THE HOSPITAL AND THE STAFF PHYSICIAN — AN EXPANDING DUTY OF CARE

INTRODUCTION

In the past three decades this country has witnessed a major revolution in the field of medical services. The hospital, once nothing more than a hotel for the sick, has become an integral part of the healing process. Along with this increased responsibility has come an enlargement of the hospital's potential for liability when a patient under its care suffers injury. The most important aspect of this expanded responsibility is the possible liability of a hospital for the negligence of an independent physician on the hospital's medical or surgical staff.[1]

AN EXPANDING DUTY OF CARE

Historically, the hospital occupied a privileged position in the field of negligence liability, a position fostered by the belief that a hospital was only a facility in which physicians treated their patients. A hospital's function in the healing process was a ministerial one and its only duty was to provide comfort to the patients and protection from external forces during their stay.[2] The professional medical process was considered entirely in the hands of the individual treating physician.[3] A hospital had neither the right nor the ability to practice medicine and was, therefore, incapable of supervising the physician who utilized its facilities but operated as an independent contractor.[4]

---

1. Throughout this article any reference to medical or surgical staff membership will refer to the arrangement whereby a self-employed physician or surgeon is permitted to practice within a particular hospital upon meeting the requirements of that hospital for staff membership. This permissive practice arrangement entails no relationship of employment. The independent staff physician receives remuneration for his services directly from his patient; and the hospital, likewise, bills the patient directly for the services it renders.

Physicians employed by a hospital will also be staff members, but such physicians are not important to this article since a hospital is, and has been, liable for the negligence of its employees under the doctrine of respondeat superior. Therefore, the situation of the hospital-employed physician will not receive specific treatment in this article.

2. Bing v. Thunig, 2 N.Y.2d 656, 664, 163 N.Y.S.2d 3, 9 (1957).

3. Southwick, *The Hospital as an Institution — Expanding Responsibilities Change its Relationship with Staff Physician*, 9 CAL. WEST. L. REV. 429, 431 (1973).

4. Moon v. Mercy Hosp., 150 Colo. 430, ———, 373 P.2d 944, 945 (1962); Purcell v. Poor Sisters of St. Francis Seraph, 147 Colo. 478, ———, 364 P.2d 184, 185 (1961);

Under this view of a hospital's status and function, it could be liable for negligence under two basic theories. The first of these, the concept of respondeat superior, subjected the hospital to liability as the responsible principal in a principal-agent relationship.[4] It could be utilized, for example, where an employed nurse administered the wrong medicine or where an aide was careless in moving a patient. The second was founded upon the negligence of the hospital itself and was characterized by a breach of the standard of care that the hospital, as an entity, owed to the public.[6] Liability under this second theory would occur, for example, in a situation where the hospital failed to provide an adequate number of attendants to assure the safety of a patient.

Consistent with this traditional view of a hospital's function, its liability for the negligence of a treating physician could only be based upon the doctrine of respondeat superior. A hospital, having neither the right nor the power to practice medicine, did not have a duty to supervise those who did have that right and power.[7] The hospital's duty of care, as an entity, extended only to the proper and careful rendition of its many ministerial services. If it chose to employ a physician, it became responsible for his conduct but it shared no responsibility for the actions of its independent staff members.[8]

In the past three decades the American hospital has undergone dramatic change.[9] It is no longer typically a poorly managed charitable organization teetering on the brink of financial disaster. Many of today's hospitals operate upon tremendous asset valuation

---

Rosane v. Senger, 112 Colo. 363, _____, 149 P.2d 372, 374 (1944); Iterman v. Baker, 214 Ind. 308, _____, 15 N.E.2d 365, 369 (1938). This view has been rejected where the negligent physician was an agent of the hospital. Stuart Circle Hosp. Corp. v. Curry, 173 Va. 136, _____, 3 S.E.2d 153, 159 (1939); Treptan v. Behrens Spa, 247 Wis. 438, _____, 20 N.W.2d 108, 114 (1945).

5. Haven v. Randolf, 342 F. Supp. 538 (D.D.C. 1972); Albritton v. Bossier City Hosp. Comm'n, 271 So. 2d 353 (La. 2nd Dist. App. 1972); Swigerd v. City of Ortonville, 246 Minn 339, 75 N.W.2d 217 (1956); Sears v. City of Cincinnati, 31 Ohio St. 2d 157, 285 N.E.2d 732 (1972).

6. Mounds Park Hosp. v. Von Eye, 245 F.2d 756 (8th Cir. 1957).

7. Moon v. Mercy Hosp., 150 Colo. 430, _____, 373 P.2d 944, 946 (1962); Purcell v. Poor Sisters of St. Francis Seraph, 147 Colo. 478, _____, 364 P.2d 184, 185 (1961).

8. Hundt v. Proctor Community Hosp., 5 Ill. App. 3d 987, _____, 284 N.E.2d 676, 677 (1972).

9. Bing v. Thunig, 2 N.Y.2d 656, 664, 163 N.Y.S.2d 3, 9 (1957).

and some towards profit expectation.[10] No longer is there a need for the judiciary to protect the very existence of defendant hospitals, since ever increasing amounts of liability insurance are available to protect hospital assets from even the most oppressive judgments.[11]

Equally as dramatic as this change in the financial structure has been the change in the hospital's function. Medical care has progressed to the point where the services offered by the hospital itself through skilled technician-employees play a major role in the quantum of patient treatment.[12] Indeed, in many routine cases the patient is under exclusive hospital care in all but the few minutes a day (during the physician's morning and evening rounds) the independent staff physician spends with the patient. Thus, the medical process has developed to the point where the physician is no longer the sole factor in the medical treatment of a particular patient. No longer is the hospital simply the instrumentality which makes the patient comfortable while he is treated by the physician. Today, *both* hospital and physician play an important role in the treatment of the patient.[13] With this expansion of the hospital's function, patients have come to look increasingly to the hospital for care and guidance, rather than to the often impersonal physician. Thus, it seems no longer appropriate for the hospital to escape liability for the negligent acts of independent physician-members of its medical or surgical staff. The patient expects the hospital to provide a setting of proper care, and may look upon his physician's hospital staff membership as a badge of competence. And yet, despite this fundamental change in nature of the hospital's role, extension of its liability has proved difficult.

The doctrine of respondeat superior represents an inefficient vehicle for the extension of a hospital's liability in this area. That doctrine is one of limited application. It can only apply where there is an employment relationship between the hospital and the persons whose negligence proximately caused the injury.[14] Likewise, the

10. Hospital Corporation of America, a 400 million dollar a year corporation, is an example of a "for profit" hospital chain. It is comprised of ninety-seven hospitals with a total of 13,000 beds. MODERN HOSPITAL, April, 1973, at 49.

11. Bing v. Thunig, 2 N.Y.2d 656, 664, 163 N.Y.S.2d 3, 9 (1957).

12. Southwick, *The Hospital's New Responsibility*, 17 CLEV.-MAR. L. REV. 146 (1968).

13. *Id.*

14. W. PROSSER, THE LAW OF TORTS § 70, at 460 (3rd ed. 1971).

negligent party must act within the scope of his employment at the time.[15] Because of these strict requirements, the hospital has enjoyed immunity from liability for the negligent acts of independent staff physicians.[16] Of course the individual physicians remained liable for their own malpractice, but often, in light of the massive injury potential in such situations, the individual physician's insurance, income and assets were insufficient to afford adequate compensation to the injured patient. The hospital could share in the culpability, yet escape liability altogether. Of more importance than this apparent inequity, however, was the lack of legal incentive for the hospital to supervise and control the individual staff physician's qualifications and activities for the welfare and safety of patients in the hospital.

In light of these strict requirements for the invocation of the doctrine of respondeat superior, any expansion of hospital liability to encompass the negligent acts of staff physicians had to come within the confines of a broadened concept of a hospital's duty, as an entity, to its patients. This is precisely the course expansion has taken. The concept of a hospital's duty of care has undergone sweeping changes in recent years. These changes are thoroughly consistent with its expanded functions, but they could spell disaster for the unwary hospital administrator.

A REDEFINITION OF A HOSPITAL'S DUTY OF CARE

DARLING V. CHARLESTON COMMUNITY MEMORIAL HOSPITAL

The initial and most important judicial reflection of this change in the hospital's role was the decision of the Illinois supreme court in *Darling v. Charleston Community Memorial Hospital*.[17] In that case, the plaintiff sought damages for the loss of his leg upon the theory that the defendant hospital had been negligent in permitting an independent staff physician[18] to handle an orthopedic problem without

15. *Id.*

16. Bulloch Co. Hosp. Authority v. Fowler, 124 Ga. 242, ———, 183 S.E.2d 586, 589 (1971); Hundt v. Proctor Community Hosp., 5 Ill. App. 3d. 987, ———, 284 N.E.2d 676, 678 (1972).

17. 33 Ill. 2d 326, 211 N.E.2d 253, *cert. denied* 383 U.S. 946 (1965).

18. Throughout the course of its opinion, the Illinois supreme court apparently assumed that Dr. Anderson, the treating physician, was an independent contracting physician functioning as a member of the hospital staff. There is some indication,

requiring him to update his procedures in light of his infrequent exposure to such a problem.[19] He also complained of the hospital's failure to require consultation with other staff members during the period of treatment.[20] The court, in holding the hospital responsible, found that liability could be supported under either of two theories:[21] 1) the failure of the hospital to have an adequate number of qualified employees on hand to observe the plaintiff's rate of recovery and advise the treating physician, medical staff or hospital administration if complications should develop,[22] and 2) the hospital's failure to require consultation with, or examination by, members of the hospital surgical staff skilled in such treatment or to review the treatment rendered to the plaintiff and require consultation as needed.[23] The first theory was not unusual and was thoroughly consistent with the historical duties of a hospital to its patients. By adopting the second theory, however, the court accepted an expanded view of a hospital's duty which included the duty to supervise and control its staff physicians, at least to the point of requiring consultation with other staff members.[24] The individual staff physician was no longer the sole judge of the competence of the procedures he used to treat his patients, and he was no longer solely responsible for a deficiency in his treatment methods.[25] Equally important as the court's acceptance

---

however, in the opinion of the Appellate Court for the Fourth District of Illinois, that Dr. Anderson was not an independent contractor but rather was employed, at least on a limited basis, by the defendant hospital. Darling v. Charleston Community Memorial Hosp., 50 Ill. App. 2d 253, ———, 200 N.E.2d 149, 169 (1964).

The Appellate Court for the Second District of Illinois interpreted the *Darling* decision as one dealing with the doctrine of respondeat superior since "the treating physician was an employee placed by the hospital on emergency duty and subject to its supervision." Lundahl v. Rockford Memorial Hosp. Ass'n, 93 Ill. App. 2d 461, ———, 235 N.E.2d 671, 674 (1968). The Appellate Court for the First District of Illinois has also adopted this view. Collins v. Westlake Community Hosp., 12 Ill. App. 3d 847, ———, 299 N.E.2d 326, 328 (1973).

19. Mr. Darling was initially admitted to the defendant hospital with a broken leg. In the three years that Charleston Community Hospital had been in operation, Dr. Anderson had set only two fracture cases, and one of those had resulted in a non-union. Darling v. Charleston Community Memorial Hosp., 50 Ill. App. 2d 253, ———, 200 N.E.2d 149, 170 (1964).

20. 33 Ill. 2d at ———, 211 N.E.2d at 258.

21. The Illinois supreme court considered only two grounds of liability since the defendant had not objected to the instructions nor moved to withdraw any issues from the jury. 33 Ill. 2d at ———, 211 N.E.2d at 257-58. Under ILL. REV. STAT. ch. 110, § 68(4) (1968) an entire verdict will not be set aside because one possible ground of recovery was inadequately proven or otherwise defective if one or more sufficient grounds for recovery was present unless a motion to withdraw the improper ground from consideration of the jury was made in the trial court.

22. 33 Ill. 2d at ———, 211 N.E.2d at 258.

23. *Id.* at ———, 211 N.E.2d at 258.

24. *Id.* at ———, 211 N.E.2d at 258.

25. *Id.* at ———, 211 N.E.2d at 257-58.

of this broadened duty of care was its expansion of the means by which that duty was to be determined.

Darling offered the first definitive ruling[26] regarding the admissibility of sources other than expert professional and administrative testimony to establish a hospital's standard of care.[27] The admissibility of rules and regulations of the state, city, and the hospital itself, as well as appropriate standards of accreditation and hospital by-laws, laid open a whole new field of evidence to establish the heretofore elusive hospital entity standard of care. This evidence allowed a comprehensive formulation of the standard of care to be met by a hospital in its duty to its patients; a standard of care that would provide a definitive guideline for nearly every situation that was likely to arise, since the coverage of the admitted material was quite extensive.[28]

It must be stressed that *Darling* leaves intact the doctrine of respondeat superior. The court made it clear that the hospital's liability for the negligent act of its staff physician was not based upon some expanded notion of respondeat superior but rather upon an expansion of the hospital's own duty of care.[29] That duty now encompasses at least three obligations heretofore absent: 1) a hospital must not allow an independent staff physician to violate a specific requirement formulated by the hospital for patient safety; 2) the hospital must operate in such a manner that employees of the hospital will discover apparent dangers to the patient and bring such dangers to the ultimate attention of the hospital medical or surgical staff and the administration so that the administration can act, through the patient's personal physician if possible, or, bypassing him if necessary, to alleviate the danger;[30] and 3) a hospital has a duty to supervise the actions of independent staff physicians, at least to the extent of requiring that they consult with other staff members concerning serious cases.[31]

---

26. In Judd v. Park Avenue Hosp., 37 Misc. 2d 614, 235 N.Y.S.2d 843 (1962) the court allowed discovery of the defendant hospital's by-laws but specifically refrained from ruling upon their eventual admissibility for the purpose of establishing a standard of care.

27. 33 Ill. 2d at ———, 211 N.E.2d at 257-58.

28. For a description of the material admitted see the opinion of the Appellate Court for the Fourth District of Illinois, 50 Ill. App. 2d at ———, 200 N.E.2d at 163-65.

29. 33 Ill. 2d at ———, 211 N.E.2d at 257-58. *See also* Southwick, *The Hospital's New Responsibility*, 17 CLEV.-MAR. L. REV. 146 (1968).

30. 33 Ill. 2d at ———, 211 N.E.2d at 258.

31. *Id.* at ———, 211 N.E.2d at 258.

Darling was seminal both because it accepted these extensions of a hospital's duty as an entity and because it expanded the means available to a plaintiff in demonstrating that duty.[32] Its true measure of importance, however, has come in its wake, for it provided the starting point for a thorough reconsideration of a hospital's duty to its patients with regard to physicians on its staff.[33]

POST-DARLING DEVELOPMENTS

Case law since *Darling* has evolved primarily in response to the three points mentioned above and for that reason can be conveniently though roughly, divided into three categories: 1) that dealing with the breach of some rule by the hospital's staff, 2) that dealing with the hospital's failure to formulate a proper rule, and 3) that dealing with the hospital's failure to supervise its staff physician in some relevant respect. The case law comprising the first two categories offers a further definition of the *Darling* theory, a definition that allows a more complete understanding of that case's impact on the hospital entity standard of care. The third category is an expansion of *Darling*, imposing a duty upon the hospital to supervise the activities of its independent staff physicians in the entire spectrum of their activity with an aim towards providing an optimum environment of medical care within the hospital.

BREACH OF A RULE

The first category of case law involves the situation in which a rule, regulation, by-law, or policy which was formulated by the hospital or some other health care agency was breached in a manner which proximately caused injury to a patient.[34] The court in *Darling* accepted the fact that such a rule, if in effect, was evidence of the hospital's standard of care.[35] In this regard, *Darling* has had a two-

32. That the medical profession realized the potential significance of the *Darling* decision can be seen from the fact that both the American Medical Association and the American Hospital Association supported defendant's petition for certiorari to the United States Supreme Court which was denied at 383 U.S. 946 (1965).

33. Perhaps the eventual result of the *Darling* approach will be the imposition of strict liability upon the hospital for all patient injury, as has already occured with respect to transfusion of hepatitis-infected blood. 48 CHI.-KENT L. REV. 292 (1971).

34. Penn Tanker Co. v. United States, 310 F. Supp. 613 (S.D. Tex. 1970); Steeves v. United States, 294 F. Supp. 446 (D.S.C. 1968); Kapuschinsky v. United States, 248 F. Supp. 732 (D.S.C. 1966); Pederson v. Domouchel, 431 P.2d 973 (Wash. 1967).

35. 33 Ill. 2d at ____, 211 N.E.2d at 258.

fold effect: 1) If the person who broke the rule was an employee of the hospital, and was acting within the scope of his or her employment at the time of the breach, liability is simply based upon respondeat superior. The *Darling* doctrine, however, is relied upon to admit the broken rule as evidence of the hospital's standard of care. Thus, the hospital's liability is broadened, not due to any change in the doctrine but due to the stricter standard of care imposed upon the employee. In *Steeves v. United States*,[36] for example, a United States Naval Hospital was subjected to liability for not requiring an employed physician to consult with other staff members following the referral of a possible appendicitis case.[37] The hospital's accreditation standards were admitted to prove its duty of care in this regard.[38] In *Penn Tanker Co. v. United States*,[39] the Galveston Marine Hospital was found liable for failing to require an employed physician to properly prepare a patient for surgery.[40] Again, the hospital's accreditation standards provided the basis for ascertaining the hospital's duty of care.[41]

2) If the person who broke the rule was a staff physician rather than an employee, the hospital liability, if any, must be premised upon the expanded notion of a hospital's duty of care as an entity. Here, liability is incurred, not for the negligent act of the staff physician as such, but for the hospital's failure to prevent the breach of a rule designed for patient protection. The case of *Pederson v. Domouchel*[42] is illustrative. There a dentist member of the hospital staff was permitted to perform oral surgery without an attending medical doctor present.[43] The hospital was held responsible for the patient's injuries because it allowed the dentist to operate under such conditions in violation of the hospital's own rule of practice.[44] *Darling* formed the touchstone for hospital liability in such a situation by permitting the introduction of pertinent hospital rules, regulations and by-laws to furnish the basis of the hospital's standard of care. Under *Darling* the breach of such a regulation is not

36. 294 F. Supp. 446 (D.S.C. 1968).
37. *Id.* at 453-54.
38. *Id.* at 454.
39. 310 F. Supp. 613 (S.D. Tex. 1970).
40. *Id.* at 616.
41. *Id.* at 618.
42. 431 P.2d 973 (Wash. 1967).
43. *Id.* at 978.
44. *Id.*

conclusive on the question of liability[45] but, in light of subsequent cases, it is evidence of negligence which obviously weighs heavily upon the minds of the fact-finder.[46] Where the action is based upon a breach by a staff physician, knowledge of the impending breach and a failure to prevent it, or, in the absence of knowledge, circumstances under which the hospital should have known, must be demonstrated.[47] When this is sufficiently demonstrated, liability appears almost certain.

Failure to Formulate a Rule

Tonsic v. Wagner[48] is indicative of a second category of case law that involves the liability of a hospital for its failure to formulate a rule necessary for the protection of its patients. In *Tonsic* a surgical instrument was left inside a patient after a surgical procedure.[49] The jury found for the defendant on the factual question although the trial court gave a jury instruction, approved on appeal, that the hospital could be found guilty if it negligently failed to establish surgical guidelines which would have prevented the injury.[50] This case is the answer to the temptation following *Darling* to formulate inferior standards of accreditation, fewer and less specific rules and regulations and less demanding by-laws in order to diminish the standard of care imposed upon a hospital with regard to the actions of its staff physicians. It is clear that the failure to formulate such a rule will not excuse a hospital. The actions of other hospitals in the formulation of their rules and regulations will be examined as evidence of what is both feasible and necessary for the protection of patients.[51] Even conforming to the customary methods evidenced by the rules and regulations of other hospitals will not furnish a conclusive defense for industy-wide failure to provide adequate patient protec-

45. 33 Ill. 2d at ———, 211 N.E.2d at 257.
46. Penn Tanker Co. v. United States, 310 F. Supp. 613 (S.D. Tex. 1970); Steeves v. United States, 294 F. Supp. 446 (D.S.C. 1968); Kapuschinsky v. United States, 248 F. Supp. 732 (D.S.C. 1966); Pederson v. Domouchel, 431 P.2d 973 (Wash. 1967).
47. Purcell v. Zimbelman, 18 Ariz. App. 75, ———, 500 P.2d 335, 343 (1972); Mitchell Cty. Hosp. Authority v. Joiner, 229 Ga. 140, ———, 189 S.E.2d 412, 414 (1972).
48. 220 Pa. Super. 468, 289 A.2d 138 (1972).
49. *Id.* at ———, 289 A.2d at 139 (Hoffman, J., dissenting).
50. *Id.* at ———, 289 A.2d at 139-40 (Hoffman, J., dissenting).
51. 33 Ill. 2d at ———, 211 N.E.2d at 257.

tion and will not excuse the negligence of an individual hospital.[52] In this respect, the similar-community test stated in *Foley v. Bishop Clarkson Memorial Hospital*,[53] a case in which a defendant hospital failed to obtain a proper history and examination of an incoming patient in violation of its own rule, is illustrative. In broad language the court suggested that the most far-sighted and stringent of hospital by-laws, rules and regulations would serve to set the nationwide standard of care at a high level.[54] The individual hospital will be required to approach this standard and may, if its own rules are inferior, be liable for the very failure to institute adequate ones.[55]

Failure to Provide Optimum Environment For Patient Protection

The third category of post-*Darling* case law is in one respect similar to the first category in that it concerns instances in which a rule, regulation, standard or by-law has been breached. However, rather than focus upon the specific breach that violated the equally specific rule, courts have focused instead upon the failure of the defendant hospital to provide the patient generally with an optimum environment for patient protection and medical care.[56] In the previous two classifications of case law discussed, no incompetence on the part of the acting physician had to be shown. All that was required was a showing that the hospital had allowed a rule for patient protection to be breached or that a hospital had failed to provide such a rule. In this third class of cases, the physician's incompetence

---

52. It is a general principle of negligence law that the failure of an industry at large to prescribe procedures comporting with proper standards of care will not relieve an individual member of that industry from liability for his conduct when it falls below the proper standard. W. Prosser, The Law of Torts § 33, at 167 (3rd ed. 1971). In The T.J. Hooper, 60 F.2d 737 (2d Cir. 1932) the court held that the failure of the tugboat industry in general to have newly developed radio receivers mounted on the bridge to receive radio warnings did not excuse the individual defendant. The court said:

> "[A] whole calling may have unduly lagged in the adoption of new and available devices. It never may set its own tests, however persuasive be its usages. Courts must in the end say what is required; there are precautions so imperative that even their universal disregard will not excuse their omission."

Id. at 740.

53. 185 Neb. 89, 93, 173 N.W.2d 881, 884 (1970).

54. *Id.* at 93, 173 N.W.2d at 884.

55. The only limiting factor is apparently the feasibility of instituting the proper rule. 33 Ill. 2d at _____, 211 N.E.2d at 257.

56. Purcell v. Zimbelman, 18 Ariz. App. 75, 500 P.2d 335 (1972); Mitchell Cty. Hosp. Authority v. Joiner, 229 Ga. 140, 189 S.E.2d 412 (1972).

must be shown, for liability centers upon the negligence of the hospital in allowing an incompetent physician to practice within its walls.[57] The resulting liability is for the negligence of the hospital itself in accepting the physician on its staff, and not as a result of any principal-agent or master-servant relationship.[58] The negligence of the independent staff physician, coupled with the previous negligence of the hospital in accepting him for staff membership, is the proximate cause of the injury to the patient and therefore each is liable for independent acts of negligence to the extent of the patient's injury.[59]

In both *Mitchell County Hospital Authority v. Joiner*[60] and *Purcell v. Zimbelman*[61] liability was based upon the premise that the hospital was in possession of either actual or imputed knowledge that indicated, or should have indicated, that a particular independent staff physician was incompetent, negligent or reckless.[62]

Under this theory, the hospital would incur liability for the acts of the negligently-admitted staff physician in a manner not unlike respondeat superior, even though the physician was not an employee of the hospital, and was in fact totally independent. This greatly expanded potential for liability is of extreme importance to the hospital administration and hospital counsel, since one initial act of negligence in admitting a physician to the hospital staff who is not qualified in a field in which the hospital allows him to practice can result in massive liability for an act of negligence on his part within his admitted field of practice. Equally important is the hospital review procedure to eliminate incompetent physicians currently members of the staff.[63] The same expanded liability outlined above will result if the physician who was competent when admitted to the staff, becomes incompetent, negligent or reckless over a period of

57. This theory is akin to that of negligent entrustment. Mitchell Cty. Hosp. Authority v. Joiner, 229 Ga. 140, ———, 189 S.E.2d 412, 414 (1972).

58. Mitchell Cty. Hosp. Authority v. Joiner, 229 Ga. 140, ———, 189 S.E.2d 412, 414 (1972).

59. *Id.* at ———, 189 S.E.2d at 414.

60. 229 Ga. 140, 189 S.E.2d 412 (1972).

61. 18 Ariz. App. 75, 500 P.2d 335 (1972).

62. *Id.* at ———, 500 P.2d at 344-45; Mitchell Cty. Hosp. Authority v. Joiner, 229 Ga. at ———, 189 S.E.2d at 414.

63. Apparently, an adequate review procedure would have resulted in the removal of the incompetent physician and avoided the hospital's liability in Purcell v. Zimbelman, 18 Ariz. App. 75, ———, 500 P.2d 335, 343 (1972).

time. If such a physician is allowed to remain on the staff and practice within the hospital when the hospital knows or should have known of his lapsed qualification, hospital liability will follow his negligent acts. Indeed this danger of a once-competent staff member becoming incompetent is probably the greatest threat of this expanded liability.[64] Medical and surgical procedures are constantly changing. No longer is extensive medical reading the mark of only the diligent physician. A failure to keep abreast of the mountain of new medical information will in a relatively short time result in a physician becoming incompetent in an ever increasing number of fields and procedures.[65] In addition to the danger of older staff members becoming incompetent, there is also a danger of established, but incompetent, physicians making application for cross-membership on the staffs of several hospitals in a given community. When a hospital is confronted with this situation, it cannot be said that it acts in good faith and with reasonable care if it admits such a physician to the medical or surgical staff of the hospital.[66] If, as in *Mitchell*, the hospital has delegated the screening of applicants for staff privileges to a medical staff committee, this act will not insulate the hospital from liability for negligent selection.[67] In such a situation the independent physicians on the staff membership committee are acting as the hospital's agents.[68] Therefore, if they knew, or from information in their possession should have known, of the applicant's incompetency, this knowledge is imputed to the defendant hospital.[69] The favor with which the courts have viewed this theory of liability may perhaps be explained by the fact that staff membership is viewed by many patients as the hospital's endorsement of their personal physician.

---

64. *See* Purcell v. Zimbelman, 18 Ariz. App. 75, 500 P.2d 335 (1972); Hull v. North Valley Comm. Hosp., 498 P.2d 136 (Mont. 1972).

65. In this respect, it may be negligence on the part of a hospital not to provide an adequate and updated medical library for the use of its staff physicians. Indeed, this was a part of the plaintiff's complaint in *Darling*. 50 Ill. App. 2d at ———, 200 N.E.2d at 162.

66. Penn Tanker Co. v. United States, 310 F. Supp. 613 (S.D. Tex. 1970); Purcell v. Zimbelman, 18 Ariz. App. 75, 500 P.2d 355 (1972); Mitchell Cty Hosp Authority v. Joiner, 229 Ga. 140, 189 S.E.2d 412 (1972).

67. 229 Ga. at ———, 189 S.E.2d at 414.

68. *Id.* at ———, 189 S.E.2d at 414.

69. *Id.* at ———, 189 S.E.2d at 414.

In view of this third category of case law, the hospital faces significantly increased liability. Once a physician is negligently admitted to staff membership the hospital faces the possibility of liability for each independent act of malpractice by the physician. It is not required that the act breach a rule, regulation, standard or by-law as in the first group of cases, or that the physician enter an area of conduct that should have been governed by a hospital rule, as in the second group of cases. The hospital, following the negligent admission of an independent physician to its medical or surgical staff, could become in effect an insurer for any damage or injury that resulted from the physician's negligence.[70]

PROTECTIVE DEVICES

In light of the above discussion of the repercussions of *Darling* and subsequent cases, it would now be useful to ascertain some protective devices allowing the hospital to meet its standard of care and avoid liability.

It is clear that a hospital has not fulfilled its duty of care to its patients merely by limiting its staff to properly licensed physicians. Practical experience has shown that a license is not indicative of sound ability, and judicial experience has shown that the possession of a license by the negligent staff member will not serve as a valid defense to the hospital's negligence in admitting him to the staff or retaining him thereafter.[71] It follows that a hospital has a clear right to refuse to grant, or to later withdraw, staff privileges.[72]

Independent means must be developed and practiced by the hospital to ascertain whether a particular applicant is in fact qualified.[73] This evaluation should include a trial period long enough to allow the applicant supervised practice in all phases of medicine

70. Mauer v. Highland Park Hosp. Fnd'n., 90 Ill. App. 2d 409, ———, 232 N.E.2d 776, 779 (1967). In *Mauer*, the court held that the hospital had the right to refuse staff membership to the plaintiff, an osteopathic physician. In support of this decision, the court noted that current Illinois law would impose potential liability upon a hospital following imprudent or careless selection of its staff members.

71. Purcell v. Zimbelman, 18 Ariz. App. 75, ———, 500 P.2d 335, 341 (1972); Mitchell Cty. Hosp. Authority v. Joiner, 229 Ga. 140, ———, 189 S.E.2d 412, 413 (1972).

72. *See generally Court Upholds Hospital's Right to Withdraw Privileges, but it Sets Tough Rules for Future Peer Review*, MODERN HOSPITAL, Oct., 1973, at 23.

73. 1 INSTITUTE OF CONTINUING LEGAL EDUCATION, HOSPITAL LIABILITY LAW: LECTURES AND TRIAL DEMONSTRATIONS 37, 39 (1968).

that he wishes to pursue at the hospital. In this manner the physician's practice within the hospital can be limited to the areas of his demonstrated ability. Following the physician's acceptance to the staff, his procedure should be periodically reviewed to confirm his continued ability in each field of allowed practice. If incompetence in a particular field later develops and is discovered, the physician can be safely retained as a staff member so long as his practice is restricted to those areas in which he has demonstrated continuing competence.[74]

As indicated above, a hospital cannot shield itself from liability by the formulation of minimal rules, regulations, standards or by-laws. In doing so it could be held liable for negligent failure to establish the rules that will afford necessary protection for the patient.[75] Likewise, in this respect the *Tonsic* and *Foley* cases appear to indicate that the strictest guidelines formulated by other hospitals (perhaps even feasible rules that could have been formulated but were not) may be introduced to show the hospital's standard of care. Under these two decisions it seems that the loftiest goals of other hospitals may be introduced into evidence to show a standard of care for the defendant hospital. It therefore behooves the individual hospital to thoroughly research the by-laws and rules, regulations and standards formulated by other hospitals, as well as state statutes and standards of accreditation.[76] The rules committee of the hospital can then consider all these sources, as well as their own ideas, in formulating a comprehensive system of rules, regulations, by-laws, policies and guidelines that combine the best features of all sources considered. In addition to the formulation of a comprehensive set of rules, this extrinsic evidence will provide a record of the committee's evaluation of the feasibility and merit of each point, and will thus form a valuable defense to the introduction of non-feasible policies of other hospitals in an action against the hospital.

The action of the rules committee of the hospital must be a continuous process. The subject matter must be exposed to frequent re-evaluation and change. Leaving this matter to a staff committee will not relieve the hospital from liability since the committee's remiss,

74. 40 UNIV. OF CIN. L. REV. 797 (1971).
75. Tonsic v. Wagner, 220 Pa. Super. 468, 289 A.2d 138 (1972).
76. 1 INSTITUTE OF CONTINUING LEGAL EDUCATION, HOSPITAL LIABILITY LAW: LECTURES AND TRIAL DEMONSTRATIONS 203 (1968).

under the principal/agent doctrine, is imputed to the hospital.[77] With respect to enforcement of rules once formulated, one brief note should suffice. For these rules to reduce rather than enhance the hospital's liability, they must be strictly enforced.[78] There must be a continued impartial monitoring of the system and the physicians within it. The hospital administration must assure that the staff physicians principally in charge of the monitoring are not overlooking infractions in a misplaced sense of professional courtesy. To avoid this problem the hospital administration, and perhaps outside expert consultants, should be involved directly in the evaluation and enforcement of the rules.

A clear danger that faces many hospitals today, and which could ironically result in self-imposed liability, is the inclusion in the hospital's by-laws of medically unrealistic goals. The danger lies in the fact that under *Darling* these goals may be introduced into evidence against the hospital that formulated them, or against other hospitals, to establish an unreasonably high standard of care.[79] Since this evidence may weigh heavily upon the fact-finder, such an unrealistic goal does not belong in the by-laws of the hospital.

CONCLUSION

In any discussion of limitation of a hospital's liability for the negligent acts of independent physicians, it is important not to lose sight of the ultimate goal of the discussion. That goal is the creation of an atmosphere of optimum medical care and patient protection within the hospital. Only an efficient interworking between hospital and physician will accomplish this goal.

The lesson of the cases cited in this article is that today it is the hospital itself which is in the best position to achieve an atmosphere of optimum medical care and patient protection. The privately retained physician no longer dominates the field of major health care services. The hospital is the instrumentality that provides the majority of such services and, in the eyes of the public, the hospital is con-

77. Mitchell Cty. Hosp. Authority v. Joiner, 229 Ga. 140, ———, 189 S.E.2d 412, 414 (1972).

78. Rules promulgated but not enforced could provide evidence of the standard of care the hospital had established for itself. A breach of its own rules would seemingly be an inexcusable departure from the hospital's standard of care.

79. 33 Ill. 2d at ———, 211 N.E.2d at 257-58.

sidered the responsible and controlling force. The hospital brings together all the factors bearing upon the patient's recovery. The independent staff physician is merely one of these factors, although admittedly an important one. No reason exists to exclude the hospital from liability for its own negligent actions. The courts of several states have so recognized, and have ruled accordingly. Not only is the hospital in the best position to control the atmosphere of medical care within its walls, it is also in the best position to shoulder responsibility for the serious mistake and consequent losses likely to occur in even the most highly supervised and well-governed hospitals.

Although the hospital's burden is great, in both formulation of policy and exposure to liability, there is little doubt that this direction of the law will bring the goal of optimum medical care several steps closer to reality.

William W. Drummy III — '75