The Broad Extension of Hospital Liability
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Introduction

After a seven year decrease in the frequency of hospital professional liability claims, the United States saw a 1% increase in claim frequency against hospitals in 2008. Analysts anticipate that, nationwide, claim frequency will continue to increase by 1% each year. The severity of the costs associated with liability claims has consistently increased since 2004. Analysts predict that claim severity will continue to increase at 4% annually. While economic conditions, the Centers for Medicare and Medicaid Services reimbursement rule changes regarding “Never Events,” and constantly evolving societal perceptions regarding health care and health care providers are also factors in this increase, this article will focus on the status of medical malpractice law in the states where hospitals are experiencing the largest costs associated with professional liability claims.

Analysts describe the combined impact of claim severity and claim frequency in terms of “loss cost per occupied bed equivalent” (“Loss Cost”). For purposes of this article, Loss Cost is a measurement of the overall fiscal impact on hospitals resulting from liability claim severity, including indemnity and defense costs, and liability claim frequency; the statistics are generated by comparison to the average number of occupied hospital beds. The average Loss Cost across the U.S. is $3,170 per occupied bed equivalent. This healthcare expense borne by hospitals and insurers is growing at a rate of 5% annually.

Florida’s hospitals led the country in the highest number of large liability losses from 1999 to 2008 and are projected to experience the highest Loss Costs in 2010. Florida’s hospitals can anticipate Loss Costs of $6,300 in 2010 and an increase in that number by 6% annually. Pennsylvania ranked second in the highest number of large losses over that ten year period. While its hospital Loss Cost is not expected to increase, its 2010 Loss Cost is projected to remain the second highest in the nation at $5,490. Aon’s actuarial study projected that after Florida and Pennsylvania, the highest Loss Costs due to liability claims would be in Tennessee with a projected 2010 Loss Cost of $3,790 that is expected increase at 8% annually; followed by North Carolina with a projected 2010 Loss Cost of $3,630 that is anticipated to increase at 7% annually; and trailed by California with a projected 2010 Loss Cost of $3,340, which is estimated to increase at 7% annually.

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2 All statistics cited within this article were generated by and published in the 2009 AON/ASHRM HOSPITAL PROFESSIONAL LIABILITY AND PHYSICIAN LIABILITY BENCHMARK ANALYSIS; October 2009.
Generally, a hospital can be vicariously liable for the malpractice or negligence of its employees or agents and, in limited circumstances, for the malpractice or negligence of its independent contractors such as physicians through the apparent agency or ostensible agency theories of liability. Increasingly, some state courts have created causes of action against a hospital for its **direct liability**. The expansion and availability of this relatively new species of claim in states such as Florida, Pennsylvania, Tennessee, North Carolina and California is a significant contributing factor in the recent increases in Loss Costs in these states and the anticipated upward trend of such costs. This article will provide an examination of hospital liability in Florida, Pennsylvania, Tennessee, North Carolina and California as a representative sample where claims are the worst.

With the exception of California, these states generally hold that while the doctrine of respondeat superior, i.e. vicarious liability, permits a principal to be held liable for the negligent actions of its employee or agent, a principal is not generally liable for the tortious acts of an independent contractor. *Guadagno v. Lifemark Hospitals of Florida, Inc.*, 972 So.2d 214, 218 (Fla. 3d DCA 2007); *McDonough v. U.S. Steel Corporation*, 228 Pa. Super. 268, 274 (2003); *Boren v. Weeks*, 251 S.W.3d 426, 432 (Tenn. 2008); *Diggs v. Novant Health, Inc.*, 628 S.E.2d 851, 857 (N.C.App. 2006). Accordingly, a hospital cannot be vicariously liable for the malpractice or negligence of its independent contractor physicians unless the plaintiff proves that the physician was the apparent or ostensible agent of the hospital. *Roessler v. Novak*, 858 So.2d 1158, 1162 (Fla. 2d DCA 2003); *Goldberg ex rel. Goldberg v. Isdaner*, 780 A.2d 654, 660 (Pa.Super. 2001); *Boren*, 251 S.W.3d at 436; *Hylton v. Koontz*, 138 N.C.App. 629, 635 (2000). The determination of whether an independent contractor physician is the ostensible agent of the hospital is usually left to the jury. *Roessler v. Novak*, 858 So.2d 1158, 1162 (Fla. 2d DCA 2003); *Goldberg*, 780 A.2d at 660-61; *Boren*, 251 S.W.3d at 437; *Diggs*, 628 S.E.2d at 863; *Ermoian v. Desert Hospital*, 152 Cal. App.4th 475, 502 (4th Dist. 2007). Accordingly, in the vast majority of cases, hospitals in these states cannot avoid the expense of litigation even when the only alleged cause of action is premised upon non-employee physician conduct and inconsistent results are common given that this issue is typically decided by a jury.

**Florida**

Of these states, Florida law contains the most stringent requirements for establishing that an independent contractor physician is the ostensible agent of a hospital. In Florida, apparent agency only exists if the plaintiff proves all three of the following elements at trial: (1) a representation by the hospital that the physician was its agent or employee; (2) the plaintiff/patient relied on that representation; and (3) the plaintiff/patient changed her position in reliance on that representation. *Roessler v. Novak*, 858 So.2d 1158, 1161 (Fla. 2d DCA 2003); *Goldberg*, 780 A.2d at 660-61; *Boren*, 251 S.W.3d at 437; *Diggs*, 628 S.E.2d at 863; *Ermoian v. Desert Hospital*, 152 Cal. App.4th 475, 502 (4th Dist. 2007). Apparent agency cannot be proven by the subjective understanding of the person dealing with the purported agent or from appearances created by the purported agent. *Stone v. Palms West Hospital*, 941 So.2d 514, 519 (Fla. 4th DCA 2006).
In 2007, a Florida court first adopted a theory of direct liability against hospitals when it held that surgical hospitals have a non-delegable duty to provide non-negligent, competent surgical anesthesia services to patients. *Wax v. Tenet Health System Hospitals, Inc.*, 955 So.2d 1, *11 (Fla. 4th DCA 2007). Deliberately contravening Florida’s established common law that did not impose liability on hospitals for the negligence of physicians who were independent contractors absent a finding of apparent agency, the court found both statutory and contractual bases to justify the imposition of direct liability for breach of this non-delegable duty.

The contractual basis for the imposition of the non-delegable duty arose because the plaintiff signed an admission consent form headed with the hospital name wherein he agreed to “general, epidural and/or other regional anesthesia with or without sedation” and accepted specified risks associated with anesthesia. *Id.* at 6-10. The court held that the hospital had expressly contracted to undertake to perform the specific duty of providing competent anesthesia services, which implicitly meant non-negligent anesthesia services. *Id.* at 8, citing *Pope v. Winter Park Healthcare Group, Ltd.*, 939 So.2d 185 (Fla. 5th DCA 2006). Because delegated contractual duties do “not relieve the promisor of the duty to perform his obligation under the contract,” the hospital could not throw off its contractual obligation by hiring an independent contractor to perform the services. *Id.* at 9, citing *Pope*, 939 So.2d at 188-89.

The Fourth District court explained its intention to divest hospitals of their ability to avoid respondeat superior liability for physicians’ malpractice by using independent contractor arrangements. *Wax*, 955 So.2d at *11 fn 3, citing Judge Altenbernd’s concurring opinion in *Roessler v. Novak*, 858 So.2d 1158, 1163 (Fla. 2d DCA 2003). Judge Altenbernd previously asserted that Florida’s “twenty year experiment with the use of apparent agency as a doctrine to determine a hospital’s vicarious liability for the acts of various independent contractors has been a failure.” *Roessler*, 858 So.2d at 1163. Because hospitals have the ability to ensure that “competent radiologists (for example) work within an independent radiology department and to bargain with those radiologists to provide adequate malpractice protections for their mutual customers” and patients do not “usually have the option to pick among several independent contractors,” Judge Altenbernd felt the theory of nondelegable duty would best serve medical economics. *Id.* In the context of these recent opinions, the trend in Florida law is that hospitals have a nondelegable duty “to provide adequate radiology departments, pathology laboratories, emergency rooms, and other professional services necessary to the ordinary and usual functioning of the hospital.” *Id.* at 1165 citing *Restatement (Second) of Torts* § 416 (1965) and William L. Prosser, *Handbook on the Law of Torts* at 468 (4th ed. 1971); see *Wax*, 955 So.2d at *11 fn 3.

The Fourth District refused to expand its holding in *Wax* to a case where a patient selected an anesthesiologist to perform an elective procedure to address chronic back pain. *Kristensen-Kepler v. Northpoint Surgery & Laser Center*, 2010 WL 2675306 (Fla. 4th DCA July 7, 2010). The court explained that a surgical hospital’s nondelegable duty to provide non-negligent anesthesia services is limited to cases where the patient is directed to a hospital by a treating physician for a particular procedure, so that the patient “has little, if any, control over who administers the anesthesia.” *Id.* at *2.
In Tarpon Springs Hospital Foundation, Inc. v. Reth, 2010 WL 2696290, *1 (Fla. 2nd DCA July 9, 2010), the Second District certified conflict with the Fourth District’s holding in Wax. The court held that while a hospital has statutory obligations to have an anesthesia department, to ensure that department has appropriate numbers of qualified personnel available, and to ensure that department is directed by a physician employed by the hospital, “the applicable statutes and rules do not impose a nondelegable duty to provide anesthesia services to surgical patients.” *Id.* at *1-3. The Second District noted that “significantly” the plaintiff in Reth did not assert that any nondelegable duty arose by contract, leaving open the possibility that a hospital can contractually assume a nondelegable duty to provide non-negligent care. *Id.* at *2.

Although it could have, unfortunately, the Second District did not go so far as to hold that there could be no private cause of action against a hospital based on the cited statutes and regulations pursuant to the Florida Supreme Court’s holding in Murthy v. N. Sinha Corp., 644 So.2d 983, 986 (Fla. 1994) (a statute that does not purport to establish civil liability but merely makes a provision to secure the safety or welfare of the public as an entity, will not be construed as establishing a civil liability absent Legislative intent to create a private cause of action). Currently then, the Florida district courts are split, so that trial courts in the Second District will be bound by Tarpon Springs, the Fourth District will remain bound by Wax, and the First, Third and Fifth Districts will be free to do what they want. The Florida Supreme Court will probably address the certified question, but an opinion is likely several months away.

Pennsylvania

In Pennsylvania, the two factors required for a finding of ostensible agency are: (1) whether the patient looks to the hospital, rather than the individual physician, for care and (2) whether the hospital “holds out” the physician as its employee by act or omission which in some way leads the patient to a reasonable belief that he is being treated by the hospital or one of its employees. *Goldberg ex rel. Goldberg v. Isdaner*, 780 A.2d 654, 660 (Pa.Super. 2001). Pennsylvania courts permit the subjective determination of whether the patient sought care from the hospital instead of the physician to be established through inferences derived from the evidence; the patient is not required to make a sworn statement on that issue. *Id.* at 661, citing *Capan v. Divine Providence Hospital*, 430 A.2d 647, 649 (1980) and *Simmons v. St. Clair Memorial Hospital*, 481 A.2d 870, 874 (1984). With regard to the second factor, a “holding-out” by the hospital can be found when the evidence establishes that the hospital acted or failed to act in a way that would give the patient a “reasonable belief” that she was receiving care from the hospital or one of its employees. *Capan*, 430 A.2d at 649.

In 1991, the Pennsylvania Supreme Court adopted the theory of “corporate negligence” or “corporate liability” for hospital defendants. *Thompson v. Nason Hospital*, 591 A.2d 703, 708 (Pa. 1991). The court defined corporate negligence as “a doctrine under which the hospital is liable if it fails to . . . ensure the patient’s safety and well-being while at the hospital.” *Id.* at 707. Under this doctrine, an injured party can rely on the enumerated non-delegable duties owed by the hospital directly to the patient, instead of relying on and establishing the negligence of a third party as required for vicarious liability. *Id.* The Pennsylvania Supreme Court subsequently held that a cause of action for corporate negligence is based on the “policies, actions or inaction of the institution itself rather than the specific acts of individual hospital employees.” *Welsh v. Bulger*,
698 A.2d 581, 585 (Pa. 1997). Although the law remains unclear, it is possible that a court would permit a claim for corporate negligence to proceed even where the plaintiff fails to identify any negligence by a specific employee. In Thompson, the court held that the failure of a hospital’s unidentified employee(s) or agent(s) to report “abnormalities in the treatment and condition of its patients” - first, to the attending physician and then, if the attending physician failed to act on the information, to the hospital authorities - created a question of fact sufficient to survive the hospital’s motion for summary judgment. 591 A.2d at 709.

The Pennsylvania Supreme Court held that in order to establish direct liability against a hospital under the corporate negligence theory, a plaintiff must show: (1) that the hospital had actual or constructive knowledge of the defect or procedures which created the harm and (2) that the hospital’s negligence was a substantial factor in causing the harm to the injured patient. Thompson, 591 A.2d at 708. Hospitals are held to the standard of care of what “a reasonable hospital under similar circumstances should have done.” Edwards v. Brandywine Hospital, 652 A.2d 1382, 1387 (Pa.Super. 1995). Subsequently, the Pennsylvania Superior Court revised the test for corporate negligence, noting that the hospital’s knowledge of the defects or procedure that created the harm is the critical distinction between corporate negligence and vicarious liability. Kennedy v. Butler Memorial Hospital, 901 A.2d 1042, 1045-1046 (Pa.Super.Ct. 2006). A plaintiff must plead and prove that: (1) “the hospital deviated from the standard of care;” (2) “the hospital had actual or constructive notice of the defects or procedures that created the harm;” and (3) “the hospital’s act or omission was a substantial factor in bringing about the harm.” Id. at 1045.

Under Pennsylvania law, a hospital’s four non-delegable duties currently include: “(1) a duty to use reasonable care in the maintenance of safe and adequate facilities and equipment; (2) a duty to select and retain only competent physicians; (3) a duty to oversee all persons who practice medicine within its walls as to patient care; and (4) a duty to formulate, adopt and enforce adequate rules and policies to ensure quality care for the patients.” Thompson, 591 A.2d at 707 (citations omitted). The Edwards court held that corporate negligence is “systemic negligence,” which includes a hospital’s failure to formulate rules or policies for catheter care where that failure causes a patient to suffer routine infections when nursing staff leave catheters in the same spot for too long. 652 A.2d at 1387. Based on the trends in the development of corporate negligence in Pennsylvania, there remains the potential for an almost limitless common law expansion of a hospital’s non-delegable duties.

Tennessee

Tennessee adopted the Restatement (Second) of Torts § 429 regarding the standard for the vicarious liability of a hospital for its independent contractor. Boren, 251 S.W.3d at 436. To hold a hospital vicariously liable for the negligent or wrongful acts of an independent contractor, the plaintiff must prove that (1) the hospital held itself out as providing medical services, (2) the plaintiff looked to the hospital rather than the individual medical provider to perform those services, and (3) the patient accepted those services in the reasonable belief that the services were being rendered by the hospital or by its employees. Restatement (Second) of Torts § 429. Generally, a hospital may avoid liability by providing meaningful notice to a patient that the care is being provided by an independent contractor. Boren, 251 S.W.3d at 436. Tennessee courts
require that the meaningful notice is written and acknowledged at the time of admission. Id. However, even if a hospital does include such a disclaimer in the consent for care form, whether the hospital provided meaningful notice remains a question of fact for the jury. Id. at 437.

Tennessee has not adopted a broad version of corporate negligence. A hospital is generally liable for the negligence of its physicians in cases of negligent selection. A health-provider, including a hospital, that does not use due care in the selection of a physician to treat its patients is liable for the subsequent negligence or malpractice of the physician selected. Crumley v. Memorial Hospital, Inc., 509 F.Supp. 531, 535 (E.D. Tenn. 1978) (interpreting Tennessee state law). However, a hospital is not liable for the negligence of the physician selected by the hospital unless, at the time the physician was selected or subsequent to his selection, the hospital knew or should have known that the physician was incompetent to perform the duties he was reasonably expected to undertake. Edmonds v. Chamberlain Memorial Hospital, 629 S.W.2d 28, 29-30 (Tenn.App. 1982), affirming Crumley, supra (above). There is no presumption of negligent selection by the hospital by virtue of a physician’s subsequent negligent act. Id. at 30.

North Carolina

Like Tennessee, North Carolina adopted the Restatement (Second) of Torts § 429 as the the standard for the vicarious liability of a hospital for its independent contractor. See, supra; Diggs v. Novant Health, Inc., 628 S.E.2d 851, 862 (N.C.App. 2006). North Carolina courts similarly hold that a hospital may avoid liability by providing meaningful notice to a patient that the care is being provided by an independent contractor. Diggs, 628 S.E.2d at 862.

North Carolina was one of the first states to adopt the doctrine of corporate negligence of hospitals as an alternative to the doctrine of respondeat superior. Bost v. Riley, 262 S.E.2d 391, 395-96 (N.C.App. 1980). Its court of appeals held that because “today’s hospitals regulate their medical staffs to a much greater degree and play a much more active role in furnishing patients medical treatment,” hospitals owe their patients direct duties. Id. at 395. These duties include: (1) to make a reasonable inspection of equipment used in the treatment of patients and to remedy any defects discoverable by such inspection; (2) to provide equipment reasonably suited for the use intended; (3) to ensure that staff do not obey instructions of a physician that are obviously negligent or dangerous; (4) to promulgate adequate safety rules for the handling, storage and administration of medications; (5) to adequately investigate the credentials of a physician selected to practice at the facility; and (6) to make a reasonable effort to monitor and oversee the treatment which is prescribed and administered by physicians practicing at the hospital. Id. at 396 (citations omitted). The breach of any of these duties creates direct liability under the doctrine of corporate negligence. Id. The Bost court left open the possibility that a hospital could have any direct duty related to a patient’s reasonable expectation that a hospital will attempt to cure him. 262 S.E.2d at 396.

Like Pennsylvania, in North Carolina a hospital is held to the standard of a “reasonable man” with regard to certain aspects of its operation such as selection of agents; selection, inspection and maintenance of equipment; monitoring performance of staff physicians; enforcement of standards of Joint Commission on the Accreditation of Hospitals. Blanton v. Moses H. Cone Memorial Hospital, Inc., 354 S.E.2d 455, 458-59 (N.C. 1987). Following the
reasoning in *Bost*, a hospital’s duty to “make a reasonable effort to monitor and oversee the treatment” includes the specific duty to make a reasonable effort to ensure that a patient’s informed consent to a vaginal delivery of a footling breach baby was obtained prior to delivery, despite the obvious interference with the physician-patient relationship. *Campbell v. Pitt County Memorial Hospital*, 352 S.E.2d 902, 908 (N.C.App. 1987). Under the same rationale, a hospital also has the specific duty to establish an effective mechanism to ensure that hospital staff promptly report any situation that creates a threat to the health of a patient. *Id.* at 909.

**California**

California case law has so relaxed the standard for vicarious liability that “ostensible agency is readily inferred” unless the patient had some reason to know of the independent contractor relationship between the physician and the hospital. *Mejia v. Community Hospital of San Bernardino*, 22 C.R.2d 233, 237 (2002). To establish ostensible agency, the plaintiff must only prove that “(1): the service of the physician is performed on what appears to be the hospital’s premises; (2) a reasonable person in the plaintiff’s position would believe that the physician’s services are part and parcel of the services provided by a hospital; and (3) the hospital does nothing to dispel this belief.” *Ermoian v. Desert Hospital*, 152 Cal. App.4th 475, 505 (4th Dist. 2007), citing with approval *Stanhope v. L.A. Coll. Of Chiropractic*, 54 Cal.App.2d 141 (1942); *Seneris v. Haas*, 45 Cal.2d 291 (1955); *Quintal v. Laurel Grove Hospital*, 62 Cal.2d 154 (1964); and *Mejia v. Community Hospital of San Bernardino*, 99 Cal.App.4th 1448 (2002). California courts appear to have accepted as fact the generalization that “it is commonly believed that hospitals are the actual providers of care when someone seeks treatment at a hospital.” *Mejia*, 99 Cal.App.4th at 1456. Therefore, despite the fact that the burden is on the plaintiff to establish ostensible agency, a hospital has the burden to dispel both the public and individual plaintiff of the belief that the physician is an employee or agent of the hospital. To establish that a physician is an ostensible agent of a hospital, the plaintiff is **not** required to show that “the patient (1) actually believed that the doctors were employed by the hospital, or (2) changed her position or otherwise relied to her detriment based upon her belief that the doctors were agents of the hospital.” *Id.* at 505.

California’s common law has long held that a hospital has a duty of reasonable care to protect patients from harm encompasses a “duty to observe and know the condition of a patient.” *Rice v. California Lutheran Hospital*, 27 Cal. 2d 296, 304 (1945). A hospital’s conduct in performing this direct duty “must be in accordance with that of a person of ordinary prudence under the circumstances.” *Id.* In 1982, California adopted the doctrine of “corporate liability” for hospitals. *Elam v. College Park Hospital*, 132 Cal.App.3d 332, 335-338 (4th Dist. 1982) citing with approval *Bost v. Riley*, 44 N.C.App. 638 (1980). Under that theory, a hospital is directly liable to a patient for the negligence of a physician or surgeon who is an independent contractor but has privileges and avails himself of the hospital facilities. *Elam*, 132 Cal.App.3d at 335. A hospital may also be directly liable to a patient for the negligence of one of its physicians with staff privileges “if the hospital’s failure to ensure the competence of its staff through appropriate selection and review procedures creates an unreasonable risk of harm to its patients.” *Goodstein v. Cedars-Sinai Medical Center*, 78 Cal.Rptr.2d 577, 583-84 fn 4 (2nd Dist. 1998).
The Developing Trend: Corporate Negligence

There is disagreement among the state courts regarding whether or not the doctrine of corporate liability is pragmatically distinct from the theory of respondeat superior or ostensible agency. Because a hospital is not a natural person and cannot practice medicine, its liability for medical malpractice generally must be based upon vicarious liability for its employee or agent. See Ermoian, 152 Cal.App.4th at 502. It is arguable that corporate negligence is “no more than the application of common law principles of negligence and is not some recently developed doctrine upon which liability is based.” Blanton, 319 N.C. at 375-76. However, as the doctrine develops through common law, there is the potential for this form of direct liability to morph into a cause of action that truly is a broader form of hospital liability than that permitted under vicarious liability. For example, the form of corporate liability adopted by Pennsylvania is distinguishable from respondeat superior and ostensible agency. See J. Flaherty’s dissenting opinion in Thompson, 591 A.2d at 709. Pennsylvania’s version of corporate negligence may not require the plaintiff to identify any specific negligence by any identified employee or agent in complete abrogation of the traditional requirements for vicarious liability. The threat of the development of corporate liability that is truly separate and distinct from vicarious liability is real if states permit corporate liability to develop via the common law.

The case law reviewed for purposes of this article contains minimal, but poignant, judicial recognition of the economic burden placed on hospitals by the increasingly recognized doctrine of corporate negligence. The adoption of corporate liability is a “monumental and ill-advised change” in Pennsylvania law that reflects a “deep pocket theory of liability.” J. Flaherty’s dissenting opinion in Thompson, 591 A.2d at 709. Justice Flaherty recognized that the financial burdens associated with this theory of liability were being placed on hospitals at a time when “hospital costs are spiraling upwards to a staggering degree,” so that the public would be further burdened by the boost in health care costs. Id. The statistics substantiate this opinion and the authors of this article wholeheartedly agree. Nonetheless, more states have begun to recognize the theory of corporate liability as a cause of action whereby hospitals are directly liable to patients for physicians’ malpractice. See, e.g. Fridena v. Evans, 127 Ariz. 516 (1980); Felice v. St. Agnes Hospital, 411 N.Y.S.2d 901 (1978); Pedroza v. Bryant, 101 Wash.2d 226 (1984).

Recommended Approach: Statutory Liability

Given the rising costs of health care and the increasing burden on taxpayers to pay for this health care, the authors of this article encourage states to codify the causes of actions for and limitations on the liability of hospitals for the malpractice of physicians. Whether state legislatures choose to adopt a bright line rule for the imposition of vicarious liability with respect to independent contractor physicians or opt to impose a version of the doctrine of corporate negligence, it is of great public importance for patients, hospitals, and their insurers to have predictable rules that establish the parameters of hospital liability. As illustrated above, permitting hospital liability to develop through the common law approach results in vague standards with often limitless possibilities for courts to expand a hospital’s liability after the alleged negligence has already occurred. The post-incident determination of vicarious liability
unfairly increases society’s healthcare burdens while failing to give states, health care providers, insurers and patients the opportunity to plan for such occurrences.

The ultimate issue courts are struggling with is how to provide a medical malpractice plaintiff with a deep-pocketed defendant when the at-fault physician’s insurance does not fully cover their damages. The most straightforward way to provide this cost-shifting and predictability would be for legislatures to dictate that for purposes of determining a hospital’s liability for the medical malpractice of a physician, all physicians are considered employees of a hospital when they are providing health care on hospital grounds. Unfortunately, this simplistic approach would wreak havoc on the relationship between hospitals and community doctors. Hospitals would be incentivized to hire their own physicians and provide insurance for those physicians, which would result in hospitals attaining an unfair advantage with regard to insurance pricing, and eventually, community physicians would be forced out of business. The better solution is for state legislatures to impose caps on certain types of medical malpractice damages and require physicians to maintain insurance that would satisfy an award up to those caps.