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IN THE SUPREME COURT OF FLORIDA

Case No.: SC19-685

GUILLERMO TABRAUE, III, ESQ. as Personal Representative of the Estate of SUYIMA TORRES,

Petitioner,

vs.

L.T. Case Nos.: 3D16-1661; 14-002006-CA-24

DOCTORS HOSPITAL, INC., ET AL.,

Respondents.

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On Discretionary Review from the District Court of Appeal, Third District, State of Florida

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INITIAL BRIEF OF PETITIONER

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PRELIMINARY STATEMENT

"TR" and "AR" refer, respectively, to the trial court's record and the record in the district court of appeal.

Because this is an appeal of an order dismissing a complaint, the facts stated in the statement of facts are taken from the dismissed second amended complaint. (TR417-35.)

This brief cites to many sources not available on Westlaw, such as: treatises and law review articles from the 1800's and early 1900's; history books; and published studies. The undersigned obtained these non-Westlaw sources from, among other places, libraries and online databases. To assist the Court and opposing counsel, the undersigned has attempted to include in the appendix excerpts of the non-Westlaw materials cited in this brief. The table of citations includes references to where these non-Westlaw materials may be found in the appendix.

INTRODUCTION

When a patient seeks emergency care from a hospital and dies because of the negligence of a contractor physician, is only the physician liable? Or may the physician's negligence be imputed to the hospital—irrespective of the physician's employment status—because the hospital's duty to the patient is nondelegable?

The answers to these questions lie in the law of imputed negligence, a broad doctrine that encompasses *respondeat superior*, nondelegable duty, and apparent agency. *See* W. Page Keeton et al. *Prosser and Keeton on Torts* §§ 69-74, at 499-533 (5th ed. 1984). "Imputed negligence" is "[n]egligence of one person charged to another." *Black's Law Dictionary* (11th ed. 2019). Due to the absence of any express legislative direction, this Court must choose the best common-law rule for imputing negligence that occurs in a hospital's emergency department. In choosing, this Court should be guided by "judicial opinions, legislation, treatises, and scholarly writings." *Air & Liquid Sys. Corp. v. DeVries*, 139 S. Ct. 986, 992 (2019) (Kavanaugh, J.)

The best rule is nondelegable duty—not *respondeat superior* or apparent agency—because it supports legislative policy, justly holds hospitals responsible for their obligations, recognizes the modern hospital as an enterprise with direct duties to patients, and achieves predictability in the law. Nondelegable duty "hold[s] the employer liable for the negligence of the contractor," even if the employer "has himself done everything that could reasonably be required of him." Keeton, *supra*

§ 71, at 511. It is a rule of vicarious liability, *id*., with deep common-law roots, *e.g.*, *Hole v. Sittingbourne and Sheerness Railway Co.*, 6 H. & N. 488 (1861).

To grasp this Court's duty to fashion a rule for imputing negligence (even without express legislative direction), one must trace the path of Florida's common law from its origins. *See* Oliver Wendell Holmes, *The Path of the Law*, 10 Harv. L. Rev. 457, 468–69 (1897). From 1822 to 1829, Florida's legislature enacted various statutes adopting the English common law, the last of which is still in effect today. James W. Day, *Extent to Which the English Common Law and Statutes are in Effect*, 3 Fla. L. Rev. 303, 303, 306-08 (1950); § 2.01, Fla. Stat. (2019). This common law has adapted over time to account for "modern conditions" and "modern statutory provisions." *Banfield v. Addington*, 104 Fla. 661, 673 (1932).

This common-law tradition of judges "discovering" the law, however, must give way to the written laws enacted by the People and their representatives. *See* Antonin Scalia, *Common-Law Courts in a Civil-Law System…*85-86 (Tanner Lectures March 1995) (https://tannerlectures.utah.edu/_documents/a-to-z/s/scalia97.pdf). Still, when the legislature "has not prescribed specific rules," the judiciary "must develop the amalgam of traditional common-law rules, modifications of those rules, and newly created rules." *The Dutra Group v. Batterton*, 139 S. Ct. 2275, 2278 (2019) (Alito, J.). Stated another way, gaps exist in statutes and constitutions, and the courts must fill these gaps with the common law.

Over centuries, judges made—and often changed—the common-law rules for imputing negligence. *See* Harold J. Laski, *The Basis of Vicarious Liability*, 26 Yale L.J. 105, 109–11 (1916). Legislators played no part in shaping these rules. So, by declining to apply one judge-made rule (nondelegable duty) and leaving in place other judge-made rules (*respondeat superior*/apparent agency), the Third District here did not defer to legislators; instead, it chose certain judge-made rules over other judge-made rules. The Third District made a judicial policy without considering the Legislature's policy. This was error. In "exercising its inherent common-law authority," a court "should look primarily to...legislative enactments for policy guidance. *The Dutra Group*, 139 S. Ct. at 2278 (Alito, J.).

For over a century, this Court has applied judge-made rules to impute negligence. *See, e.g.*; *Camp v. Hall*, 39 Fla. 535, 562-63 (1897) (nondelegable duty); *Parrish v. Clark*, 107 Fla. 598, 603 (1933) (hospital vicariously liable due to patient's contract). It has done so to fill legislative gaps. For example, when in the early 1900's the Legislature created a cause of action for a child's wrongful death, its statute was silent on whether masters were liable for deaths caused by their servants. *See Nolan v. Moore*, 81 Fla. 594 (1920). This Court held that statutes "must be read in the light of the principles of the common law." *Id.* at 605. Thus, it was "wholly unnecessary" for the Legislature to expressly say in the statute that a master was liable if his servant negligently caused a death. *Id.* at 606. This gap was filled

by a common-law imputation rule: *respondeat superior*. *See id.* at 605-06.

This case concerns emergency care in a hospital. Our Legislature's policy is clear: "Every general hospital which has an emergency department shall provide emergency services and care for any emergency medical condition." § 395.1041(3)(a), Fla. Stat. (2012). Unlike other medical care, only a licensed hospital may provide emergency care, and it must provide such care. A hospital has no power to decline such care. In contrast, a patient has no power to choose her emergency physician; the hospital chooses.

So, the Legislature's policy holds hospitals responsible for providing patients with emergency care. This Court must respond and fashion a common-law imputation rule that best fits this legislative policy. Nondelegable duty is that rule. The competing common-law rules (*respondeat superior*/apparent agency) are: unmoored from legislative policy; manipulated by hospitals to avoid responsibility; ignore the hospitals' profits from emergency care and their statutory and contractual duties to patients; and have produced unpredictability. Applying a rule of nondelegable duty will correct these faults and injustices.

STATEMENT OF THE CASE AND FACTS

Statement of Facts. Petitioner is the personal representative of Suyima Torres' estate (Estate). (TR417-18, ¶3.) Mrs. Torres was a healthy, 28-year-old married mother of two young daughters. (TR421, ¶16.) On April 11, 2013, she

received a cosmetic injectable at a facility. (*Id.* at ¶17.) As she left the facility, she nearly fainted, prompting a bystander to call 911. (*Id.*) Fire rescue transported her to the hospital of Respondent, Doctors Hospital (Hospital). (*Id.*) The Florida Agency for Health Care Administration, under Chapter 395, Florida Statutes, has licensed the Hospital to provide emergency medical services. (AR89.)

Between when fire rescue took Mrs. Torres' vitals, and when her vitals were recorded at the hospital, her pulse rate accelerated, her oxygen saturation precipitously dropped, and she was noted to be "in distress." (TR421, ¶¶18-19.) Despite her health issues, Mrs. Torres remained alert and oriented x4 both in the ambulance and when admitted to the emergency department. (*Id.*) The Third District, however, incorrectly stated in its opinion that "Ms. Torres lost consciousness" and was "incapacitated" when she arrived at the emergency department. (AR210-11.)

The Hospital's staff performed an ECG and reported the abnormal findings to the emergency physician, Dr. Joseph Bowers. (TR421, ¶20.) Dr. Bowers, and other health care providers, failed to timely evaluate Mrs. Torres, or perform the necessary emergency treatments. (TR422, ¶¶21-26.) Over five hours after her admission, Mrs. Torres was transferred to the Hospital's intensive care unit. (*Id.* at ¶¶ 19, 26.) Later, Mrs. Torres died because of the substandard care provided. (TR423 at ¶¶28-29.)

Trial court proceedings. The Estate sued the Hospital, two physicians, and the physicians' groups. (TR418, ¶¶ 4-6.) This appeal concerns the Estate's claims

against the Hospital pled in counts 5 to 8 of the second amended complaint. (TR428-32.) Those counts alleged that: the Hospital had a nondelegable duty—under statutes, regulations, contract law, and the common law—to provide medical care to Mrs. Torres; it had breached that duty; and the breach caused Mrs. Torres' death. (*Id*.) The Estate did not rely on agency or any other imputation rule to hold the Hospital liable. (*Id.*) After a series of amendments, summary judgment rulings, hearings, and motion practice (AR21-22), the trial court dismissed with prejudice counts 5 to 8 of the complaint (TR841-42). The Estate appealed. (TR830.)

Proceedings in the Third District. Judge Scales and then-Judges Lagoa and Luck held oral argument on May 10, 2017. Twenty-two months later, Judge Scales authored a 13-page opinion, joined by Judges Salter and Fernandez, affirming the trial court's dismissal. (AR209-22.) The panel acknowledged that, under settled case law dating back to 1982, a hospital could not avoid responsibility for negligent emergency medical services simply because it hired an independent contractor to provide the services, at least in the absence of an express contract. (AR219-220 (citing *Irving v. Doctors Hosp. of Lake Worth, Inc.*, 415 So. 2d 55 (Fla. 4th DCA 1982); *Newbold-Ferguson v. Amisub (N. Ridge Hosp.), Inc.*, 85 So. 3d 502 (Fla. 4th DCA 2012)); *see also Pardo v. State*, 596 So. 2d 665, 666 (Fla. 1992) (requiring trial courts to follow any DCA's decision absent a DCA conflict).

Despite this longstanding Fourth District precedent with which no other DCA

had disagreed, the panel said it would "expand[]" liability if it followed this precedent. (AR221.) Of course, by repudiating precedent that had established such liability throughout Florida, the panel was *reducing* liability, at least in the Third District. The panel noted the statutes regulating emergency medical services (Chapter 395) were "*silent*" about nondelegable duty. (*id.*), just as they are silent on any common-law rule imputing negligence (*respondeat superior,* apparent agency, etc.). Due to this silence, the panel opined this case presented "a public policy decision that is within the purview of Florida's legislative branch," or, "to the extent the issue is one of common law, it call[ed] for a Florida Supreme Court decision." (AR221.) The panel thus certified conflict to let this Court decide. (AR221-22.)

SUMMARY OF ARGUMENT

Because of the Legislature's silence, this Court must make a choice. It must decide whether to apply the judge-made nondelegable-duty rule to impute negligence to a modern hospital emergency department, or instead just allow other judge-made rules (*respondeat superior* or apparent agency) to fill the legislative gaps. This Court cannot punt to the Legislature or another court.

The common-law rule of nondelegable duty is not new. Like *respondeat superior*, its roots can be traced to Lord Holt's 1709 rule. *Infra* at 12-14. It took shape in the mid-1800's, and Justice Holmes used it in 1889. *Infra* at 18-20 The rule has been applied to hold many enterprises responsible for the hazards of their

business. This Court in 1933 applied the rule to hold a hospital enterprise responsible for medical negligence. *See infra* at 45-47 (discussing *Parrish*, 107 Fla. at 603).

In modern times, the respected Judge Altenbernd taught us why nondelegable duty is the best rule for imputing medical negligence to a hospital's emergency department and other core functions. *Roessler v. Novak*, 858 So. 2d 1158, 1163-65 (Fla. 2d DCA 2003) (Altenbernd, C.J. concurring) (citing Oliver Wendell Holmes, *The Common Law* 89–90 (1881)). After concluding the most commonly used rule (apparent agency) had been a "failure" because of the unnecessary litigation, inefficiencies, and unpredictability it has spawned, Judge Altenbernd made the case for the nondelegable-duty rule:

> [H]ospitals should be vicariously liable…for activities within the hospital where the patient cannot…realistically…shop on the open market for another provider. Given modern marketing…in which hospitals aggressively advertise the quality and safety of [their] services …, it is quite arguable that hospitals should 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. The patient does not usually have the option to pick among several independent contractors at the hospital and has little ability to negotiate and bargain in this market….

Id. at 1164-65.

In reasoning that applies equally to emergency departments and physicians, Judge Altenbernd added: "The hospital…has great ability to assure that competent radiologists work within an independent radiology department and to bargain with

those radiologists to provide adequate malpractice protections for their mutual customers." *Id.* at 1165. And he noted: "Our society can undoubtedly function well and provide insurance coverage to protect the risks of malpractice if there is either broad liability upon the hospital for these services as nondelegable duties or if liability is restricted to the independent contractor." *Id.* at 1163. Other judges have supported Judge Altenbernd's reasoning. *See Kristensen-Kepler v. Cooney*, 39 So. 3d 518, 520 n.1 (Fla. 4th DCA 2010); *Pope v. Winter Park Healthcare Group, Ltd.*, 939 So. 2d 185, 186–87 (Fla. 5th DCA 2006); *Wax v. Tenet Health Sys. Hosp., Inc.*, 955 So. 2d 1, 11 n. 8 (Fla. 4th DCA 2007).

Judge Altenbernd was filling legislative gaps, just as Justice Holmes taught us to do when applying the common law: "I recognize without hesitation that judges do and must legislate, but they can do so only interstitially; they are confined from molar to molecular motions." *S. Pac. Co. v. Jensen*, 244 U.S. 205, 221 (1917) (Holmes, J. dissenting). The common-law rules for imputing negligence have interstitially filled legislative gaps for over 300 years.

Honoring Justice Holmes' "molar to molecular" admonition, we do not seek a broad rule to hold hospitals vicariously liable for all medical negligence in their facilities. Instead, solely for medical negligence in a hospital's emergency department, we ask the Court to cease using judge-made imputation rules (*respondeat superior* and apparent agency) that have not worked in emergency

departments, where many contractors work side-by-side to care for patients. *See Roessler*, 858 So. 2d at 1163 (Altenbernd, C.J. concurring). In lieu of these failed rules, we ask the Court to apply a different, well-established common-law imputation rule—nondelegable duty—a sibling of *respondeat superior*.

This Court should rule interstitially, leaving for another day such questions as: Could a hospital disclaim its nondelegable duty in a contract signed by the patient upon admission in the emergency department? Should the nondelegable-duty imputation rule apply to any other core medical services offered by a hospital (as suggested by Judge Alternbernd), or be limited solely to emergency care?

To fashion a common-law rule, this Court should consider "judicial opinions, legislation, treatises, and scholarly writings." *DeVries*, 139 S. Ct. at 992.[1] Using this process, we journey the path of the law of imputed negligence and the history of hospitals and emergency departments. *See infra* Part I, at 11. Then, we make the case that nondelegable duty is the best common-law rule for imputing medical negligence in an emergency department. *See infra* Part II, at 50.

[1] In federal maritime cases (*DeVries* and *Dutra Group*, 139 S. Ct. at 2275), a federal court acts as a "'common law court,' much as state courts do in state common-law cases." *DeVries*, 139 S. Ct. at 992 (2019). Though *DeVries* and *Dutra Group* are not binding on this Court, they may persuade it on how to fashion common-law rules.

ARGUMENT

Issue presented: **Whether a physician's negligence occurring in a hospital's emergency department should be imputed to the hospital under the common-law nondelegable-duty rule (used by courts for over 165 years) in lieu of other imputation rules (like *respondeat superior* or apparent agency).**

Standard of review: *De novo*. *E.g., Siegle v. Progressive Consumers Ins. Co.*, 819 So. 2d 732, 734 (Fla. 2002) (order dismissing a complaint).

I. The path of the law of imputed negligence and the history of hospitals.

"If we want to know why a rule of law has taken its particular shape," we must know the path of the law and its history "because without it we cannot know the precise scope of rules which it is our business to know." Holmes, *supra*, 10 Harv. L. Rev. at 468–69. Buckle up. We are about to guide you through the history of: (A) the law of imputed negligence; (B) hospitals, emergency departments, and their federal and state regulations; and (C) how negligence has been imputed to hospitals. The path we travel will teach that nondelegable duty grew out of the same branch of the law as *respondeat superior*, and that it is the "best fit" to plug the legislative gap for imputing negligence in the modern hospital's emergency department.

A. The path of the common law of imputing negligence.

Imputed negligence, also known as vicarious liability, is a common-law doctrine that judges, not legislators, have developed over the centuries. This doctrine has many branch lines sharing common origins: *respondeat superior*, nondelegable duty, apparent agency, etc. *See* Keeton, *supra* §§ 69-71 at 500-03, 508, 511-15.

Justice Douglas once queried, "[W]hat rationale justifies the various rules of

vicarious liability in modern society?" William O. Douglas, *Vicarious Liability and Administration of Risk I*, 38 Yale L.J. 584, 584 (1929). In the early twentieth century, the "most commonly accepted" rationale (the "entrepreneur theory") was that the "hazards of a business should be borne by the business directly." *Id.* at 585-86; *see* Keeton, *supra* §§ 69, 71 at 500-01, 509. A related rationale is that vicarious liability "ensures that a financially responsible party will cover damages." *Am. Home Assur. Co. v. Nat'l R.R. Passenger Corp.*, 908 So. 2d 459, 467 (Fla. 2005) (citing Restatement (Third) of Torts: Apportionment of Liability § 13 cmt. b. (2000).) These rationales fit the modern hospital. Courts arrived at these rationales after a long journey; we start our trip with Lord Holt's rule, the parent of vicarious liability.

1. The parent of vicarious liability: Lord Holt's rule.

Today's modern lawyer is most familiar with the imputation rule of *respondeat superior*—also called the actual-agency or master-servant rule[2]—under which an "employer or principal [is held] liable for the employee's or agent's wrongful acts committed within the scope of the employment or agency." *Black's*

[2] Differences may exist between the actual-agency and master-servant (a/k/a employer-employee) rules. *See, e.g., Goldschmidt v. Holman*, 571 So. 2d 422, 424 & nn.3, 5 (Fla. 1990). For our purposes, these differences are not germane, as the central inquiry of both rules is whether the principal/employer/master has a "right to control" the acts of the agent/employee/servant. Also, sometimes, the phrase "*respondeat superior*" is used to refer to all forms of vicarious liability. *See* Keeton, *supra* § 69, at 499. In this brief, however, we use this phrase to refer solely to the master-servant and actual-agency rules and not to other imputation rules (*e.g.* apparent agency or nondelegable duty).

Law Dictionary (11th ed. 2019). In modern times, an employer is liable under *respondeat superior* for the negligence of an "independent contractor" only if he has the "right to control" the contractor. *Stoll v. Noel*, 694 So. 2d 701, 703 (Fla. 1997) (agency); *Gulf Ref. Co. v. Wilkinson*, 94 Fla. 664, 668-69 (1927) (master-servant).

But the "right to control" principle was not always the rule. In the sixteenth and seventeenth centuries, English common law held a master liable for his servant's tort only if the master expressly commanded the tortious act. Keeton, *supra* § 69, at 500; *accord* John H. Wigmore, *Responsibility for Tortious Acts: Its History. - II*, 7 Harv. L. Rev. 383, 392 (1894). Then, in the eighteenth century, the law changed. English courts found the old rule "far too narrow to fit the expanding complications of commerce and industry;" thus, they expanded the rule to make a master strictly liable for his servant's torts performed within the scope of the servant's employment. Keeton, *supra* § 69, at 500. The principal architect of this change was Lord Holt.

Today's *respondeat-superior* rule, like its sibling imputation rules (nondelegable duty and apparent agency), has its roots in cases decided by Lord Holt from 1690 to 1709, where the torts were "inextricably bound up with a contract." *See* T. Baty, *Vicarious Liability* 11, 24-26 (1916) (discussing *Hern v. Nichols*, 1 Salk. 289 (1709) and other cases). In *Hern*, a merchant's agent lied to a purchaser about the quality of goods sold; the purchaser sued the merchant for "deceit." *Id.* 9-10. Lord Holt ruled the merchant was liable for the agent's tort, and his rule rested

on the "privity" between the merchant and the purchaser. *Id.* at 10, 11-12. The merchant, engaged in an enterprise, was responsible because he had tacitly invited the purchaser to place confidence in the agent. *Id.* at 12; Wigmore, *supra*, 7 Harv. L. Rev. at 398. Lord Holt's rule was grounded in morality and a sense of justice. *See* Baty, *supra* 13; Wigmore, *supra*, 7 Harv. L. Rev. at 393 n.1. An enterprise should be responsible for the torts resulting from its business.

2. The path of *respondeat superior* and its "right to control" principle.

Lord Holt's rule changed with time. By the end of the eighteenth century, the rule had drifted from its original purpose and lost its moral foundation. *See* Baty, *supra* 13, 28, 31. The evolved rule allowed a principal to be liable to a third party with whom the principal had "no privity" and to whom he owed "no moral responsibility." *Id.* at 13. According to Blackstone in 1765, the rule had evolved such that "if a servant by his negligence does any damage to a stranger, the master shall answer for his neglect." *Id.* at 28.

How far Lord Holt's rule had wandered is best illustrated by the seminal 1799 English case of *Bush v. Steinman*. There, a homeowner (desiring to repair his house) contracted with a surveyor, who contracted with a carpenter, who contracted with a bricklayer, who contracted with a lime-burner. 1 Bos. & Pul. 404. The lime-burner negligently laid lime in the road adjacent to the house, causing the plaintiff's carriage to overturn. *Id.* The homeowner was found liable for the lime-burner's negligence

(his sub-sub-sub-sub-contractor), even though, unlike the merchant in Lord Holt's case, he was not engaged in any enterprise, had no privity with the plaintiff, and owed no duty to the plaintiff. *See id.* at 406-10.

Bush (decided in 1799) was followed by a period of 40-50 years in which courts rejected today's rule that precludes employer liability for the negligence of an independent contractor. *See* 4 Thomas Beven, *Negligence in Law* 597-600 (1908) (discussing *Bush*); Keeton, *supra* § 71, at 509 n.4 (citing *Inhabitants of Lowell v. Boston & L.R. Corp.*, 40 Mass. 24 (1839)); *Stone v. Cheshire R. Corp.*, 19 N.H. 427 (1849)). As a commentator noted: "For a time there was an inclination to favour the proposition that a person is answerable for injury arising in executing work that he has employed another to do; and to hold that the question whether a man were contractor or servant made no difference in the liability of his employer." 4 Beven, *supra* 597 (emphasis added).

Clearly, if the 1799 *Bush* ruling—which sprung from Lord Holt's rulings from 1690 to 1709—stated today's rule, a hospital would be liable for the torts of its contractor physicians under *respondeat superior*. But it is not today's rule because judges—not legislators—have since changed the rule.

In 1844, Justice Story in his commentaries disapproved of *Bush*, describing a then-recent contrary 1840 English decision, *Quarman*, as the "better opinion." Joseph Story, *Commentaries on the Law of Agency as a Branch of Commercial and*

Maritime Jurisprudence § 453a, at 558 & nn.1-2 (2d ed. 1844); (citing *Quarman v. Burnett*, 6 Mees. & Welsb. 499, 509, 510 (1840)). By the 1850's, American judges were agreeing with Justice Story and rejecting *Bush*'s rule. *See, e.g., Blake v. Ferris*, 5 N.Y. 48, 62-65 (1851); *Hilliard v. Richardson*, 69 Mass. 349, 357 (1855).

Bush's unsound rule failed because it lacked a limiting principle. *See* Clarence Morris, *Torts of an Independent Contractor*, 29 Ill. L. Rev. 339, 345 n. 10 (1934). True, *respondeat superior* (even under *Bush*) had limited a master's liability to a servant's acts within the "'scope of authority,' 'exercise of trade,' or 'course of employment.'" Wigmore, *supra*, 7 Harv. L. Rev. at 397-98 & n.1. But to provide any concrete limit on an employer's liability, these concepts had to be coupled with a "fiction" that long had been embedded in *respondeat superior*: a servant acts in the scope of his employment only if the master has given him an "implied command." *Cf.* Laski, *supra* 26 Yale L.J. at 115–16 (discussing this "fiction"). *Bush* had erased this "implied command" fiction from the law of *respondeat superior.*

Reacting to the path taken by *Bush*'s rule of near limitless liability, nineteenth-century courts made a course correction. They restored the "implied command" fiction into *respondeat superior*. They required proof that the tort was "done by one whom [the employer] had the right to command, over whose conduct he had the efficient control, whose operations he might direct, whose negligence he might restrain." *E.g., Hilliard*, 69 Mass. at 366 (emphasis added); *see* Story, *supra* § 453b,

at 559-60 (noting, under *Quarman,* a master was liable for his servant's torts because the servant was "bound to receive and obey" the master's orders); *Mumby v. Bowden,* 25 Fla. 454, 456-57 (1889) (citing *Hilliard*; an employer is relieved from liability if the work was under "the independent control of the employé or contractor").

This "right to command" limiting principle still exists today, relabeled as the "right to control." *See, e.g. Stoll v. Noel*, 694 So. 2d 701, 703 (Fla. 1997). The principle is linked to the "entrepreneur" rationale for vicarious liability. *Cf.* Douglas, *supra*, 38 Yale L.J. at 585-86. For example, the common law generally did not impute an independent contractor's negligent work to his employer because such work was "to be regarded as the contractor's own enterprise" if the employer had no "control over the manner in which the work [was] to be done by the contractor." Restatement (Second) of Torts § 409 cmt. b (emphasis added).

While the "right to control" principle corrected *Bush*'s overextension of Lord Holt's rule, it never was meant to erase the core of the rule—that a principal "in privity" with a party (i.e., a principal who directly owes a duty to the party) cannot escape his responsibilities to the party by sending someone else (agent or contractor) to carry out his business. No court has ever held that a plaintiff's only recourse to impute a contractor's tort to the employer is to show the employer's "right to control" under *respondeat superior*. Such a rule would have perverse consequences. It would tempt a principal to delegate away all his duties (even those owed by statute

or contract to a party "in privity" with the principal) and cede his control to contractors, just so the principal can evade all his responsibilities.

To avoid this unjust result, judges in the mid-1800's started another path of the law at the same time they were developing the "right to control" principle. They "discovered" the nondelegable-duty rule, another branch of imputed negligence that is an offspring of Lord Holt's rule and a sibling to *respondeat superior*.

3. The path of nondelegable duty.

The same nineteenth-century cases that receded from *Bush*'s broad rule of vicarious liability recognized one could not avoid responsibility by delegating certain duties. *See, e.g., Hilliard*, 69 Mass. at 353 (stating a corporation "intrusted by the legislature with the execution of these public works…cannot escape this responsibility by a delegation of this power to others"); *see also Pierce v. O'Keefe*, 11 Wis. 180, 182–83 (1860) (stating one is responsible for another's negligence occurring in "a work under public authority, where the law will not permit those to whom the power is delegated to evade the responsibilities imposed, by employing others, even though…the direct relation of master and servant does not exist").

An early case finding a nondelegable duty was *Hole v. Sittingbourne and Sheerness Railway Co.*, 6 H. & N. 488 (1861). Parliament authorized the defendant railway company to construct a bridge across a river with an opening for ships to pass through. *Hole*, 6 H. & N. at 489. The plaintiff's vessels could not navigate the

river because the defendant's contractor negligently constructed the bridge so that it would not open, causing the plaintiff economic harm. *Id.* at 488-91. The defendant denied responsibility, as it did not control or direct the contractor. *Id.* at 491.

The court rejected the defendant's attempt to evade responsibility simply because it had an independent contractor construct the bridge. *Id.* at 497-501. The lead opinion explained why the "the principal [was not] exempt from responsibility" even though he was not "the master of the person [who was] negligen[t]":

> Where a person is authorized by act of parliament or bound by contract to do particular work, he cannot avoid responsibility by contracting with another person to do that work….[T]he legislature empowered the [defendant] to build the bridge: in building that bridge the contractor created an obstruction…, and for that the [defendant is] liable.

Id. at 497-98 (emphasis added). Thus, *Hole* and multiple English cases from the second half of the nineteenth century established that one with a statutory or contractual duty to do work could not avoid liability for the negligent performance of that work simply because one chose to have a contractor perform the work. *See* Stephen Chapman, *Liability for the Negligence of Independent Contractors*, 50 L.Q. Rev. 71, 71-80 (1934) (discussing cases).

The rule from these English cases travelled to the United States. In 1889, Justice Holmes, speaking for Massachusetts' high court, approved of the nondelegable-duty rule from the 1861 *Hole* decision. *Woodman v. Metro. R. Co.*, 149 Mass. 335, 340 (1889) (citing *Hole*, 6 H. & N. at 500 and multiple American

and English cases). In *Woodman*, the defendant railroad had its contractor lay track in the street, and the contractor negligently placed rails beyond a barrier, causing the plaintiff's testator to fall. *Id.* at 339-40. The fact that a contractor did this work did "not exonerate the defendant." *Id.* at 339. "In some cases," Justice Holmes noted, "a party is liable, notwithstanding the intervention of an independent contractor"—for example, when the party "is made personally responsible by statute for the prevention of the cause of the damage complained of." *Id.* Considering, *inter alia*, "[t]he work was done under a permit issued to the defendant," and "the policy of the [legislature's] statutes," Justice Holmes imputed the contractor's negligence to the defendant. *Id.* at 340 (emphasis added).

By the end of the nineteenth century, the nondelegable-duty rule was a frequent, well-known traveler on the path of the American common law. *See, e.g.,* 1 Thomas G. Shearman and Amasa A. Redfield, *Law of Negligence* § 14, at 14-15 & nn.2-5 (5th ed. 1898). "The weight of reason and authority" was "that, where a party is under a duty to the public or third person to see that work…is carefully performed, …he cannot, by letting it [be done by] a contractor, avoid his liability, in case it is negligently done to the injury of another." *Covington & Cincinnati Bridge Co. v. Steinbrock*, 61 Ohio St. 215, 223(1899).

While these early cases often involved railroads, bridges, and canals, the nondelegable-duty rule quickly travelled to other enterprises. In 1897, it made its

way to a Florida sawmill. In *Camp v. Hall*, this Court held a sawmill owner vicariously liable under the nondelegable-duty rule, while, at the same time, it held the owner not liable under *respondeat superior*.[3] 39 Fla. 535, 562-63.

In the twentieth century, the nondelegable-duty rule journeyed to other Florida enterprises. In 1933, it visited a Florida hospital in *Parrish* where this Court held the hospital vicariously liable, based on a contract, for a nurse's negligent medical care. 107 Fla. at 603 (discussed *infra* at 45-47). Then, in 1950, the rule travelled to hotels, inns, and the like. In *Goldin v. Lipkind*, this Court held these facilities had a nondelegable duty to their guests. 49 So. 2d 539, 541 (Fla. 1950). The rule journeyed to many other Florida enterprises during second half of the twentieth century. *See, e.g., Bialkowicz v. Pan Am. Condo. No. 3, Inc.*, 215 So. 2d 767, 771 (Fla. 3d DCA 1968) (construction work under a building permit); *Nazareth v. Herndon Ambulance Serv., Inc.*, 467 So. 2d 1076, 1078-79(Fla. 5th DCA 1985) (ambulance services).

In the late twentieth and early twenty-first centuries, the nondelegable-duty

[3] In this pre-worker's compensation case, a sawmill's child employee lost his leg due to a co-employee's negligence. *Camp,* 39 Fla. at 538. Under *respondeat superior*, "a master [was] not liable to his servant for personal injuries received in the course of his employment, through the negligence of a fellow servant, when engaged in the same undertaking or common work." *Id.* at 562. Yet, this Court held, a master directly owed to his employees, *inter alia*, a duty to furnish a reasonably safe place to work. *Id.* This Court further held that, if the master delegates this duty to an employee, "the master will be responsible for their nonperformance, or for their negligent performance, notwithstanding the master has exercised due care in the selection of the agent to whom these duties are intrusted." *Id.* at 563.

rule was used to hold Florida licensees liable—like operators of nursing homes, taxicabs, and transportation services. *See NME Props., Inc. v. Rudich*, 840 So. 2d 309, 313 (Fla. 4th DCA 2003) (nursing home); *Hamid v. Metro Limo, Inc.*, 619 So. 2d 321, 322 (Fla. 3d DCA 1993) (taxicab); *Metrolimo, Inc. v. Lamm*, 666 So. 2d 552, 553 (Fla. 3d DCA 1995) (transportation of disabled persons). Notably, the Hospital is licensed to provide emergency care (AR89), and only licensed hospitals in Florida may provide emergency medical services. *See infra* Part I.B.4, at 31-35.

So, on our journey down the common law's path, we've seen that *respondeat superior* and nondelegable duty are well-travelled imputation rules. There's another rule. Apparent agency. Our journey goes there next.

4. The path of apparent agency.

Under today's law, negligence may be imputed to a principal for an "apparent" agent's tort if the following elements are established: "(a) a representation by the purported principal; (b) a reliance on that representation by a third party; and (c) a change in position by the third party in reliance on the representation."[4] *Mobil Oil Corp. v. Bransford*, 648 So. 2d 119, 121 (Fla. 1995). Justice Story in his 1844 treatise said: "[G]ood faith requires, that the principal

[4] Some call this doctrine "ostensible" agency and distinguish between apparent "authority" and "agency." *E.g.,* Martin C. McWilliams, Jr. & Hamilton E. Russell, III, *Hospital Liability for Torts of Independent Contractor Physicians*, 47 S.C.L. Rev. 431, 445-46 & nn.75-76 (1996). These distinctions do not impact our argument.

should be held bound by the acts of the agent, within the scope of his general authority; for he has held him out to the public as competent to do the acts, and to bind him thereby." Story, *supra* § 127, at 142. The rule was meant to protect "innocent persons" from "fraud" and "injustice[s]," and it was applied in equity. *Id.*

The rule of apparent agency (or authority) first arrived in Florida in the early 1900's and traveled for 50 years only in commercial and contractual disputes. *See, e.g., Indian River State Bank v. Hartford Fire Ins. Co.* 46 Fla. 283, 333 (1903) (insurance policy); *T.G. Bush Grocery Co. v. Conely*, 61 Fla. 131, 132-37 (1911) (citing Story, *supra* § 127) (commercial); *Beekman v. Sonntag Inv. Co.*, 67 Fla. 293, 307-08 (Fla. 1914) (real-estate contract); *Gen. Motors Acceptance Corp. v. Lynch Bldg. Corp.*, 118 Fla. 2, 3-4 (Fla. 1935) (lease agreement); *John S. Barnes, Inc. v. Paducah Box & Basket Co.*, 147 Fla. 362, 364 (1941) (guaranty contract); *Thomkin Corp. v. Miller,* 156 Fla. 388, 389-90 (1945) (realty contract).

In 1952, the apparent-authority rule first appeared in a Florida tort case. This Court held a hotel liable for a contractor/parking attendant's negligent operation of an automobile. *Stuyvesant Corp. v. Stahl*, 62 So. 2d 18, 19–20 (Fla. 1952). From the 1950's to the 1970's, Florida courts occasionally held principals liable for the torts of apparent agents, but never in any case involving medical negligence. *See, e.g., Van Engers v. Hickory House, Inc.*, 104 So. 2d 843, 843–44 (Fla. 3d DCA 1958) (holding restaurant liable for its contractor/attendant's negligent operation of an

automobile); *Hertz Intern., Ltd. v. Richardson*, 317 So. 2d 824, 826 (Fla. 3d DCA 1975) (holding Hertz liable for faulty brakes though its contractor was the lessor).

Then, in the 1980's, Florida courts tried out the rule of apparent agency/authority to impute to hospitals the negligence of contractor physicians. *See, e.g. Webb v. Priest*, 413 So. 2d 43, 47 (Fla. 3d DCA 1982) (citing *Stuyvesant*). Two decades later, Judge Altenbernd called this experiment a "failure" and suggested the use of the nondelegable-duty rule instead. *Roessler*, 858 So. 2d at 1163-65 (Altenbernd, C.J. concurring). Soon, our journey down the law's path will get to the judge-made law imputing negligence on hospitals. *Infra* Part I.C, at 35-50. But now our journey turns to hospitals, their evolution, and their current practices.

B. History of American hospitals and emergency departments.

To find the right common-law imputation rule for today's emergency department, this Court must know the hospital's history up to the modern times.[5]

1. Hospitals from the Founding until 1870.

In the early 1800's, hospitals were "an insignificant aspect of American medical care." Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* 4 (1987). "Respectable" persons were treated normally at home and

[5] "The rational study of law is…to a large extent the study of history." Holmes, *supra*, 10 Harv. L. Rev. at 469; *see* Arthur F. Southwick, *The Hospital's New Responsibility*, 17 Clev.-Marshall L. Rev. 146, 146 (1968) ("What legal duties does the hospital…owe the patient...? To…answer…this question one must first have an understanding of the role and nature of a hospital in modern society.").

rarely in a hospital. *Id.* at 4-5, 18. The poor normally went to "almhouses," rather than hospitals, when they were too sick to be cared for at home. *Id.* at 4, 18. By 1821, only three hospitals existed in the United States. *Id.* at 18.

By the start of the Civil War, American hospitals had not significantly changed since 1800. *Id.* at 4. Few hospitals were integrated with medical school instruction. *Id.* at 5. Obligatory residency and internship programs did not exist. *Id.* Hospitals were not directed by credentialed administrators or dominated by medical professionals. *Id.* A hospital was "defined primarily by need and dependency, not by the existence of specialized technical resources." *Id.*

2. Hospitals from 1870 to the present.

From 1870 until 1917, "the American hospital was transformed from an asylum for the indigent into a modern scientific institution." Rosemary Stevens, *In Sickness and Wealth: American Hospitals in the Twentieth Century* 17 (1999). During this period, hundreds of hospitals sprang up under the aegis of charities, religious orders, and other similar groups. *Id.* at 17, 38; Rosenberg, *supra* 109-13, 267-71. Though today such charitable and religious hospitals would be considered "private," during the early twentieth century, they had a "public" character to them and received government aid. Stevens, *supra* 40. The new hospitals were dominated by "views of social welfare and individual responsibility; medicine occupied a necessary but still clearly subordinate place." Rosenberg, *supra* 99.

By the 1920's, the modern hospital as we know it today had started to take shape. Rosenberg, *supra* 9-10. Hospitals were "central" in medical care and physicians' careers. *Id.* at 5, 10. The "prosperous and respectable as well as the indigent" were treated in hospitals. *Id.* at 6. Hospitals became "middle-class institution[s]" that engaged in "sophisticated marketing techniques." Stevens, *supra* 105, 109. Hospitals "had grown in size, had become more formal and bureaucratic, and increasingly unified in authority, consistently reflecting medical needs and perceptions." Rosenberg, *supra* 6.

By the 1940's and 50's, hospitals were no longer viewed as almshouses. Arthur F. Southwick, *Hospital Liability: Two Theories Have Been Merged*, 4 J. Legal Med. 1, 2 (1983). From 1965 through 1980, hospitals were transformed by the "golden stream" of public funding (Medicare/Medicaid). Stevens, *supra* 284. A high court in 1978 said, "'The modern hospital, whether operated by a city, a church, or a group of private investors, is essentially a business.'" *Id.* 316 & n. 70 (quoting *Parker v. City of Highland Park*, 273 N.W.2d 413, 417 (Mich. 1978)).

By the early 1970's, hospitals were "no longer a mere building where private practitioners of medicine care for their private patients." Arthur F. Southwick, *The Hospital as an Institution—Expanding Responsibilities Change its Relationship with Staff Physician*, 9 Cal. W.L. Rev. 429, 429 (1973). Instead, hospitals were "called upon to assume the role of a comprehensive health center ultimately responsible for

arranging and co-ordinating total health care." *Id.* Hospitals were "actively engaged in furnishing directly, or arranging for, the total spectrum of diagnostic and outpatient services, home care programs, extended care facilities for the elderly and chronically ill, and treatment for patients suffering from alcoholism or drug addiction." *Id.* Physicians practicing at hospitals became subjected to a "peer review" process because state governments or private health insurers demanded such oversight. *Id.* at 429-30. As such, a physician could no longer be considered an "independent contractor" as that term historically had been understood. *Id.* at 430. In 1972, the American Hospital Association issued its Patient Bill of Rights; it recognized the hospital itself had "a responsibility to the patient." *Id.* at 433 & n.9.

In 1973, Professor Southwick, a prolific hospital scholar, observed how the triangular relationship between hospitals, physicians, and patients was changing. *Id.* at 434. He described how, in the past, hospitals "played little or no role with respect to patient care" and were "simply a physical place...where the private practicing physician found facilities to support his art." *Id.* Thus, in the past, the hospitals' duties to the patient "were limited to an obligation to exercise reasonable care with respect to the maintenance of buildings and grounds, the equipment, and in the selection for employment of lay and paramedical personnel." *Id.* In other words, a hospital had been "viewed as simply a 'workshop' for the doctor," who, in turn, was viewed as "an independent contractor." *Id.*

But Professor Southwick observed "[t]his view ha[d] changed and [would] continue to change" because "[i]n actual fact the practice of medicine [was being] institutionalized." *Id.* In short, the modern hospital was "play[ing] an active role in direct patient care, suggesting a vastly different relationship between the [hospital] and the practicing physician than is suggested by the historical distinction separating 'hospital' and 'medical' services." *Id.* at 435.

In the 1980's and 90's, the old "workshop" notion was left even further behind for a new concept, "managerialism." Stevens, *supra* 341-44. Hospitals were transformed with the "emergence of large-scale systems, corporate enterprises, and an overtly profit-making ethos." *Id.* at 321. Hospitals were successful businesses with significant profit margins, *id.* at 332-41, and a "great majority" of them advertised, *id.* at 336. Large hospitals established "major corporate structures" and often were a "consortium of related businesses" that "reward[ed] entrepreneurial behavior geared toward financial efficiency." *Id.* at 342.

In the late twentieth century, hospitals "increasingly engaged in regulating and manipulating physician behavior" by, for example, providing "economic incentives to doctors to admit 'profitable' patients." *Id.* at 343. Hospitals re-worked employment contracts, changing physicians from employees to independent contractors, to reduce potential tort liabilities. This tactic frequently was used in the emergency department, pathology and clinical laboratories, and radiology

department. H. Ward Classen, *Hospital Liability for Independent Contractors: Where Do We Go From Here?*, 40 Ark. L. Rev. 469, 469-72 & nn2-3, 7-8 (1987).

3. Hospital emergency departments, 1960-present.

Scholars consider the 1960's and 1970's to be the period when specialized emergency medical services were first offered at American hospitals.[6] Since the 1960's, emergency departments have been "transformed into a highly effective setting for urgent and lifesaving care" with a wide range of capabilities: "highly trained emergency providers, the latest imaging and therapeutic technologies, and on-call specialists in almost every field." IOM, *supra* 37 (citation in note 6). "Beginning in the early 1970s and accelerating through the 1980s and 1990s, [emergency-department] staffing shifted from part-time coverage by community physicians, rotating house officers, or moonlighters to full-time, around-the-clock coverage by residency-trained, board-certified emergency physicians." Kristy Gonzalez Morganti et al., *The Evolving Role of Emergency Departments in the United States* 1 (2013). (https://www.rand.org/pubs/research_reports/RR280.html).

[6] *See, e.g.,* Robert E. Suter, *Emergency Medicine in the United States: A Systemic Review*, 3 World J. Emerg. Med. 5, 5-10 (2012). While hospitals had emergency rooms before the 1960's, *see Bourgeois v. Dade County*, 99 So. 2d 575, 576 (Fla. 1956), they were "a single room staffed by nurses and physicians with little or no training" in emergency medicine, Institute of Medicine (IOM), *Future of Emergency Care: Hospital-Based Emergency Care at the Breaking Point* 37 (2007).

In 1968, the American College of Emergency Physicians was founded. Suter, *supra,* 3 World J. Emerg. Med. at 6. In 1972, the American Medical Association recognized emergency medicine as a specialty; *id*. at 7, and the Florida College of Emergency Physicians was founded (https://www.emlrc.org/fcep/about/). Other steps towards the specialization of emergency medicine occurred in the 1970's, culminating in 1980 with the first certification exam. IOM, *supra* 212. By 1983, 96.5% of hospitals provided emergency services, and more than 90% of hospitals provided these services only within the hospital. *Survey Reflects Emergency Care Changes*, 58. J. Am. Hosp. Assoc. 65 (1984). A 2013 study found emergency departments had become "an important source of [hospital] admissions," accounting by 2009 for roughly half of inpatient admissions. Morganti et al., *supra* ix, 25.

Currently, the exact percentage of emergency physicians who are hired as contractors is difficult to ascertain, but it's fair to say contractors are a substantial percentage of emergency physicians. One survey reported more than 60% of emergency departments in 1983 were staffed by contract physicians. *Survey*, *supra*, 58. J. Am. Hosp. Assoc. 65. In 2003, the American Academy of Emergency Medicine estimated that half of all physicians in emergency departments were staffed by national contract management groups. IOM, *supra* 211. The Institute of Medicine stated in 2006 that "[emergency department] physicians often are not hospital employees," and it estimated that close to 40% of emergency physicians

were employed by contract management groups. *Id.* at 214, 216. A 2013 bank study reported hospitals outsourced 65% of their emergency physicians. Zack Cooper et al., *Surprise! Out-of Network Billing for Emergency Care in the United States* 4, 8 (2018) (https://www.nber.org/papers/w23623).

4. Federal and state regulation of emergency departments.

Not long after emergency departments were established in the 1960's/70's, the 1980's saw the adoption of federal and state laws to regulate emergency care. The upshot of these laws is that, unlike other medical care, only a licensed hospital may provide emergency care; indeed, it must provide such care; and it may not decline such care. On the other hand, a patient does not choose her emergency physician; the hospital chooses. The patient can choose only the hospital.

Since 1986, federal law has required hospitals receiving Medicare and Medicaid benefits to "meet the emergency needs of patients in accordance with the acceptable standards of practice."[7] 42 C.F.R. § 482.55 (emphasis added); *see also* 42 C.F.R. § 482.12(f)(1) ("If emergency services are provided at the hospital, the hospital must comply with the requirements of § 482.55."); 51 FR 22010-01 (June 17, 1986) (adopting these regulations).

[7] A 2017 report shows that nearly 66% of Florida hospital patients were Medicare or Medicaid patients. Florida Hospital Association, Facts & Stats, Page to Reports & Resources, FHA.ORG, www.fha.org/reports-and-resources/facts-and-stats.aspx (last visited Oct. 7, 2019).

Before this federal law existed, the Florida Legislature in 1982 created Chapter 395, Florida Statutes to regulate emergency care. *See* Ch. 82-182, § 26, Laws of Fla. It directed that no licensed general hospital "shall deny any person treatment for any emergency medical condition." *Id.* (§ 395.005(3), Fla. Stat. (1982)). In 1986, the Legislature defined the "[d]uty of hospitals to provide emergency service" by directing that "a full-time emergency room service shall…admit [a person seeking emergency services]," if a "licensed hospital physician" determined the person "shall be admitted." Ch. 86-125, § 1, Laws of Fla.

In 1988, the Legislature "[found] and declare[d] it to be of vital importance that emergency services and care be provided by hospitals[8] to every person in need of such care." Ch. 88-186, § 6, Laws of Fla. (§ 395.0142, Fla. Stat. (1988)) (emphasis added). It also found "that persons ha[d] been denied emergency services and care by hospitals." *Id.* (emphasis added). It enacted section 395.0142, Florida Statutes (1988), which is largely identical to today's section 395.1041 and the 2012 version that controls this case. *Compare*, *id. with* § 395.1041, Fla. Stat. (2012 & 2019).

The Legislature has directed, since 1988, that "[e]very general hospital which has an emergency department shall provide emergency services and care for any emergency medical condition." § 395.1041(3)(a), Fla. Stat. (2012) (emphasis

[8] Later, the Legislature amended this finding by adding "and physicians" after the word "hospitals." Ch. 92-289, § 24, Laws of Fla.; § 395.1041(1), Fla. Stat. (2012).

added). "'Emergency services and care' means medical screening, examination, and evaluation by a physician...to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition."[9] *Id.* § 395.002(9). In 1991, the Legislature granted each patient "the right to treatment for any emergency medical condition that will deteriorate from failure to provide such treatment." Ch. 91-127, § 1, Laws of Fla; § 381.026(4)(d)2, Fla. Stat. (2012).

In 1992, the Legislature authorized hospitals to contract with other hospitals or physicians to provide the statutorily required emergency services. Ch. 92-289, § 24, Laws of Fla. (codified at § 395.1041(3)(d)1&(k)2, Fla. Stat. (2012)). But the Legislature placed the responsibility for providing such services on the original hospital: "Every hospital shall ensure the provision of [emergency] services…at all times, either directly or indirectly through an arrangement with another hospital, through an arrangement with one or more physicians, or as otherwise made through prior arrangements." § 395.1041(3)(d)1, Fla. Stat. (2012) (emphasis added).

To ensure that hospitals provided emergency medical services, the Legislature has directed the Agency for Health Care Administration (AHCA) to "vigorously enforce the ability of persons to receive all necessary and appropriate emergency

[9] This definition, as well as a definition for "emergency medical condition", were added in 1992. Ch. 92-289, § 3, Laws of Fla.; *see* § 395.002(8), Fla. Stat. (2012).

services and care." *Id.* § 395.1041(1). AHCA has directed: "Every hospital offering emergency services and care shall provide emergency care"—including physician care—"24 hours a day within the hospital to patients presenting to the hospital." Fla. Admin. Code R. 59A-3.255(6)(a) (emphasis added).

The Legislature also has directed AHCA to place on each hospital license whether it is licensed to provide emergency services and to publish to the public a list of all hospitals providing such services § 395.1041(2), Fla. Stat. (2012). A hospital may not cease providing emergency services without first notifying AHCA, and it must "reaffirm" its capability to provide such services when renewing its license. *Id.* No person may operate an emergency department without an AHCA-issued license. *See id.* § 395.003(1)(a)&(b)1. The Legislature imposed these licensing requirements to "protect[]...the public health and safety." *Id.* § 395.001. The Hospital's license here states it provides emergency services. (AR89.)

The Legislature's 1988 bill provided for criminal and civil "penalties," including a "civil action against the responsible administrative or medical personnel." Ch. 88-186, § 6, Laws of Fla. (§ 395.0142(5)(b), Fla. Stat. (1988)). Since 1988, this provision has not been amended to address, one way or the other, a "civil action" against hospitals. *See* § 395.1041(5)(b), Fla. Stat. (2012&19). The 1992 bill added a sentence, stating that "this paragraph" (¶b) establishing the civil action "shall not be construed to create a cause of action beyond that recognized by [section

395.1041] and [the] rules adopted [there]under…as they existed on April 1, 1992."[10] Ch. 92-289, § 24, Laws of Fla. (codified at § 395.1041(5)(b), Fla. Stat. (2012)).

Now, our journey leaves these written laws and returns to the common law.

C. The path of the of law of imputed negligence for hospitals.

We just sketched the history of hospitals to show how they changed over the last 200 years. This sketch, we hope, puts in perspective the ensuing section, which travels down the common law's path for imputing negligence to hospitals.

1. Early development of rules for imputing physician negligence.

The common law's rules for imputing negligence to hospitals are young. Recall, the hospitals' embryonic stages began only in the 1870-1917 period. *See supra* at 25. Once modern hospitals started to take shape, the judiciary in most states hindered the development of any imputation rules by immunizing charitable hospitals from liability. *See* McWilliams & Russell, *supra*, 47 S.C.L. Rev. at 434-35 & nn.10-12; Comment, *Tort Responsibility of Charitable Corporations*, 34 Yale L.J. 316, 317-19 & nn.3-12 (1925). These courts reasoned that "that the rule of repondeat [sic] superior should not be applied because the institution receives no private profit or benefit from the acts of its servants." *Nicholson v. Good Samaritan Hosp.*, 145

[10] Our claim, if upheld, does not require "this paragraph" (¶b) to be "construed to create a cause of action." Instead, it requires a court to first adjudge a physician negligent (under the common law for a personal injury and the wrongful-death statute for a death), and then to apply the common-law rules for imputing negligence. *Infra* Part II.C, at 59-60.

Fla. 360, 368–69 (1940). By the 1940's and 1950's, however, courts largely abolished charitable immunity because hospitals no longer were charities but instead were businesses directly treating patients, and thus "the reasons for the immunity no longer prevailed in a changing society." Southwick, *supra*, 4 J. Legal Med. at 1-2.

Even with for-profit hospitals during this incubating period, the *respondeat-superior* rule did not apply to "medical judgments," but rather applied only to torts based on a "lay" judgment—like "[m]aintaining safe premises and guarding mentally irresponsible patients." *Liability of Hospital for Injuries to Patients Using Hospital Facilities*, 48 Yale L.J. 81, 82-83 (1938). The rationale for this lay-medical distinction (or administrative-medical distinction[11]) was that hospitals could not control "mistakes in medical judgment made by carefully selected physicians and nurses who [were] employed to practice their profession according to their own discretion." *Id.* at 83 & n.12 (citing *Schloendorff v. N. Y. Hosp.*, 211 N. Y. 125, 131 (1914)). The early twentieth-century thinking was that "[h]ospitals [did] not practice medicine through agents..., but rather [were] places where professional practitioners [could] give medical treatment to patients." *Id.* at 83 & n.14. Hospitals should be held liable, some argued, only if they failed "to use reasonable care and diligence in selecting staff physicians and nurses." *Id.* at 83 & n. 16 (citing the American Hospital Association's 1935 bulletin).

[11] Southwick, *supra*, 4 J. Legal Med. at 8.

As hospitals changed over time, so too did the common-law rules for imputing negligence to hospitals. In a landmark 1957 case, New York's highest court "eliminated the previously recognized distinction between administrative and medical acts, thereby settling the then existing controversy whether or not professional status of an employee prevented the imposition of vicarious liability." Southwick, *supra*, 4 J. Legal Med. at 8. The New York court astutely observed:

> The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact. Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. They regularly employ on a salary basis a large staff of physicians, nurses and internes, as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such services, if necessary, by legal action. Certainly, the person who avails himself of "hospital facilities" expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility.

Bing v. Thunig, 2 N.Y.2d 656, 666 (1957) (rejecting *Schloendorff*, 211 N. Y. at 125).

Florida took its own path to develop imputation rules for hospitals. The question of charitable immunity reached this Court for the first time in 1940, *Nicholson*, 145 Fla. at 360, long after the first American courts had adopted it.[12] This Court rejected the immunity. *Id.* at 374.

Florida, however, followed a path similar to other states by recognizing the

[12] *See, e.g., McDonald v. Mass. Gen. Hosp.,* 120 Mass. 432 (1876).

lay-medical distinction. *See City of Miami v. Oates*, 152 Fla. 21, 28 (1942) (holding a hospital liable under *respondeat superior* for an intern's negligence because it was not an exercise of "professional skill and judgment"); *see also Pensacola Sanitarium v. Wilkins,* 68 Fla. 447, 448 (1914) (holding a hospital liable for lay negligence—a burn "caused by leaving a hot water bottle" in the patient's bed).

Before the 1980's, almost none of the Florida hospital-liability cases involved imputing a physician's negligence to a hospital.[13] Yet, in two cases involving railroads in 1893 and 1911, this Court held that *respondeat superior* did not impute medical negligence to corporations. *See S. Fla. R. Co. v. Price*, 13 So. 638, 638-39 (Fla. 1893); *Atl. Coast Line R. Co. v. Whitney*, 56 So. 937, 937-38 (Fla. 1911). The rationale for these decisions sprung from the then-contemporaneous hostility to the corporate practice of medicine. *See* Jeffrey F. Chase-Lubitz, *The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry*, 40 Vand. L. Rev. 445, 455–59 & nn. 68-73 (1987).

This same corporations-cannot-practice-medicine rationale has been used in modern times to argue that applying *respondeat superior* to a hospital is "problematic." McWilliams & Russell, *supra*, 47 S.C.L. Rev. at 440-41 & nn.45-51. The argument goes like this: "If a hospital cannot practice medicine, then

[13] *See, e.g., Bourgeois*, 99 So. 2d at 577 (nurses and interns). The one exception is *Wilson v. Lee Mem'l Hosp.*, 65 So. 2d 40 (Fla. 1953) (discussed *infra* at 41).

presumably the hospital cannot control or have the right to control the professional acts of physicians." *Id.* at 440-41; *see, e.g., Pamperin v. Trinity Mem'l Hosp.*, 144 Wis. 2d 188, 200 (1988) (holding a hospital not liable under *respondeat superior* because the "very nature of a radiologist's function requires the exercise of independent professional judgment"). Below, the Hospital made a similar argument against the nondelegable-duty rule. (AR163.)

Over time, however, Florida courts stopped looking at the principal's control of the medical decisions. They examined other "control" factors: "the physician's sources of income, billing practices, [and] source of patients." Ellen B. Gwynn, *Hospital Liability Doctrine in Florida: The Nondelegable Duty Doctrine*, 64 Fla. B.J. 14, 17 (1990). Eventually, by 1997, courts focused on the self-serving employment agreement drafted by hospitals to hire contractors. *Infra* at 42-43. Hospitals then had the power to manipulate the "right to control" principle to avoid responsibility for the hazards of their business. This power to manipulate was bestowed by courts, not legislators. Our journey now moves to this path of the law.

2. Recent development of the imputation rules.

a. *Respondeat superior.*

How has the rule of *respondeat superior*—discovered by Lord Holt in 1709, modified in the 1800's to include a "right to control" principle, and justified in the 1900's by the "entrepreneurial theory"—fared when applied to modern Florida

hospitals, physicians, and patients of the last half century? Very poorly. It has been manipulated and abused such that private hospitals are rarely, if ever, held responsible for physician negligence under this rule.

Recall, the original rationale of Lord Holt's rule was that a business (a merchant in the *Hern* case) should have to pay the damages inflicted by his servant's tort on a party with whom the business was "in privity"—i.e., owed a direct duty. Baty, *supra* 10-12; *supra* at 13-14. Recall, also, as Justice Douglas taught in 1929, the most compelling rationale for vicarious liability was that the "hazards of the business should be borne by the business directly." Douglas, *supra*, 38 Yale L.J. at 585-86; *supra* at 11-12. Recall, finally, the nineteenth-century "right to control" principle was developed not to undermine either of these rationales we just mentioned, but rather to limit the liability borne by a person, not engaged in a business, who merely hires a contractor to do some work—like the homeowner in *Bush* found liable for his sub-sub-sub-sub-contractor's negligence. *Supra* at 16-17.

Modern private hospitals—profit-seeking businesses owing duties directly to their patients—have exploited the "right to control" principle to thwart the central rationales of Lord Holt's evolved rule. No longer able to hide behind charitable immunity or the medical-lay distinction, modern hospitals now manipulate the "right to control" principle to avoid responsibilities that other businesses must bear. The Legislature did <u>not</u> authorize this shirking of responsibility. The Judiciary did; it did

so by creating judge-made rules that grant hospitals the right to choose whether their contractor physicians will be their actual agents or not. How did this happen? A tour of Florida case law shows how.

In thinly reasoned decisions from 1953 to 1987, this Court cracked the door open to imputing physician negligence to hospitals via *respondeat superior*, as it silently reversed course from its 1893 and 1911 decisions, discussed *supra* at 38, that had held corporations were not responsible for physician negligence. None of these post-1950 decisions, however, recited facts from which one could glean the proof required to establish a hospital's "right to control" a physician. *See Wilson v. Lee Mem'l Hosp.*, 65 So. 2d 40, 40-42 (Fla. 1953); *Pinillos v. Cedars of Lebanon Hosp. Corp.*, 403 So. 2d 365, 368 (Fla. 1981); *Pub. Health Tr. of Dade County v. Valcin*, 507 So. 2d 596, 601 (Fla. 1987).

In fact, in the 1987 *Valcin* case, the hospital (a sovereign entity) did not contest the physician's status as an employee. 507 So. 2d at 601. Why? In 1980, sovereign agents were granted—for the first time in Florida's history—immunity from suit. *See* § 768.28, Fla. Stat. (1980-2019); *State Dep't of Transp. v. Knowles*, 402 So. 2d 1155, 1156 (Fla. 1981); *Dist. Sch. Bd. of Lake Cnty. v. Talmadge*, 381 So. 2d 698, 700 (Fla. 1980). So, after 1980, sovereign hospitals and their physicians were advantaged if the physicians, even contractors, were classified as agents, as their collective liability could be capped. Thus, nearly every post-1980 case on imputing

physician negligence to hospitals has involved claims by physicians (not patients) that they were a sovereign hospital's agent. *See, e.g., Robinson v. Linzer*, 758 So. 2d 1163 (Fla. 4th DCA 2000).

The seminal case on whether a contractor physician is a hospital's agent is *Stoll v. Noel*, 694 So. 2d 701 (Fla. 1997). There, this Court, for the first time in its history, explained the proof required to show a hospital's right to control a physician. This Court ruled that, if a hospital did a really good job of papering its relationship with its contractor physicians, then it would be deemed to have the right to control the physicians. *Id*. at 703 (holding "the right to control depend[ed] upon the terms of the employment contract"). Unsurprisingly, since *Stoll*, not a single Florida appellate decision has held a private hospital responsible under *respondeat superior* for a physician's negligence.

Stoll's rule is judge-made, never endorsed by the Legislature. Under this rule, a private hospital, represented by able counsel, can carefully draft its employment contracts to choose the degree of control, if any, it has over contractor physicians and minimize, if not eliminate, its liability for its physicians' negligence. This point is illustrated by two cases. *See Bean v. Univ. of Miami*, 252 So. 3d 810 (Fla. 3d DCA 2018); *Jaar v. Univ. of Miami*, 474 So. 2d 239 (Fla. 3d DCA 1985). In *Jaar*, a private university supplying physicians to a sovereign hospital under a contract argued it was a sovereign agent; the court disagreed based on the contract's terms. 474 So. 2d

at 245-46. Years later, in *Bean*, the university and the hospital re-wrote the contract to grant the hospital the "right to control" the private university, and like magic, the university was transformed into a sovereign agent and thus immunized from suit. 252 So. 3d at 818-20 (citing *Stoll*, 694 So. 2d at 703).

Indeed, hospital attorneys draft agreements so their clients are not responsible under *respondeat superior* for their "independent" contractors' torts. *See* Classen, *supra*, 40 Ark. L. Rev. at 469-71 nn.1, 3, 7-8. In short, the judge-made rules for *respondeat superior*—not legislative laws—have allowed private hospitals to avoid responsibility for negligent medical care provided in their facilities (from which they make significant profits). Because of the difficulties imposed by *respondeat superior*, courts have crafted other rules for imputing physician negligence to hospitals. Next, our journey goes to the apparent-agency rule as applied to hospitals.

b. Apparent agency.

Justice Story's and Florida's early rule of apparent agency/authority was an equitable doctrine, created to prevent fraud and deceit, and mainly used in commercial disputes. *See supra* at 22-23. From the 1950's to the 1970's, it was lightly used in Florida tort cases. *See id.* at 23. Then, from the 1980's onwards, Florida courts experienced many cases where patients used this rule to try to impute to hospitals alleged physician negligence—often in the emergency department. *See, e.g., Webb*, 413 So. 2d at 47; *Roessler*, 858 So. 2d at 1162.

In this century, Florida hospitals—to avoid responsibility for their emergency departments—have turned this equitable rule on its head by requiring patients to sign forms upon admission to the emergency department. These forms disclaim the hospital's responsibility by disavowing any agency relationship between the hospital and the physician. Often, patients must sign these forms under medical distress. *See, e.g., Guadagno v. Lifemark Hosp. of Fla., Inc.*, 972 So. 2d 214, 216–17 (Fla. 3d DCA 2007) (rejecting apparent-agency claim because of form signed by decedent as she was admitted to the emergency department for injuries stemming from a mini-bike crash); *Quesada v. Mercy Hosp., Inc.*, 41 So. 3d 930, 931 (Fla. 3d DCA 2010) (same for patient needing immediate surgery who was admitted through the emergency department). Here, the Hospital tried to disclaim responsibility for Mrs. Torres' death based on a form her father signed. (AR124-54, 211.)

That brings our journey of the law's path to where we launched it: Judge Altenbernd's common-law reasoning. In 2003, he concluded that Florida's use of the apparent-agency rule in hospitals had been a "failure" because it had spawned unpredictability, inefficiency, and unnecessary litigation:

> Patients, hospitals, doctors, nurses, other licensed professionals, risk managers for governmental agencies, and insurance companies all need to have predictable general rules establishing the parameters of vicarious liability in this situation. Utilizing case-specific decisions by individually selected juries to determine whether a hospital is or is not vicariously liable for the mistakes of a radiology department, an emergency room, or some other corporate entity that has been created as an independent contractor to provide necessary services within the

> hospital is inefficient, unpredictable and, perhaps most important, a source of avoidable litigation.

Roessler, 858 So. 2d at 1163 (Altenbernd, C.J. concurring).

While apparent agency may work "for isolated cases of [ordinary] negligence," Judge Altenbernd opined it had "not worked well to establish responsibility for torts in the context of a complex institution like a hospital that has many interrelated independent contractors working side-by-side for the same customers." *Id.* at 1164. Apparent agency had not "establish[ed] predictable, general rules of liability" because its required elements (representation by the principal and reliance by the plaintiff) were "inherently case specific." *Id.* This approach, the judge explained, meant that "if a hospital were sued by two different patients for two identical acts of malpractice occurring on the same day and committed by the same doctor in the [same] department, the hospital's vicarious liability would be a fact question for resolution by two different juries." *Id*.

Judge Altenbernd urged this Court or the Legislature "to simplify the rules of liability in this area." *Id.* He recommended the nondelegable-duty rule for a hospital's core services (emergency, radiological, etc.). *Id.* at 1163-65. Our last stop on our historical journey looks at the nondelegable-duty rule in the hospital setting.

c. Nondelegable duty.

Contractual nondelegable duty. In the hospital context, this Court first applied the nondelegable-duty rule in a 1933 case, without expressly using the word

"nondelegable." *See Parrish v. Clark*, 107 Fla. 598 (1933).[14] Admittedly, in *Parrish*, the tortfeasor was a nurse in "the service and employ of the [hospital]." *Id*. at 600. So, the modern reader might assume the hospital's vicarious liability in *Parrish* lie in *respondeat superior*. Not so. The nursing negligence in *Parrish* involved medical care—an "improperly prepared or administered saline solution which was injected into [the patient]…while she was…under the nurse's and hospital's care." *Id.* Recall, in 1933, courts applied *respondeat superior* to impute only "lay" negligence to hospitals, but not "medical" negligence. *Supra* at 36-38; *Oates*, 152 Fla. at 28.

Not only does this historical context prove that *Parrish* did not rely on *respondeat superior* to hold the hospital liable, but the Court's opinion itself also shows this. In *Parrish*, the hospital "contended only the physician should have" injected the needles. 107 Fla. at 601. In other words, the hospital contended the nurse's negligent act was unauthorized and outside of her employment. *See id*. In response, this Court said it was "not necessary" to decide whether the nurse's negligence was "imputable to the hospital which employed her." *Id*. While this "imputable" term may be ambiguous, the Court's holding—discussed next—clarifies it was using this term to say it was not necessary to decide any liability

[14] A commentator said *Parrish* "foreshadowed" the nondelegable-duty rule because it employed "language typically used when describing the creation of a nondelegable duty." Gwynn, *supra*, 64 Fla. B.J. at 18. *Parrish* and similar cases from that era show "duties undertaken" by hospitals in contracts "override the independent contractor doctrine of nonliability for physician negligence." *Id.* at 18 & n.20.

based on *respondeat superior*.

This Court held the contract between the hospital and the patient in *Parrish* was the basis of the hospital's vicarious liability for the nurse's tort:

> [T]he hospital is liable for the positive negligent infliction of injury on the patient by an employee nurse, *regardless of whether or not it used due care in the selection of only competent nurses* to attend the patients …, and especially in cases where the inception of the duty of the hospital toward the patient lies in a contract by the hospital to furnish rooms and nursing care to the sick person who suffers such negligent personal injuries. And in cases like this an action may arise for the breach of the contract, or for the positive tort committed by the violation of a duty arising out of the assumption of the contractual relation.

107 Fla. at 603 (emphasis added) (citing, among others, *Armstrong v. Wesley Hosp*., 170 Ill. App. 81 (1912) (holding hospital liable to patient in contract, though it was not liable based on *respondeat superior* due to charitable immunity)). The italicized language above clarifies the hospital's liability was no-fault, vicarious liability. The underlined language shows the hospital's liability lie in its contractual duty to the patient, from which the hospital was not relieved simply because the nurse may have been acting outside the scope of her employment when she injured the patient. Notably, *Parrish* never mentions an express contract, suggesting the hospital-patient contract there (like the one here) may have been implied. *See id*. at 599-605.

In the 4th DCA 1982 *Irving* case, an implied contract between a hospital and its emergency-department patient was the basis on which the court applied the nondelegable-duty rule. 415 So. 2d at 60. The Third District twice approved *Irving's*

holding, *Cedars Med. Center, Inc. v. Ravelo*, 738 So. 2d 362, 366 n. 1 (Fla. 3d DCA 1999); *Jaar*, 474 So. 2d at 243, but the panel below labeled these statements "dicta" (AR221 n.11). *Irving* and its holding are reflected and cited in this Court's standard jury instructions. *See* Fla. Std. Jury Instructions in Civil Case 402.9a. During the past thirty-seven years, other district courts of appeal routinely cited and discussed *Irving* as good law, never questioning its reasoning (until now). *See, e.g., Pope*, 939 So. 2d at 189-90. The Fourth District recently re-affirmed *Irving* under facts identical to this emergency-department case. *Newbold-Ferguson*, 85 So. 3d at 502.

The Fifth District, addressing an express, patient-hospital contract, explained why the common law does not allow one party to a contract (the hospital) to escape its responsibilities undertaken in a contract with the other party (the patient) simply because it retained an independent contractor to perform its obligations:

> [D]uties assumed under a contract cannot be transferred to another. Performance of the duties assumed under a contract are usually delegable, but, even if delegable, the delegation will not relieve the promisor of the duty to perform his obligation under the contract. Thus, if a hospital does undertake by contract to provide medical care, it cannot throw off that obligation simply by hiring an independent contractor. The use by hospitals of independent-contractor physicians eliminates "respondeat superior" liability, but it will not relieve the hospital of any contractual duties it has undertaken.

Pope, 939 So. 2d at 188-89 (emphasis altered);[15] *accord Shands Teaching Hosp. & Clinic, Inc. v. Juliana*, 863 So. 2d 343, 350 (Fla. 1st DCA 2003) (same rationale).

Before the decision below, no DCA conflict existed on applying the contractual nondelegable-duty rule to a hospital providing emergency care where no contrary express contract existed. The Fourth District's 37-year-old *Irving* decision, recently re-affirmed in *Newbold-Ferguson*, had been settled law.

Statutory nondelegable duty. In contrast to the previously settled (Fourth District) case law on contractual nondelegable duties in the emergency-medical-services context, there was no case law—before the decision below—on whether a hospital had a statutory nondelegable duty to provide emergency medical services. Yet, the panel below certified "conflict" on this issue with the Fourth District's decision in *Wax*, 955 So. 2d at 1 , claiming it was "align[ing]" the Third District with the Second District. (AR217-18 (citing *Tarpon Springs Hosp. Found., Inc. v. Reth*, 40 So. 3d 823, 838 (Fla. 2d DCA 2010)). The flaw in the panel's certification on statutory nondelegable duty was that *Wax* and *Reth* both concerned surgical anesthesia services, not emergency medical services. The statutes and regulations governing

[15] *Pope* also said: "Florida law does not currently recognize an implied nondelegable duty on the part of a hospital to provide competent medical care to its patients." 939 So. 2d at 187. The Hospital below misconstrued this statement. (AR137.) The Estate does not seek a broad, freestanding "implied" duty that would hold the Hospital responsible for all medical care in its facilities. *See infra* Part II.D, at 63-64. The Estate's argument is grounded in statutes and regulations, and well-established rules recognizing implied-in-fact contracts. *See, e.g., infra* Part II.A, at 50-53.

anesthesia services and emergency medical services are different. *Compare, e.g.*, § 395.1055, Fla. Stat. (2012), *with, e.g.*, § 395.1041, Fla. Stat. (2012). To be sure, lessons can be learned from *Wax's* and *Reth's* application of those different statutes and regulations. As we argued below, "*Wax's* rationale applies even more persuasively to the [emergency-care] circumstances of this case," and this argument was "supported by [*Reth's*] criticism of *Wax*." (AR42.)

Here, we end our historical journey of the law's path. We now make the case that the nondelegable-duty rule—not *respondeat superior* or apparent agency—is the best common-law rule for imputing medical negligence to a hospital.

II. This Court should apply the nondelegable-duty rule to impute to the Hospital medical negligence occurring in the emergency department.

A. The Hospital, by contract or statute (or both), assumed a duty to provide emergency care, and it is responsible for the harm inflicted on Mrs. Torres resulting from the negligent performance of this duty.

Under Lord Holt's evolved rule, an enterprise undertaking a duty to a third party is responsible for injuries inflicted on that party by the tortious conduct of the person whom the enterprise sent to carry out the duty. The "right to control" principle, introduced in the mid-1800's, restored this original rationale by protecting persons who neither were engaged in an enterprise nor owed any duty themselves to the injured party. But, for enterprises assuming duties directly owed to a third party (either by a contractual undertaking or a statutory directive), the "right to control" principle did not apply (and still does not apply). Such enterprises—like the Hospital

here—are responsible for the harm inflicted on the third party resulting from the negligent performance of these duties, irrespective of whether they send an employee or contractor to perform the duty.

The Estate relies on the Hospital's: (i) implied contractual duties to Mrs. Torres and (ii) statutory and regulatory obligations to all patients presenting at the emergency department. Either basis, alone or combined, justifies imputing to the Hospital the emergency medical negligence that caused Mrs. Torres' death.[16]

In 1933, this Court held a hospital had a contract duty to furnish nursing care to a patient. The hospital was not absolved of responsibility just because it had hired competent nurses; it was liable when a nurse, providing unauthorized medical care, negligently inflicted an injury on a patient. This ruling's lynchpin was the hospital's "assumption" of a contract duty (furnishing nursing care) owed to the patient. *Parrish*, 107 Fla. at 603; *supra* at 45-47 (discussing *Parrish*). Today's courts use a similar phrase: "undertake" a duty. They hold that, if a hospital undertakes a duty to provide medical care to a patient, it cannot delegate its responsibility for injuries flowing from that undertaking. *E.g., Pope*, 939 So. 2d at 188-89.

Has anything changed since 1933, or is anything different about this case, to make this Court rule differently than it did in *Parrish*? Times have changed and this

[16] To be clear, the Estate is not waiving either basis. The arguments for both bases overlap and are similar, and thus the Estate weaves its arguments for both bases together for the sake of efficiency.

case has some differences, but only in ways that favor this Court adhering to its *Parrish* decision and ruling for the Estate.

Today, hospitals and patients still may have implied-in-fact contracts. Hospitals themselves sue under implied contracts when their patients don't pay the bills. *E.g.*, *Variety Children's Hosp., Inc. v. Vigliotti*, 385 So. 2d 1052, 1054 (Fla. 3d DCA 1980); *see also Goff v. City of Fort Lauderdale*, 65 So. 2d 1, 1 (Fla. 1953) (recognizing implied contract between hospital and patient). Under an implied contract, this Court gives "effect [to that] which the parties, as fair and reasonable [persons]" would have agreed had they contracted expressly. *Bromer v. Fla. Power & Light Co.*, 45 So. 2d 658, 660 (Fla. 1949). Written laws—like those requiring the Hospital to provide emergency medical care to Mrs. Torres—are part of an implied contract. *See, e.g.*, *Shavers v. Duval County*, 73 So. 2d 684, 689 (Fla. 1954).

Since 1933, hospitals have changed and so have our reasonable expectations about what hospitals do and what our written laws require them to do. Today, hospitals do a lot more than just furnish rooms and nursing care. *Supra* at 26-28. Among other things, they provide emergency medical services, as required by written laws enacted in the 1980's. *Supra* at 29-35. By applying for, and being granted, a license to provide emergency medical services (AR89), the Hospital assumed a duty, owed to patients, to provide such services. This assumption of a duty by the Hospital—owed to Mrs. Torres contractually and all emergency patients

statutorily—is no different than the duty the *Parrish* hospital assumed to furnish the patient there with nursing care. In short, the practical and regulatory changes since 1933 make this Court's *Parrish* decision indistinguishable from this case.

The nondelegable-duty rule—that sprouted in the law with *respondeat superior*'s "right to control" principle (*supra* at 16-20)—does not permit the Hospital to shirk its responsibilities. As the English court said in 1861, "[w]here a person is authorized by [a legislative] act…or bound by contract to do particular work, he cannot avoid responsibility by contracting with another person to do that work." *Hole*, 6 H. & N. at 497-98; *supra* at 18-19. Only hospitals are authorized by the Legislature to do the work of emergency medical care, and this Hospital was bound by contract and statute to provide such care to Mrs. Torres when she presented at the emergency department on April 11, 2013. The Hospital was free to hire any physician it wanted—contractor or employee—to provide the care to Mrs. Torres. But, by hiring a contractor, the Hospital did not avoid its responsibility to Mrs. Torres; it delegated merely the performance of its duty.

B. The nondelegable-duty rule best fills the legislative gap.

By declining to apply the nondelegable-duty rule to impute negligence in the emergency department, the panel chose (silently) other judge-made imputation rules (*respondeat superior* and apparent agency). The panel's opinion suggests it believed

it was deferring to the Legislature. (AR221-22.) It did no such thing. None of these rules were enacted by legislators.

The Legislature hardly ever instructs the Judiciary on imputation rules.[17] This Court long has decided what imputation rules to apply when statutes are "silent." *See Nolan*, 81 Fla. at 605-06 (applying common-law imputation rule, *respondeat superior*, to the wrongful-death statute, though the statute was silent on how to impute negligence); *S. Cotton Oil Co. v. Anderson*, 80 Fla. 441, 456-63 (1920) (applying a common-law imputation rule, dangerous instrumentality, to modern automobiles due to modern statutes, though the statutes did not declare the automobile dangerous). That is what American common-law courts have always done. *See Funk v. United States*, 290 U.S. 371, 384 (1933).

So, this Court must craft a common-law rule. As we said at the outset, the nondelegable-duty rule is the best rule. It supports legislative policy, justly holds hospitals responsible for their obligations, recognizes the hospital as an enterprise with direct duties to patients, and is a predictable rule. *Supra* at 1.

Let's start with legislative policy. State and federal laws since the 1980's evince a policy that hospitals must—and only hospitals may—provide emergency medical care. *Supra* at 31-35. The nondelegable-duty rule holds hospitals

[17] A rare, inapplicable example of a legislative imputation rule concerns lessors of motor vehicles. *See Vargas v. Enter. Leasing Co.*, 60 So. 3d 1037, 1042 (Fla. 2011) (discussing federal Graves Amendment and § 324.021(9)(b)2, Fla. Stat. (2007)).

accountable for emergency care that they, by statute and regulation, must provide. As judicial opinions, treatises, and scholarly articles show, the nondelegable-duty rule historically has been used to hold enterprises responsible for the injuries of a third party—to whom the enterprise undertook a duty—that have resulted from the tortious conduct of the person whom the enterprise sent to carry out its assumed duty. These very circumstances exist here with the Hospital. *See supra* Part II.A., at 50-53.

Let's compare the nondelegable-duty rule to a competing imputation rule, *respondeat superior*. Does *respondeat superior* flow from a legislative rule? No. The rule is purely judge-made, and it has not been updated to account for modern statutes or complex institutions like a hospital where multiple contractors serve a common customer. In contrast, the nondelegable-duty rule, since its origins, inextricably has been bound up with statutes. *See supra* at 18-22. For example, in 1950, this Court relied on a statute when it decided to apply the nondelegable-duty rule to impute negligence to hotels and the like. *Goldin*, 49 So. 2d at 541.

How has *respondeat superior* worked in practice for holding hospitals responsible? Not well, though the hospitals have loved it. For the first half of the twentieth century, courts held hospitals had no responsibility for medical negligence in their facilities. *Supra* at 35-38. In the second half of the twentieth century, Florida courts slightly opened the door to holding hospitals responsible for medical

negligence under *respondeat superior*. *Id.* at 41. But this Court slammed that door shut in 1997, practically speaking for private hospitals, by allowing them to self-determine their responsibility. *Id.* at 42-43 (discussing *Stoll*, 694 So. 2d at 701). In sum, the judge-made *respondeat-superior* rule has failed in holding hospitals responsible, and it is wholly unmoored from any legislative policy.

What about the other judge-made rule, apparent agency? Does it support a legislative policy? No. Has the Legislature endorsed it for medical-malpractice cases? No. Does it achieve predictability?[18] No. Instead, liability turns on trivial facts, like the physician's I.D. badge. *See, e.g., Jones v. Tallahassee Mem'l Reg'l Healthcare, Inc.*, 923 So. 2d 1245, 1247 (Fla. 1st DCA 2006).

The nondelegable-duty rule, if applied to hospitals, would achieve more predictable rulings than the apparent-agency rule does. It would allocate responsibility based on the nature of the triangular relationship between the hospital, the physician, and the patient, and based on the legislative policies in statutes and regulations. With time, as the common law developed, hospitals, providers, insurers, and patients could know for which medical services the hospital bore vicarious liability and for which medical services the provider was solely liable. *Roessler*, 858 So. 2d at 1163-65 (Altenbernd, C.J. concurring).

[18] The law has long tried to achieve predictability. *See Regan v. People of State of New York*, 349 U.S. 58, 64 (1955).

The current system promotes unnecessary litigation and inefficiencies. *See id.* If it one could predict with certainty that the hospital was ultimately responsible for negligence occurring in the emergency department, patient's counsel would not be required to sue the multiple providers who treated the patient. On the other hand, if the nondelegable-duty rule excluded a certain category of medical services from hospital liability (like elective procedures or where the patient had an opportunity to select another physician), then the patient's counsel would know her only recourse would be against the providers. And counsel then could allocate litigation resources efficiently in pursuing relief solely from the providers.

The current system increases the number of defendants in malpractice cases. It also causes litigation on a host of vicarious-liability issues unrelated to the core issue of medical negligence. Who benefits from this system? Lawyers. Why? More parties needing lawyers. More litigation on collateral issues. More fees. Who loses? Everyone else: overworked judges, insurers, patients, hospitals, and providers.

The nondelegable-duty rule serves the most compelling rationale for vicarious liability: the hazards of a business should be borne by the business directly. *Supra* at 12. Hospitals are enterprises selling medical care; they are no longer mere workshops. *Id.* at 26-29. Emergency departments drive hospital admissions, which drive hospital profits. *See id.* at 30. More certainty in the rules for vicarious liability will reduce a hospital's litigation costs. Regardless, patients—the hospital's

customers—should not bear the costs of the hazards of the hospital's business. The business (the hospital) should bear these costs.

Finally, this Court should ask why each of the present rules (*respondeat superior* and apparent agency) are being applied to determine a hospital's vicarious liability. "[I]f the grounds upon which [the rule] was laid down have vanished long since, and the rule simply persists from blind imitation of the past," then in Justice Holmes' words, that is "revolting." Holmes, *supra*, 10 Harv. L. Rev. at 469. This Court should choose the best rule and not blindly apply the present rules.

C. The test on implying a statutory cause of action does not apply where a court exercises its common-law power to impute negligence, and this Court should recede from *Villazon* insofar as it holds differently.

The panel's opinion indicates it misunderstood the difference between the common-law imputation rules (that originated in 1709) and a late twentieth-century doctrine on implied statutory causes of action. (AR218 (citing *Murthy v. N. Sinha Corp.*, 644 So. 2d 983 (Fla. 1994)). The panel's misunderstanding may have stemmed from this Court's suspect reasoning in *Villazon v. Prudential Health Care Plan, Inc.*, 843 So. 2d 842 (Fla. 2003). The two doctrines are separate and distinct, serve different purposes, and should not be intertwined with one another.

In *Murthy*, this Court adopted the *Lewis* test, formulated by the U.S. Supreme Court, "to determine whether a private cause of action should be judicially inferred" from a statute. 644 So. 2d at 985 (citing *Transamerica Mortg. Advisors, Inc. (TAMA)*

v. Lewis, 444 U.S. 11, 15–16 (1979)[19]). This test is "the proper approach where the common-law power to create legal claims is *not* being exercised." Scalia and Garner, *supra* § 51, at 316 (emphasis added) (full cite in note 19). The test was a reaction primarily to twentieth-century federal courts—which have no common-law powers outside of select fields (like admiralty law)—that had claimed a "power to create private claims to accompany statutory prohibitions." *Id.* at 313 (emphasis added).

In sum, the *Murthy*/*Lewis* test applies when: (1) a court is attempting to make a statutory violation into a private claim and (2) a court is not exercising common-law powers. *See id*. at 313, 316. Neither criterium is satisfied here.

First, the Estate's claim is not based on any statutory or regulatory violation, or corporate wrongdoing, committed by the Hospital. Its claim is based on the wrongful-death statute, which expressly creates a cause of action. § 768.19, Fla. Stat. (2012). It claims emergency medical providers like Dr. Bowers—not the Hospital—violated the wrongful-death statute (not Chapter 395) by causing Mrs. Torres' death due to their own "negligence." *Id.* Travelling under the nondelegable-duty rule, the

[19] The precursor to *Lewis* was *Touche Ross & Co. v. Redington*, 442 U.S. 560 (1979). *See* Antonin Scalia and Bryan A. Garner*, Reading Law: The Interpretation of Legal Texts* § 51, at 315 & n.12 (2012).

Estate claims the Hospital is vicariously liable for the providers' negligence.[20] Vicarious liability, by definition, is no-fault liability. *E.g.,* Keeton, *supra* § 69, at 499. It involves imputing the negligence of person A (e.g., Dr. Bowers) to person B (the Hospital). *See id*. Nearly 100 years ago, this Court used a common-law rule (*respondeat superior*) to impute negligence under a wrongful-death statute. *See Nolan*, 81 Fla. at 605-06. The Estate seeks to do the same thing here (albeit by using a sibling rule, nondelegable duty).

Second, vicarious liability—under every rule (*respondeat superior*, apparent agency, and nondelegable duty)—is a creature of the common law.[21] *See supra* Part I.A, at 11-24. Thus, when a court decides which imputation rule to apply, it exercises

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[20] In *Villazon*, this Court correctly called the nondelegable-duty rule a vicarious-liability theory. 843 So. 2d at 851-52; *accord* Keeton, *supra* § 71, at 511; *Carrasquillo v. Holiday Carpet Serv., Inc.*, 615 So. 2d 862, 863 (Fla. 3d DCA 1993). Some courts have incorrectly classified the rule as imposing direct liability. *See, e.g., Armiger v. Associated Outdoor Clubs, Inc.*, 48 So. 3d 864, 875 (Fla. 2d DCA 2010). Even if this other view is correct, liability based on a nondelegable duty is still like vicarious liability in that the party employing the contractor is held liable for the contractor's negligent performance of the duty. *See Daniel v. Morris*, 181 So. 3d 1195, 1198 n. 4 (Fla. 5th DCA 2015) (citing *Armiger*, 48 So. 3d at 875).

[21] The sources of a common-law nondelegable duty include statutes, contracts, and the common law itself. Keeton, *supra* § 71, at 511. This is similar to this Court's recognition that common-law tort duties my arise from statutes, contracts, and judicial decisions. *E.g., McCain v. Fla. Power Corp.*, 593 So. 2d 500, 503 n. 2 (Fla. 1992); *Clay Elec. Co-op., Inc. v. Johnson*, 873 So. 2d 1182, 1186 (Fla. 2003). The panel below correctly noted that the Estate relied on statutory and contractual duties to impute negligence to the Hospital, and it was not seeking to impute negligence under a stand-alone common-law duty. (AR215.) But if the panel was suggesting the Estate did not rely on the common law at all, then the panel was wrong, and it misapprehended the nature of the common law and the nondelegable-duty rule.

a common-law power. A court, of course, should consider statutes when exercising a common-law power. *E.g., DeVries*, 139 S. Ct. at 992. But don't be fooled. When imputing negligence, a court is making the common law and not interpreting statutes (even if it is considering statutes to make this common law).

That bring us to this Court's puzzling reasoning in *Villazon v. Prudential Health Care Plan, Inc.*, 843 So. 2d 842 (Fla. 2003). There, this Court both followed, and departed from, Justice Scalia's teaching on the *Murthy*/*Lewis* test. *See supra* at 58-59. Consistent with Justice Scalia's teaching, the *Villazon* court correctly recognized that, even if no private right of action exists under a statute per the *Murthy*/*Lewis* test, a party still could "bring a common law negligence claim based upon" statutory violations. 843 So. at 852. This makes sense. After all, as we just said, common-law rules should be guided by legislation. *See, e.g., DeVries*, 139 S. Ct. at 992. Indeed, this Court repeatedly has held that a tort duty may arise out of a statute or regulation. *E.g., McCain*, 593 So. 2d at 503 n. 2.

It would be illogical to say, on the one hand, that common law rules should be fashioned based on legislation, but then, on the other hand, say a common-law rule can be based on a statute only if the statute creates a cause of action. Yet, unfortunately, the *Villazon* opinion, written by Justice Lewis, follows this same type of illogical reasoning, departs from Justice Scalia's teaching, and muddied Florida law. After concluding that the plaintiff could state a common-law negligence claim

based on statutory violations (even though the statute did not create a cause of action), Justice Lewis applied two common-law imputation rules (agency and apparent agency) to hold a question of fact existed as to whether the physicians there were agents or apparent agents of the corporate defendant. 843 So. 2d at 852-53. This holding was correct and consistent with Justice Scalia's teaching.

But Justice Lewis's reasoning was inconsistent, both internally and with Justice Scalia's teaching, when he concluded another common-law rule (nondelegable duty) could not impute negligence to the corporate defendant simply because the statute did not create a cause of action per the *Murthy*/*Lewis* test. *Villazon*, 843 So. 2d at 852. Contrary to what Justice Lewis wrote in *Villazon*, the *Murthy*/*Lewis* test—Justice Scalia taught us—is proper only when a court is not exercising its common-law powers. Scalia and Garner, *supra* § 51, at 316. Where, as here, courts are imputing negligence (by agency or nondelegable duty), they are making common law to fill gaps left by the legislature. *See, e.g., Nolan*, 81 Fla. at 605-06; *supra* Part I.A, at 11-24. Thus, here, the *Murthy*/*Lewis* test is neither proper nor relevant. Insofar as *Villazon* relied on the *Murthy*/*Lewis* test to preclude a court from imputing negligence under the nondelegable-duty rule, this Court should recede from *Villazon*.

D. This Court should interstitially apply the nondelegable-duty rule to impute medical negligence in the emergency department.

Per Justice Holmes' wisdom that the common law be developed interstitially from the molar to the molecular, we clarify the limits of a ruling in the Estate's favor.

First, as no express contract existed between Mrs. Torres and the Hospital,[22] this case will not resolve the question of whether a hospital could disclaim its nondelegable duty in a written contract. That issue must be decided in a future case.

Second, for purposes of this case, the Estate concedes that only medical negligence arising in the emergency department should be imputed to the Hospital and that negligence occurring outside of the emergency department (*e.g.,* in the ICU) should not be imputed to the Hospital. This concession simplifies this appeal and moots the concern raised in footnote 5 of the panel's opinion.[23] (AR 211 & n.5.)

Third, the Estate is not asking this Court to hold hospitals responsible for all medical negligence in their facilities. For example, this Court could conclude emergency medical services here involve a nondelegable duty, but still conclude in a later case that the anesthesiologist's negligence in *Wax* did not involve a

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[22] Only Mrs. Torres' father signed the admission form (AR211; TR430, ¶57), and thus Mrs. Torres (an adult) was not bound by the form, *see, e.g., Mendez v. Hampton Court Nursing Ctr., LLC*, 203 So. 3d 146, 148 (Fla. 2016).

[23] "Emergency services and care" include "the care, treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition," § 395.002(9), Fla. Stat. (2012), which could include the alleged negligent physician care given to Mrs. Torres in the ICU. The Estate's concession, however, relieves this Court from having to decide this subsidiary issue.

nondelegable duty. *See* 955 So. 2d at 1. The written laws governing emergency services are significantly clearer and broader than the written laws governing anesthesia services. (AR43-44.) Thus, no holding here on emergency medical services will bind any future court addressing different medical services, statutes, and regulations.

Fourth, a ruling in the Estate's favor will be limited if the Court adopts Judge Altenbernd's reasoned principles for applying the nondelegable-duty rule to hospitals. *Roessler*, 858 So. 2d at 1164-65 (Altenbernd, C.J. concurring). A primary consideration, he suggested, is whether the patient "realistically [has] the ability to shop on the open market for another provider." *Id.* at 1164. Often, this consideration will cause a court to not apply the nondelegable-duty rule. For instance, the Fourth District declined to hold a surgical center responsible for an anesthesiologist's negligence because the patient there chose the anesthesiologist and did not rely on the center to choose him. *Kristensen-Kepler*, 39 So. 3d at 520.

In sum, a ruling in the Estate's favor will not establish a nondelegable duty for medical services for which the hospital has no statutory, regulatory, or contractual obligation to provide and for which patients (not hospitals) routinely select the physician.

CONCLUSION

For almost two hundred years, our Legislature has been largely silent on the rules for imputing negligence. The courts have "discovered" or "made" these common-law rules. Here, the Court must decide again, this time for medical negligence occurring in a hospital's emergency department. In this context, the best common-law rule to fill the legislative gap is the nondelegable-duty rule. This Court should vacate the Third District's decision, reverse, and remand with instructions consistent with the principles stated herein.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing motion was filed with the Clerk of Court on October 25, 2019, via the Florida Courts E-Filing Portal and that a true and correct copy of the foregoing has been furnished via email to:

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I HEREBY CERTIFY that the foregoing brief is in Times New Roman 14-point font and complies with the font requirements of Rule 9.210(a)(2), Florida Rules of Appellate Procedure.

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