entire reliance requirement is sat-

Hospital, 496 N.E.2d 1200 (Ill. App. Ct. 1986). The *Gilbert* opinion, however, did not cite to any portions of *Kashishian* which explicitly expanded VIC liability to non-emergency room situations.

124. Universal refers to a detrimental reliance requirement for both emergency room and non-emergency room situations.

125. See *United States v. Turkette*, 452 U.S. 576, 580 (1981) ("[A]uthoritative administrative constructions should be given the deference to which they are entitled, absurd results are to be avoided and internal inconsistencies in the statute must be dealt with . . ."); ELIZABETH A. MARTIN, A CONCISE DICTIONARY OF LAW 189 (1987) ("An Act must be construed as a whole, so that internal inconsistencies are avoided."); Maxwell L. Stearns, *The Misguided Renaissance of Social Choice*, 103 YALE L.J. 1219, 1274-75 (1994) ("ordinary rules of statutory interpretation require that courts attempt where possible to avoid the inconsistency").

126. See *supra* notes 91-93 and accompanying text (discussing the assumed reliance interpretation of the justifiable reliance language).

127. See *Golden v. Kishwaukee Cmty. Health Serv. Ctr.*, 645 N.E.2d 319, 326 (Ill. App. Ct. 1994).

ified by accepting treatment from an emergency room based on the justifiable reliance language.

The third interpretation is universal assumed reliance.¹²⁸ This interpretation promotes the application of an assumed reliance standard to emergency room and non-emergency room situations alike, despite the fact that much of the *Gilbert* opinion points to a detrimental reliance standard. The justification for this interpretation is *Gilbert's* explicit use and plain meaning of the “element” of justifiable reliance language, and *Gilbert's* failure to explicitly mention detrimental reliance or any emergency room limitations. Using the canon *expressio unius est exclusio alterius*,¹²⁹ the assumed element of justifiable reliance replaces any possible unspoken alternatives.

It is not surprising that post-*Gilbert* courts promote contradictory interpretations of the reliance requirement for hospital VIC liability, given the uncertainty created by *Gilbert*.

IV. ANALYSIS OF POST-GILBERT LAW: THE CURRENT STATE OF CONFUSION

This Part examines the treatment of hospital VIC liability reliance requirements by the post-*Gilbert* Illinois Supreme Court, legislature, and appellate courts. The Part is organized according to the various reliance standards: (A) the “selecting hospital based on reputation” standard; (B) the third-party reliance standard; (C) the “selecting hospital based on apparent agency” standard; (D) the “accepting treatment based on apparent agency” standard; (E) the forced to rely standard.

A. *The “Selecting Hospital Based on Reputation” Standard*

*Chicago Title and Trust Company v. Sisters of Saint Mary*¹³⁰ was the first post-*Gilbert* hospital VIC liability case. Whether by accident or by design, *Chicago Title* modified the traditional agency by estoppel detrimental reliance standard. The court substituted a “selecting hospital based on reputation” standard for a “selecting hospital based on the apparent hospital-physician relationship” standard.¹³¹ A reputation-based standard comports with *Gilbert's* reputation-based rationale.¹³²

In the emergency room related case, the court stated “*Gilbert* clearly established that the rule in Illinois regarding the reliance element

128. Assumed reliance is satisfied by merely accepting care from a hospital, rather than a personal physician.

129. “[T]he expression of one thing implies the exclusion of another.” See JIM EVANS, STATUTORY INTERPRETATION 296 (1988).

130. 637 N.E.2d 543, 545 (Ill. App. Ct. 1994).

131. See *supra* notes 33–40 and accompanying text (discussing the traditional agency by estoppel detriment reliance standard).

132. See *supra* note 82 and accompanying text.

necessary to support action under the apparent agency theory should be predicated on justifiable, not detrimental reliance.”¹³³ Ironically, the *Chicago Title* court did not follow this “clear” rule. The court stated that the plaintiff satisfied the justifiable reliance requirement by “particularly select[ing] the defendant instead of another hospital because he believed [he] would receive good medical care from the doctors at [the hospital].”¹³⁴ In other words, the evidence which formed the basis for the court’s finding of justifiable reliance is a perfect example of detrimental reliance: the plaintiff selected one hospital over another (i.e. changed his position), based on the reputation of the defendant hospital.

Perhaps the court was struggling to reconcile *Gilbert*’s rationale with *Gilbert*’s language. By differentiating between a change in position based on the physician-hospital relationship and a change in position based on the reputation of the hospital, and perhaps equating the former with detrimental reliance and the latter with justifiable reliance, the *Chicago Title* court may have attempted to create a rule consistent with its underlying rationale.

B. *The Third-Party Reliance Standard*

As previously discussed, the issue of third-party reliance arises when the plaintiff seeking to hold a hospital liable relies on a third party for treatment decisions.¹³⁵ Section 429 of the *Restatement of Torts* provides the common-law basis for the sufficiency of third-party reliance in VIC liability cases.¹³⁶ Two cases demonstrate the expansion of *Gilbert*’s doctrine of apparent authority to address third-party reliance.¹³⁷

In the first case, *Monti v. Silver Cross Hospital*,¹³⁸ the court held that sufficient reliance could be established when ambulance drivers, who were responsible for an unconscious plaintiff, relied on a hospital for complete care, rather than on the plaintiff’s personal physician.¹³⁹ *Monti* promoted third-party reliance in situations where the plaintiff needing

133. *Chi. Title & Trust Co. v. Sisters of St. Mary*, 637 N.E.2d 543, 546 (Ill. App. Ct. 1994).

134. *Id.*

135. *See supra* note 15 and accompanying text.

136. *See supra* note 31 and accompanying text.

137. *Kane v. Doctors Hosp.*, 706 N.E.2d 71 (Ill. App. Ct. 1999); *Monti v. Silver Cross Hosp.*, 637 N.E.2d 427 (Ill. App. Ct. 1994); *see also* *Golden v. Kishwaukee Cmty. Health Serv. Ctr.*, 645 N.E.2d 319, 326 (Ill. App. Ct. 1994) (endorsing *Monti*).

138. 637 N.E.2d 427 (Ill. App. Ct. 1994).

139. *Id.* at 430. The court stated that when the plaintiff was unconscious, those persons responsible for her obviously relied upon [the defendant] to provide complete emergency room care for her . . . [and because] the emergency personnel who responded to a call for assistance selected [the defendant] because it was the nearest hospital, the implication is clear that they relied upon the hospital’s ability to provide the services she [required].

Id. The court went on to say that “[t]hose responsible for [the plaintiff] sought care from the hospital, not from a personal physician, and thus, a jury could find that they relied upon the fact that complete emergency room care . . . would be provided.” *Id.*

emergency room care was unconscious or badly injured.¹⁴⁰ The court stated that there was an “implied reliance on the hospital” in such situations.¹⁴¹ Under this implied reliance standard, *Monti* appears to create an exception to *Gilbert*’s voluntary acceptance of emergency room treatment standard for establishing justifiable reliance.¹⁴²

Monti’s rationale for this departure from *Gilbert* is that “[n]either logic nor equity would be served by drawing a distinction between conscious and unconscious patients, allowing the former to recover on a theory of vicarious liability but not the latter.”¹⁴³ By extending third-party reliance to ambulance drivers, however, *Monti* weakens the public policy basis provided by *Gilbert*. Unlike the public who is unaware of the independent contractor status of emergency room physicians, ambulance drivers, as health care industry insiders, should know that such physicians are not typically hospital employees or agents. Additionally, *Monti* acknowledged that the ambulance drivers took the plaintiff to the nearest hospital, rather than considering which was the most reputable hospital.¹⁴⁴ Therefore, the implied third-party reliance was not supported by the public’s perception of hospital reputation or the relationship between the hospital and physician. Furthermore, the *Gilbert* court stated that “[i]f a patient knows, or should have known, that the treating physician is an independent contractor, then the hospital will not be liable.”¹⁴⁵ If the ambulance driver’s reasons for bringing the plaintiff to a specific hospital are extended to the plaintiff, then should not the ambulance driver’s knowledge be extended as well? If so, the implied reliance is undermined by the ambulance driver’s presumed knowledge of the employment status of emergency room physicians.

Another case discussing third-party reliance was *Kane v. Doctors Hospital*.¹⁴⁶ *Kane* held that, in general, relying on others to choose a particular medical facility for treatment was sufficient to establish reliance.¹⁴⁷ *Kane* based its decision on *Monti*, and added “[n]othing in *Gilbert*, how-

140. *Id.* (“The same is true for all seriously or badly injured patients, whether conscious or not, who come to a hospital emergency room for emergency medical care.”).

141. *Id.*; see also *Golden*, 645 N.E.2d at 326 (endorsing *Monti*). *Golden* held that a plaintiff brought to an emergency room in an unconscious state was not precluded from a VIC liability claim “because the emergency personnel who transported him there implicitly relied upon the hospital’s ability to provide the services and care he required.” *Id.*

142. See *Gilbert v. Sycamore Mun. Hosp.*, 622 N.E.2d 788, 796 (Ill. 1993) (“[I]f a person voluntarily enters a hospital without objecting to his or her admission to the hospital, then that person is seeking care from the hospital itself. An individual who seeks care from a hospital itself, as opposed to care from his or her personal physician, accepts care from the hospital in reliance upon the fact that complete emergency room care . . . will be provided.”) (emphasis added).

143. *Monti*, 637 N.E.2d at 430.

144. *Id.* (“[T]he emergency personnel who responded to a call for assistance selected [the defendant] because it was the nearest hospital”).

145. *Gilbert*, 622 N.E.2d at 794.

146. 706 N.E.2d 71 (Ill. App. Ct. 1999).

147. *Id.* at 76. According to the court, the fact that the plaintiff originally went to the hospital because his personal physician set up the appointment was inconsequential to the plaintiff’s ability to establish the reliance element. *Id.*

ever, suggests a plaintiff must make an independent determination of whether to rely on a particular hospital for treatment. . . . [A] patient may rely on others to choose a . . . medical facility for treatment. . . . [T]hat is sufficient.”¹⁴⁸

Kane significantly expanded *Monti* by allowing plaintiffs who were neither unconscious nor severely injured to rely on others to make treatment decisions in both emergency and non-emergency room situations. The facts of *Kane* are so far removed from a situation where hospital advertising and public perception are important factors, that the applicability of *Gilbert* is questionable.¹⁴⁹ *Kane* appears to have obliterated the reliance requirement in all situations, and supports a universal assumed reliance standard.¹⁵⁰

C. The “Selecting Hospital Based on Apparent Agency” Standard

The traditional doctrine of agency by estoppel, based on section 267 of the *Restatement of Agency*, requires detrimental reliance on the perceived agency relationship.¹⁵¹ In terms of hospital VIC liability, traditional detrimental reliance translates into a “selecting hospital based on the apparent hospital-physician relationship” standard. A number of post-*Gilbert* courts, in addition to the Illinois legislature, adopted reliance standards akin to agency by estoppel.

Effective March 9, 1995, the Illinois Legislature enacted the Civil Justice Reform Amendments of 1995, which included “Requirements for Claims Based Upon Apparent or Ostensible Agency.”¹⁵² Section 5/2-624 of the statute applied to any action in tort, contract or otherwise involving “apparent agency” and explicitly included actions for medical malpractice.¹⁵³ To recover under 5/2-624, a plaintiff was required to establish three elements: (1) holding out; (2) the plaintiff reasonably relied on the holding out; and (3) “that a reasonable person would not have sought goods or services from the alleged principal if that person was aware that the alleged agent was not the alleged principal’s actual agent.”¹⁵⁴ The legislature set out clear, separate requirements for both justifiable and

148. *Id.* *Contra supra* note 75 (discussing *Gilbert*’s rejection of reliance on reputation of a hospital when a patient is referred to a hospital by the patient’s physician).

149. *Kane*, 706 N.E.2d at 76. The court rejected the defendant’s argument that the plaintiff “could not have relied on any representations from the Hospital . . . because the decision to choose the Hospital was taken out of [the plaintiff’s] hands.” *Id.*

150. *See supra* notes 128–29 and accompanying text for a discussion of universal assumed reliance.

151. *See supra* notes 33–40 and accompanying text.

152. 735 ILL. COMP. STAT. 5/2-624 (2002); *Harraz v. Snyder*, 669 N.E.2d 911, 913 (Ill. App. Ct. 1996). One major goal of the compilation of statutes was tort reform, as evidenced by the title of the act.

153. *See* 735 ILL. COMP. STAT. 5/2-624.

154. *Id.*; *see also* *Harraz v. Snyder*, 669 N.E.2d 911, 913–14 (Ill. App. Ct. 1996).

detrimental reliance, elements two and three respectively.¹⁵⁵ In December of 1997, the Illinois Supreme Court held the entire tort reform act invalid under the Illinois Constitution.¹⁵⁶ Ironically, in regards to the requirements for VIC liability, the Illinois Supreme Court criticized the legislature's poor drafting of the act.¹⁵⁷ Although the act was eventually overturned, the legislature clearly promoted a traditional detrimental reliance standard.¹⁵⁸

In *Harraz v. Snyder*,¹⁵⁹ the court stated,

Even the most casual comparison of the elements of apparent agency found in *Gilbert* with those found in section 5/2-624 of the Code readily discloses that the elements are indeed quite different and that the new statute abrogates the judicially developed law of apparent agency as applied to hospitals and other medical care providers.¹⁶⁰

The issue on appeal in the *Harraz* case was whether to apply *Gilbert* or 5/2-624 retroactively, and the court did not expound on the differences it perceived.¹⁶¹ Few of the subsequent cases mentioned 5/2-624.¹⁶²

*O'Banner v. McDonalds Corporation*¹⁶³ was the first apparent authority case to reach the Illinois Supreme Court after *Gilbert*. The court applied *Gilbert* to a franchisor-franchisee relationship.¹⁶⁴ *O'Banner* repeated the but-for justifiable reliance causation requirement spelled out in *Gilbert*, and found that the fundamental obstacle to recovery was the plaintiff's inability to establish the detrimental reliance element: the plaintiff provided no evidence as to why he chose to go to the franchi-

155. The third element's "would not have sought goods or services from the alleged principal if that person was aware" language is similar to the causation language requirement in agency by estoppel and the but-for causation statement from *Gilbert*. 735 ILL. COMP. STAT. 5/2-624.

156. See *Best v. Taylor Mach. Works*, 689 N.E.2d 1057, 1064 (Ill. 1997) (declaring that the act "as a whole is invalid" based on the Special Legislation and Separation of Powers Clauses of the Illinois Constitution, and a right to privacy).

157. Michael J. Polelle, *Best v. Taylor Machine Works: A Resounding "No" to the Tort Reform Act*, 86 ILL. B.J. 130, 130 (1998).

158. The legislature did not support *Gilbert's* assumed justifiable reliance requirement for emergency room situations. Compare 735 ILL. COMP. STAT. 5/2-624, with *Gilbert v. Sycamore Mun. Hosp.*, 622 N.E.2d 788, 795 (Ill. 1993).

159. 669 N.E.2d at 913-14.

160. *Id.* The court also viewed the statute as imposing more stringent requirements than *Gilbert*. *Id.* at 913.

161. *Id.* at 914.

162. See *id.* at 919. The holding in *Harraz* was that, given the circumstances of the specific case, section 5/2-624 could not be applied retroactively. The event at issue in the case occurred prior to the enactment of the code. *Id.* at 912 (the alleged negligence occurred in February, 1989 while section 5/2-624 became effective on March 9, 1995). Perhaps all the cases between 1995 and 1997 stemmed from events prior to the enactment of the code and therefore the act was not applicable. The 1995-1997 cases, however, and especially *O'Banner v. McDonald's Corporation*, 670 N.E.2d 632, 634 (Ill. 1996), appeared to more explicitly require detrimental reliance. Perhaps the courts were influenced by section 5/2-624. See *Malanowski v. Jabamoni*, 688 N.E.2d 732, 737 n.1 (Ill. App. Ct. 1997) (acknowledging the statute but noting that it could not be applied retroactively).

163. 670 N.E.2d 632 (Ill. 1996).

164. *Id.* at 633-34. The case involved a plaintiff who slipped and fell in a McDonald's bathroom, and sought recovery from the franchisor, the McDonald's Corporation.

see's restaurant.¹⁶⁵ In other words, *O'Banner* required a "selecting franchisee based on the apparent agency" reliance requirement. The court explained that to establish reliance, the plaintiff must "show that he *actually did rely* on the apparent agency in going to the restaurant where he was allegedly injured."¹⁶⁶ Merely showing that the defendant franchisor's holding out could entice a plaintiff to enter the franchisee's restaurant in the belief that he was dealing with an agent of the franchisor, was not sufficient.¹⁶⁷ The court reasoned that the association between the franchisor and the franchisee may have been irrelevant to the plaintiff's decision to go to the franchisee's restaurant: the plaintiff may have selected the franchisee's restaurant because it had the *closest bathroom* or because a friend was to meet him there.¹⁶⁸ *O'Banner* weakened *Monti* and *Kane* on two grounds: (1) *O'Banner* required actual reliance, as opposed to implied reliance; and (2) *O'Banner* rejected the proximity of the restaurant as a valid basis for reliance, whereas *Monti* held that relying on an ambulance driver to take an unconscious patient to the *closest hospital* was sufficient.

Because *O'Banner* was a franchisor-franchisee case, one can argue that the opinion is irrelevant to hospital VIC liability. However, Chief Justice Bilandic, who wrote the dissenting opinion in *O'Banner*, provided insight into *Gilbert's* hospital liability reliance requirements.¹⁶⁹ Citing *Gilbert*, he stated that the plaintiff must show that he "[acted] in justifiable reliance on such representations of the franchisor, [and] has dealt with the agent to [his] detriment."¹⁷⁰ Thus, the Chief Justice explicitly attributed both a justifiable and detrimental reliance requirement to *Gilbert*. The dissent also stated that "the element of justifiable reliance is satisfied if the plaintiff relies on the franchisor to provide the goods and services, rather than on the franchisee."¹⁷¹ This language is almost identical to the language used in *Gilbert*: "The element of justifiable reliance . . . is satisfied if the plaintiff relies upon the hospital to provide complete emergency room care, rather than upon a specific physician."¹⁷²

165. *Id.* at 634–35 ("[A] principal can be held vicariously liable in tort for injury caused by the negligent acts of his apparent agent if the injury would not have occurred but for the injured party's justifiable reliance on the apparent agency.").

166. *Id.* at 635 (emphasis added) (citing *Miller v. Sinclair Ref. Co.*, 268 F.2d 114, 118 (5th Cir. 1959)). Liability under the apparent agency theory was rejected because there was no evidence as to the reason why appellant patronized the filling station where he was injured. *Miller*, 268 F.2d at 118.

167. *O'Banner*, 670 N.E.2d at 635. In other words, even if a restaurant franchisee or franchisor held out information that would lead a reasonable person to believe that an agency relationship existed, there could be no franchisor liability if the plaintiff did not prove she actually relied on such a holding out in choosing to go to the restaurant.

168. *Id.*

169. *Id.* at 635–37 (Bilandic, J., dissenting).

170. *Id.* at 636 (citing *Gilbert*, 622 N.E.2d at 788, and *Crinkley v. Holiday Inns, Inc.*, 844 F.2d 156, 166 (4th Cir.1988)).

171. *Id.* From a comparison of Bilandic's language and *Gilbert's* language, Bilandic is simply adjusting the language in *Gilbert* to account for the franchisor-franchisee situation in the *O'Banner* case. See *Gilbert*, 622 N.E.2d at 796.

172. *Gilbert*, 622 N.E.2d at 796.

These statements, read together, indicate a universal detrimental reliance standard for hospital VIC liability, where only justifiable reliance is assumed in emergency room situations and the detrimental reliance requirement remains.

In summary, both the Illinois legislature and the Illinois Supreme Court, at least in its *O'Banner* opinion, promoted a "selecting hospital based on apparent agency" standard requiring universal detrimental reliance. A number of post-*Gilbert* appellate decisions, such as the emergency room related cases of *James v. Ingalls Memorial Hospital*¹⁷³ and *Butkiewicz v. Loyola University Medical Center*,¹⁷⁴ also required universal detrimental reliance.

D. The "Accepting Treatment Based on Apparent Agency" Standard

The traditional doctrine of apparent agency, based on section 429 of the *Restatement of Torts*, requires only that services are accepted under the justifiable belief that they are rendered by the employer.¹⁷⁵ In terms of hospital VIC liability, traditional justifiable reliance translates into an

173. 701 N.E.2d 207 (Ill. App. Ct. 1998). The court stated that the plaintiff's "testimony . . . was not equivocal and did not indicate that the relationship between [the doctor] and the hospital would have made a difference in her decision to go to [that hospital]." *Id.* at 212. The court then stated "thus . . . [plaintiff] cannot meet her burden in establishing the element of reliance because she did not in fact rely on any representations of the hospital or doctor in going to [the hospital]." *Id.* at 212. Although the *James* court cited *Gilbert* a number of times, the *James* opinion never mentioned justifiable reliance. *James* stated that the pre-*Gilbert* case of *Sztorc v. Northwest Hospital*, 496 N.E.2d 1200 (Ill. App. Ct. 1986), was "the seminal case on reliance in an apparent agency case." *James*, 701 N.E. 2d at 211. For a discussion of *Sztorc*, see *supra* notes 101–03 and accompanying text; see also *Plooy v. Paryani*, 657 N.E.2d 12 (Ill. App. Ct. 1995). In *Plooy*, a VIC liability case unrelated to medical malpractice, the court cited *Gilbert* for the "but for" justifiable reliance requirement. *Plooy*, 657 N.E.2d at 22. *Plooy* relied on the *O'Banner* appellate opinion and stated that liability requires "detrimental reliance on the agent's apparent authority." *Id.* *O'Banner*, stated:

The elements of apparent agency are most often set out in Illinois as being: (1) the principal's consent to or knowing acquiescence in the agent's exercise of authority, (2) the third party's knowledge of the facts and good-faith belief that the agent possessed authority, and (3) the third party's detrimental reliance on the agent's authority.

O'Banner, 653 N.E.2d at 1270 (citations omitted).

174. 724 N.E.2d 1037 (Ill. App. Ct. 2000). The plaintiff went to the defendant hospital's emergency room on direction of his personal physician, and over the course of a number of months, the plaintiff was treated by a group of doctors, including a radiologist. *Id.* at 1038–39. The court relied on *O'Banner* and *James* and stated that the "[p]laintiff must show that [he] actually did rely on the apparent agency in going to the hospital." *Id.* at 1040. Relying on *Gilbert*, the court stated that the "[p]laintiff has failed to show that [he] actually relied on any representations of the hospital or [physician] in going to [the] hospital." *Id.* at 1040. The court stated that the plaintiff was "not relying on the hospital's representations about the excellence of its care and quality of its physicians; he was relying on [his doctor]." *Id.* at 1041. The *Butkiewicz* court rejected *Kane's* interpretation of *Gilbert* and *Monti*, which was that reliance was established when "[the patient] relied on [his doctor] to set up treatment he desperately wanted." *Id.* at 1041–42 (citing *Kane v. Doctors Hosp.*, 706 N.E.2d 71 (Ill. App. Ct. 1999)). The court pointed out that the "*Monti* finding applies in situations where the patient is unable to make a decision for himself. Such was not the case in *Kane* [nor in this case]." *Id.* at 1042. Furthermore, the court held that the reliance element was not established and that the defendant "was fully conscious and able to make his own determination as to which hospital to attend. He chose to rely on [the referring doctor]." *Id.* at 1042.

175. See *supra* notes 29–32 and accompanying text.

“accepting treatment from physicians in the justifiable belief that they are hospital employees” standard. A number of post-*Gilbert* opinions promoted an accepting treatment standard in both emergency and non-emergency room situations.

In *Scardina v. Alexian Brothers Medical Center*,¹⁷⁶ the plaintiff was referred to a specific hospital’s emergency room by his physician.¹⁷⁷ *Scardina* held that “[t]he mere fact that [a doctor] sent a plaintiff to [the hospital in question], without more, does not [mean] that plaintiff did not rely on [the hospital] for his care.”¹⁷⁸ *Scardina* recognized and rejected hospital selection-based reliance standards. The court stated that *Gilbert*’s test for reliance “is not whether the plaintiff relied on the reputation of [a hospital] in choosing to seek treatment there, but whether the plaintiff relied on the holding out of [the hospital] that [a physician] was its agent or employee when he accepted [the physician’s] services.”¹⁷⁹

The court claimed that *James v. Kayla* “improperly held the plaintiff to a standard of detrimental reliance, which requires a showing by [the plaintiff] that he relied on the ‘holding out’ of the hospital or agent to his detriment in accepting treatment.”¹⁸⁰ Contrary to the court’s representation, *James* required detrimental reliance on the apparent agency in selecting the hospital, not in accepting treatment.¹⁸¹ *Scardina* cited *Chicago Title* for the proposition that the appropriate requirement is justifiable reliance.¹⁸² The *Scardina* court failed to realize that, despite the language used in *Chicago Title* indicating a rejection of detrimental reliance, the test applied was a detrimental reliance standard related to selecting a hospital based on its reputation for quality care.¹⁸³

In a non-emergency room case, *McCorry v. Evangelical Hospitals Corp.*,¹⁸⁴ the court held that “[i]f a plaintiff shows that he relied in part on the hospital when he accepted treatment . . . he has met the reliance element of the proof needed to hold the hospital liable under the theory of apparent agency.”¹⁸⁵ Like *Scardina*, *McCorry* did not negate reliance

176. 719 N.E.2d 1150 (Ill. App. Ct. 1999).

177. *Id.* at 1152. During the course of emergency room treatment, and months of continuing treatment thereafter, an independent contractor radiologist of the defendant hospital participated in diagnosing the plaintiff’s health problems, resulting in alleged negligence. *Id.*

178. *Id.* at 1156. The court stated that “*Gilbert* clearly indicates [] the focus under the reliance element is whether the patient depends on the hospital to provide care, rather than on services provided by a specific physician.” *Id.* at 1154–55.

179. *Id.* at 1155.

180. *Id.* at 1156.

181. See *supra* note 173 and accompanying text.

182. *Scardina*, 719 N.E.2d at 1156 (“Thus a showing that the plaintiff would have acted differently, *i.e.*, gone to a different hospital, had he been aware of the status of his treating physician as an independent contractor is not necessary to satisfy the reliance element.”).

183. *Id.* at 1154–56. See *supra* note 134 and accompanying text for a discussion of *Chicago Title*’s reputation-based standard.

184. 771 N.E.2d 1067 (Ill. App. Ct. 2002).

185. *Id.* at 1071.

merely because a patient was referred to the hospital.¹⁸⁶ Instead, both *McCorry* and *Scardina* implied a “hospital selecting physician” standard,¹⁸⁷ a variation of the accepting treatment standard: even if the plaintiff was referred to a hospital by a personal physician or sought treatment at a hospital by her personal physician, the plaintiff can establish reliance if she accepts treatment from supporting physicians selected by the hospital.¹⁸⁸ *McCorry* cited *Scardina* and *Kane* with approval, and then criticized *Butkiewicz* for improperly focusing “on the plaintiff’s reasons for choosing the hospital, rather than the plaintiff’s reasons for accepting treatment.”¹⁸⁹

In *York v. El-Ganzouri*,¹⁹⁰ the plaintiff was a physician who was harmed by an independent contractor anesthesiologist.¹⁹¹ Despite the fact that the physician-plaintiff had worked with independent contractor anesthesiologists for a long period of time in his own practice, the *York* court held that the plaintiff had no reason to know that the defendant anesthesiologist was an independent contractor.¹⁹²

In *York*, the hospital defendant argued that the reliance standard under *Butkiewicz* and *James* was diametrically opposed to that of *McCorry* and *Scardina*.¹⁹³ The defendant called upon the *York* court to resolve the split in authority on the reliance requirement of apparent authority.¹⁹⁴ The *York* court criticized *Butkiewicz* and *James* for focusing on the plaintiff’s failure to rely on hospital reputation and stated that *Scardina* and *McCorry* properly interpreted *Gilbert*.¹⁹⁵ The *York* court also found no inconsistency between *McCorry* and *O’Banner*.¹⁹⁶ Ultimately, however, the court held that sufficient evidence existed to establish reliance under either reliance standard.¹⁹⁷

186. *Id.* But see *supra* note 75 (discussing *Gilbert*’s rejection of sufficient reliance when a patient’s doctor refers her to a hospital).

187. *McCorry*, 771 N.E.2d at 1071 (discussing how the personal physician did not refer the plaintiff to the specific radiologist, and the plaintiff did not select the radiologist).

188. *Id.* The court stated that “if the plaintiff claims that her personal physician acted negligently, and she chose the physician prior to the choice of hospital, then the plaintiff could not hold the hospital liable . . . [b]ut the hospital might remain responsible for [] negligence of doctors the personal physician consulted, if the hospital held [them] out [] as its apparent agents.” *Id.* at 1070 (citing *Pamperin*, 423 N.W.2d 848, 857 (Wis. 1988)).

189. *Id.* at 1071 (“*Butkiewicz* misapplied *Gilbert*, and used reasoning inconsistent with . . . *Pamperin* and *Kashishian* as adopted in *Gilbert* . . .”). For a discussion of *Butkiewicz*, see *supra* note 174. Note that *Butkiewicz* criticized *Kane*. *Butkiewicz v. Loyola Univ. Med. Ctr.*, 724 N.E.2d 1037, 1042 (Ill. App. Ct. 2000).

190. 817 N.E.2d 1179 (Ill. App. Ct. 2004).

191. *Id.* at 1183.

192. *Id.* at 1205.

193. *Id.* at 1200–01.

194. *Id.*

195. *Id.* at 1201–04.

196. *Id.* at 1202.

197. *Id.* at 1203–05.

E. The Forced-to-Rely Standard

In *Petrovich v. Share Health Plan of Illinois, Inc.*¹⁹⁸ the Illinois Supreme Court considered a second apparent authority case, this one related to non-emergency room medical malpractice.¹⁹⁹ Justice Bilandic delivered the opinion of the court.²⁰⁰ The court held that the doctrine of apparent authority is applicable to HMOs.²⁰¹ The court reaffirmed *Gilbert* and cited it for the elements of apparent authority which “are a ‘holding out’ by the hospital and ‘justifiable reliance’ by the plaintiff.”²⁰² Noticeably missing from the opinion was any mention of the but-for causation language found in both *Gilbert* and *O’Banner*. Justice Bilandic’s discussion of the justifiable reliance element in *Petrovich* was inconsistent with his detrimental-reliance-based interpretation of *Gilbert* in the *O’Banner* dissent.²⁰³

To qualify for benefits, the plaintiff had to select a primary care physician to provide overall care and authorize referrals when necessary.²⁰⁴ The defendant HMO analogized the case to *O’Banner*, and equated the plaintiff’s failure to indicate why she chose a specific primary care physician from a list of over 500 doctors to *O’Banner*’s failure to indicate why he chose to enter the particular restaurant where he was injured.²⁰⁵ The court rejected this analogy because, in its view, the plaintiff was “forced” to use the HMO by her employer and she was “required” to select a primary care physician from the pre-defined HMO list.²⁰⁶ The court reasoned that because the plaintiff was required to select a physician from the list, she did not rely on a specific physician, and therefore

198. 719 N.E.2d 756 (Ill. 1999).

199. *See id.* at 760.

200. *Id.*

201. *Id.* at 766. The plaintiff’s employer provided health care coverage to its employees through the defendant HMO, which only paid for medical care provided by its in-network physicians. *Id.* at 760–61.

202. *See id.* at 765–66 (holding that the elements for establishing liability against an HMO for contracting physicians are: “(1) that the HMO held itself out as the provider of health care, without informing the patient that the care is given by independent contractors, and (2) that the patient justifiably relied upon the conduct of the HMO by looking to the HMO to provide health care services, rather than to a specific physician.”); *id.* at 768 (defining justifiable reliance as requiring that the “plaintiff acted in reliance upon the conduct of the HMO or its agent, consistent with ordinary care and prudence.”).

203. *See supra* notes 169–72 and accompanying text.

204. *See Petrovich*, 719 N.E.2d at 761.

205. *See id.* at 769–70.

206. *See id.* The court also stated that where a “plaintiff selects the HMO and does not rely upon a specific physician, then that person is relying upon the HMO to provide health care” and that “[e]qually true, however, is that where a person has no choice but to enroll with a single HMO and does not rely upon a specific physician, then that person is likewise relying upon the HMO to provide health care.” *Id.* at 769. But the court seems to have ignored the following facts: (1) employers cannot usually require employees to accept the medical benefits provided by the employer; (2) the list she was “forced” to select a doctor from had over 500 physicians; and (3) the plaintiff did in fact rely on this specific primary care physician she selected, who was responsible for authorizing her referrals. *See id.* at 760–61.

relied on the HMO.²⁰⁷ The court endorses a requirement of proving the reason for selecting the source of treatment, rather than why one accepted treatment. As in *Kane*, the facts of this case are so far removed from the underlying public policy concerns of emergency room profits and advertising set forth in *Gilbert* that *Gilbert* seems inapplicable.

F. *The Current State of Illinois Hospital VIC Liability Law*

As expected, given the ambiguity and mixed messages of the *Gilbert* opinion, the post-*Gilbert* VIC liability case law ranges from inconsistent to outright contradictory. Courts have consistently applied VIC liability to both emergency room and non-emergency room situations.²⁰⁸ Although the strength of the rationale and public policy concerns are stronger for emergency room situations, the treatment situation seems to have no bearing on which of the different reliance standards is applied.

Ignoring terminological inconsistencies, courts generally apply three separate reliance standards: (1) a plaintiff selecting a hospital based on hospital reputation;²⁰⁹ (2) a plaintiff selecting a hospital based on the perception of an employer/employee relationship between the physician and the hospital;²¹⁰ and (3) a plaintiff accepting treatment based on the apparent employer-employee relationship.²¹¹ A number of cases implied a fourth reliance standard: hospital selection of treating physicians.²¹² Courts addressed third-party reliance without consistency.²¹³ Furthermore, the Illinois Supreme Court, which clarified *Gilbert* in *O'Banner*, created more confusion in *Petrovich*. In sum, the requirements for establishing hospital VIC liability in Illinois are unpredictable.

207. *Id.* at 770 (“As outlined above, plaintiff was enrolled in Share’s health plan by her employer. Plaintiff then selected Dr. Kowalski from a list of physicians that Share provided to her. . . . She chose Dr. Kowalski because Share’s health plan required her to obtain her primary medical care from one of its primary care physicians, if her care was to be covered. This case, therefore, is distinguishable from *O'Banner*.”).

208. Only one case explicitly addresses the expansion of *Gilbert* to non-emergency room situations. *See Malanowski v. Jabamoni*, 688 N.E.2d 732, 738 (Ill. App. Ct. 1997) (rejecting defendant’s argument that *Gilbert* only applies to emergency room situations); *see also supra* note 161–62 and accompanying text. The court also rejected the defendant’s argument that *Gilbert* prohibited hospital liability when the plaintiff’s personal physician allegedly was negligent. The court stated that *Gilbert* does not hold that the mere existence of a regular physician-patient relationship precludes any claim by the patient of reliance upon the hospital. Further we decline to read such a holding into [*Gilbert*] as we do not believe that *Gilbert* was intended to circumscribe all apparent agency claims in the medical area.

But see supra note 90 (discussing *Gilbert*’s rejection of hospital liability when the plaintiff seeks care from a specific physician).

209. *See supra* notes 130–34 and accompanying text.

210. *See supra* notes 152–74 and accompanying text.

211. *See supra* notes 179–87 and accompanying text.

212. *See supra* notes 187–89 and accompanying text.

213. *See supra* notes 138–50 and accompanying text; *see also supra* note 174.

V. THE INADEQUACY OF COMMON-LAW DOCTRINES: THE NEED FOR A HOSPITAL-SPECIFIC APPROACH

Commentators agree that the failure by courts to distinguish between the doctrines of apparent agency and agency by estoppel is a major source of legal confusion in determining hospital VIC liability.²¹⁴ In other areas of law, however, Illinois courts appear to recognize the difference between these doctrines, as well as the difference between justifiable and detrimental reliance.²¹⁵ Given that courts are capable of understanding these differences in other contexts, perhaps the inconsistency of the case law stems from the inadequacy of either doctrine to fully address the underlying problem to be solved.

The justification for abrogating the longstanding common-law hospital immunity to VIC liability is that: (1) hospitals create reputations for being providers of complete and quality care through expensive advertising campaigns; (2) the general public is induced to rely on the hospitals for complete, quality care based on these representations; and (3) hospitals that financially benefit from this inducement should be liable when the care provided is substandard.²¹⁶ The reliance requirements of both apparent agency and agency by estoppel, however, are based on the perceived relationship between the principal and the apparent agent, rather than on the reputation of the principal.²¹⁷ Therefore, these doctrines do not adequately address the reputation-based public policy focus of the courts and the reputation-based treatment decisions made by typical patients. Furthermore, the typical patient seeking treatment from a hospital does not appreciate the legal implications of the hospital-physician relationship.²¹⁸ To base a reliance inquiry on the apparent relationship itself, a factor which is irrelevant to an average patient's decision whether to select a hospital or accept treatment, is misguided.²¹⁹ Given the rationale's focus on reputation, the typical plaintiff's reliance on reputation for treatment decisions, and the typical patient's ignorance of applicable legal theories, existing common-law doctrines do not sufficiently address the underlying public policy concerns justifying the abrogation of the common-law hospital immunity to VIC liability.

214. See *supra* note 26 and accompanying text.

215. Getz, *supra* note 3, at 213–14; see also *supra* notes 45–47 and accompanying text.

216. See *supra* notes 68–82 and accompanying text.

217. See *Pamperin v. Trinity Mem'l Hosp.*, 423 N.W.2d 848, 860 (Wis. 1998) (Steinmetz, J. dissenting); McWilliams, *supra* note 3, at 451. Steinmetz's discussion of reliance on relationship rather than reputation is quoted in *supra* note 82.

218. Getz, *supra* note 3, at 219 (discussing the premise that requiring patients to be familiar with the law of respondeat superior is absurd and citing *Capan v. Divine Providence Hospital*, 430 A.2d 647, 649 (Pa. 1981)).

219. McWilliams, *supra* note 3, at 445 (“[P]ublic perceptions and patients’ reasonable expectations are more important in assessing liability than are the bargained-for relationship between hospital and physician and the policies traditionally underlying principal liability for the negligent acts of agents.”).

An additional shortcoming of apparent agency, and related passive reliance standards discussed above, involves the concept of timely notice.²²⁰ As *Gilbert* stated, if a patient knows, or should know, that a physician is an independent contractor at the time she accepts treatment, then there can be no hospital VIC liability.²²¹ Therefore, passive reliance standards provide hospitals with a potential escape mechanism from liability by merely informing the patient about the hospital-physician relationship after the patient has already selected the hospital and has arrived for treatment.²²² However, a patient's reliance upon a hospital's reputation is manifested solely by her selecting and entering a hospital.²²³ Thus, even if the patient understands the applicable legal theories, informing her of the nature of the hospital-physician relationship after she arrives is too late. The purpose of any notice requirement is to impart knowledge sufficient to enable the patient to make an informed decision about which hospital to enter.²²⁴

To highlight this point, consider the following emergency room situation. A seriously injured patient needing immediate medical attention drives to the nearest hospital for which she has seen advertisements regarding complete, quality, medical care. She arrives at the hospital emergency room, only to be informed that the treating physicians are independent contractors. Should the patient be expected to leave and search for another hospital, one with employee physicians, in order to fully protect herself against any possible physician negligence? Not according to the reputation-based rationale for hospital VIC liability. Apparent agency and passive reliance standards, therefore, fail to address the relevant reliance inquiry based on the VIC liability rationale—why did the patient choose a particular hospital?—and instead focus on the irrelevant, *ex post* inquiry—why did the patient accept treatment once there?²²⁵ The selecting-physician standard has the same defects as the

220. The “accepting treatment” and “hospital selection of physician” reliance standards, discussed in *supra* notes 203–04 and accompanying text, are passive in nature because they do not require any affirmative act by the plaintiff. These passive standards are akin to the apparent agency standard for justifiable reliance. The passive standards are distinguishable from the more active “selecting hospital” standards, discussed in *supra* notes 201–03 and accompanying text. The active standards are akin to agency by estoppel, because they require an affirmative decision to select one option over another.

221. *Gilbert v. Sycamore Mun. Hosp.*, 622 N.E.2d 788, 794 (Ill. 1993); *see also* *Owens*, *supra* note 5, at 1146 (stating that the court should properly deny the patient protection if he had notice of the true relationship before the contract was made: notice prior to the execution of the contract makes reliance unreasonable).

222. *See Pamperin*, 423 N.W.2d at 860 (Steinmetz, J., dissenting). *But see* *Owens*, *supra* note 5, at 1147 (rejecting the existence of an escape mechanism based on notice because late notice invalidates the contract).

223. *Owens*, *supra* note 5, at 1147.

224. *Id.*

225. *Id.* (“The plaintiff who by definition is injured and under stress, is relying upon the hospital to provide services that the hospital has held out that it can provide. The plaintiff’s reliance upon the hospital’s competence has been demonstrated by her walking (or being wheeled) into the ER.”).

accepting-treatment standard.²²⁶ The relevant issue is whether the patient relied on the held out reputation of the hospital when choosing the hospital for treatment, not whether the patient relied on the hospital to select physicians once the patient has already elected to go to the particular hospital.

Some commentators argue that courts should devise a hospital-specific doctrine of liability, and refrain from modifying existing doctrines to meet new needs.²²⁷ After finding neither apparent agency, nor agency by estoppel, sufficient to address the underlying public policy concerns at issue, and no logical way to reconcile the case law, a new approach is warranted.²²⁸ Prior to formulating a new hospital-specific rule for VIC liability, the following Part examines both substantive and procedural policy issues to ensure a proper legal basis for the new rule.

VI. PROCEDURAL AND SUBSTANTIVE POLICY ISSUES: A CALL FOR JUDICIAL RESTRAINT

One can justifiably criticize the Illinois Supreme Court for judicial activism in *Gilbert* because the court abrogated the longstanding common-law hospital immunity to VIC liability based on judicially defined public policy concerns. Although there are exceptions, Illinois law provides that common-law doctrines can only be repealed by statute.²²⁹ *Gilbert* did not cite any statute authorizing the drastic change it imposed on the hospital industry. After *Gilbert*, the Illinois legislature abrogated the common-law hospital immunity to VIC liability. The statutory language, however, differed from the judicially created law.²³⁰ In order to define

226. For a discussion of the selecting physician standard, see *supra* notes 187–89 and accompanying text.

227. McWilliams, *supra* note 3, 451 (stating that “courts should free themselves from the vocabulary of the existing doctrine and create a new one” and discussing how courts “assume away or ignore great chunks” of the required analysis under established doctrines and advance policy justifications for outcomes favorable to the plaintiff, where such justifications are merely result oriented, rather than based on sound legal theories.); see also *id.* (stating that changing public perceptions of hospitals does not justify “rejigging” the established doctrines of apparent agency and agency by estoppel to support the court’s advocacy towards a just result in a given case).

228. See *Moore v. Moyle*, 92 N.E.2d 81 (Ill. 1950) (“The law is not static and must follow and conform to changing conditions and new trends in human relations to justify its existence and protector of the people, and when necessary, new remedies must be applied . . .”); see also *Molitor v. Kaneland Cmty. Unit Dist. No. 302*, 163 N.E.2d 89 (Ill. 1959) (“[W]hen it appears that public policy and social needs require a departure from prior decisions, it is our duty as a court to . . . establish a rule consonant with our present day concepts of right and justice.”).

229. *People v. Gill*, 173 N.E.2d 568, 576 (Ill. App. Ct. 1961) (proclaiming Illinois to have the well established rule: “The common law is the law of Illinois unless it has been altered by statute.”); *People v. Davis*, 116 N.E.2d 372, 373 (Ill. 1954) (“It is axiomatic that in those areas where the common law applies, the common-law principles obtain unless they are expressly revoked. In the absence of legislative intent to the contrary, the repeal of a statute declaratory of the common law does not necessarily abolish the common law.” (citations omitted)); 11 ILL. LAW & PRAC. *Common Law* § 3 (2003) (“The common law of England, so far as the same is applicable and of a general nature, [is in] full force [in Illinois] until repealed by legislative authority.”).

230. See *supra* notes 150–60 and accompanying text.

the proper scope of a new hospital-specific VIC liability rule, and to ensure that the new rule does not usurp the authority of the legislature, this section discusses procedural issues related to judicially developed common-law and substantive policy issues related to hospital liability.

A. *Procedural Policies for Developing Law*

Generally speaking, courts have both the right and the duty to refine the common law in light of changing conditions in society.²³¹ When an old rule is no longer suited to present conditions, it should be set aside and replaced with a new rule—one that addresses the present conditions and meets the demands of justice.²³² Where the traditional common law, however, has been the rule of practice, courts may not authorize causes of action wholly foreign to the common law.²³³ The judiciary should promote only gradual changes in the law, as common-law principles are entitled to great weight.²³⁴ Courts must also ensure that changes in the common law are consonant with the will of the legislature.²³⁵

Based on these procedural policies, efforts to change the common law significantly are subject to judicial restraint. Therefore, when creating a new hospital-specific doctrine of VIC liability, courts should adhere to three procedural principles. First, courts should give deference to any relevant legislative public policies as communicated by statute. Second, courts should only depart from existing common-law principles to address substantial new public policy concerns. In situations where a court's departure from common law is warranted, the court should rely on the maxim *cessante ratiō legis, cessat ipsa lex* ("the reason of the law ceasing, the law itself ceases") as a guiding principle.²³⁶ Third, a new rule

231. 15 AM. JUR. 2D *Common Law* § 13 (2003). The rule of stare decisis does not bar courts from discharging this duty. *Id.*

232. *In re the Adoption of M.M.G.C., H.H.C., and K.E.A.C.*, 785 N.E.2d 267, 270 (Ind. Ct. App. 2003) ("The strength and genius of the common law lies in its ability to adapt to the changing needs of the society it governs. We cannot close our eyes to the legal and social needs of our society, and this Court should not hesitate to alter, amend, or abrogate the common law when society's needs so dictate." (citation omitted)); 15 AM. JUR. 2D *Common Law* § 13 (2003).

233. 15 AM. JUR. 2D *Common Law* § 14 (2003).

234. See *Adkins v. Sky Blue, Inc.*, 701 P.2d 549, 551 (Wyo. 1985) ("There are times when change is necessary; but the doctrine of stare decisis is also important in an organized society. Change, therefore, should occur slowly, deliberately after much experience, and if possible so as not to affect vested rights or things in the past." Furthermore, *Adkins* acknowledges "that 'there ought to be an extreme reluctance to change the common law and [a recognition of] the obvious benefits of the doctrine of stare decisis'"); RESTATEMENT (FIRST) OF CONFLICT OF LAWS § 5 (1934); *The Supreme Court, 2002 Term—Leading Cases*, 117 HARV. L. REV. 420, 421–22 (2003).

235. *In re the Adoption*, 785 N.E.2d at 270 ("Such determinations should be consonant with the evolving body of public policy adopted by the General Assembly."); *Vermont v. Pollander*, 706 A.2d 1359, 1365 (Vt. 1997); 15 AM. JUR. 2D *Common Law* § 14 (2003).

236. *Zadvydus v. Davis*, 533 U.S. 678, 699 (2001) ("the rationale of a legal rule no longer being applicable, that rule itself no longer applies"); *Rogers v. Tennessee*, 532 U.S. 451, 474 (2001) (Scalia, J., dissenting) ("This maxim is often cited by modern devotees of a turbulently changing common law—often in its Latin form (*cessante ratiō legis, cessat ipse lex*) to create the impression of great

should avoid being result oriented, and working backwards from a desired result, rather than working forward from established legal principles.²³⁷ Additionally, courts should investigate the underlying substantive issues relating to the change in law.

B. *Substantive Policy Issues of Hospital Liability*

When developing a new cause of action for hospital VIC liability, and determining where to set the threshold for establishing reliance, a number of competing substantive policy arguments must be considered.²³⁸ Pro-liability arguments for relieving the plaintiff of the burden to establish reliance include: (1) if a hospital receives the benefits of its advertised association with physicians when the physicians are successful, it should also bear the burden when the physicians are negligent; (2) hospital liability will result in broad and equitable distribution of the cost of medical malpractice; and (3) holding the hospital liable increases the likelihood of malpractice victims receiving compensation—the deep pocket approach.²³⁹ All three arguments are relevant in the hospital VIC liability debate.

Advocates using the first argument to support the expansion of hospital liability fail to recognize that hospitals already bear a proportional responsibility when contracting physicians are negligent. The benefit to a hospital of representing an association with reputable doctors is the public perception that the hospital provides complete and quality care. When a physician associated with the hospital is negligent, the reputation of the apparent principal hospital suffers. Although negative information about physician negligence may not be as readily accessible to the public as positive hospital advertising, an argument that hospitals carry no burden and assume no risk by holding out associations with groups of physicians is unfounded.

The second argument, that increased hospital liability will result in broad and equitable distribution of the cost of medical malpractice, is unpersuasive. Advocates of limiting hospital liability argue that juries are known to award larger damages when a defendant is a corporate entity, like a hospital, than when the defendant is an individual, like a phy-

venerability.”). Note that although Justice Scalia recognized the maxim’s use by the judiciary, he appeared to disfavor it.

237. See *supra* note 219 and accompanying text.

238. *The Supreme Court, 2002 Term—Leading Cases*, *supra* note 234, at 421–22. (“The selection of [a] policy . . . involves a host of considerations that must be weighed and appraised” (quoting *United States v. Gilman*, 347 U.S. 507, 512–13 (1954))).

239. John Dwight Ingram, *Vicarious Liability of an Employer-Master: Must There Be a Right of Control?*, 16 N. ILL. U. L. REV. 93, 93 (1995). Other rationales for expanding liability include: liability tends to provide an incentive for careful selection of agents and employees and incentive for training and supervision of employees. *Id.*

sician.²⁴⁰ Under the current U.S. health care system, millions of Americans are already without access to health care.²⁴¹ Advocates of limiting hospital liability argue that increased liability will likely drive up the costs of health care and increase the number of people who have no medical coverage.²⁴² Increased hospital liability may, therefore, harm consumers rather than benefit them.

The third argument, the deep pocket theory, is unpersuasive for the same reason—by providing the jury with a deep pocket defendant, damages will increase, the cost of healthcare will increase, and fewer people will be able to afford medical coverage.

The primary argument for limiting hospital VIC liability and setting a high threshold for reliance is based on the fundamental rule of the American tort system: there can be no tort liability without fault.²⁴³ Advocates for hospital immunity claim: (1) because hospitals do not control the actions of independent contractor physicians, they are not at fault when a physician is negligent, and therefore should not be held liable;²⁴⁴ and (2) setting the reliance threshold too low will create a strict liability standard for hospitals.²⁴⁵

If a hospital delegates the duty of medical treatment to an independent contractor physician but remains liable to patients for any negligence caused by that physician, then such liability is an exception to the no-fault rule.²⁴⁶ Such an exception is referred to as a nondelegable duty.²⁴⁷ A nondelegable duty, which can be imposed with a low reliance threshold, should only be created to uphold a particularly significant

240. Valerie P. Hans & Stephanie Albertson, *Empirical Research and Civil Jury Reform*, 78 NOTRE DAME L. REV. 1497, 1508–09, 1515 (2003) (discussing the theory that deep-pocket defendants are more likely to be found liable and more likely to pay higher jury awards in civil trials); Amanda L. Maxfield, Comment, *Punitive Damages: Cooper Industries v. Leatherman Tool Group: Will a Constitutional Objection to the Excessiveness of a Punitive Damages Award Save Defendants from Oklahoma's Punitive Damages Statute?*, 55 OKLA.L. REV. 449, 488 (2002).

241. Timothy Stoltzfus Jost, *Eleanor Kinney's Protecting American Health Care Consumers*, 28 AM. J.L. & MED. 503, 504–05 (2002) (book review) (“As healthcare premiums are increasing at alarming rates, and millions of Americans are losing employment-related health insurance, anxieties about healthcare costs and access seem to be moving ahead of concerns about consumer protection on the public agenda.”).

242. Kelly M. Jolley, Note, *Simmons v. Tuomey Regional Medical Center and Osborne v. Adams: Expanding or Limiting Patients' Access to Quality Care?*, 54 S.C. L. REV. 519, 534–35 (2002); Bradford C. Kendall, Note, *The Ostensible Agency Doctrine: In Search of the Deep Pocket?*, 57 UMKC L. REV. 917, 930 (1989); Moran, *supra* note 3, at 347.

243. McWilliams, *supra* note 3, at 452–53; *see also* KEETON ET AL., *supra* note 3, at § 85 (discussing the fault principle of the American legal system). Note that respondeat superior is no-fault liability. KEETON ET AL., *supra* note 3, at § 69.

244. *See supra* text accompanying notes 63–65 (discussing the rationale for the *Gilbert* appellate opinion in rejecting VIC liability); *see also* McWilliams, *supra* note 3, at 452–53.

245. KEETON ET AL., *supra* note 3, at § 69; Jolley, *supra* note 234, at 534 (discussing that reliance requirements under the doctrine of apparent agency will result in a reliance threshold so low, that it paves the way toward strict liability); Moran, *supra* note 3, at 319, 323, 347–48.

246. McWilliams, *supra* note 3, at 454.

247. *Id.*

public policy.²⁴⁸ On the other hand, proving that a plaintiff relied on the representations of a hospital can be difficult. Setting the reliance threshold too high, particularly in emergency room situations where a patient has no time to select a hospital, will result in an insurmountable burden of proof for the plaintiff.²⁴⁹

A new hospital-specific rule for VIC liability should be based on established legal principles and depart from those principles only when required by underlying public policy concerns supporting the new rule. The new rule should include an effective reliance requirement that balances the difficulty in proving reliance for emergency room situations with the desire to maintain the no-fault principle of the tort system and refrain from creating nondelegable, strict liability in the absence of particularly significant policy concerns.²⁵⁰

VII. RECOMMENDATION

A. *Where to Start: Agency by Estoppel*

In order to create a meaningful reliance requirement for hospital VIC liability, the underlying rationale for abolishing hospital VIC liability immunity should be the primary consideration. The new rule should only depart from common-law principles when necessary to address the defined public policy concerns, and legislative policy should be acknowledged.

The appropriate starting point for a hospital-specific VIC liability rule is agency by estoppel with a detrimental reliance requirement. According to the courts, the general public policy concern supporting a change in the common law is directly related to hospitals inducing patients to choose a particular hospital through advertising.²⁵¹ This concern is detrimental in nature, as it involves a change in position: actively selecting one hospital over another based on held out reputations.²⁵² Furthermore, many factors examined in this note support an agency by estoppel basis for a hospital-specific rule: (1) the prevailing common law at the time of *Gilbert* required detrimental reliance for hospital VIC liabil-

248. KEETON ET AL., *supra* note 3, § 71; McWilliams, *supra* note 3, at 453–54 (“Nondelegable duty is liability without fault and therefore, in our fault-based tort system, is strong medicine, assigned only on the basis of potent policy. . . . Put another way, nondelegable duties established by common law are reflections of particularly significant public policy, as perceived by the courts.”) (citations omitted); *see also id.* at 453 n.117 (discussing nondelegable duties are typically only created for inherently dangerous activities such as using explosives or raising vicious animals).

249. Moran, *supra* note 3, at 323 n.28 (citing *Torrence v. Kusminsky*, 408 S.E.2d 684, 692 (W. Va. 1991) (holding that in emergency room situations, there is often no time to arrange for services, and the patient has no other choice but to use the emergency room)); *see also* Ingram, *supra* note 231, at 105; McWilliams, *supra* note 3, at 451–52.

250. KEETON ET AL., *supra* note 3, § 71 at 511–12; McWilliams, *supra* note 3, at 454–55.

251. *See supra* note 82 and accompanying text; *see also supra* note 70 and accompanying text.

252. *See supra* note 38 (discussing detrimental reliance in terms of a hospital inducing patients into selecting hospitals).

ity;²⁵³ (2) the Illinois legislature expressed its desire to limit liability through tort reform and explicitly promoted a detrimental reliance requirement for hospital VIC liability;²⁵⁴ and, (3) accepting treatment and selecting hospital standards based on apparent agency do not address the relevant underlying public policy concerns giving rise to the abrogation of hospital VIC liability immunity.²⁵⁵ Therefore, the proper common-law baseline for the new rule is agency by estoppel.

B. *The General Rule for Hospital-Specific VIC Liability*

As was previously discussed, the common-law reliance requirement of agency by estoppel is inappropriate because the object of a typical patient's reliance and the focus of the underlying policy concerns is a hospital's reputation, not the contractual hospital-physician relationship.²⁵⁶ Limiting changes to those warranted by the underlying policy concern, the elements for a general hospital-specific VIC liability rule are: (1) the hospital held out an association with independent contractor physicians; (2) a reasonable person would believe, based on the hospital's representations, that the associated independent contractor physicians are employees or agents of the hospital; and (3) the plaintiff actually selected the hospital for treatment based on the reputation promoted by the hospital.

C. *The Emergency Room Exception*

In emergency room situations, the proposed general rule may not be sufficient to address public policy concerns for two reasons: (1) patients generally do not have time to make an informed choice in an emergency situation;²⁵⁷ and (2) courts have defined a specific and compelling public policy concern relating to hospital profits, advertising expenditures, and public perception of emergency room physicians.²⁵⁸ A single rule cannot adequately address both emergency and non-emergency room situations. Therefore, instead of adulterating the general rule, emergency room situations should be treated as an exception.

Gilbert, with its justifiable reliance language and approval of *Pamperin*, promotes an assumed reliance standard for emergency room situa-

253. See *supra* text accompanying notes 120–21 (concluding that the pre-*Gilbert* hospital VIC liability cases required detrimental reliance); see also *supra* notes 97–99 and accompanying text (concluding that the *Gilbert*'s but-for language, secondary sources cited, and particular cases cited required detrimental reliance).

254. See *supra* notes 152–62 and accompanying text.

255. See *supra* notes 212–18 and accompanying text.

256. See *supra* notes 209–11 and accompanying text.

257. See *supra* note 241 and accompanying text. Note, this exception is not meant to address patients who choose to go to emergency rooms for routine treatment.

258. See *supra* notes 81–82 and accompanying text discussing rationale of *Gilbert*.

tions based on public policy.²⁵⁹ One can reasonably interpret the assumed reliance standard as applying only to the justifiable reliance element, and not to any detrimental reliance element. However, in an emergency situation where there is no time to make a choice, and therefore no possible position to change, the detrimental reliance element becomes untenable.²⁶⁰ Without patient choice, the creation of nondelegable hospital liability for emergency room treatment based on assumed reliance seems unavoidable. The alternative, requiring proof of reliance, would result in plaintiffs rarely being able to meet their burden, and the hospitals would often escape liability when the patient required immediate care. Therefore, the emergency room exception requires only the first element of the general rule: proof that the hospital held out an association with independent contractor physicians, thereby creating a reputation for complete or quality care.²⁶¹ The general rule, in conjunction with the emergency room exception, form a conditional detrimental reliance standard.

D. *Third-Party Reliance*

The doctrine of apparent agency provides the common-law foundation for hospital VIC liability based on third-party reliance.²⁶² Third-party reliance must be addressed separately for emergency and non-emergency room situations in order to promote a consistent rule of law. Based on the underlying policy concerns and common-law principles, third-party reliance requirements should reflect the individual characteristics of the third party.

1. *Non-Emergency Room Third-Party Reliance*

The simplest situation is where a patient relies on a third person from the general public to choose a hospital for treatment. For example, when a minor relies on a guardian or an out-of-town patient relies on a friend or relative to choose a hospital. In such situations, the burden under the general rule should shift to the third party. In accordance with the general rule, if the third party can show that she relied on a held out

259. *Gilbert v. Sycamore Mun. Hosp.*, 622 N.E.2d 788, 794 (Ill. 1993) (“a patient who is unaware that the person providing treatment is not the employee or agent of the hospital should have a right to look to the hospital in seeking compensation for any negligence in providing emergency room care” (citation omitted)).

260. *See McWilliams*, *supra* note 3, at 451–52 (discussing how changes in agency by estoppel for hospital VIC liability should only occur in emergency room cases, “where causation and reliance as a practical matter are very difficult to prove, and where it is most likely that the patient is looking to the institution itself for care. Where the patient has time for reflection and therefore for reliance, section 267 is applied more in accord with its terms.”).

261. However, one can argue that if the plaintiff has knowledge of the hospital industry, such as a physician who is seeking treatment at a hospital, the hospital should not be liable.

262. *See supra* note 31 and accompanying text.

reputation in selecting the hospital, then the patient has established sufficient reliance.

If the third party relied upon is not a member of the general public, such as a referring physician, then the hospital should be immune from VIC liability. The rationale for VIC liability is premised on reputation, public perception, and public ignorance regarding the hospital business.²⁶³ If one gets an expert opinion, one should not be able to claim the benefit of a rule of law based on perceived ignorance. A physician knows, or should know, about typical hospital-physician relationships, their legal implications, and presumably does not premise her referral on hospital advertising campaigns. Furthermore, *Gilbert* rejected hospital liability when a patient was referred to a hospital by her doctor.²⁶⁴

2. *Emergency Room Third-Party Reliance*

Given that the rationale and public policy for hospital VIC liability apply equally to a conscious patient and a general public third party, reliance should be assumed in an emergency room situation when the general public third party brings the patient to the hospital. However, when the third party is a referring physician or an ambulance driver, the underlying rationale for VIC liability is weakened.

The ambulance driver or referring physician should not reasonably be induced into selecting a hospital by mere hospital advertising and should also have ample knowledge of the hospital business. Therefore, the underlying rationale does not support VIC liability in this situation.²⁶⁵ On the other hand, a true emergency situation will require that the patient go to the nearest hospital, removing any possibility of choice. Should the patient be treated differently, merely because she asked a physician where the nearest emergency room is or was unable to drive herself? The *Monti* court explicitly addressed this dilemma and held that if a patient could hold a hospital liable by getting herself to the hospital, she should also be able to hold the hospital liable when she *had* to rely on someone else.²⁶⁶ Therefore, in emergency situations, an assumed reliance seems appropriate, even if the patient relies on a third party who is a health care industry insider.²⁶⁷

263. See discussion *supra* Parts IV.A, IV.C, and IV.D.

264. *Gilbert*, 622 N.E.2d at 794 (“Absent a situation where the patient is directed by his own physician or where the patient makes an independent selection as to which physicians he will use while there, it is the reputation of the hospital itself upon which he would rely.” (citing *Arthur v. St. Peters Hosp.*, 405 A.2d 443, 447 (N.J. Super. Ct. Law Div. 1979))).

265. For a critique of *Monti*'s third-party implied reliance standard, see *supra* notes 141–45 and accompanying text.

266. *Monti v. Silver Cross Hosp.*, 637 N.E.2d 427, 430 (Ill. App. Ct. 1994) (“Neither logic nor equity would be served by drawing a distinction between conscious and unconscious patients, allowing the former to recover on a theory of vicarious liability but not the latter.”).

267. Of all the situations discussed, third-party reliance on a health care industry insider is the most contentious, given the strong arguments for and against hospital VIC liability.

In sum, the rule proposed in this note departs from common-law principles only where required to address the public policy concerns giving rise to the original abrogation of hospital VIC liability immunity. The rule places a heavy burden on the plaintiff in non-emergency room situations, where the underlying public policy concern supporting hospital liability is less compelling, and creates a nondelegable duty in the hospital for emergency room situations, where the underlying public policy concern is most compelling.

VIII. CONCLUSION

As the hospital industry changes, so must the laws governing hospital liability. However, courts across the country have failed to adapt VIC liability law to these changes in a coherent manner. Due to the ambiguity of *Gilbert*, misunderstandings of common-law VIC liability doctrines, and the inability of common-law doctrines to adequately address new public policy concerns, Illinois courts promote contradictory reliance requirements to establish hospital VIC liability. This note has proposed a new and comprehensive hospital-specific VIC liability rule, which addresses emergency, non-emergency, and third-party reliance situations. Based on procedural policy issues regarding changes in law, the rule was created by modifying the common law only where necessary to address new issues brought about by changes in the hospital industry. By considering substantive policy issues relating to hospital liability, the new rule balances the interests of patients and hospitals in such a way that is consistent with the underlying rationale giving rise to hospital VIC liability.

