


1-1-2002

Apparent Authority and Healthcare in Illinois, 22 N. Ill. U. L. Rev. 475 (2002)

Marc Ginsberg

The John Marshall Law School, 9ginsberg@jmls.edu

Follow this and additional works at: <http://repository.jmls.edu/facpubs>

 Part of the [Agency Commons](#), [Health Law and Policy Commons](#), [Medical Jurisprudence Commons](#), and the [State and Local Government Law Commons](#)

Recommended Citation

Marc D. Ginsberg, Apparent Authority and Healthcare in Illinois, 22 N. Ill. U. L. Rev. 475 (2002).

<http://repository.jmls.edu/facpubs/148>

This Article is brought to you for free and open access by The John Marshall Institutional Repository. It has been accepted for inclusion in Faculty Scholarship by an authorized administrator of The John Marshall Institutional Repository.

Apparent Authority and Healthcare in Illinois

MARC D. GINSBERG*

INTRODUCTION

The intersection of medical negligence and apparent authority in Illinois is undeniable. In the 1990s, the Supreme Court of Illinois utilized apparent authority in *Gilbert v. Sycamore Municipal Hospital*¹ and *Petrovich v. Share Health Plan of Illinois, Inc.*² to hold a hospital and an HMO, respectively, vicariously liable for non-agent or non-servant agent physician negligence.

*Gilbert*³ and *Petrovich*⁴ are significant public policy statements by the Supreme Court of Illinois. Hospitals and HMOs which hold out physicians as extensions of the hospital or HMO “family” and which advertise “their physicians” to consumers (patients and potential patients) may be answerable for the medical negligence committed in the hospital or within the HMO setting.⁵ The economic benefits derived by hospitals and HMOs from the competitive healthcare market come with the detriment of vicarious tort liability.⁶

The problem with *Gilbert*⁷ and *Petrovich*⁸ is not so much with the policy statement as with the effort by the Supreme Court of Illinois to

* Marc Ginsberg is a partner with Rooks, Pitts and Poust in Chicago, Illinois, where he primarily represents physicians. He earned his B.A., with Honors, from the University of Illinois (Chicago), his M.A. from Indiana University, his J.D., with Highest Distinction, from The John Marshall Law School (Chicago), and his LL.M. in Health Law from the DePaul University College of Law. He is also an Adjunct Professor of law at The John Marshall Law School. The author acknowledges Janice Ginsberg, his wife, for her inspiration and support, and also acknowledges Professor Michael Closen of The John Marshall Law School (Chicago) for his encouragement and editorial assistance. The views expressed in this article are solely those of the author and not of the law firm of Rooks, Pitts and Poust, or its clients.

1. 622 N.E.2d 788 (Ill. 1993).

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

3. 622 N.E.2d 788 (Ill. 1993).

4. 719 N.E.2d 756 (Ill. 1993).

5. 622 N.E.2d at 795; 719 N.E.2d at 775.

6. It should be noted that HMOs may be subject to a direct negligence claim, known as institutional negligence. *Jones v. Chicago HMO Ltd. of Ill.*, 730 N.E.2d 1119 (Ill. 2000). For many years, hospitals have been subject to institutional negligence claims. *Darling v. Charleston Cmty Mem’l Hosp.*, 211 N.E.2d 253 (Ill. 1965).

7. 622 N.E.2d 788.

ground these decisions in classical agency law. This effort is simply misplaced. The agency concepts of principal-agent and master-servant (with *respondeat superior*) do not fit healthcare related negligence. An examination of these fundamental agency principles reveals that the Supreme Court has incorrectly applied the law rather than asserting policy reasons for not following the law at all.

I. BACK TO BASICS

The doctrine of *respondeat superior* is well known to agency law. It provides that a master principal (employer) is liable for the negligence committed by a servant agent within the course and scope of the servant's employment.⁹ The master is without fault.¹⁰ The master's liability is predicated on the negligence of the servant.¹¹ Essentially, the employer is required to anticipate that certain employees will commit negligent acts in carrying out the business of the employer.¹²

Respondeat superior applies in the master-servant setting.¹³ This setting does not comprise every principal-agent relationship. Therefore, it is necessary to distinguish servant agents from non-servant agents. The most prominent factor used to evaluate the type of agency is "control."¹⁴ Masters retain the right to control servants.¹⁵ Furthermore, servants tend to be less skilled than non-servant agents, utilize less expertise than non-servant agents, tend to exercise little or no discretion in their work and are not compensated by the job.¹⁶ Agents who are not servants may be regarded as independent contractors.¹⁷ Independent contractor agents are employed by principals, but they are not subject to the right of control¹⁸ and their negligent torts are not imputed to their principals.¹⁹

8. 719 N.E.2d 756.

9. See WARREN SEAVEY, LAW OF AGENCY Ch. 6, § 83-84 (1964); HAROLD GILL REUSCHLEIN & WILLIAM A. GREGORY, HANDBOOK ON THE LAW OF AGENCY AND PARTNERSHIP Ch. 5, § 52 (2d ed. 1990); *Montgomery v. Petty Mgmt. Corp.*, 752 N.E.2d 596, 598 (Ill. App. Ct. 2001).

10. FLOYD R. MECHEM, LAW OF AGENCY Ch. V, § 1856 (2d ed. 1903).

11. *Id.* at § 1857.

12. *Id.* at § 1856.

13. *Id.* at § 1858.

14. See *id.* at §1856.

15. SEAVEY, *supra* note 9, Ch. 6 § 84.

16. *Id.*

17. MECHEM, *supra* note 10, Ch. V § 1870.

18. *Hartley v. Red Ball Transit Co.*, 176 N.E. 751 (Ill. 1931).

19. *Id.*

The distinction between servant agents and non-servant agents is crucial to the application of *respondeat superior*. It is also crucial to an understanding of agency law in the healthcare setting.

II. THE HOSPITAL

Hospitals employ an array of agents – some are professionals and some are not. Hospital employed physicians, nurses and technicians are highly skilled employees. Obviously, hospitals employ many other lesser-skilled, non-professional employees. Most physicians who practice medicine on hospital premises are not employed by the hospital.²⁰ These are on-staff physicians who have privileges to admit patients to and treat patients at the hospital.²¹ These physicians are not paid by the hospital.²² They are not salaried by the hospital and receive no other stipend from the hospital.²³ They are not agents of the hospital. How, then, is the negligence of a non-agent physician imputed to a hospital in Illinois? Is it through the application of the doctrines of “apparent authority” and *respondeat superior* despite the tortured use of the doctrines?

III. THE HMO

The health maintenance organization (HMO) is a type of managed care organization (MCO).²⁴ The HMO described in *Petrovich*²⁵ is an individual practice association (IPA) model. A physicians group can contract with an HMO to provide health care for enrollees for a set fee, paid in advance.²⁶ The individual physicians are not compensated by the HMO.²⁷

20. See FURROW ET AL., *HEALTH LAW: CASES, MATERIALS AND PROBLEMS*, Ch. 7, § 1 (1997) (“A physician or other health care professional may treat patients in a particular hospital only if the practitioner has “privileges” at that hospital. The hospital does not pay a fee or salary to a health care professional who only holds privileges and who has no other relationship (such as employment, a contract for services or a joint business venture) with the hospital.”). *Id.* at 455.

21. See SMITH, J., *HOSPITAL LIABILITY*, Ch. 1, § 1.03 (Law Journal Press 2001).

22. See FURROW ET AL., *supra* note 20.

23. *Id.*

24. *Petrovich*, 719 N.E.2d at 763.

25. 719 N.E.2d 756.

26. See Integrated Healthcare Ass’n, *Managed Health Care—A Brief Glossary*, at <http://www.iha.org/gloss.htm> (last visited Apr. 3, 2002).

27. *Id.*

This type of financial arrangement, the capitation fee, provides the HMO with power over physicians.²⁸ It has been argued that MCOs control the supply of insured patients, create incentives to undertreat enrollees and encourage physicians to limit services, intensive care and referrals to specialists.²⁹ The idea is that control over physicians will help to maximize profits.³⁰ As with hospitals, HMOs may be vicariously liable for the negligence of non-agent physicians through the application of apparent authority and *respondeat superior*.³¹

28. Eleanor D. Kinney, *Tapping and Resolving Consumer Concerns About Health Care*, 26 AM. J.L. & MED. 335, 337 (2000).

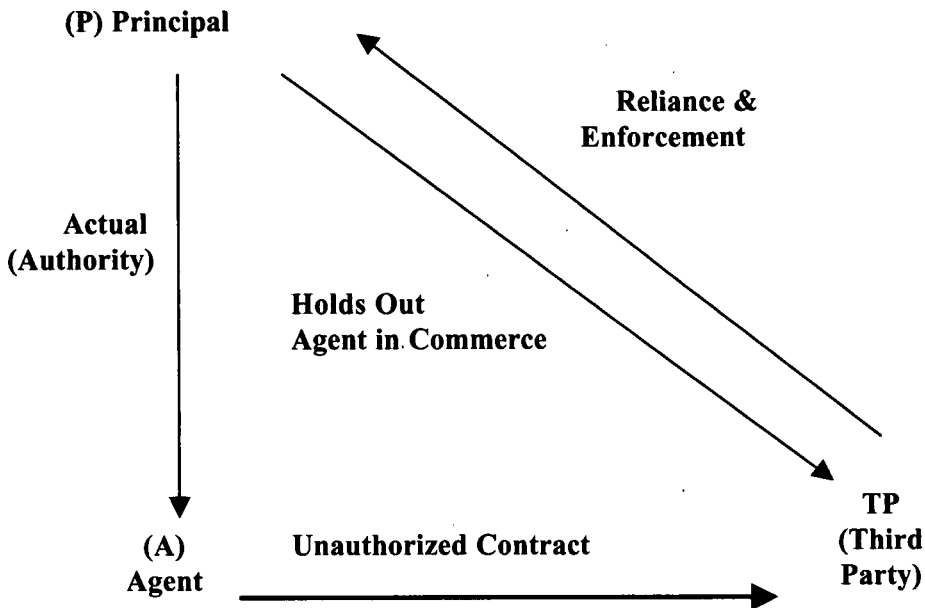
29. *Id.* at 338.

30. *Id.* at 337-38.

31. 622 N.E.2d at 795; 719 N.E.2d at 775.

IV. APPARENT AUTHORITY

Apparent authority classically and most frequently applies to the commercial side of agency.³² The scenario is simplistically diagrammed as follows:



The principal employs the agent and grants the agent authority to enter into certain transactions on behalf of the principal.³³ The authorized transaction of the agent binds the principal.³⁴ The unauthorized transaction does not, unless the principal has held the agent out to third parties as if the agent has authority and the third party reasonably relies upon the holding out of the agent in commerce.³⁵

32. MECHEM, *supra* note 10, Ch. I § 724.

33. MECHEM, *supra* note 10, Ch. IV §§ 128-29.

34. REUSCHLIN & GREGORY, *supra* note 9, Ch. 9 § 95.

35. See *Kasselder v. Kapperman*, 316 N.W.2d 628 (S.D. 1982).

Therefore, apparent authority is a doctrine which classically allows a third party to enforce an unauthorized contract against the principal.³⁶

In the commercial context, apparent authority seems sensible. It is an approach which requires a principal to bear the risk of loss of an agent entering into unauthorized transactions on behalf of the principal with third parties who cannot know the extent of an agent's authority, and who can rely on the indicia of authority "communicated" by the principal – i.e., the "holding out."

A simple example illustrates the point: P employs A as a buyer of goods. A is expressly authorized by P to spend no more than \$500 per purchase. If A purchases \$600 of goods from the seller, the contract is unauthorized and P is not responsible to the seller for \$100 of the purchase price. To the extent the agent has exceeded the authority granted by the principal, the agent is responsible to the seller as if the agent entered into the contract on his own behalf,³⁷ unless the seller can prove that the principal held out the agent to the seller as if the agent had the requisite authority to enter into the transaction and the seller could reasonably rely on the holding out. The reliance might be proved by a history or course of dealings between the agent and seller. If apparent authority is proven, the seller can enforce the unauthorized contract against the buyer's principal. This is the theory. How did this theory come to apply to the healthcare-negligence context in Illinois? Is the application appropriate or disingenuous? The answers are found by examining *Gilbert v. Sycamore Municipal Hospital*.³⁸

V. THE MARRIAGE OF APPARENT AUTHORITY AND HEALTHCARE

The facts of *Gilbert*³⁹ are straightforward. Sycamore Municipal Hospital was served by on-staff physicians, one of whom was Dr. Frank.⁴⁰ The hospital did not salary these physicians and did not pay their business expenses, social security taxes or provide them with insurance, vacations or sick leave.⁴¹ Dr. Frank, as did typical on-staff physicians, set his fees,

36. See GARY S. ROSIN & MICHAEL L. CLOSEN, AGENCY, PARTNERSHIPS AND LIMITED LIABILITY COMPANIES, Ch. 5, 241, n.1 (2000) (noting that "[a]pparent authority is the basic doctrine used by the Restatement to allocate the risk of an unauthorized transaction entered into by an agent.").

37. REUSCHLEIN & GREGORY, *supra* note 9, Ch. 11, § 119.

38. 622 N.E.2d 788 (Ill. 1993).

39. *Id.*

40. *Id.* at 791.

41. *Id.* at 791.

determined his schedule and salary, and billed patients for his services.⁴² In short, Dr. Frank was not an agent of the hospital.⁴³

Jack Gilbert, the patient, arrived at the hospital emergency room one afternoon.⁴⁴ He signed a consent for emergency treatment indicating that he would be treated “by physicians and employees of the hospital.”⁴⁵

The emergency room telephoned Dr. Frank who arrived shortly thereafter, tested Gilbert for heart problems, found none, prescribed pain medication and discharged him.⁴⁶ Later that evening, Gilbert died of a myocardial infarction.⁴⁷ An autopsy revealed the presence of heart disease.⁴⁸

The special administrator of the estate sued Dr. Frank and the hospital.⁴⁹ The claim against the hospital was based upon the alleged negligence of its “agents or employees,” including Dr. Frank.⁵⁰ The hospital was granted summary judgment and the judgment was upheld by the appellate court.⁵¹

The Supreme Court of Illinois reversed and remanded the judgment of the appellate court, holding that: “[U]nder the doctrine of apparent authority, a hospital can be vicariously liable for the negligent acts of a physician providing care at the hospital, regardless of whether the physician is an *independent contractor*, unless the patient knows, or should have known, that the physician is an *independent contractor*.”⁵²

By referring to the prior discussion of the two types of agents for tort purposes – the servant agent and the independent contractor agent – it is noteworthy that the Supreme Court has misused the “independent contractor” label.⁵³ Dr. Frank was an on-staff physician.⁵⁴ He was neither

42. *Id.*

43. Interestingly, the court noted the hospital’s consideration of its active staff physicians as independent contractors. *Gilbert*, 622 N.E.2d at 791. I consider this a mischaracterization. The hospital did not pay Dr. Frank a salary or compensate him in any respect. *Id.* Independent contractors are paid non-servant agents. SEAVY, *supra* note 9, Ch. I § 6. Dr. Frank was not an agent at all. *Gilbert*, 622 N.E.2d at 791.

44. *Gilbert*, 622 N.E.2d at 791.

45. *Id.*

46. *Id.* at 791-92.

47. *Id.* at 792.

48. *Id.*

49. *Gilbert*, 622 N.E.2d at 792.

50. *Id.*

51. *Gilbert v. Frank*, 599 N.E.2d 143 (Ill. App. Ct. 1992).

52. *Gilbert v. Sycamore Mun. Hosp.*, 622 N.E.2d 788, 795 (Ill. 1993) (emphasis added).

53. *See id.*

54. *Id.* at 791.

a servant agent nor an independent contractor agent. He was not paid by the hospital.⁵⁵ Independent contractors are paid for their services. Simply stated, Dr. Frank, whose negligence could be imputed to the hospital, was *not* an agent of the hospital at all.

The supreme court then pronounced the elements of the action based upon apparent authority:

- The hospital, or its agent, acted in a manner that would lead a reasonable person to conclude that the allegedly negligent physician was an employee or agent of the hospital;
- the acts of the physician created the appearance of authority;
- the plaintiff must prove that the hospital had knowledge of and acquiesced in those acts, and
- the plaintiff acted in reliance upon the conduct of the hospital or its agent.⁵⁶

The “holding out” element under *Gilbert* is satisfied if the hospital holds itself out as a provider of emergency care without informing a patient that the care is provided by a non-agent.⁵⁷ The justifiable reliance element under *Gilbert* is satisfied if the patient relies on the hospital to provide complete emergency care instead of relying on a particular physician to provide care.⁵⁸ This element carries its own significant features and will be revisited later in this article.

The *Gilbert* court discussed the pre-*Gilbert* apparent authority/healthcare history in Illinois.⁵⁹ In *Sztorc v. Northwest Hospital*, the court considered a claim that the staff members of a hospital’s radiology department were apparent agents of the hospital in a negligence context.⁶⁰ The department was actually staffed by a radiology group.⁶¹ The radiologists had staff privileges but were not hospital employees.⁶² The radiology department doors display the names of the radiologists.⁶³

55. *Id.*

56. *See id.* at 795.

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

58. *Id.*

59. *See id.*

60. 496 N.E.2d 1200, 1201-02 (Ill. App. Ct. 1986).

61. *Id.* at 1200.

62. *Id.* at 1201.

63. *Id.*

There was no method by which patients or the public could differentiate employees of the radiology group from employees of the hospital.⁶⁴ The court referred to non-Illinois apparent authority cases and the plaintiff's testimony which indicated that she did not know if the "independence" of the radiologists would have made any difference to her.⁶⁵ The court held that a question of fact existed as to plaintiff's reliance on a holding out by the hospital and that there may be a basis in evidence for finding the hospital liable under apparent authority.⁶⁶

In *Greene v. Rogers*,⁶⁷ decided shortly after *Sztorc*, the court held that an emergency room physician, employed by a group which contracted with a hospital, was not a servant agent of the hospital.⁶⁸ The court refused to apply apparent authority in the healthcare context, noting that this doctrine is thought to be a contract theory.⁶⁹ The court would not recognize an exception to this usage.⁷⁰

In *Johnson v. Sumner*, another emergency physician case, the court followed its decision in *Greene*.⁷¹ It would not impute physician liability to the hospital in the absence of an express agency relationship between the hospital and the physician.⁷² The court was concerned that the application of apparent authority would fail to recognize that physicians, not hospitals, direct the care of patients.⁷³ The court was also concerned that apparent authority would not promote tort law policy which requires the tortfeasor to be financially responsible for his or her negligence.⁷⁴

In *Northern Trust Co. v. St. Francis Hospital*, the court considered yet another emergency physician apparent authority claim.⁷⁵ The emergency physician was employed by a practice group which contracted with the hospital.⁷⁶ The court found no actual agency relationship between the physician and the hospital and, therefore, the inapplicability of *respondeat*

64. *Id.*

65. *Sztorc*, 496 N.E.2d at 1202.

66. *Id.*

67. 498 N.E.2d 867 (Ill. App. Ct. 1986).

68. *Id.*

69. *Id.*

70. *Id.* at 872.

71. 513 N.E.2d 149, 151-52 (Ill. App. Ct. 1987).

72. *Id.* at 151.

73. *Id.*

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

75. 522 N.E.2d 699, 703 (Ill. App. Ct. 1988).

76. *Id.* at 702.

superior.⁷⁷ However, the court, citing *Sztorc*, held that apparent authority was an appropriate issue for the jury.⁷⁸

It is interesting that the Illinois Supreme Court relied, in part, on a Wisconsin Supreme Court opinion, *Pamperin v. Trinity Memorial Hospital*,⁷⁹ to support its application of apparent authority in *Gilbert*.⁸⁰ *Pamperin* concerned an apparent authority claim based upon the alleged negligence of a radiologist.⁸¹ The *Pamperin* court was much more concerned about the need to join *respondeat superior* and apparent authority to impose vicarious liability upon the hospital. The court found that the hospital did not exercise control over radiological services.⁸² The radiology group which employed the radiologist, maintained its own offices, was responsible for billing for professional services, established fees, provided its own professional liability insurance and could provide services to other hospitals.⁸³ The *Pamperin* court found there was no master-servant relationship between the hospital and the radiologist.⁸⁴ The court, therefore, would not apply *respondeat superior* but applied apparent authority as "consistent with this concept of the modern-day hospital facilities."⁸⁵ The *Gilbert* court really never addressed *respondeat superior* in any detail and, presumably, disregarded it.⁸⁶ In this fashion, the *Gilbert* court used apparent authority to create a fictitious agency relationship and to ignore or excuse *respondeat superior* as a doctrine to support the hospital's vicarious liability.⁸⁷

Four Illinois Supreme Court opinions purport to constitute the building blocks of *Gilbert*. These opinions are *State Security Insurance Co. v. Burgos*,⁸⁸ *Lynch v. Board of Education of Collinsville*,⁸⁹ *Faber-Musser Co. v. William E. Dee Clay Manufacturing Co.*,⁹⁰ and *Union Stock-Yard & Transit Co. v. Mallory, Son & Zimmerman Co.*⁹¹ The challenge is to determine if these opinions really support the application of apparent

77. *Id.*

78. *Id.* at 705.

79. 423 N.W.2d 848 (Wis. 1988).

80. 622 N.E.2d 788.

81. *Pamperin*, 423 N.W.2d at 849.

82. *Id.* at 852.

83. *Id.* at 853.

84. *Id.*

85. *Id.* at 855.

86. 622 N.E.2d 788.

87. *Id.* at 795.

88. 583 N.E.2d 547 (Ill. 1991).

89. 412 N.E.2d 447 (Ill. 1980).

90. 126 N.E. 186 (Ill. 1920).

91. 41 N.E. 888 (Ill. 1895).

authority to medical negligence committed by non-agent physicians occurring on hospital premises.

Regrettably, but not surprisingly, the aforementioned opinions do not provide any guidance or insight as to why the Illinois Supreme Court in *Gilbert* opted to recognize apparent authority in a healthcare context. In *State Security Insurance Co.*, the court considered the question of whether an insurance broker is an agent or apparent agent of an insurance company regarding the authority to accept notice of a claim.⁹² In *Lynch*, the court concluded that teachers were acting with the appearance of authority granted by the school board when coaching a powder puff football game in which plaintiff was injured.⁹³ In *Faber-Musser Co.*, the court considered apparent authority in the commercial context of a contract claim for damages based on the failure to deliver fire brick.⁹⁴ Finally, in *Union Stock-Yard & Transit Co.*, the court considered a trover action in connection with conversion of cattle.⁹⁵ The court's reference to apparent authority related to commercial transactions.⁹⁶

These cases are not particularly compelling reasons to apply apparent authority in the healthcare setting. Also not compelling is the court's comment, without citation, that "we conclude Illinois case law sufficiently recognizes the realities of modern hospital care and defines the limits of a hospital's liability."⁹⁷ The *Gilbert* court essentially created this case law.

Was the use of apparent authority the best approach for the Illinois Supreme Court to utilize in order to recognize that a hospital might be vicariously liable for the negligence of a non-agent physician committed on the hospital premises? Perhaps not. This question can be re-examined after an examination of the Illinois Supreme Court's extension of the *Gilbert* principles to the HMO context in *Petrovich v. Share Health Plan*.⁹⁸

In *Petrovich*, the court considered whether an HMO can be vicariously liable for the negligence committed by a non-agent physician who provided healthcare services through an HMO.⁹⁹ As with *Gilbert*, the basic facts are not complicated. Plaintiff's employer provided healthcare to its employees through an HMO.¹⁰⁰ The employees were enrolled in the

92. *State Sec. Ins. Co.*, 622 N.E.2d at 550.

93. *Lynch*, 412 N.E.2d at 456.

94. *Faber-Musser Co.*, 126 N.E. at 187.

95. *Union Stock Yard & Transit Co.*, 41 N.E. at 891.

96. *Id.* at 892-93.

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

98. 719 N.E.2d 756 (Ill. 1999).

99. *Id.* at 764.

100. *Id.* at 760.

HMO.¹⁰¹ For an employee to qualify for HMO healthcare, the employee must choose a physician from a list of participating physicians.¹⁰² The physician chosen by plaintiff was employed by a medical center satellite facility.¹⁰³ This facility contracted with the HMO to provide medical care to HMO members.¹⁰⁴ The HMO in *Petrovich* was an independent practice association (IPA) model.¹⁰⁵ This model contemplates that the HMO contracts with a physician organization, which contracts with individual physicians. In short, the HMO in *Petrovich* did not employ the chosen physician.¹⁰⁶ The physician was not an agent of the HMO.

In *Petrovich*,¹⁰⁷ plaintiff claimed that physicians who rendered care to her through the HMO were negligent in failing to diagnose cancer.¹⁰⁸ She also claimed that the HMO should be vicariously liable for this negligence under agency principles.¹⁰⁹

The other operative facts concern the HMO's "communication" to its members through a member handbook.¹¹⁰ The handbook did not identify the employment status of the HMO physicians.¹¹¹ It referred to them as "Share physicians," "your Share physician" and "our staff." It also characterized Share as "your health care manager," "a good partner in sickness and health," and stated that "Share would provide all healthcare needs."¹¹²

The Illinois Supreme Court in *Petrovich*, following its decision in *Gilbert*, held that apparent authority can be used to impose vicarious liability on HMOs.¹¹³ Curiously, the court pronounced, without citation: "The principle that organizations are accountable for their tortious actions and those of their agents is fundamental to our justice system."¹¹⁴ This pronouncement is simply not an accurate statement of law. Organizations or principals may be vicariously liable for the negligent torts committed by their servant agents within the course and scope of employment.¹¹⁵ The

101. *Id.* at 760-61.

102. *Id.* at 761.

103. *Petrovich*, 719 N.E.2d at 761.

104. *Id.*

105. *Id.* at 763.

106. *Id.* at 762-63.

107. *Id.*

108. *Petrovich*, 719 N.E.2d at 760.

109. *Id.*

110. *Id.* at 762.

111. *Id.* at 762.

112. *Id.*

113. *Petrovich*, 719 N.E.2d at 766.

114. *Id.* at 764.

115. SEAVY, *supra* note 9, Ch. III § 83.

supreme court apparently desired that we overlook the fundamentals of *respondeat superior*, as it held in *Gilbert*.¹¹⁶ Of course, even if a physician was directly employed by an HMO, the physician would seem more like an independent contractor agent than a servant agent due to the level of skill and expertise possessed by the physician as well as the need to exercise judgment in caring for patients. Consequently, the classic *respondeat superior* approach does not fit well in the HMO scenario.

More telling is the economic basis of *Petrovich*.¹¹⁷ The supreme court stated, "Moreover, HMO accountability is essential to counterbalance the HMO goal of cost-containment. To the extent that HMOs are profit-making entities, accountability is also needed to counterbalance the inherent drive to achieve a large and ever-increasing profit margin."¹¹⁸ This statement undoubtedly provides the true motive of *Petrovich*. If the physician group is compensated by the HMO on an annual basis to provide healthcare, the less healthcare provided to a patient population will theoretically yield a higher profit to the physician group. If the supreme court viewed cost-containment as a device by which to deny healthcare, the court might desire to impose vicarious liability upon the HMO as a semi-punitive, economic measure.

The supreme court in *Petrovich* had no trouble dealing with the holding out and justifiable reliance elements of apparent authority.¹¹⁹ If the HMO holds itself out as providing care without informing patients that it does not do so, the holding out requirement is satisfied.¹²⁰ The language of the member handbook fulfills this requirement.¹²¹

The justifiable reliance element is built into the HMO process. This element is satisfied by the employee having no choice but to enroll with the provided health plan. If the employee chooses a non-health plan physician, the HMO does not cover the medical costs. Essentially, the patient has no choice at all. The act of enrolling in the HMO with the attendant "choice" of a physician within the plan constitutes justifiable reliance.¹²²

116. 622 N.E.2d at 795.

117. 719 N.E.2d at 764.

118. *Id.*

119. *See generally id.* at 766.

120. *Id.*

121. *Id.* at 768.

122. *Petrovich*, 719 N.E.2d at 768-69.

VI. SPECIAL PROBLEMS

A. RELIANCE

When, under *Gilbert*, does the patient not fulfill the justifiable reliance requirement of apparent authority? Should a consumer-patient, unlikely ever to know the precise relationship between physician and hospital, have a realistic obstacle to hurdle insofar as this requirement is concerned?

Initially, it is noteworthy that *Gilbert* is not thought to limit the apparent authority-hospital scenario to emergency room care.¹²³ In fact, the vicarious liability of the hospital might exist even if the medical negligence did not occur in the hospital proper, but at an “affiliated” location.¹²⁴ Even an intentional tort can constitute the basis for hospital vicarious liability.¹²⁵ Justifiable reliance can, in any event, constitute a formidable problem.

Consider the following issues regarding the justifiable reliance on the “holding out” requirement:

- Can the patient justifiably rely only if the patient is conscious while treated? Can an unconscious patient rely upon anything at all?
- Can the patient justifiably rely if there is no choice of hospital to be made?
- Can the patient justifiably rely on the holding out of physicians whom the patient never sees, such as a radiologist, a pathologist or other physician-consultant?
- Upon what, precisely, is the patient relying? Is reliance necessary to “lure” the patient to the hospital in the first instance? What reliance exists if the patient has no choice but to go to a specific hospital?

In *Butkiewicz v. Loyola University Medical Center*, a patient was directed to a hospital by his primary physician.¹²⁶ The patient followed his physician’s advice.¹²⁷ Therefore, the appellate court held that a radiologist

123. *Malanowski v. Jabamoni*, 688 N.E.2d 732, 737 (Ill. App. Ct. 1997).

124. *Id.*

125. *Gragg v. Calandra*, 696 N.E.2d 1282, 1287 (Ill. App. Ct. 1998).

126. 724 N.E.2d 1037, 1038 (Ill. App. Ct. 2000).

127. *Id.*

who allegedly misinterpreted an x-ray was not the apparent agent of the hospital.¹²⁸ The patient's decision to enter the hospital was not due to a desire to receive treatment from the hospital.¹²⁹ The patient was conscious and relied upon his primary care physician's advice to enter the hospital.¹³⁰

In *James v. Ingalls Memorial Hospital*, a patient entered a hospital because she was a public aid recipient and believed she was required to go to that hospital for care.¹³¹ She testified that she would have gone to the hospital even if she knew that her physician was not an employee of the hospital.¹³²

In *Monti v. Silver Cross Hospital*, the appellate court considered the case of an unconscious patient receiving hospital care.¹³³ The court held that apparent agency could apply despite the patient's inability to decide which hospital to attend.¹³⁴ Essentially, the court reasoned that persons responsible to help the patient obtain emergency care relied on the hospital to provide this care.¹³⁵ The *Monti* court did not desire to exclude unconscious patients from using apparent authority to hold a hospital vicariously liable for medical negligence.¹³⁶

Of course, the "reasoning" in *Monti* further contorts the concept of apparent authority.¹³⁷ There simply cannot be any patient reliance when the patient is unconscious; there is no state of mind. That others may "rely" on the hospital by taking a patient to an emergency room is of no moment. There is either a reliance element or there is not. *Monti*¹³⁸ is a perfect example of how a contorted theory is easy to further contort by merely excusing proof of an element of the cause of action.

Under Illinois law, actual reliance on the apparent agency seems to be required.¹³⁹ How, then, should a court consider the following situation: Mother takes baby to Hospital A emergency room where child receives care. Mother is advised that child needs admission to intensive care unit, but there are no beds available in Hospital A. Attending physician at

128. *Id.* at 1041.

129. *Id.*

130. *Id.*

131. 701 N.E.2d 207, 211-12 (Ill. App. Ct. 1998).

132. *Id.* at 212.

133. 637 N.E.2d 427, 428 (Ill. App. Ct. 1994).

134. *Id.*

135. *Id.*

136. *Id.*

137. *Id.*

138. 637 N.E.2d 427.

139. *O'Banner v. McDonald's Corp.*, 670 N.E.2d 632, 634 (Ill. 1996) (citing *Gilbert v. Sycamore Mun. Hosp.*, 622 N.E.2d 788, 795 (Ill. 1996)).

Hospital A tells mother the child will be transferred to Hospital B, which is affiliated with Hospital A. Child is transferred and receives care at Hospital B, where medical negligence allegedly occurs. Is there a viable claim against Hospital B under an apparent authority theory? Mother clearly did not rely upon a holding out by Hospital B of physicians in deciding to transfer her child from Hospital A to Hospital B. The child was already at Hospital B when the allegedly negligent care was given. Should mother be able to “rely” on all care as administered by Hospital B, as an afterthought, since she was not lured to Hospital B by any “holding out” to her as a potential consumer or patient?

B. ILLINOIS PATTERN JURY INSTRUCTIONS FOR APPARENT AGENCY

As previously discussed, the reliance issues in apparent agency and healthcare can be complicated. The Illinois Civil Pattern Jury Instructions 105.10¹⁴⁰ and 105.11¹⁴¹ require proof that the patient relied upon the “apparent principal” to provide certain care. Is this the same reliance as that discussed in *Butkiewicz*¹⁴² and *James*¹⁴³ and required by *O’Banner*?¹⁴⁴ Does reliance exist to lure the patient to the hospital or to convince the patient that the hospital is providing all care once the patient has arrived at the hospital? Are these instructions subject to modification if the patient is not able to form the state of mind necessary to establish reliance?

C. APPARENT AUTHORITY AND OFF PREMISES HEALTH CARE

*Malanowski*¹⁴⁵ suggests that *Gilbert*¹⁴⁶ did not limit apparent authority to medical negligence committed within the hospital premises. If a patient sees a private physician, not recommended by a hospital, not provided through an HMO, at a non-hospital facility which bears the hospital name, is the hospital subject to vicarious liability based upon apparent authority? If the private physician’s group uses a name which incorporates the name or a portion of the name of a hospital, should the hospital subject itself to

140. 126 ILL. SUPREME COURT COMM. ON JURY INSTRUCTIONS IN CIVIL CASES, ILLINOIS PATTERN JURY INSTRUCTIONS: CIVIL No. 105.10 (3d ed. 1995).

141. 126 ILL. SUPREME COURT COMM. ON JURY INSTRUCTIONS IN CIVIL CASES, ILLINOIS PATTERN JURY INSTRUCTIONS: CIVIL No. 105.11 (3d ed. 1995).

142. 724 N.E.2d at 1040-1042.

143. 701 N.E.2d at 211-12.

144. 670 N.E.2d at 634-35.

145. 688 N.E.2d at 737.

146. 622 N.E.2d 788.

vicarious liability based upon apparent authority? If there is a purpose to apparent authority in healthcare, is the purpose achieved by imposing vicarious liability upon a hospital when care is not provided at a hospital?

VII. DOES APPARENT AUTHORITY WORK IN A HEALTH CARE CONTEXT WITH CLASSIC AGENCY PRINCIPLES?

Whether hospitals and HMOs should be subject to vicarious liability for the negligence of non-agent, non-employed healthcare providers is a subject for fair debate. Hospitals compete for healthcare dollars and this competition includes efforts to influence consumers to seek hospital services. It has been argued that vicarious liability is necessary in the managed care context as an attention-getting device and as an incentive to facilitate better care.¹⁴⁷

The problem, however, with the use in healthcare of the classic doctrine of apparent authority is that the doctrine is simply not a good fit. Remember, the use of apparent authority is only part of the classical vicarious liability process. Apparent authority is used to create an agency relationship where there is none. Vicarious liability for the negligence committed by an agent classically is based upon a master-servant agency relationship. Negligent torts committed by a servant within the course and scope of employment are imputed to the master. Physicians do not seem to qualify as servant agents even if they were compensated by hospitals. They occupy positions of skill, judgment and discretion. They are not subject to the right of control which characterizes a master-servant relationship.

The reason that apparent authority as an agency principle does not fit well with the debate over vicarious liability of hospitals and HMOs is that agency law has its roots in commercial transactions. In fact, Mechem, long ago, stated that agency "belongs to a condition of society in which commercial transactions are highly developed."¹⁴⁸

Why must the Illinois courts contort classic agency principles to effect policy decisions requiring hospitals and HMOs to vicariously answer for medical negligence? In a teaching context, *Gilbert*¹⁴⁹ and *Petrovich*¹⁵⁰ are difficult to explain. Should the student merely accept the position that apparent authority has always been a part of Illinois law? Should the

147. See Clark C. Havinghurst, *Vicarious Liability: Relocating Responsibility for the Quality of Medical Care*, 26 AM. J.L. & MED. 7 (2000).

148. MECHEM, *supra* note 10, Ch. I § 10.

149. 622 N.E.2d 788.

150. 719 N.E.2d 756.

student read the cases cited by the court to support these decisions or merely faithfully assume that there is case support? Should the student question pronouncements which seem to articulate well known legal principles but which are not followed by any citation of authority?

Instead of trying to squeeze apparent authority into healthcare like a shoe that does not fit, the Illinois Supreme Court could have applied a vicarious liability doctrine on a policy basis, driven by economic considerations. This would have provided students and the legal community with a modern, relevant approach to a legal issue. Instead, we are left with two significant Illinois Supreme Court opinions¹⁵¹ which have, regrettably, misused agency principles, and which are difficult to apply in practice.

151. See *supra* notes 1 and 2; see also *Burger v. Lutheran Gen. Hosp.*, 759 N.E.2d 533, 552, 557 (Ill. 2001) (recognizing Illinois Supreme Court's earlier references to *Petrovich, Gilbert and Pamperin.*) *Id.*