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Damned If You Do, Damned If You Don't: Hospitals' Liability for Physicians' Malpractice

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Damned If You Do, Damned If You Don't: Hospitals' Liability For Physicians' Malpractice

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I. INTRODUCTION

It is becoming increasingly difficult for a hospital to escape liability for any acts of professional negligence occurring within its walls. Traditionally, hospitals have been held liable under the doctrine of respondeat superior for the negligent acts of their employees and agents. But because non-employee physicians were considered independent contractors, hospitals were not liable for their negligence absent special circumstances.¹ The assault on the status of physicians as independent contractors has begun and is proceeding apace.² Further, the doctrines of ostensible agency³ and corporate negligence⁴ have

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1. See *infra* notes 29-31 and accompanying text.

2. See *infra* notes 29-44 and accompanying text.

3. See *infra* notes 45-89 and accompanying text.

arisen as alternative bases for holding hospitals liable for the negligent acts of non-employee physicians.

Moreover, steps taken by hospitals to minimize the likelihood of liability under one of these theories often increase the likelihood of liability under a different theory. For example, although hospitals might develop stricter evaluation and selection controls for the granting and retention of staff privileges to avoid a finding of corporate negligence, attempts to control physicians' practice by review and supervision increase the potential for a finding of agency.⁵ If the hospital attempts to circumscribe its relationships with the physician by contractual arrangements delineating the independence of the physician, this very instrument may be used to show either control or an employer-employee relationship.⁶ Should the hospital attempt no supervision over the physician, it may be in violation of accreditation requirements⁷ for the monitoring of medical practice within its walls and, therefore, negligent under a corporate responsibility theory.⁸

The difficulty of escaping liability has proven so great that it has been recommended that hospitals accept the inevitable, expect liability for the torts of their independent contractors, insure themselves for that eventuality, and establish indemnification agreements between the physicians' and hospitals' carriers.⁹

This Article explores some of the problems hospitals face in avoiding liability for the negligence of their independent contractors. After a critical analysis of the theories underlying imposition of liability, we discuss the sometimes conflicting public policy considerations respecting the mandates given to the modern hospital as these mandates affect hospitals' liability.

II. EMERGENCE OF THE PROBLEM

Hospitals were originated by religious and military orders in medieval times.¹⁰ Plagues were rampant, life expectancies short, and any care was better than no care. Hospitals continued under the control of religious orders and governmental agencies and, in more modern

4. See *infra* notes 91-133 and accompanying text.

5. See *infra* notes 93-95.

6. See *infra* notes 41-44 and accompanying text.

7. JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, I to V ACCREDITATION MANUAL FOR HOSPITALS, MEDICAL STAFF STANDARDS 89-104 (1984) [hereinafter cited as JCAH STANDARDS]. The Commission shall be hereinafter cited as JCAH; the Manual as AMH.

8. See *infra* notes 91-134 and accompanying text.

9. Southwick, *Hospital Liability: Two Theories Have Been Merged*, 4 J. LEGAL MED. 1, 49 (1983).

10. For example, the Sisters of Charity of St. Vincent de Paul and the Sisters of Knight Hospitallers of St. John (also known as the Knights of Malta) established hospitals. See generally J. DOLAN, HISTORY OF NURSING (1968).

times, charitable¹¹ and governmental¹² immunity arose, precluding suit or greatly limiting recovery.

The emergence of liability insurance, the replacement of The Little Sisters of the Poor by proprietary secular hospital corporations, the inconsistencies among jurisdictions, and the belief that stare decisis should not be an excuse to justify unfair laws have caused legislatures¹³ and courts¹⁴ to abolish or reduce the impact of immunities.¹⁵ The end result is a less sympathetic target with a much deeper pocket for potential litigation.

Concomitant with the change in the legal climate was a change in the relationships among hospitals, patients, and physicians. Health care is "big business" in the United States, and hospitals are run increasingly for profit by large national health corporations.¹⁶ Hospital

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11. Charitable immunity was first pronounced in the United States in *McDonald v. Massachusetts Gen. Hosp.*, 120 Mass. 432 (1876). The Massachusetts court relied upon the English case *Holliday v. St. Leonard*, 11 C.B. (N.S.) 192, 142 Eng. Rep. 769 (1861), which, apparently unknown to the Massachusetts court, had been overruled by *Mersey Docks v. Gibbs*, L.R. 11 H.L.C. 686, 11 Eng. Rep. 1500 (1866), and *Foreman v. Mayor of Canterbury*, 6 L.R.-Q.B. 214 (1871). Nevertheless, other jurisdictions in the United States accepted the doctrine with full knowledge of the English repudiation. Prior to 1942 most jurisdictions adhered to charitable immunity at least in part. For a discussion of the pre-1942 status of charitable immunity, see *President and Directors of Georgetown College v. Hughes*, 130 F.2d 810 (D.C. Cir. 1942).
 12. The hospitals of both federal and state governments were historically immune from suit under the common law doctrine of sovereign immunity. This was incorporated into American law at an early date, seemingly without much consideration as to whether it was appropriate for a republic. A justification for its reception was offered by Justice Holmes in *Kwanakoa v. Polyblank*, 205 U.S. 349, 353 (1907). For a detailed exposition of the historical origins of governmental immunity, see Borchard, *Governmental Responsibility in Tort* (pts. 7 & 8), 28 COLUM. L. REV. 577, 734 (1928), noted in J. HENDERSON & R. PEARSON, *THE TORTS PROCESS* 620 (2d ed.) (1981); Borchard, *Governmental Responsibility in Tort*, (pts. 4-6), 36 YALE L.J. 1, 757, 1039 (1926-27); Borchard, *Government Liability in Tort* (pts. 1-3), 34 YALE L.J. 1, 129, 229 (1924-25).
 13. *E.g.*, MASS. GEN. LAWS ch. 231 § 85K (West Supp. 1984-85); NEV. REV. STAT. § 41.480 (1981); N.J. STAT. ANN. § 2A:53A-8 (West Supp. 1984-85); N.C. GEN. STAT. § 1.539-9 (1983); R.I. GEN. LAWS § 9-1-26 (1969).
 14. *E.g.*, *President and Directors of Georgetown College v. Hughes*, 130 F.2d 810 (D.C. Cir. 1942); *Tuengel v. City of Sitka*, 118 F. Supp. 399 (D. Alaska 1954); *Malloy v. Fong*, 37 Cal. 2d 356, 232 P.2d 241 (1951). By 1982 over 30 jurisdictions had abrogated the doctrine of charitable immunity.
 15. Governmental immunities have been slower to be abrogated. Legislation such as the Federal Tort Claims Act of 1946 (28 U.S.C. § 1346(b) (1976), §§ 2671-2680 (1982)) is an example of the trend toward allowing suits in tort under certain circumstances against governmental hospitals.
 16. By 1979, 10 percent of all hospitals were run for profit. P. JOSKOW, *CONTROLLING HOSPITAL COSTS: THE ROLE OF GOVERNMENT REGULATION* 6 (1981). Since 1979, large health care corporations such as Humana and Health Care Corporation of America, and various Health Maintenance Organizations (HMO's), such as the Kaiser Plan hospitals, have increased their numbers of facilities by both construc-

services are depersonalized and consumers feel no special reverence for the hospital or its employees. The depersonalization of the patient within the institution was an inevitable result of the dehumanization of the hospital. Health care is an industry subject to cost-controls,¹⁷ governmental regulation,¹⁸ job actions,¹⁹ and, frequently, malpractice suits.

Not only hospital care but medical care generally is more specialized and less personal than in the past. The concept of the single physician caring for the entire family, making house calls, and becoming a friend of the family to be called on in any emergency is no longer common.²⁰ Patients look increasingly to the hospital to provide primary medical care. Often they have no personal physician,²¹ or, if they do, that physician merely admits them to the hospital for specialized care. At least one court has found that patients expect the hospital to cure them.²² They rely on the hospital to provide good care and any doctor with whom they come in contact at the hospital is presumed to be the hospital's agent.

As technology advances increased specialization is inevitable. Indeed, to qualify for government funds hospitals are required to pro-

tion and purchase of existing hospitals. Lecture, Health Care Law, Carl Schramm, Univ. of Md. (Oct. 11, 1984).

17. For a good general discussion of traditional and newer cost control measures, see D. SALKEVER & T. BICE, HOSPITAL CERTIFICATE OF NEED CONTROLS: IMPACT ON INVESTMENT, COSTS AND USE (1979); D. SALKEVER & T. BICE, PROPOSALS FOR REGULATION OF HOSPITAL COSTS (1978).
18. *E.g.*, National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, §§ 1521(2)(c)(4)(d), 1523, 88 Stat. 2225 (1975) (creating the Health Systems Agencies); Medicare Program: Prospective Payment for Medicare Inpatient Hospital Services, 48 Fed. Reg. 39,752 (1983) (to be codified at 42 C.F.R. §§ 405, 409, 489) (establishing "DRG" (Diagnostically Related Group) prospective payment for all Medicare payments). For a good general discussion of governmental regulation, see H. AARON & W. SCHWARTZ, THE PAINFUL PRESCRIPTION: RATIONING HOSPITAL CARE (1984); P. JOSKOW, *supra* note 16; M. STRICKLER & F. BALLARD, REPRESENTING HEALTH CARE FACILITIES (1981). For a comprehensive legal analysis of Professional Standards Review Organizations (PSRO's), see Havighurst & Blumstein, *Coping with Quality/Cost Trade-Offs in Medical Care: The Role of PSRO's*, 70 NW. U. L. REV. 6 (1975); Note, *Federally Imposed Self-Regulation of Medical Practice: A Critique of the Professional Standards Review Organization*, 42 GEO. WASH. L. REV. 822 (1974).
19. For a discussion of the extension of federal labor legislation to hospitals, see ASPEN SYSTEMS CORPORATION, PROBLEMS IN HOSPITAL LAW 91-101 (1968).
20. The emergence of the board certified Family Practitioner as a specialist in his own right is but one reaction to this depersonalization. While the number of family practitioners is increasing, especially in rural areas, the more personal aspects of health care services such as house calls have not been repopularized. AMERICAN BOARD OF FAMILY PRACTITIONERS, ANN. REP. (1979).
21. It is estimated that, in 1984, 60 percent of American citizens had no personal physician. Schram lecture, *supra* note 16.
22. *See, e.g.*, Bing v. Thunig, 2 N.Y.2d 656, 666, 143 N.E.2d 3, 8, 163 N.Y.S.2d 3, 11 (1957).

vide certain services and may be prohibited from providing others, depending on regional need and supply.²³ To be cost effective and to guarantee services, hospitals execute exclusive service contracts with groups of independent contractor physicians to staff clinical areas, such as radiology, pathology, and emergency room service, which must be available on a twenty-four hour basis.²⁴ Consequently, patients' ability to select physicians becomes limited by the restriction of clinical practice to contracting physicians. Finally, expansion of services, introduction of medical sub-specialties,²⁵ and the requirements of governmental and accrediting agencies²⁶ force hospitals to establish a complicated framework of review committees²⁷ to monitor the quality of care provided.

Thus, hospitals serve as employers, contractors, and evaluators. Each of these roles has spawned a theory of liability for patients who rely on the hospital to provide adequate, safe, and comprehensive medical care. The hospital as employer suggests the respondeat superior theory of liability. As contractor, the hospital may be subject to liability for the acts of contracting physicians who, while not employees, may be viewed as apparent or ostensible agents for the purpose of establishing the hospital's liability. As evaluator, the hospital may be subject to liability for corporate negligence should the evaluation process go awry. The law assumes that the average person is not medically sophisticated or knowledgeable and that he places his fate in the

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23. Regional Health Services Agencies may issue "certificates of need" based on cost, demographic data, and availability of services. See *supra* note 18. For a symposium on the subject, see *Symposium: Certificate-of-Need Laws in Health Planning*, 1978 UTAH L. REV., 1-210 (1978). See also Havighurst, *Regulation of Health Facilities and Services by "Certificate of Need,"* 59 VA. L. REV. 1143 (1973); Schonbrun, *Making Certificate of Need Work*, 57 N.C.L. REV. 1259 (1979). For a review of various state certificate of need legislation, see CHAYET & SONNENREICH, *CERTIFICATE OF NEED: AN EXPANDING REGULATORY CONCEPT* 155-944 (1978).
 24. See *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 104 S. Ct. 1551 (1984) (legality of a kind of tying arrangement contract for anesthesia services).
 25. As of 1978 the American Board of Medical Specialties recognized the following specialties as members: Allergy and Immunology; Anesthesiology; Colon and Rectal Surgery; Dermatology; Family Practice; Internal Medicine; Neurological Surgery; Nuclear Medicine; Obstetrics and Gynecology; Ophthalmology; Orthopedic Surgery; Otolaryngology; Pathology; Pediatrics; Physical Medicine and Rehabilitation; Plastic Surgery; Preventive Medicine; Psychiatry and Neurology; Radiology; Surgery; Thoracic Surgery; and Urology. There were numerous special certifications within some of these basic groups, particularly Internal Medicine, Pathology, and Pediatrics. For a detailed history of specialization and the development of specialty boards, see R. STEVENS, *AMERICAN MEDICINE AND THE PUBLIC INTEREST* (1971).
 26. See *JCAH STANDARDS*, *supra* note 7.
 27. See generally Hall, *Hospital Committee Proceedings and Reports: Their Legal Status*, 1 AM. J.L. & MED. 245, 248 (1975).

care of the hospital and those who practice within it.²⁸ For these reasons, among others, hospital liability is expanding.

III. THEORIES OF LIABILITY

A. Respondeat Superior

The liability of hospitals for the torts committed by their employee nurses and physicians is a relatively recent phenomenon.²⁹ In 1914, in *Schloendorff v. Society of New York Hospital*,³⁰ the court held that a hospital corporation could not be licensed to practice medicine, and, therefore, could not direct the activities of licensed professionals. If the doctors and nurses were independent contractors not subject to control, the hospital could not be liable under the theory of respondeat superior even if these professionals were salaried.³¹

Unable to recover against the hospital, creative plaintiffs fictionalized a distinction between "administrative" and "medical" acts. Thus, for example, a nurse scheduling staff hours would be performing an administrative act, but her bedside patient care would constitute a medical act. Hospitals were liable for an employee physician's administrative acts because no medical judgment was involved. In *Bing v. Thunig*,³² the court obliterated this distinction, holding hospitals liable for the professional actions of its salaried employees. The court noted the changing role of the hospital, stating that hospitals were more than just facilities where professionals practiced. They employed large numbers of nurses and billed for their services routinely. They undertook to "cure" patients using their professional staff members. Therefore, they should not expect an exemption from general principles of liability.³³ The *Bing* rule won widespread acceptance,³⁴ with one court holding payment of even a part-time salary sufficient to trigger application of the doctrine.³⁵

28. *Arthur v. St. Peters Hosp.*, 169 N.J. Super. 575, 405 A.2d 443 (1979); *Bing v. Thunig*, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957).

29. *See, e.g., Bing v. Thunig*, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957) (overruling *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 105 N.E. 92 (1914)).

30. 211 N.Y. 125, 105 N.E. 92 (1914).

31. While technically correct in its interpretation of medical and nursing practice acts, the exception to the theory created by this decision was not necessary in light of actual supervisory practice. Hospitals typically employ nurses and physicians to supervise the practice of independent contractor nurses and physicians. In such instances the hospital is not directing professional practice; its professional employees are doing so.

32. 2 N.Y.2d 656, 666, 143 N.E.2d 3, 8, 163 N.Y.S.2d 3, 11 (1957).

33. *Id.*

34. Slawkowski, *Do the Courts Understand the Realities of Hospital Practice*, 1979 SPECIALTY DIG: HEALTH CARE 5, 6.

35. *Niles v. San Rafael*, 42 Cal. App. 3d 230, 116 Cal. Rptr. 733 (1974), *noted in Southwick, supra* note 9, at 8.

An assertion of liability based on respondeat superior charges the hospital with vicarious liability, not direct negligence. Theoretically, imposition of liability is justified by the hospital's right to control its employees.³⁶ Existence of control allows the institution to take remedial action to tighten supervisory procedures, thus theoretically lessening the likelihood of the recurrence of a similar negligent act. Because respondeat superior traditionally has been limited in application to employees or other agents and based on the employer's (principal's) right to control the work, it should follow that a hospital would not be liable for the negligence of an independent contractor who, unlike the salaried employee, has sole control over his work methods.³⁷ Nonetheless, *Mduba v. Benedictine Hospital*,³⁸ held that the general guidelines established by a hospital's rules, bylaws, and regulations constitute control sufficient to establish an employer-employee relationship. In *Mduba*, because it controlled his practice through such bylaws, rules and regulations, the hospital was held vicariously liable for the negligence of a non-employee (independent contractor) physician providing services in its emergency room.

Plaintiff's decedent, a victim of an automobile accident, was brought to Benedictine Hospital's emergency room where she was treated by Dr. Bitash, the physician covering the emergency department. Although the exact nature of Dr. Bitash's treatment of the decedent is not documented, it appears that he failed to obtain a sample of plaintiff's blood for the purpose of matching it with blood available for transfusion. When her private physician arrived he was unable to obtain the blood sample. By the time an anesthesiologist was able to get the sample and the transfusion was begun, the decedent was in irreversible hypovolemic shock³⁹ and died despite any further resuscitative attempts.⁴⁰ The medicolegal inference was that Bitash could have obtained blood from decedent, and that his failure to do so in a timely fashion in compliance with accepted standards of medical care deprived her of her last chance for life.

36. *Grant v. Touro Infirmary*, 207 So. 2d 235, 242 (La. App. 1968); *Principles of Hospital Liability*, § 2, HOSPITAL LAW MANUAL, Health Law Center, Aspen Systems Corp. at 7 (1972); Galatz, *Hospital Liability: The Institution, the Physician, the Staff*, 20 TRIAL 64 (May 1984); Southwick, *supra* note 9, at 4.

37. See generally Slawkowski, *supra* note 34; Southwick, *supra* note 9.

38. 384 N.Y.S. 2d 527, 52 A.D.2d 450 (1976).

39. Hypovolemic shock results from the loss of so much blood volume that vital body organs are deprived of adequate circulation and cease to function. Certain organs automatically shut down some of their function to protect themselves from volume depletion. Other organs require a specified volume to function and are irreversibly damaged by prolonged or even transient volume depletion. Physiologically, if too much blood volume is lost, the pressure in the vessel decreases until the sides of the vessel walls collapse and venipuncture becomes impossible. A. GUYTON, *FUNCTION OF THE HUMAN BODY* 175 (1969).

40. *Mduba v. Benedictine Hosp.*, 384 N.Y.S.2d 527, 528, 52 A.D.2d 450, 451 (1976).

Plaintiff brought a wrongful death action against Benedictine, contending that the hospital did not provide the blood soon enough to prevent the decedent from going into irreversible shock. The trial court, on a showing of the contract between Benedictine and Bitash, dismissed the complaint against the hospital based on the absence of an employer-employee relationship.⁴¹ The Appellate Division reversed, finding the dispositive factor to be the right of control exercised by the hospital over the functioning of the emergency room, not the independent contractor status defined in the contract.⁴²

In dicta, the court noted that even without an employer-employee relationship the hospital would be liable under an apparent agency theory because a patient would assume, without contrary notice, that an emergency room physician was an employee. Patients entering through an emergency room "are not bound by secret limitations as are contained in a private contract between the hospital and the doctor."⁴³ Although such service contracts are advocated by some authorities as a method of avoiding agency and vicarious liability exposure,⁴⁴ under *Mduba* such an instrument may be fatal to the institution. The contract was treated as evidence of the actual control the hospital had over the physician, notwithstanding the use of the term "independent contractor."

B. Apparent Agency and Estoppel to Deny Agency

When a court determines that there is no master-servant relationship and, that respondeat superior therefore cannot be applied, it may determine that the facts allow recovery based on a theory of "apparent or ostensible agency"⁴⁵ or "estoppel to deny agency."⁴⁶ Although the "doctrine of apparent agency is steeped in principles of estoppel,"⁴⁷ apparent agency and estoppel to deny agency are not theoretically identical. In practice, however, commentators⁴⁸ and courts⁴⁹ often use these terms as if they were interchangeable, causing confusion and possible misapplication of the law.⁵⁰

Apparent agency is based upon a "holding out" of the ostensible agent by the ostensible principal such that the reasonable plaintiff

41. *Id.* at 528, 52 A.D.2d at 452.

42. *Id.* at 529, 52 A.D.2d at 454.

43. *Id.* at 529, 52 A.D.2d at 453.

44. Levin, *Hospital Liability for Independent Emergency Room Service*, 22 SANTA CLARA L. REV. 791, 804 (1982).

45. Southwick, *supra* note 9, at 10.

46. *Mehlman v. Powell*, 281 Md. 269, 378 A.2d 1121 (1977).

47. *Stewart v. Midani*, 525 F. Supp. 843, 850 (N.D. Ga. 1981).

48. Southwick, *supra* note 9, at 10-13.

49. *Stewart v. Midani*, 525 F. Supp. 843, 850 (N.D. Ga. 1981).

50. *See, e.g., infra* notes 78-81 and accompanying text.

would conclude that there existed an agency relationship.⁵¹ Estoppel to deny agency, by contrast, requires that the plaintiff's actual reliance on the identity of the principal causes or induces the plaintiff to act or forbear.⁵² Thus, theoretically, there need be no causal relationship between the principal's conduct and the plaintiff's reliance to warrant a conclusion of ostensible agency; such a causal relationship and such a change of position, however, is the essence of estoppel to deny agency.⁵³

Yet this important though subtle distinction often is elusive. In *Stewart v. Midani*,⁵⁴ for example, the court recognized that the required change of position suggests that the estoppel doctrine will generally be inapplicable in the typical personal injury case:

[T]here are of course instances in which an ostensible agency may be created by permitting a person to drive a truck under [certain] conditions, but it cannot reasonably be contended that a motorist would be more likely to wish to collide with a truck bearing the insignia of [Texaco] than with one bearing any other insignia.⁵⁵

Nonetheless, the *Stewart* court reasoned from the presence of reliance in similar cases against hospitals that, in the absence of evidence on the question, "a jury may well conclude that [plaintiff's decedent] relied on the hospital and its apparent agents."⁵⁶ Permitting the factfinder to draw such an inference on no evidence dilutes any requirement of the change in position caused by the hospital's apparent representations that should be the gravamen of an argument based on estoppel.

Thus, it is difficult at times to discern whether a court is basing its finding of liability on estoppel, apparent agency, or on respondeat superior. It may be nigh impossible to decide which theory of agency a court is using to impose liability even when it discusses its rationale at length.⁵⁷ Perhaps more regrettable is the perpetuation of error that occurs when a later court either relies on the precedent of a case that was incorrectly decided based on its confusion of agency theory, or incorrectly interprets the language of the former court.

Illustrative of the cases confusing liability under the theory of ostensible (or apparent) agency is a recent New Jersey decision, *Arthur v. St. Peters Hospital*.⁵⁸ The court held a hospital liable for the conduct of an independent contractor because it found the patient could reasonably have believed that the contractor was an employee, and the

51. RESTATEMENT (SECOND) OF AGENCY § 8 (1958).

52. *Id.* at § 267.

53. *Id.* at § 8 comment d.

54. 525 F. Supp. 843 (N.D. Ga. 1981).

55. *Id.* at 851 (citing *Duvall v. T.W.A.*, 98 Cal. App. 2d 106, 219 P.2d 463, 470 (1950)).

56. *Id.* at 853.

57. *Id.* at 845-53.

58. 169 N.J. Super. 575, 405 A.2d 443 (1979).

hospital had done nothing to dispel that belief.⁵⁹

In *Arthur*, the plaintiff sought treatment for an injured wrist at the emergency room of the defendant hospital. He was examined and sent to Radiology for x-rays. He was advised that no fracture existed and was released. Continuing pain forced him to seek the care of an outside physician who diagnosed a fracture of the wrist. Plaintiff sued the physicians and the hospital. The hospital filed an affidavit claiming that the physicians were independent contractors and submitted proof that no social security or withholding tax deductions were made from the physicians' receipts. The hospital did bill for the physicians' charges on hospital stationery, however, and made no attempt to put patients on notice that the doctors were not hospital employees.⁶⁰

The court found that the hospital held these doctors out as employees and might, therefore, be liable for the physicians' negligence.⁶¹ Although there is some language in the opinion suggesting an estoppel theory,⁶² the court seemed to be relying more on a theory of ostensible agency. It speaks, for example, of "holding out."⁶³ What is remarkable, however, as in many other cases, is the court's citation of apparent agency and estoppel cases⁶⁴ with no perceivable distinction drawn among them.⁶⁵

In applying apparent agency theory, it is important to note that the actions to be examined are those of the principal, not the agent. The test is simply whether the hospital voluntarily placed the independent contractor in such a position that an ordinarily prudent person would be justified in assuming that the apparent agent had authority to act in a particular manner.⁶⁶ In making a determination of ostensible agency, courts presume that hospitals are in the business of providing health care services, that patients frequently depend on hospitals to provide primary care, and that decisions to admit from an emergency room are often made by non-employees acting on behalf of the hospital.⁶⁷

A leading authority for imposition of liability based on estoppel to deny agency is *Mehlman v. Powell*.⁶⁸ The patient was taken by his

59. *Id.* at 584, 405 A.2d at 447.

60. *Id.* at 578, 405 A.2d at 444.

61. *Id.* at 584, 405 A.2d at 447.

62. *E.g., id.* at 580, 405 A.2d at 446.

63. *Id.*

64. *See, e.g., infra* note 68.

65. *Arthur v. St. Peters Hosp.*, 169 N.J. Super 575, 580-81, 405 A.2d 443, 446 (1979).

66. *Id.*

67. Levin, *supra* note 44, at 800.

68. 281 Md. 269, 378 A.2d 1121 (1977). *Arthur* relied upon the RESTATEMENT (SECOND) OF TORTS § 429 (1965), which provides:

One who employs an independent contractor to perform services for another which are accepted in the reasonable belief that the services are being rendered by the employer or by his servants, is subject to liability

family to the Holy Cross Hospital emergency room, where he was treated by an emergency room physician who was not an employee of the hospital. Shortly after his discharge from the emergency room, Powell died. His family brought suit against the physician and the hospital. The evidence established that the emergency room was run not by the hospital but by a group of contract physicians as independent contractors.⁶⁹ The Maryland Court of Appeals recognized that the law theretofore had required a master-servant relationship if vicarious liability were to be imposed upon the hospital. It found that there was no master-servant relationship between the hospital and the emergency room doctors.⁷⁰ But, relying on the Restatement of Agency,⁷¹ the court concluded that the hospital nonetheless could be vicariously liable for the acts of the emergency room doctor.

The hospital had, by its actions, represented that the doctor was its servant and thereby caused other persons to rely upon the care or skill of that doctor.⁷² The court noted that from all outward appearances the hospital's emergency room, where Powell sought treatment, was an integral part of the hospital itself. There was no reason for Powell or his family to believe that there was other than a master-servant relationship between the physician and the hospital. The court found that:

Holy Cross represented to the decedent that the staff of the . . . emergency room were its employees, thereby causing the decedent to rely on the skill of the emergency room staff, and that the Hospital is consequently liable to the decedent as if the emergency room staff were its employees.⁷³

Mehlman has sometimes been referred to as an example of apparent agency. The key factor in *Mehlman*, however, was the patient's change of position in justifiable reliance upon the hospital's implied representation that it was responsible for the emergency room staff. It is clear that for liability to be imposed upon an individual or entity

for physical harm caused by the negligence of the contractor in supplying such services, to the same extent as though the employer were supplying them himself or by his servants.

Mehlman v. Powell, 281 Md. 269, 273, 378 A.2d 1121, 1123 (1977), by contrast, was predicated on the arguably stricter standard of the RESTATEMENT (SECOND) OF AGENCY § 267 (1958), which provides:

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

Typically, *Arthur* cites *Mehlmann* without discussion. *Arthur v. St. Peters Hosp.*, 169 N.J. Super. 575, 582, 405 A.2d 443, 446 (1979).

69. *Mehlman v. Powell*, 281 Md. 269, 272, 378 A.2d 1121, 1123 (1977).

70. *Id.*

71. *Id.* at 273, 378 A.2d at 1123.

72. *Id.* at 275, 378 A.2d at 1124.

73. *Id.*

on the basis of agency by estoppel, there must be actual reliance upon the part of the person injured.⁷⁴ Absent evidence of reliance upon the representations of the principal — evidence to support an estoppel — there can be no vicarious liability imposed upon one who did not perform a negligent act. The *Mehlman* court seems to be saying that a mere “holding out” of the agent is not sufficient; the plaintiff must have detrimentally relied on the principal to provide service through its alleged agent.

In an effort to avoid imposition of liability under this theory, *Mehlman* has caused Maryland hospitals (and perhaps those in other states) to initiate actions to distance themselves from their independent contractors and provide notice to patients of the nature of the hospital-physician relationship. Posting of signs, separate billing, notices in area newspapers, and the like have met with only partial success. Signs and newspaper notices are of no value to an unconscious, intoxicated, or non-English speaking patient, especially if he enters through ambulance bay doors. Separate billing may not provide advance notice unless a sign indicates the fact of and the reason for this practice.

Further, in states that have established mandatory pretrial procedures, such as arbitration or screening, the initial steps and decisions in the judicial process — where one would expect the hospitals’ notice procedures to be conclusive — present further problems. These steps and decisions are unreported,⁷⁵ and often are made by panel chairmen who lack judicial experience⁷⁶ and who hesitate to grant motions for summary judgment or directed verdict. Moreover, because published opinions are lacking, there is virtually no precedential value in a finding of nonliability based on notice procedures in a previous arbitration.

Another approach taken by hospitals to avoid imposition of liability under this theory has been to attack the justifiable or detrimental reliance prong of estoppel to deny agency. In *Mehlman* the patient chose Holy Cross Hospital specifically.⁷⁷ But, if a patient is brought to the hospital unconscious by ambulance personnel, not only does he not know where he is, but he could have made no conscious decision to enter that particular hospital.

Johnson v. Lutheran Hospital,⁷⁸ was a medical malpractice action heard before a panel empowered by the Health Claims Arbitration

74. *Id.* at 273, 378 A.2d at 1123 (citing *B.P. Oil Corp. v. Mabe*, 279 Md. 632, 645, 370 A.2d 554, 560 (1977)).

75. *See* MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-05 (1984) (no provision for a written opinion to issue from the arbitration panel except for a simple notice of award that is entered on a form; the only information necessary is for whom the judgment was entered and the amount of damages and costs).

76. *See id.* at § 3-2A-04(b).

77. *Mehlman v. Powell*, 281 Md. 269, 271, 378 A.2d 1121, 1122 (1977).

78. HCA 82-146.

Article of the Maryland Annotated Code.⁷⁹ The claimant was brought to Lutheran Hospital by ambulance in a highly intoxicated, semi-stuporous condition after sustaining injuries when he was thrown from a second floor porch during a fist fight. Ambulance personnel made the decision to go to Lutheran Hospital without any request from the claimant or his family. The claimant was rolled into the emergency room, treated by independent contractor physicians, and discharged to his home accompanied by his father. The next day he awoke quadraplegic.

Arguing an absence of employer-employee relationship between the hospital and the physician, Lutheran moved for summary judgment,⁸⁰ and later for a directed verdict. Further, Lutheran produced evidence of strategically placed signs noting the status of the physician and warning of separate billing due to this status.⁸¹ The chairman of the arbitration panel denied these motions. Defense counsel argued further that the plaintiff's loss of orientation as to place due to intoxication, and his failure to choose the hospital (in fact, he admitted he did not know where he was) meant that he could not have detrimentally relied upon any expectation of care from a particular hospital as had the plaintiff in *Mehlman*. Not only must the physician appear to be an agent, but, more importantly under *Mehlman*, the claimant must justifiably rely to his detriment on this appearance of agency. Nonetheless, these facts did not lead the panel chairman to grant the motion. Given this ruling, at least in Maryland, the necessity for detrimental reliance as a practical matter is unclear. The panel chairman seemed to apply the rules of apparent agency that arguably do not require any choice.

It should be noted that confusion abounds not only in the areas of apparent agency versus estoppel to deny agency, but also between liability based on agency and respondeat superior.⁸² A few recent cases, conflating actual and ostensible agency, hold that the proper test is not the subjective belief of the patient nor the "holding out" by the principal, but the degree of control exercised by the hospital over the physician's care. In the absence of control, these courts continue to deny imposition of vicarious hospital liability for the actions of these contractors on any basis. In *Overstreet v. Doctors Hospital*,⁸³ for example, the fact that the "hospital reserved no right to control the specific medical techniques employed by the emergency room doctors, but merely exercised a limited surveillance in order to monitor the quality

79. See MD. CTS. & JUD. PROC. CODE ANN. §§ 3-2-A-01 to -09 (1984).

80. *Johnson*, HCA 82-146, Motion for Summary Judgment, filed with the Health Claims Arbitration Office, Sept. 27, 1983.

81. *Johnson*, HCA 82-146, Defendants Exhibit # 5.

82. See, e.g., *Beeck v. Tucson Gen. Hosp.*, 18 Ariz. App. 165, 500 P.2d 1153 (1972).

83. 142 Ga. App. 895, 237 S.E.2d 213 (1977).

of medical care provided," insulated the hospital from liability.⁸⁴ The emergency room physician had a contract with the hospital to provide emergency room services, to maintain records, and to promulgate rules and regulations.⁸⁵ The court found that these physicians were not employees of the hospital, thus releasing the hospital from liability based on respondeat superior. Further obscuring the issue, the court also found that the hospital did not control the medical actions of the physicians, thus releasing them from any apparent agency claim.

Lack of control is usually the rationale given for denying liability based on respondeat superior, while the existence of a contract or a "significant relationship"⁸⁶ between the physician and the hospital, coupled with "holding out" of an agent, could be used to establish apparent agency based on contractual grounds, as the court noted in *Mduba*.⁸⁷ In *Rivera v. Bronx-Lebanon Hospital Center*,⁸⁸ the trial court had held that the degree of control exercised by the hospital determined independent contractor status. The appellate court stated that a hospital is ordinarily not liable for the acts of its independent contractors; under certain circumstances, however, such liability could be imposed. Citing *Mduba*, the court held that the degree of control exercised determines whether liability would lie under an agency theory.⁸⁹ In another case, following *Overstreet*, the Georgia court again stated that the traditional criterion, control, is the appropriate one to be used in determining agency.⁹⁰ Thus, not only are apparent agency and estoppel to deny agency confused, but even the more basic theories of respondeat superior and apparent agency easily can be blurred.

C. Corporate Negligence

The hospital is directly liable for its corporate negligence, predi-

84. *Id.* at 897, 237 S.E.2d at 215. Such surveillance and monitoring might provide a basis for liability under a corporate negligence theory. See *infra* text accompanying notes 91-134.

85. *Overstreet v. Doctors Hosp.*, 142 Ga. App. 895, 896, 237 S.E.2d 213, 214 (1977).

86. See Comment, *The Hospital-Physician Relationship: Hospital Responsibility for Malpractice of Physicians*, 50 WASH. L. REV. 385, 400 (1975).

87. See *supra* notes 42-44 and accompanying text.

88. 70 A.D.2d 794, 417 N.Y.S.2d 79 (1979).

89. *Id.* at 796, 417 N.Y.S.2d at 82.

90. *Allrid v. Emory Univ.*, 249 Ga. 35, 285 S.E.2d 521 (1982). The court stated that: [T]he true test of whether the relationship is one of employer-employee or employer-independent contractor is whether the employer, under a contract either oral or written, assumes the right to control the time, manner and method of executing the work as distinguished from the right merely to require certain definite results in conformity to the contract.

Id. at 39-40, 285 S.E. 2d at 525-26 (quoting *Hodges v. Doctors Hosp.*, 141 Ga. App. 649, 651, 234 S.E.2d 116, 117 (1977)).

cated on the breach of a legally defined duty to a patient to assure adequate provision of equipment and medical services. While provision of equipment is not often a challenged responsibility,⁹¹ provision of medical services continues to be a frequently litigated issue. A failure to exercise reasonable care in the selection and retention of medical staff represents the greatest expansion of liability under this theory.⁹²

The degree of control hospitals wield over medical practice is widely debated. Some hospitals believed that establishment of medical staff committees composed of independent contractor physicians insulated the hospital administration from liability under a respondeat superior theory because the doctors themselves controlled their practice by peer review.⁹³ Although most cases have held that administrative representation on medical staff committees requires a finding against the hospital due to that participation,⁹⁴ non-representation would constitute corporate negligence because of the Joint Commission on Accreditation's requirements that demand hospital administrative review of medical care.⁹⁵

Darling v. Charleston Community Memorial Hospital,⁹⁶ was the landmark case in the emergence of hospital liability for inadequate medical care provided within corporate boundaries.⁹⁷ Although it did not directly impose liability for a hospital's failure in selection and retention of competent medical staff, it is nonetheless cited as the original authority for the doctrine of hospitals' corporate negligence. This doctrine has since expanded far beyond the narrow holding of *Darling*.⁹⁸

Plaintiff fractured his leg while playing football. He was seen in Charleston's emergency room by Dr. Alexander, an attending surgeon who was "on call" for the emergency room.⁹⁹ Alexander instituted surgical care, placed Darling in a cast, and continued follow-up. In the following days, Darling began to suffer increasing pain in the affected

91. Perdue, *Direct Corporate Liability for Hospitals: A Modern Day Legal Concept of Liability for Injury Occuring in the Modern Day Hospital*, 24 S. TEX. L. J. 773, 789 (1983).

92. *See id.* at 792-97.

93. *See* Schloendorff v. Society of New York Hosp., 211 N.Y. 125, 105 N.E. 92 (1914).

94. *See* Elam v. College Park Hosp., 132 Cal. App. 3d 332, 183 Cal. Rptr. 156 (1982).

95. *Cf.* *Darling v. Charleston Community Memorial Hosp.*, 50 Ill. App. 2d 253, 200 N.E. 2d 149 (1964), *aff'd*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. den.*, 383 U.S. 946 (1966).

96. 33 Ill. 2d 326, 211 N.E.2d 253 (1965).

97. Southwick, *supra* note 9, at 29.

98. *Id.*

99. *Darling v. Charleston Community Memorial Hosp.*, 50 Ill. App. 2d 253, 268, 200 N.E.2d 149, 158 (1964). Community hospitals without full employee specialist staffs often require attending physicians, as a condition precedent to full admitting privileges, to alternate emergency call in their specialties.

leg. Various medical steps were taken, all to no avail. Ultimately, the patient was transferred to another facility where his leg was amputated below the knee to remedy the gangrenous condition that was by then threatening his life.¹⁰⁰

Dr. Alexander's care was found substandard for several reasons, yet the court did not base the hospital's liability vicariously on the actions of this independent physician.¹⁰¹ The nurses, employees of the hospital, were independently negligent in failing to recognize symptoms that were within their powers of observation and should have prompted them to seek review of the physician's care by other physicians or nurse supervisors. Thus, the hospital was liable for the negligence of its nurses under respondeat superior¹⁰² and the court did not need to create a new basis for establishing hospital liability to hold Charleston responsible. Nonetheless, *Darling* held that the hospital's failure to review negligent medical care rendered by an independent contractor physician or to require consultation amounted to direct negligence of the hospital.¹⁰³ Further, *Darling* established that the standards contained in a hospital's medical staff bylaws, in addition to those found in the Joint Commission on Accreditation of Hospitals (JCAH)¹⁰⁴ yearly standards and in state licensing regulations, may determine the applicable standard of care for a hospital to follow in selection and retention of medical staff and are admissible to establish negligence.¹⁰⁵

Darling may have been the high water mark of hospital liability founded on the duty to supervise the ongoing medical care of patients. Although its narrow holding of a requirement to supervise ongoing medical care has not been followed by an appellate court to date, its impact is not insignificant. Indeed, its impact on hospital practices involving staff selection, evaluation and retention is incalculable. Hospitals that believed incorrectly that they had no direct legal responsibility to their patients for the quality of care rendered within their walls were forced to acknowledge such responsibility.¹⁰⁶ It is impossible to assess the totality of remedial measures that hospitals may have undertaken following *Darling*.¹⁰⁷ While courts may not be following the narrow holding of *Darling*, the broader theory enunciating

100. *Darling v. Charleston Community Memorial Hosp.*, 33 Ill. 2d 326, 329, 211 N.E.2d 253 256 (1965).

101. *Id.* at 339, 211 N.E.2d at 261.

102. *Id.* at 333, 211 N.E.2d at 258.

103. *Id.*

104. *Id.* at 331, 211 N.E.2d at 257.

105. *Id.* at 332, 211 N.E.2d at 258.

106. Interview with David Kennedy, Risk Manager, Easton Memorial Hospital, in Easton, Md. (July 23, 1984).

107. See Comment, *Piercing the Doctrine of Corporate Hospital Liability*, 17 SAN DIEGO L. REV. 383, 386 n.16 (1980).

the hospital's corporate and direct responsibility to patients has been widely expanded. Its impact in the medico-legal field has been analogized to that of *Palsgraf*¹⁰⁸ in the area of general negligence.¹⁰⁹ Following *Darling*, several states enacted legislation embodying its general pronouncement of expanded hospital liability.¹¹⁰ Moreover, whether *Darling* was cited or not, soon after that decision the corporate negligence doctrine was recognized by appellate courts in at least eight states.¹¹¹ It has been suggested that *Darling* wrought the greatest change in hospital liability law in the past twenty-five years.¹¹²

While the trend is toward broadening corporate liability, the pendulum swing is not complete. In *Fiorentio v. Wenger*,¹¹³ for example, the court, although finding liability, cautioned that a hospital, to be held liable for the delict of an independent contractor, must have reason to know the act of malpractice would take place.¹¹⁴ Other courts, purporting to apply a similar test, have held that hospitals have a duty to supervise physician competency and quality of care.¹¹⁵ Thus, for example, in *Fridena v. Evans*,¹¹⁶ the court predicated liability on actual or constructive knowledge of incompetence. The hospital was held to have had knowledge of the negligent act and was therefore liable, although no previous acts of negligence or incompetency were in evidence. The physician had committed only a single negligent act that was the basis of the instant claim and the hospital was held to have knowledge only of this single negligent act. It is noteworthy, however, that the negligent physician held several administrative positions within the hospital (as well as part ownership). The court imputed to the hospital the knowledge that the tortfeasor-physician had

108. *Palsgraf v. Long Island R.R. Co.*, 248 N.Y. 339, 162 N.E. 99 (1928).

109. Springer, *Medical Staff Law and the Hospital*, 285 NEW ENG. J. MED. 952, 954 (1971).

110. See Southwick, *The Hospital as an Institution — Expanding Responsibility Changes its Relationship with the Staff Physician*, 9 CAL. W. L. REV. 429, 445 n. 47-50 and accompanying text (1973).

111. Comment, *supra* note 107, at 386 n.16. See also Peters, *Reallocating Liability to Medical Staff Review Committee Members: A Response to the Hospital Corporate Liability Doctrine*, 10 AM. J. OF L. & MED. 115, 126 (1984).

112. *Elam v. College Park Hosp.* 132 Cal. App. 3d 332, 345-46, 183 Cal. Rptr. 156, 164 (1982); Slawkowski, *supra* note 34, at 6.

113. 19 N.Y.2d 407, 227 N.E.2d 296, 280 N.Y.S.2d 373 (1967).

114. *Id.* at 414, 227 N.E.2d at 299, 280 N.Y.S.2d at 378. See also *Corleto v. Shore Memorial Hosp.*, 138 N.J. Super. 302, 350 A.2d 534 (1975) (staff and board of trustees could be joined as defendants to a surgeon's malpractice *only if* they knew or should have known of his incompetence).

115. *Fridena v. Evans*, 127 Ariz. 516, 622 P.2d 463 (1980); *Tucson Med. Center Inc. v. Misevch*, 113 Ariz. 34, 545 P.2d 958 (1976). See also *Ahrins v. Katz*, 164 Ga. App. 729, 297 S.E.2d 108 (1983); *Wallace v. Garden City Osteopathic Hosp.*, 111 Mich. App. 212, 314 N.W.2d 557 (1981); *Porter v. Pandey*, 423 So. 2d 126 (Miss. 1982).

116. 127 Ariz. 516, 622 P.2d 463 (1980).

through his administrative capacities.¹¹⁷ In other words, the hospital administration had instant knowledge of the malpractice because an administrator-physician committed it.

In *Gonzales v. Nork*,¹¹⁸ evidence was admitted indicating that the surgeon had performed about thirty-eight similar negligent or unnecessary operations. The hospital was found to have had no actual knowledge of the substandard nature of these operations; liability was based on its lack of an evaluatory mechanism to supervise medical care.¹¹⁹ The hospital defended on the ground that its evaluatory mechanisms were not only in conformity with industry (JCAH) standards, but went beyond those standards. The California Superior Court held that a hospital could be held liable despite good faith compliance with industry standards.¹²⁰ The court found that the hospital's liability was not strict, but that the hospital had a duty to acquire and use information about risk creating activities.¹²¹

Although *Darling* was based on the hospital's failure to review ongoing medical care, rather than on a negligent granting of staff privileges theory,¹²² many cases do recognize a duty to use due care in selecting staff members.¹²³ In *Johnson v. Misericordia Community Hospital*,¹²⁴ for example, the court held that a hospital must exercise that degree of care in selecting its staff as would be exercised by an average hospital.¹²⁵ The defendant surgeon had been granted privileges to practice without proper investigation of references, previous

117. *Id.* at 519, 622 P.2d at 466.

118. No. 228566 (Super. Ct. Cal., Sacramento County, filed Nov. 19, 1973), cited in Kahn, *Hospital Malpractice Prevention*, 27 DE PAUL L. REV. 23, 32-34 (1977).

119. Kahn, *supra* note 118, at 32.

120. *Id.* at 33.

121. *Id.* at 34.

122. See, e.g. *Purcell v. Zimbelman*, 18 Ariz. App. 75, 500 P.2d 335 (1972); *Mitchell County Hosp. Auth. v. Joiner*, 229 Ga. 140, 189 S.E.2d 412 (1972); *Corleto v. Shore Memorial Hosp.*, 138 N.J. Super. 302, 350 A.2d 534 (1975).

123. See, e.g., *Tucson Med. Center Inc. v. Misevch*, 113 Ariz. 34, 545 P.2d 958 (1976); *Mitchell County Hosp. Auth. v. Joiner*, 229 Ga. 140, 189 S.E.2d 412 (1972); *Holton v. Resurrection Hosp.*, 88 Ill. App. 3d 665, 410 N.E.2d 969 (1980); *Hannola v. City of Lakewood*, 68 Ohio App. 2d 61, 426 N.E.2d 156 (1981).

124. 99 Wis. 2d 708, 301 N.W.2d 156 (1981).

125. *Id.* at 731, 301 N.W.2d 156 (1981). But see W. KEETON, PROSSER & KEETON ON THE LAW OF TORTS 187 (5th ed. 1984). The *Johnson* court delineated the four principal elements of the theory of corporate negligence: 1) the existence of a duty on the part of the hospital to exercise reasonable care in the selection of its medical staff—a question of law, not fact; 2) a breach of the standard of care required of a hospital under similar circumstances—a question of fact; 3) causation—a question of fact; and 4) damages or injury. In short, the same elements needed to establish any negligence action. *Id.* at 179. Also noteworthy is the intermediate court of appeals' view, left undisturbed by the supreme court, that the hospital's corporate negligent act need only be a substantial factor in the plaintiff's injury and not a sole or even primary factor. *Johnson v. Misericordia Community Hosp.*, 97 Wis. 2d 521, 560, 294 N.W.2d 501, 520-21 (1980).

staff appointments, or the current status of his malpractice record, conveniently left incomplete on his application.¹²⁶ Soon after his privileges were initially granted he was made Chief of Staff. The court found that the hospital did not follow even minimum requirements for establishing the suitability and qualifications of this physician. Hospitals must evidence good faith and reasonable care in making staff appointments and retaining physicians once privileges are granted.¹²⁷

Similarly, the defendant hospital in *Elam v. College Park Hospital*,¹²⁸ was held liable for negligently conducting peer review. There were no negligent or incompetent practices on the part of the physician while at College Park Hospital before the incident forming the basis of the action. The court found the practices of the peer review committee negligent because the committee did not report to the hospital administration the filing of a malpractice suit against the physician. The suit had been filed after the physician was granted privileges at College Park Hospital and arose from care rendered at another hospital prior to his association with College Park. The peer review committee had obtained knowledge of this suit four and one-half months prior to the Elam surgery, during its periodic review of the physician's credentials, and did not report it to the hospital administration.¹²⁹ The committee checked available credentials prior to granting privileges and monitored the physician's care according to hospital policies. It found no apparent deviations from the standard of care at this hospital until the time of the incident that gave rise to *Elam's* claim. Yet, *Elam* has been cited as an enlightened example of the proper application of law of corporate negligence.¹³⁰

By contrast, in *Ferguson v. Gonyaw*,¹³¹ the court held that the hospital's failure to check the doctor's credentials did not establish negligence where no evidence was presented showing the hospital would have denied privileges if it had done so. *Pickle v. Curns*,¹³² held a hospital not liable for a breach of its corporate duty to select and review medical care absent evidence that it knew the doctor would not follow hospital policies. The court noted that a hospital has no duty to insure that an attending physician will never commit malpractice.¹³³ It is

126. *Johnson v. Misericordia Community Hosp.*, 99 Wis. 2d 708, 714, 301 N.W.2d 156, 159 (1981).

127. See *Elam v. College Park Hosp.*, 132 Cal. App. 3d 332, 183 Cal. Rptr. 156 (1982); *Joiner v. Mitchell County Hosp. Auth.*, 125 Ga. App. 1, 186 S.E.2d 307, *aff'd*, 229 Ga. 140, 189 S.E.2d 412 (1972); *Moore v. Board of Trustees of Carson-Tahoe Hosp.*, 88 Nev. 207, 495 P.2d 605, *cert. den.*, 409 U.S. 879 (1972).

128. 132 Cal. App. 3d 332, 183 Cal. Rptr. 156 (1982).

129. *Id.* at 336, 183 Cal. Rptr. at 158.

130. Southwick, *supra* note 9, at 41.

131. 64 Mich. App. 685, 236 N.W.2d 543 (1975).

132. 106 Ill. App. 3d 734, 435 N.E.2d 877 (1982).

133. *Id.* at 739, 435 N.E.2d at 881.

noteworthy that this case was decided in the same jurisdiction that decided *Darling*, but did not hold that the hospital had a duty to supervise ongoing medical treatment.¹³⁴

IV. DUTY OF THE HOSPITAL

A. General Considerations

Physicians have long been suspected of "conspiring by silence" to protect inadequate care rendered by their peers.¹³⁵ Critical expert testimony has been difficult for plaintiffs to obtain in medical malpractice suits.¹³⁶ Few physicians are reported by peers to the Medical Board's Disciplinary Committee for even egregious standard of care infractions.¹³⁷ State licensing establishes minimum levels of competency, but provides no systematic review of ongoing medical care.¹³⁸ Notice of malpractice judgments and awards made against individual physicians often are not disseminated, requiring hospitals to bear a heavier burden of monitoring and responsibility for the care provided by the physicians to whom it grants privileges. The expansion of hospitals' liability for physicians' malpractice represents the contributions of many courts to the hospital's mandate to take responsibility for the quality of health care. Additionally, governmental agencies, legislatures, and the public increasingly ascribe to the hospital the final responsibility for the quality of health care.¹³⁹ Whether the realities of medical practice make this approach viable remains problematic.¹⁴⁰

Complicated systems of regulation have been developed within which the hospital operates. Capital equipment and facilities cannot be purchased or built without a certificate of need from a Regional Health Services Agency.¹⁴¹ Reimbursements for hospital services are

134. Perdue, *supra* note 91, at 810. See *supra* notes 96-112 and accompanying text.

135. See *Graham v. Sisco*, 248 Ark. 6, 11, 449 S.W.2d 949, 951 (1970); Note *Overcoming the "Conspiracy of Silence": Statutory and Common Law Innovations*, 45 MINN. L. REV. 1019 (1961). But cf. *Agnew v. Parks*, 172 Cal. App. 2d 756, 343 P.2d 118 (1959) (unsuccessful conspiracy action against local medical society based on alleged pressure it exerted on a physician not to testify for the plaintiff).

136. W. KEETON, *supra* note 125, at 188.

137. S. LAW & S. POLAN, *PAIN AND PROFIT: THE POLITICS OF MALPRACTICE* 41-46 (1978). For a general discussion of the problems of licensure, disciplinary review procedures, and interstate reporting mechanisms, see F. GRAD & N. MARTE, *PHYSICIANS' LICENSURE AND DISCIPLINE* (1979).

138. F. GRAD & N. MARTE, *supra* note 137, at 70-71.

139. See Hall, *Hospital Committee Proceedings and Reports: Their Legal Status*, 1 AM. J. L. MED. 245 (1975).

140. See generally Slawkowski, *supra* note 34.

141. SALKEVER & BICE, *supra* note 17, at 5-6. A certificate of need (CON) is required when a covered agency (such as a hospital, nursing home, outpatient clinic, etc.) desires to make a capital expenditure to change the physical plant or to purchase equipment or expand services. For a detailed discussion of CON's, see JOSKOW, *supra* note 16, at 76.

made by Medicare or private third party payors according to established formulae.¹⁴² Retrospective denial of payment can be made if a hospital's quality assurance protocols do not pass muster in a given case.¹⁴³

Hospitals are required by state agencies to comply with procedures to ascertain currency of licensure by their employees and agents.¹⁴⁴ JCAH standards cover all major functions of the modern hospital.¹⁴⁵ In addition to JCAH regulations, state licensing regulations, PSRO and Medicare requirements, among others, must be met.¹⁴⁶

The hospital is no stranger to bureaucratic conflict. Hospitals may be cited by state licensing agencies for physical plant defects remediable only by capital improvements that the local health care services agency denies for inability to prove certifiable area need.¹⁴⁷ It appears that hospitals may be caught between the bureaucratic Scylla of physical plant requirements and the equally bureaucratic Charybdis of refusal of the funding agencies. Nor is this the only example of conflicting demands on the modern hospital.¹⁴⁸

B. State Licensing

In the past, hospitals had no control over medical practice. The state had little, and the courts less. The medical profession was largely self-regulating. This self-regulation proved unsatisfactory and states began to enact medical and nursing practice acts that required licensing of practitioners.¹⁴⁹ New practitioners had to submit to examination, but those already in practice at the statute's inception were

142. See *supra* note 18.

143. Medicare-Medicaid Anti-Fraud and Abuse Amendments, 42 U.S.C.A. §§ 1320c-1 to 1320c-11 (1974).

144. Holbrook & Dunn, *Medical Malpractice Litigation: The Discoverability and Use of Hospitals' Quality Assurance Committee Records*, 16 WASHBURN L.J. 54, 58 (1976).

145. See *supra* note 7.

146. See Holbrook & Dunn, *supra* note 144, at 58.

147. For example, in 1978 a hospital in rural New Jersey was cited by the State licensing authority for a number of violations in its labor and delivery suite. Specifically, separate bathroom facilities were required for nurses and patients; an additional delivery room was necessary because of the conversion of an existing delivery room into a "birthing room" (one in which patients labor, deliver and recover); and a larger on-call sleeping facility for physicians was needed. To meet these demands would have required the hospital to initiate renovations that would have cost more than \$150,000, which, in turn, required a CON. The Regional Health Services Agency denied the request for CON because the number of deliveries (below 1,000 per year) did not warrant a new construction or renovation. One of the authors (Janulis) was the nursing care coordinator of the obstetrical unit of the hospital at the time.

148. See, e.g., *infra* text accompanying notes 181-206.

149. F. GRAD & N. MARTE, *supra* note 137, at 2.

“grandfathered” in.¹⁵⁰ States have been slow to update their practice acts to reflect the changing state of health care practice.¹⁵¹ Moreover, these statutes require only minimum levels of competence, and often require no upgrading and reevaluation after the initial license is issued.¹⁵²

Injured patients were stymied in their attempts to recover for alleged negligent practice due to their inability to get expert medical testimony crucial to establishing the applicable standard of care and its breach.¹⁵³ Physicians were not only unwilling to regulate themselves by peer review, but also unwilling to testify against their colleagues. Fortunately this “conspiracy of silence” is much less prevalent today than it once was.¹⁵⁴ Individual civil actions, however, cannot be expected to police adequately the quality of medical practice.

Medical societies and state medical boards have established disciplinary commissions whose role is to review reported cases of physician malpractice and misconduct.¹⁵⁵ Yet little action is taken by these boards.¹⁵⁶ They function—like courts—only retrospectively and in specific cases. More importantly—and again like courts—they rely on reporting from the public and other health care providers. A computer service linking one state to another is available for dissemination of information of disciplinary actions taken by member states.¹⁵⁷ Although membership is not mandatory, all states are voluntary members of the service. The speed and comprehensiveness of reporting, however, depends upon the resources of each state.¹⁵⁸

As a result of these inadequacies it may be necessary for hospitals to investigate the competence of physicians despite state licensure. In *Joiner v. Mitchell County Hospital Authority*,¹⁵⁹ the Georgia Supreme Court concluded that a hospital might incur liability if it grants privileges to an incompetent physician despite its reliance on the state’s licensure process as an assurance of competency.¹⁶⁰ Further, the hos-

150. Interview with Hilda Stevan, Executive Director, Md. State Bd. of Med. Examiners (July 19, 1984) [hereinafter cited as Stevan Interview].

151. The result of this tardiness is that practitioners may be routinely practicing in violation of the relevant statute. Medical practice changes rapidly with changing technology, and many tasks formerly part of medical practice may be delegated to para-professionals without preceding changes in medical practice acts.

152. The trend is to require a specified number of hours of continuing professional education for relicensure. See F. GRAD & N. MARTE, *supra* note 137, at 56.

153. See, e.g., *supra* notes 135-36.

154. *Id.*

155. F. GRAD & N. MARTE, *supra* note 137, at 112.

156. S. LAW & S. POLAN, *supra* note 137, at 31.

157. Stevan Interview, *supra* note 150.

158. *Id.*

159. 229 Ga. 140, 189 S.E.2d 412 (1972).

160. *Id.*

pital could not avoid liability by delegating this responsibility to a medical staff committee composed solely of physicians.¹⁶¹ All appointments made by the committee were to be imputed to the hospital.

In a malpractice action the physician is held to the level of the reasonable, prudent, and similarly skilled physician in similar circumstances.¹⁶² Because this level is higher than the minimal level of competence required to obtain a license to practice, a hospital must require more from a physician than a license prior to granting him privileges. The hospital's mandate to review medical practice may be viewed as an analogue to state licensing. Its function of insuring the competence of practitioners parallels the governmental function. However, because the medical review committee operates at an institutional level, it has a better opportunity to supervise, review, and evaluate medical care than does the state agency. Thus the hospital may be better able to protect the public.¹⁶³ Plainly, not all licensed physicians consistently practice in accordance with acceptable standards of care as defined by expert medical witnesses. If hospitals are to be held responsible for this higher level of competence, they must seek it in their staff physicians.¹⁶⁴

Yet the opinions in cases in which physicians challenge denial or termination of privileges sometimes suggest that hospitals have no need to exclude licensed physicians from privileges to practice. Although most cases are finally decided on the adequacy of the hospital's fair notice and hearing procedures,¹⁶⁵ occasionally an opinion may declare that there is no necessity to go beyond documentation of state licensure to practice medicine. As one judge observed:

This resolution does not create a risk that a hospital will be liable for the negligence of its physicians, yet lack the capacity to exclude them. With the possible exception of one decision courts have always held that a hospital is not liable for the negligent acts of the physicians who are not employed by the hospital. The ordinary physician is not the hospital's "servant" because the hospital has no "right to control" the acts of an "independent contractor." *Since the hospital is not liable for the independent physician's negligence, it has no need to guarantee that he is competent.*

The danger that the hospital's admission of a physician to its staff will encourage patients to seek the services of a doctor who may be incompetent is also chimeral [sic]. Patients are admitted to hospitals only *after* they have chosen a doctor. Even in emergency rooms, patients are treated by doctors in

161. *Id.*

162. See generally W. KEETON, *supra* note 125, at 186; Southwick, *supra* note 9.

163. Hall, *supra* note 27, at 246-47.

164. For an innovative suggestion for imposition of accountability for review of medical care, see Peters, *supra* note 111.

165. See Hirsh, *A Fish Without Water: Hospital Administration Privileges*, 84 CASE & COM., No. 4 July-Aug. 18 (1979). See also Comment, *Hospital Medical Staff Privileges: Recent Developments in Procedural Due Process*, 12 WILLAMETTE L.J. 137, 139-150 (1975-1976).

the employ of the hospital, or by a physician of their own choosing.¹⁶⁶

Hospitals should not be compelled to open their doors to any physician or other licensed practitioner solely on a showing of a license to practice in that jurisdiction. If hospitals must comply with JCAH and judicially determined medical care standards, they must have the right to determine the quality of medical care and the number of practitioners rendering it. Privileges should be more difficult, not easier, to obtain.

C. Protection Against Discovery

The hospital has a non-delegable legal duty to its patients to assure the quality of medical care and services provided by its employees and professional staff. Joint Commission accreditation, although voluntarily sought, greatly enhances the standing of a hospital. The Federal Medical Act of 1965¹⁶⁷ strengthened the Commission's status by requiring that before the government, as a third party payor, would pay benefits for services rendered a hospital must be in substantial compliance with federal standards or have Joint Commission accreditation.¹⁶⁸

Commission requirements mandate that hospitals develop a complex system of medical staff review committees to control and monitor the quality of their medical care. The findings and records of these committees could be of immense value to the parties in a malpractice action, especially if liability is being predicated on a theory of corporate negligence. Many states, however, have passed statutes preventing discovery of the proceedings, files, and minutes of these committees. These statutes also provide personal immunity from liability for defamation for the members of the committee. The type of privilege and the scope of protection varies among jurisdictions.¹⁶⁹ Most jurisdictions have recognized a conditional or qualified privilege, abrogated by a finding of "malice," in the areas of medical staff appointments and evaluation of professional medical competence.¹⁷⁰ Few jurisdictions provide an absolute privilege—one not destroyed by malice.¹⁷¹ Those states that have enacted statutes providing some form of immunity to participants in peer review and hospital committees generally have codified the qualified privileges recognized by their courts.¹⁷²

The dilemma is obvious: the very records most valuable to prove

166. *Silver v. Castle Memorial Hosp.*, 53 Haw. 475, 489-90, 497 P.2d 564, 573-74 (1972) (Abe, J., concurring) (emphasis added).

167. Health Insurance for Aged and Disabled, 42 U.S.C. §§ 1395 to 1395xx (1965).

168. *Id.* at § 1395bb (1972).

169. Holbrook & Dunn, *supra* note 144, at 74.

170. Hall, *supra* note 27, at 255.

171. *Id.* at 258.

172. *Id.* at 262.

the adequacy or reasonableness of the hospital's corporate actions may be shielded statutorily from discovery. One legitimately might inquire, in those jurisdictions whose courts have adopted liability based on corporate negligence, but whose legislatures have passed shielding statutes, what is the true public mandate.

1. Federal Protection

The Professional Standards Review Organization (PSRO) sections¹⁷³ of the Social Security Act provide immunity for physicians and hospitals reviewing the medical care reimbursed by Medicare and Medicaid program within the scope of the statute. This review, although federally mandated, is provided by community-based, local PSRO's staffed by private physicians. These community organizations insure that federal funds expended through these programs are solely for medically necessary services.¹⁷⁴ Individual physicians may be required to provide information on the extent of payments they have received through the programs, and may be asked to justify the services rendered. If a physician is suspected of inflating his billings, other physicians may review the necessity and adequacy of the care provided. In the absence of malice, individuals who provide relevant information or services to the PSRO are immune from liability.¹⁷⁵ PSRO qualified immunity applies only to the review of medical care undertaken to determine the suitability of reimbursement under the Social Security Act.¹⁷⁶

173. Medicare-Medicaid Anti-Fraud and Abuse Amendments, 42 U.S.C.A. §§ 1320c-1 to 1320c-11 (1974).

The Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, 182 U.S. Code Cong. & Ad. News 7, amended the federal quality assurance program by replacing the PSRO program with a similar program — the PRO. The PRO is to function similarly to the PSRO's, which will be gradually phased out. During the phase-out period, the PSRO requirement will remain in force.

As of mid-1983 no federal regulation had yet been issued for PRO's. One significant change between PRO's and PSRO's is that PRO's are not to be considered federal agencies, thus precluding litigative attempts to obtain privileged quality assurance information under the Freedom of Information Act, 42 U.S.C. § 1320 c-9, as amended by Pub. L. No. 97-248 (1982). The courts had been in conflict over these "end-runs" around statutory restriction of information. Another substantial change is that PRO's must review only Medicare services, but *may* review State Medicaid services. Under the PSRO's both Medicare and Medicaid were reviewed. HOSPITAL LAW MANUAL, *Medical Staff* § 8-3 (Sept. 1983) at 91.

174. AMERICAN ENTERPRISE INSTITUTE, PROPOSAL FOR REGULATION OF HOSPITAL COSTS, 1978.

175. Medicare-Medicaid Anti-Fraud and Abuse Amendments, 42 U.S.C.A. § 1320c-6 (1974). *But cf.* Hackethal v. Weissbein, 147 Cal. Rptr. 284, 286 (1978), *rev'd*, 24 Cal. 3d 55, 529 P.2d 1175, 154 Cal. Rptr. 423 (1979), which held originally that an absolute privilege extended to physician members even if the testimony or participation were motivated by malice.

176. Hall, *supra* note 27, at 264.

Federal law provides other protections as well. Federal legislation, such as the Federal Tort Claims Act, may preclude discovery of minutes and reports of committees inquiring into hospital procedures and professional conduct of hospital personnel.¹⁷⁷ *Bredice v. Doctors Hospital*,¹⁷⁸ the leading case applying the federal common law of privilege,¹⁷⁹ denied access to medical review committee minutes in a wrongful death case, holding that confidentiality was essential to the improvement of patient care, and that to require disclosure of these deliberations would lead to their eventual extinction.¹⁸⁰

2. *Shielding Statutes*

Many states have passed shielding statutes to provide a privilege for the files, minutes, and decisions of the medical review committees that evaluate credentials, take disciplinary actions, and evaluate medical care rendered by staff physicians.¹⁸¹ Absent malice, personal immunity may extend to the committee members.¹⁸² The purpose of these statutes is to promote frank, unfettered discussion and to maintain and improve health care. Shielding statutes are important in imposing limits on discoverability and admissibility of such matters as the committees consider. These statutes are also important because they appear to give powerful advantage to potential malpractice defendants by shielding deliberations of the hospital that might be used to prove negligence.

The arguments against discovery and admissibility of committee proceedings are founded on the public policy that the records are created only to improve medical care and that this function will be severely undermined if the records can be subpoenaed in civil actions. It is thought that colleagues will not offer candid or critical opinions about each other if they fear such statements will be used as evidence in a subsequent malpractice trial.¹⁸³ Conversely, in restricting discovery, it is feared that the interests of the litigant and of justice will not be served.¹⁸⁴

While many states have enacted statutes shielding such records

177. *Gillmann v. United States*, 53 F.R.D. 316 (S.D.N.Y. 1971).

178. 51 F.R.D. 187 (D.D.C. 1970).

179. FED. R. EVID. 501.

180. *Bredice v. Doctors Hosp.*, 51 F.R.D. 187, 188 (D.D.C. 1970).

181. *E.g.*, CONN. GEN. STAT. ANN. § 39-19a (West Supp. 1984); DEL. CODE ANN. tit. 24, § 1768 (1974); MD. HEALTH OCC. CODE ANN. §§ 14-201, 14-602 (1981).

182. FLA. STAT. ANN. § 395.065(2) (Supp. 1977); MD. HEALTH OCC. CODE ANN. § 14-603 (1981).

183. *Holbrook & Dunn*, *supra* note 144, at 63-64.

184. *Id.* at 64. See Bernstein, *Access to Physician's Hospital Records*, 45 J. AM. HOSP. ASSOC. 148 (1971) (suggesting that protection of confidentiality outweighs the interests of the litigant).

from discovery, the extent of protection varies.¹⁸⁵ Most statutes protect only medical staff committee activities,¹⁸⁶ but some are sufficiently comprehensive to protect other hospital review committees.¹⁸⁷

It is important to distinguish between litigation involving a physician's negligence and that involving the hospital's negligence when discussing the impact of these statutes.¹⁸⁸ If corporate negligence is alleged, founded on the inadequacy of the review committee system, then the very issue in contention is the adequacy of the system. It would seem that the records evidencing its adequacy should be admissible. Nevertheless, two cases to consider this argument have held the records privileged.

In *Matchett v. Petway*,¹⁸⁹ plaintiff alleged corporate negligence predicated on the negligent granting of privileges to the defendant physician and sought discovery of relevant hospital records. The court denied this request, stating that these records were immune from discovery and that the statute represented a legislative choice between conflicting public policy concerns, despite plaintiff's argument that an exception to the California Evidence Code rendered the immunity inoperative.¹⁹⁰ The petitioner had specifically argued that the portion of the code that declared "the prohibition relating to discovery or testimony shall not apply . . . to any person requesting hospital staff privileges . . ." made the immunity inapplicable in a lawsuit charging the hospital with negligent selection or retention of "any person requesting hospital staff privileges."¹⁹¹

In *Oviatt v. Archbishop Bergan Mercy Hospital*,¹⁹² plaintiff, having suffered sciatic nerve injury during a hysterectomy, had alleged that the hospital should have suspended the surgeon's privileges due to incompetence. The court, citing *Bredice*,¹⁹³ sustained defendant's motion *in limine* to prevent plaintiff from introducing hospital records showing that the surgeon's staff privileges had been restricted in prior years.¹⁹⁴

185. See HOSPITAL LAW MANUAL, *Medical Records*, at 77-100 (1973) (Attorney's Vol. IIA) (state by state analysis). See also Jacobs & Weagley, *The Liability Myth Exposed: Hospital Review Activities Pose No Risk*, Performance Evaluation Procedure for Auditing and Improving Patient Care, JHC (1975).

186. HOSPITAL LAW MANUAL, *supra* note 185, at 72.

187. *E.g.*, LA. REV. STAT. ANN. §§ 44:7 & 13:3715.3; MINN. STAT. ANN. §§ 145.61 to 145.65.

188. Hall, *supra* note 27, at 280-81.

189. 40 Cal. App. 3d 623, 115 Cal. Rptr. 317 (1974).

190. CAL. EVID. CODE § 1157 (West 1968).

191. *Matchett v. Petway*, 40 Cal. App. 3d 623, 625, 115 Cal. Rptr. 317, 318 (1974).

192. 191 Neb. 224, 214 N.W.2d 490 (1974).

193. See *supra* notes 178-80 and accompanying text.

194. *Oviatt v. Archbishop Bergan Mercy Hosp.*, 191 Neb. 224, 226, 214, N.W.2d 490, 492 (1974).

Not all jurisdictions construe the privilege so broadly.¹⁹⁵ In *Matviuw v. Johnson*,¹⁹⁶ for example, a physician brought a defamation action against a colleague who had spoken against him in a peer review committee meeting that led to revocation of the plaintiff's privileges. Plaintiff was permitted to gain access to the minutes of the meeting. The court reasoned that if the legislature had intended to grant an absolute immunity it would have done so specifically.¹⁹⁷

The Washington Supreme Court recently interpreted its shield statute very broadly in *Coburn v. Seda*.¹⁹⁸ Although the statute seemed to shield these records only in civil actions between health care providers,¹⁹⁹ the court held the statute's purpose was to prevent *any opposing party* from using a hospital's careful self-assessment to his advantage in any civil action, including medical malpractice. In *Coburn*, the trial court had ordered production of any reports of committees pertaining to the death of plaintiff's spouse during a cardiac catheterization.²⁰⁰ The Washington Supreme Court reversed.²⁰¹

Even more recently, in *Anderson v. Breda*,²⁰² the same court retreated from its position in *Coburn*, characterizing that case as holding merely that disclosure would be denied if it would interfere with the statutory purpose.²⁰³ In *Anderson*, the plaintiff sought to discover whether the defendant physician's hospital privileges had been revoked, suspended, or terminated as a result of review committee proceedings. The court distinguished the results of review committee proceedings from the records of the proceedings themselves, holding the former, like other evidence generated or recorded outside the committee, to be without the protection of the privilege.²⁰⁴

Because recognition of a privilege or immunity impedes discovery, courts may be reluctant to deny access to these records absent specific statutes. Seeking to make its intent abundantly clear, the Maryland legislature, in its 1982 session, amended § 4-601 of the Health Occupations Article specifically to shield the records, files, and memoranda of medical review committees from discovery by a medical malpractice plaintiff.²⁰⁵ The legislature thus codified dicta in *Unnamed Physician*

195. See Hall, *supra* note 27 (reviewing cases both compelling and denying discovery); Holbrook & Dunn, *supra* note 144.

196. 70 Ill. App. 3d 481, 388 N.E.2d 795 (1979).

197. *Id.* at 487, 388 N.E.2d at 800.

198. 101 Wash. 2d 270, 677 P.2d 173 (1984).

199. WASH. REV. CODE ANN. § 4.24.250 (1962).

200. *Coburn v. Seda*, 101 Wash. 2d 270, 677 P.2d 173 (1984).

201. *Id.*

202. 103 Wash. 2d 901, 700 P.2d 737 (1985).

203. *Id.*, citing *Coburn v. Seda*, 101 Wash. 2d 270, 677 P.2d 173 (1984).

204. *Id.*

205. MD. HEALTH OCC. CODE ANN. § 14-601 (Supp. 1982).

*v. Commission on Medical Discipline.*²⁰⁶ The court had stated that the former statute did not prevent discovery of the hospital's disciplinary records on a physician in the physician's action against the hospital for unfair denial of privileges. Instead, the court found the intent of the statute was to protect such records from discovery by a person such as a medical malpractice plaintiff.²⁰⁷ Thus, the purpose of the amendment was not to limit but to clarify that at least one class of plaintiffs was to be denied access to these records.

As is true of all claims of privilege, two valuable public policy concerns are in conflict: broad discovery of all relevant facts, and the necessity for confidentiality of the frank deliberations on the quality of care rendered within an institution. The 1982 action by the Maryland legislature in codifying the immunity from discovery for medical review committee proceedings might evidence a legislative choice between these conflicting concerns similar to that noted in *Matchett*.²⁰⁸ These statutes do not prevent discovery of facts or outside documents considered by the committees, as is sometimes mistakenly contended; those are discoverable through other sources. What is protected are those documents generated by and for the committee during its review and deliberations.

Even in the absence of privilege, because the standards set by a hospital to determine adequacy of care and professional behavior might be significantly higher than those set by courts to determine negligence, a review committee disciplinary action or denial or revocation of privileges might be unduly prejudicial — given more weight than it deserves — in a negligence case tried to a jury.²⁰⁹

V. CONCLUSION

The ability of or extent to which hospitals are capable of controlling or policing medical care is problematic. Any contention that they control minute-to-minute or even day-to-day medical care has no basis in reality. Hospital administrators are without power to change or, generally, even to delay the care ordered by a physician. Frequently, because medical care must be ordered and carried out immediately, prospective review of orders, even if possible, would be detrimental to the health of the patient. Where there are several equally acceptable methods of treatment, a hospital may not select the one to be used.²¹⁰

Hospitals are not allotted, nor can they generate funds sufficient for pervasive monitoring and timely review of medical care within

206. 285 Md. 1, 400 A.2d 396 (1979).

207. *Id.*

208. See *supra* notes 189-91 and accompanying text.

209. FED. R. EVID. 403.

210. See *Toth v. Community Hosp. at Glen Cove*, 22 N.Y.2d 255, 239 N.E.2d 368, 292 N.Y.S.2d 440 (1968).

their walls. Moreover, given society's current emphasis on hospital cost-containment,²¹¹ such funds are not likely to be forthcoming. Thus, to the extent liability on a theory of respondeat superior is premised on the hospital's ability to control physicians, it is inappropriate to the realities of the hospital-physician relationship.

Liability predicated on estoppel to deny agency is not found when the doctor-patient relationship is established outside the hospital. Typically, such liability exists when a patient first encounters the physician after admission on the theory that the reasonable patient would believe that this physician is the hospital's agent.²¹² Patients apparently have no affirmative obligation to inquire; releases signed by patients outlining these relationships are often worthless, and strategically posted signs may also be legally ineffectual.²¹³

If hospitals attempt to limit the control they wield by contractual means these instruments may be struck down. They may be used as evidence of a contractual relationship or as evidence of institutional negligence under regulatory mandate. Even more ironic is the fact that hospitals established contracts for service with physicians to staff twenty-four hour departments in order to meet the requirements of governmental and private regulators.

Perhaps a solution might be to require all physicians to be employees, permitting the hospital to exercise maximal control. This "solution" was the basis of a since disbanded experiment in health care delivery in rural New Jersey.²¹⁴ In the early 1950's the Hunterdon experiment commenced, requiring all specialist staff to be hospital employees as a predicate to the granting of privileges. All specialists were housed in a Diagnostic Center physically adjacent to the hospital. Only family practitioners were allowed to practice "off campus." All referrals were made through these family practitioners to center specialists. Maximal control was achieved by the hospital administration. The experiment ended when the system was splintered by legal action of the specialists claiming "restraint of trade."²¹⁵

There may be an unspoken "public policy" reason for expansion of hospital liability. Bluntly stated, plaintiffs would have greater monetary recoveries if hospitals were found to be joint tortfeasors with the defendant physician. This is especially true in cases in which the award exceeded the physician's liability coverage and the physician's

211. See, e.g., N.Y. Times, Jan. 20, 1985, § 4, at 3.

212. Arthur v. St. Peters Hosp., 169 N.J. Super. 575, 584, 405 A.2d 443, 447 (1979).

213. See Johnson v. Lutheran, HCA 82-146 (Md. Health Claims Arb. 1984).

214. See generally H. CURRY, TWENTY YEARS OF COMMUNITY MEDICINE: A HUNTERDON MEDICAL CENTER SYMPOSIUM (1974); R. TRUSSEL, HUNTERDON MEDICAL CENTER: THE STORY OF ONE APPROACH TO RURAL MEDICAL CARE (1956).

215. Interview with Doris Edwards, Vice-President for Patient Services, Hunterdon Med. Center (July 22, 1984).

personal assets were shielded by various financial arrangements. If the hospital were not held liable, the plaintiff could recover only up to the physician's policy limits. If, however, the hospital were found liable, its policy limits would be added to the amount available for recovery, greatly increasing plaintiff's final monetary award.

Another advantage to the plaintiff is the tendency of juries to find liability against institutional defendants more easily than against individuals.²¹⁶ Thus, the expansion of liability may be little more than an attempt to find a deeper and less sympathetic pocket from which the plaintiff may recover. The court in *Adamski v. Tacoma General Hospital*,²¹⁷ hinted at this, stating that the application of hornbook rules of agency in hospital-physician relationships led to such unsatisfactory results, from the standpoint of the injured plaintiff, that a substantial body of special law has been emerging in this area.

The expansion of hospital liability may also be an expression of the frustration of the public in its dealing with the health care system. Patients are often inconvenienced when they are required to wait for long periods of time in hospital emergency rooms and doctor's waiting areas. Hospitals and doctors do not ordinarily advertise their service costs and many patients are unpleasantly surprised by the final cost of the services they undergo.

There is some indication that malpractice awards may, in some cases, be motivated by sympathy. This may be especially true with awards against institutional providers who may be expected to have some type of liability insurance. Recently, there have been stirrings about the establishment of a kind of no-fault insurance reimbursement system for the victims of malpractice.²¹⁸ Transactional costs could be kept to a minimum if such a system were established. Investigation of claims to separate the victims of malpractice from those who suffered "poor results" would be mandatory. The deterrence factor found in fault-based liability might, however, be lost.²¹⁹

Under prevailing theories of liability hospitals are not yet strictly liable for malpractice by physicians. Yet certain trends are evident: hospitals' liability for negligence occurring within their walls is expanding; hospital services are becoming more specialized and depersonalized; malpractice litigation is flourishing; and health care consumers and providers wish to open privileges to greater numbers and types of practitioners. At the center of these sometimes conflicting trends lies the hospital. At least one commentator believes that

216. Cf. W. WAGNER, ART OF ADVOCACY, JURY SELECTION § 1.07[8] (1981) (discussing the difficulty of getting over the hurdle of the impression of many potential jurors that physicians can do no wrong).

217. 20 Wash. App. 98, 579 P.2d 970 (1978).

218. S. LAW & S. POLIN, *supra* note 137, at 149-57.

219. *Id.* at 155.

the courts are slowly establishing an "enterprise tort," which would impose hospital liability for any tort occurring as part of the "hospital enterprise."²²⁰

Another means to the same end is that taken by *Schagrin v. Wilmington Medical Center*,²²¹ which described as a non-delegable duty the establishment of emergency services as part of the hospital enterprise. Hospitals cannot escape liability for torts of independent contractors who are performing a non-delegable duty. Indeed, the label "non-delegable duty" is merely a question-begging device used to impose liability which may or may not be independently justified. It would follow that notice, billing, or contractual disclaimers would have no mitigating effect on such liability. At the core of such enterprise liability, of course, is the failure of the hospital itself to fulfill its duty to those within its walls.

Hospitals seem to be in a vortex of sometimes conflicting regulations and demands. They are required by courts to assure the quality of physician practice without being given, in some cases, the right to refuse privileges to a physician who is state licensed. They are required by one state agency to improve facilities to maintain licensure, yet denied the certificate for construction by another state agency. They are advised to execute service contracts with physicians to insulate themselves from liability, only to find that this very instrument may create the liability. Patients want to be able to have the physician of their choice render professional services in any hospital they may choose to enter; yet they demand that the hospital, which may be an unwilling host to the physician, assume full responsibility for the quality of his care.

Hospitals may or may not be able to satisfy all these demands. What is unclear is whether the public will be well served by their effort. Also, unclear, in the face of conflicting messages from courts and legislatures, is the strength of the mandate to regulate and assure quality medical care. What is clear is that the cost in terms of money and human effort will be dear. Serious investigation of the true mandate for hospitals in today's litigious and regulated society must be undertaken to enable the hospital to clarify the role it is being asked to assume.

220. Comment, *supra* note 107, at 385. "Hospital enterprise" is defined as any service, medical or otherwise, the hospital purports to provide the patient. *Id.* at 418. Presumably, this would include coffee shop, gift shop, and barber service.

221. 304 A.2d 61 (Del. 1973).