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Piercing the Doctrine of Corporate Hospital Liability

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PIERCING THE DOCTRINE OF CORPORATE HOSPITAL LIABILITY*

According to the doctrine of corporate hospital liability, hospitals may be held liable for the negligent conduct of their nonemployee, professionally autonomous staff physicians. This Comment concludes that courts that have adopted this principle have ignored basic procedural and organizational realities of hospital and medical practice which make the imposition of corporate liability unsound. The author submits that the more logical defendants are those staff physicians who are aware of the negligent physician's incompetence and fail to take reasonable steps to prevent the plaintiff's injury.

INTRODUCTION

When a hospital patient is injured by a negligent physician, against whom may the aggrieved plaintiff legally proceed? Certainly the derelict physician will incur personal liability.[1] However, suppose the physician carries little or no malpractice insurance and it is obvious that the plaintiff's verdict will exceed the doctor's personal financial capacity? Or suppose the plaintiff would rather not sue the individual physician or refuses to do so because the two maintain an extraordinarily close personal or physician-patient relationship? Has the plaintiff a viable cause of action against the hospital? May the plaintiff bring suit against the other hospital staff physicians[2] who were on notice of the neg-

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1. Rickett v. Hayes, 256 Ark. 893, 904, 511 S.W.2d 187, 195 (1974); Valdez v. Percy, 35 Cal. 2d 338, 342, 217 P.2d 422, 425 (1950); Jones v. Furnell, 406 S.W.2d 154, 156 (Ky. 1966); Crosby v. Grandview Nursing Home, 290 A.2d 375, 380 (Me. 1972); Hill v. Stewart, 209 So. 2d 809, 812 (Miss. 1968); Starnes v. Taylor, 272 N.C. 386, 392, 158 S.E.2d 339, 343 (1968); Darby v. Union Planters Nat'l Bank, 222 Tenn. 417, 421, 436 S.W.2d 439, 441 (1969).

2. "Staff physicians" are those physicians who have been granted "staff privileges" at one or more hospitals. Pursuant to staff bylaws, medical staff appointment is ordinarily granted for a period of not longer than two years. At the time of initial appointment or reappointment, there is a delineation of clinical privileges for each physician on the medical staff. JOINT COMMISSION ON ACCREDITATION OF

ligent doctor's misconduct? Can the plaintiff simply name the entire medical staff as a defendant?[3]

This Comment examines the significance and development of the doctrine of corporate hospital liability,[4] which originated in the landmark case of *Darling v. Charleston Community Memorial Hospital*.[5] According to this doctrine, hospitals are legally accountable for the negligence of their staff physicians.[6] The author concludes that the rationale advanced by courts which have accepted the *Darling* principle is not consonant with the realities of hospital structure. The more logical defendants are those staff physicians who are, through means of professional contact or mandatory medical committee review, on notice of the negligent physician's incompetence and who fail to take reasonable steps to prevent the plaintiff's injury.[7]

SIGNIFICANCE OF THE CORPORATE HOSPITAL LIABILITY DOCTRINE

Hospitals are liable for the negligent acts of their employees under the doctrine of respondeat superior.[8] Hospitals may even be held vicariously liable for the negligent acts or omissions of physicians who are employed by the hospital or subject to a significant degree of hospital control.[9] However, many physicians

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HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS 83, 87 (1979) [hereinafter cited as ACCREDITATION MANUAL].

The Joint Commission on Accreditation of Hospitals (JCAH) is a private, nonprofit organization whose purpose is to certify the safety and quality of hospitals in accordance with its minimum standards. Most hospitals seek accreditation with the JCAH to become eligible to participate in Medicare and other beneficial programs.

3. In Corleto v. Shore Memorial Hosp., 138 N.J. Super. 302, 350 A.2d 534 (1975), the plaintiff named as a defendant the entire medical staff of 141 physicians for the negligence of one derelict surgeon. The court denied the staff defendants' motion to dismiss the complaint.

4. Although cases decided upon the doctrine of corporate hospital liability have not used this term, most commentators have attached this or a similar label to the theory of liability espoused by *Darling* and its progeny. *See, e.g.*, Copeland, *Hospital Responsibility for Basic Care Provided by Medical Staff Members: "Am I My Brother's Keeper?"*, 5 N. KY. L. REV. 27, 32 (1978) (hospital corporate responsibility doctrine); Southwick, *The Hospital as an Institution—Expanding Responsibilities Change Its Relationship with the Staff Physician*, 9 CAL. W.L. REV. 429, 443 (1973) (corporate negligence doctrine).

5. 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966).

6. *See* Moore, *Medical Staff—Corporate Accountability*, 43 INS. COUNSEL J. 110, 115 (1976); Zaslow, *A New Reason for Liability: Hospital Medical Staff Membership*, J. LEGAL MED., Feb., 1977, at 20, 21 [hereinafter cited as Zaslow, *A New Reason for Liability*].

7. *See* Zaslow, *A New Reason for Liability*, *supra* note 6, at 22.

8. Bowers v. Olch, 120 Cal. App. 2d 108, 260 P.2d 997 (1953) (resident); Bernardi v. Community Hosp. Ass'n, 166 Colo. 280, 443 P.2d 708 (1968) (nurse); Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957) (nurse); Sepaugh v. Methodist Hosp., 30 Tenn. App. 25, 202 S.W.2d 985 (1946) (intern).

9. Beeck v. Tucson Gen. Hosp., 18 Ariz. App. 165, 500 P.2d 1153 (1972) (radiol-

operate from private, office-based, community practices and use hospital facilities only when necessary to admit and treat their patients. Such doctors are independent contractors[10] and are professionally autonomous.[11] The obvious significance of this principle, in the hospital setting, is that a hospital should not be held liable for the negligence of independent contractor physicians.[12] This was indeed the rule in all jurisdictions until 1965 when the Illinois Supreme Court, in the *Darling v. Charleston Community Memorial Hospital* opinion,[13] announced that a hospital may be liable for the negligent conduct of a private practitioner who is a member of the medical staff.[14]

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ogist was employed by the hospital on a five-year contract); Seneris v. Haas, 45 Cal. 2d 811, 291 P.2d 915 (1955) (anesthesiologist was "on call" at the hospital); Kober v. Stewart, 148 Mont. 117, 417 P.2d 476 (1966) (radiologist was "on call' at the hospital); Lundberg v. Bay View Hosp., 175 Ohio St. 133, 191 N.E.2d 821 (1963) (pathologist was represented by the hospital as an employee).

10. Mills, *Corleto in Perspective*, J. LEGAL MED., Feb., 1977, at 3, 3; Southwick, *Vicarious Liability of Hospitals*, 44 MARQ. L. REV. 153, 166 (1960-61); Zaslow, *Vicarious Liability of a Hospital for Tortious Acts of Its Independent Contractors Delivering Medical Care*, 49 PA. B.A.Q. 466, 469 (1978); Comment, *The Hospital's Responsibility for its Medical Staff: Prospects for Corporate Negligence in California*, 8 PAC. L.J. 141, 143 (1977).

Such independent physicians bill their patients directly for provided medical treatment; likewise, the hospital receives remuneration from all hospital patients for the services it renders. Comment, *The Hospital and the Staff Physician—An Expanding Duty of Care*, 7 CREIGHTON L. REV. 249, 249 n.1 (1974). Mere membership on a hospital medical staff does not make such independent contractor physicians "agents" of the hospital. *See* Mayers v. Litlow, 154 Cal. App. 2d 413, 417-18, 316 P.2d 351, 354 (1957); Hundt v. Proctor Community Hosp., 5 Ill. App. 3d 987, 990, 284 N.E.2d 676, 678 (1972).

11. O'Sullivan & Wing, *The Hospital-Based Physician: Current Status and Significance*, J. LEGAL MED., May-June, 1973, at 20, 21.

12. *See* Cramer v. Hoffman, 390 F.2d 19, 23 (2nd Cir. 1968); Mayers v. Litlow, 154 Cal. App. 2d 413, 418, 316 P.2d 351, 354 (1957).

13. 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966).

14. *See* Moore, *Medical Staff—Corporate Accountability*, 43 INS. COUNSEL J. 110, 114 (1976); Zaslow, *A New Reason for Liability*, *supra* note 6, at 21.

Prior to the *Darling* decision, an injured patient was able to sue only the individual negligent physician. The impact of this case in the medico-legal field has been analogized to that of the *Palsgraf* decision in the area of general negligence. Springer, *Medical Staff Law and the Hospital*, 285 NEW ENG. J. MED. 952, 954 (1971).

Profuse academic comment followed the *Darling* decision. For a sampling of the articles which have been written analyzing the significance of *Darling* and its progeny or advocating the increased adoption of the doctrine of corporate hospital liability, see Copeland, *Hospital Responsibility for Basic Care Provided by Medical Staff Members: "Am I My Brother's Keeper?"*, 5 N. KY. L. REV. 27 (1978); Ludlam, *The Impact of the Darling Decision Upon the Practice of Medicine & Hospitals*, 11 FORUM 756 (1975-76); Moore, *Medical Staff—Corporate Accountability*, 43 INS. COUNSEL J. 110 (1976); Rapp, *Darling and Its Progeny: A Radical Approach To-*

Since *Darling* was decided, the corporate negligence doctrine has been recognized by appellate courts in at least eight states.[15] In still other states, notwithstanding the lack of local appellate authority, the *Darling* decision has been relied upon by trial courts to find hospital liability.[16] Because of the geographical and doctrinal expansion of the *Darling* principle, a case-by-case evaluation of the related significant cases is warranted.

DEVELOPMENT OF THE CORPORATE HOSPITAL LIABILITY DOCTRINE

In *Darling*, a college student broke his leg during a football game. He was taken to the Charleston Community Memorial Hospital emergency room where he was treated by Dr. Alexander.[17] Dr. Alexander applied traction and encased the leg in a plaster cast. The cast was improperly applied so that the circulation in Mr. Darling's leg was blocked. His protruding toes became swollen, dark, and insensitive. Dr. Alexander, in an attempt to loosen the cast, split the sides of the cast with a saw. He negligently cut the plaintiff's leg on both sides.[18] Blood and other

ward Hospital Liability, 60 ILL. B.J. 883 (1972); Slawkowski, *Do the Courts Understand the Realities of Hospital Practices?*, 22 ST. LOUIS U.L.J. 452 (1978); Southwick, *The Hospital as an Institution—Expanding Responsibilities Change Its Relationship with the Staff Physician*, 9 CAL. W.L. REV. 429 (1973); Note, *Independent Duty of a Hospital to Prevent Physicians' Malpractice*, 15 ARIZ. L. REV. 953 (1973); Note, *Hospital Liability—A New Duty of Care*, 19 ME. L. REV. 102 (1967); Comment, *The Hospital and the Staff Physician—An Expanding Duty of Care*, 7 CREIGHTON L. REV. 249 (1974); Comment, *The Hospital's Responsibility for its Medical Staff: Prospects for Corporate Negligence in California*, 8 PAC. L.J. 141 (1977); Comment, *The Hospital-Physician Relationship: Hospital Responsibility for Malpractice of Physicians*, 50 WASH. L. REV. 385 (1975).

15. Purcell v. Zimbelman, 18 Ariz. App. 75, 500 P.2d 335 (1972); Joiner v. Mitchell County Hosp. Auth., 125 Ga. App. 1, 186 S.E.2d 307 (1971), *aff'd*, 229 Ga. 140, 189 S.E.2d 412 (1972); Gridley v. Johnson, 476 S.W.2d 475 (Mo. 1972); Foley v. Bishop Clarkson Memorial Hosp., 185 Neb. 89, 173 N.W.2d 881 (1970); Corleto v. Shore Memorial Hosp., 138 N.J. Super. 302, 350 A.2d 534 (1975); Fiorentino v. Wenger, 19 N.Y.2d 407, 227 N.E.2d 296, 280 N.Y.S.2d 373 (1967); Moore v. Board of Trustees, 88 Nev. 207, 495 P.2d 605, *cert. denied*, 409 U.S. 879 (1972); Pederson v. Dumouchel, 72 Wash. 2d 73, 431 P.2d 973 (1967).

16. In California, for example, no appellate court has ever been asked to recognize or refute the corporate negligence doctrine. However, numerous trial court decisions have relied on it to reach liability. *See, e.g.*, Eng v. Valley Memorial Hosp., Civ. No. 460898-3 (Super. Ct. Alameda County, Cal. Dec. 15, 1977); Gonzales v. Nork, Civ. No. 228566 (Super. Ct. Sacramento County, Cal. Nov. 27, 1973), *rev'd for failure to grant jury trial*, 60 Cal. App. 3d 728, 131 Cal. Rptr. 717 (1976), *rev'd and retransferred to Court of Appeal for disposition on the merits*, 20 Cal. 3d 500, 573 P.2d 458, 143 Cal. Rptr. 240 (1978). In jurisdictions such as California, it appears that hospitals are not eager to appeal adverse trial court decisions for fear of establishing the corporate negligence doctrine as appellate precedent.

17. Dr. Alexander was a private practitioner on back-up call for the hospital emergency room.

18. Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 328, 211 N.E.2d 253, 255 (1965), *cert. denied*, 383 U.S. 946 (1966).

seepage produced a nauseous stench in the room. Despite these obvious signs of malpractice, neither Dr. Alexander nor any other medical personnel administered further treatment to the plaintiff for the next eleven days.[19] When the plaintiff was finally transferred to another hospital, it was determined that the leg contained so much dead tissue that amputation was necessary.[20] From these harsh facts, the Illinois Supreme Court held that the hospital itself was liable for negligently failing to adequately supervise the treatment rendered to the patient by Dr. Alexander.[21] In effect, the court found the hospital owed an independent duty of care directly to the plaintiff.[22] From this genesis,[23] the doctrine of corporate hospital liability has been utilized and expanded to impose other affirmative duties upon hospitals.[24]

For example, in *Pederson v. Dumouchel*,[25] the plaintiff suffered a broken jaw in an automobile accident. He was taken to St. Joseph Hospital and admitted by Dr. Dumouchel, a private practitioner.[26] As the attending physician, Dr. Dumouchel called in a dentist to reduce surgically plaintiff's fracture under general anes-

19. *See id.* at 328-29, 211 N.E.2d at 255.

20. *Id.* at 329, 211 N.E.2d at 256.

21. *See id.* at 328-33, 211 N.E.2d at 255-58; Copeland, *Hospital Responsibility for Basic Care Provided by Medical Staff Members: "Am I My Brother's Keeper?"*, 5 N. KY. L. REV. 27, 33 (1978); Moore, *Medical Staff—Corporate Accountability*, 43 INS. COUNSEL J. 110, 114 (1976); O'Sullivan & Wing, *The Hospital-Based Physician: Current Status and Significance*, J. LEGAL MED., Sept.-Oct., 1973, at 25, 26.

22. *See* Copeland, *Hospital Responsibility for Basic Care Provided by Medical Staff Members: "Am I My Brother's Keeper?"*, 5 N. KY. L. REV. 27, 33 (1978); Rapp, *Darling and Its Progeny: A Radical Approach Toward Hospital Liability*, 60 ILL. B.J. 883, 888 (1972); Comment, *The Hospital's Responsibility for its Medical Staff: Prospects for Corporate Negligence in California*, 8 PAC. L.J. 141, 144 (1977).

23. Note that because Dr. Alexander was on call at the Charleston Community Memorial Hospital emergency room, the court might have chosen to hold the hospital vicariously liable on the grounds that Dr. Alexander was subject to a significant degree of hospital control. *See* cases cited note 9 *supra*.

24. *E.g.*, Purcell v. Zimbelman, 18 Ariz. App. 75, 500 P.2d 335 (1972) (duty to revoke hospital privileges from incompetent physicians); Joiner v. Mitchell County Hosp. Auth., 125 Ga. App. 1, 186 S.E.2d 307 (1971), *aff'd*, 229 Ga. 140, 189 S.E.2d 412 (1972) (duty to use due care in selection of staff physicians); Gridley v. Johnson, 476 S.W.2d 475 (Mo. 1972) (duty to require that physicians perform proper preoperative diagnostic testing to assure surgery is necessary); Foley v. Bishop Clarkson Memorial Hosp., 185 Neb. 89, 173 N.W.2d 881 (1970) (duty to assure that adequate medical histories are taken for admitted patients); Pederson v. Dumouchel, 72 Wash. 2d 73, 431 P.2d 973 (1967) (duty to assure the presence of a licensed physician during surgery).

25. 72 Wash. 2d 73, 431 P.2d 973 (1967).

26. As will be the situation with all cases discussed hereafter, the negligent physician in *Pederson* was an independent contractor, not a hospital employee.

thetic. The dentist had no working knowledge of the use of general anesthetics and, therefore, left the responsibility of administering the anesthetic to a hospital nurse.[27] The surgery was performed without Dr. Dumouchel, or any other medical doctor, present in the operating room. During recovery, plaintiff experienced convulsive seizures, apparently as a result of improper administration of the anesthetic. The plaintiff sustained brain damage and the hospital was named as a defendant.

The Supreme Court of Washington concluded that "it is negligence as a matter of law for a hospital to permit a surgical operation upon a patient under general anesthetic without the presence and supervision of a medical doctor in the operating room . . . ."[28] The court's decision was supported by the fact that the hospital had permitted the breach of one of its own rules: when a patient requiring dental care is admitted, the attending physician "shall perform an adequate medical examination prior to dental surgery, and be responsible for the patient's medical care."[29] In this case, Dr. Dumouchel left the hospital prior to surgery and returned just as the plaintiff was being transferred to another hospital. Clearly, Dr. Dumouchel had not assumed the responsibility for the patient's medical care while in surgery.[30]

In *Fiorentino v. Wenger*,[31] the New York Court of Appeals recognized the corporate negligence doctrine and emphasized that the notice requirement is the key element in the imposition of hospital liability.[32] In *Fiorentino*, a staff physician negligently failed to obtain the informed consent of a minor patient or his parents prior to performing a novel and dangerous surgical procedure.[33] The issue before the court was whether the hospital had breached any duty owed by it to the patient or his parents.[34] The court held that liability did not attach to the hospital because the evidence did not show that the hospital knew or should have

27. Pederson v. Dumouchel, 72 Wash. 2d 73, 74, 431 P.2d 973, 975 (1967).

28. *Id.* at 80, 431 P.2d at 978.

29. *Id.*

30. *Id. Darling*'s impact on the *Pederson* court was twofold: first, it allowed the court to find the hospital liable for failing to adequately supervise its staff physicians; second, it permitted the introduction of pertinent hospital bylaws and regulations to furnish the basis of the hospital's standard of care.

31. 19 N.Y.2d 407, 227 N.E.2d 296, 280 N.Y.S.2d 373 (1967).

32. *Id.* at 411, 227 N.E.2d at 297, 280 N.Y.S.2d at 375.

33. *Id.* at 413, 227 N.E.2d at 298-99, 280 N.Y.S.2d at 377. That the surgical procedure was novel and dangerous may be an understatement. The operation was at best experimental, as the surgeon himself had devised this "spinal jack" operation. In fact, he was the only surgeon in the country using this technique. Of the 35 times he had previously performed it, one operation resulted in paralysis; four others were followed by serious complications. *Id.* at 412, 227 N.E.2d at 298, 280 N.Y.S.2d at 376.

34. *Id.* at 414, 227 N.E.2d at 299, 280 N.Y.S.2d at 377.

known that the doctor had not received an informed consent.[35]

Notwithstanding the lack of hospital liability in *Fiorentino*, the New York court's verbalization of the actual or constructive knowledge concept was subsequently advanced by the Arizona Court of Appeals in *Purcell v. Zimbelman*.[36] Dr. Purcell was negligent in his performance of an abdominal surgical operation.[37] The plaintiff named Tucson General Hospital as a defendant on the theory that the hospital knew or should have known that Dr. Purcell lacked the skill to perform the surgical procedure in question.[38] The plaintiff offered evidence that twice previously Dr. Purcell had been sued successfully for malpractice in the performance of the identical surgical procedure. The hospital defended on the ground that the two prior malpractice cases had been presented to the hospital's department of surgery. The hospital contended that because the department of surgery was comprised of a group of independent staff physicians, the hospital could not be held liable for its inaction.[39] The court dismissed the hospital's defense and stated that "[because] the department was negligent in not taking any action against Purcell or recommending to the board of trustees that action be taken, then the hospital . . . [was] also . . . negligent."[40]

Thus Tucson General Hospital had an affirmative duty to examine continually medical staff privileges. A breach of this duty occurred when the department of surgery became aware that Dr. Purcell lacked the skill to treat the plaintiff's condition and the department failed to take reasonable steps to prevent the plaintiff's injury or to report this knowledge to the hospital administration.[41]

35. *Id.* at 418, 227 N.E.2d at 301, 280 N.Y.S.2d at 381.
36. 18 Ariz. App. 75, 500 P.2d 335 (1972).
37. During the operation to remove an obstruction in plaintiff's colon, Dr. Purcell found a lesion. He could not tell by sight whether the lesion was cancerous. Rather than obtaining a frozen section with which a determination could be made, Dr. Purcell relied on the opinion of a pathologist who said the lesion looked like cancer. The doctor then proceeded to perform a "pull through" operation which entailed opening the abdomen and removing a piece of the bowel. *Id.* at 79, 500 P.2d at 339. Expert testimony revealed that an "anterior resection" was the procedure ordinarily used by surgeons and that Dr. Purcell's choice of treatment was below the average standard of a competent bowel surgeon. As a result of the negligence, the plaintiff suffered loss of sexual function, loss of a kidney, and urinary problems. *Id.* at 80, 500 P.2d at 340.
38. *Id.* at 80, 500 P.2d at 340.
39. *Id.* at 81, 500 P.2d at 341.
40. *Id.*
41. Southwick, *The Hospital as an Institution—Expanding Responsibilities*

In *Joiner v. Mitchell County Hospital Authority*,[42] the hospital's obligation was extended further to include a duty to assure that only competent physicians are granted staff privileges in the first instance. The plaintiff brought her husband, who had been complaining of chest pains, to the defendant hospital's emergency room. Dr. Gonzales examined the patient, told him his condition was not serious, and sent him home. Less than three hours later, the patient's chest pains worsened and he died. The plaintiff sued Dr. Gonzales for negligent diagnosis and treatment. In addition, the plaintiff alleged independent negligence against the hospital for granting Dr. Gonzales staff privileges without making an investigation into his background to ascertain his competence.[43] The hospital sought to absolve itself from liability on the ground that the screening of applicants for admission to the medical staff was a function of the existing staff members. The Georgia Court of Appeals held that the physicians responsible for staff selection are agents of the hospital and therefore the hospital is accountable for any negligence committed by them.[44]

In summary, the doctrine of corporate hospital liability has evolved to impose at least three general duties on hospitals: to supervise the medical care given to patients by staff physicians; to suspend the privileges, temporarily or permanently, of discovered incompetent physicians; and to use reasonable care to select only competent staff physicians in the first instance.[45]

How may a hospital effectively discharge these duties? Once on notice of the malpractice of an independent contractor physician on its medical staff, the hospital must take affirmative action to prevent injury to its patients. The hospital might require the suspension or curtailment of the doctor's privileges to reflect more accurately the physician's true capabilities.[46] Or the hospital might even revoke the staff privileges of an incompetent doctor.[47]

Change Its Relationship with the Staff Physician, 9 CAL. W.L. REV. 429, 451 (1973). The court listed suspension from the staff, remonstration, and restriction of staff privileges as possible steps the hospital could have taken against Dr. Purcell to preclude further patient injury.

42. 125 Ga. App. 1, 186 S.E.2d 307 (1971), *aff'd*, 229 Ga. 140, 189 S.E.2d 412 (1972).

43. *Id.* at 2, 186 S.E.2d at 308.

44. *Id.*

45. *See* text accompanying notes 17-44 *supra*.

46. The governing body has the power to effect such reduction of privileges. ACCREDITATION MANUAL, *supra* note 2, at 53. *See* Purcell v. Zimbelman, 18 Ariz. App. 75, 500 P.2d 335 (1972).

Clinical privileges are hospital-specific. Each hospital must define the scope of physician clinical privileges based on individual qualifications, medical experience, and demonstrated competence. Such delineation of privileges is subject to annual or biennial review. ACCREDITATION MANUAL, *supra* note 2, at 53, 84-87.

47. The governing body has the power to effect such revocation of privileges.

Once aware, actually or constructively, of prior malpractice claims against a physician who is applying to the hospital for staff privileges for the first time, the hospital may find it necessary to deny the application to escape later charges of negligence.[48]

AN UNREALISTIC STANDARD FOR HOSPITALS

What is the legal basis for holding a hospital liable for the breach of one or more of the aforementioned independent duties? This question is more than academic because, even with respect to *Darling v. Charleston Community Memorial Hospital*, there has been much confusion among the courts as to the grounds for hospital liability.[49] As discussed, the theory of liability cannot be respondeat superior because the doctrine of corporate hospital liability applies only to independent contractor physicians.[50] The rationale advanced by courts that have invoked the doctrine is that the hospital "delegates" to the medical staff the duty to supervise the medical care given by staff physicians and the duty to select competent staff physicians.[51] The medical staff thus be-

ACCREDITATION MANUAL, *supra* note 2, at 53. *See* Moore v. Board of Trustees, 88 Nev. 207, 495 P.2d 605, *cert. denied*, 409 U.S. 879 (1972); Khan v. Suburban Community Hosp., 45 Ohio St. 2d 39, 340 N.E.2d 398 (1976).

48. *See* Joiner v. Mitchell County Hosp. Auth., 125 Ga. App. 1, 186 S.E.2d 307 (1971), *aff'd*, 229 Ga. 140, 189 S.E.2d 412 (1972); Mauer v. Highland Park Hosp. Foundation, 90 Ill. App. 2d 409, 232 N.E.2d 776 (1967).

49. The Supreme Court of Illinois decided *Darling* in 1965. Since then, even appellate courts in Illinois have misunderstood the legal theory imposed by the Illinois Supreme Court to hold the Charleston Community Memorial Hospital liable. These courts, unable to ascertain another logical legal basis for liability, have erroneously read *Darling*, presuming that Dr. Alexander was a hospital employee. *E.g.*, Collins v. Westlake Community Hosp., 12 Ill. App. 3d 847, 851, 299 N.E.2d 326, 328 (1973), *rev'd on other grounds*, 312 N.E.2d 614 (1974); Lundahl v. Rockford Memorial Hosp. Ass'n, 93 Ill. App. 2d 461, 466, 235 N.E.2d 671, 674 (1968). At least one other court has also misinterpreted *Darling* in this fashion. *See* Hull v. North Valley Hosp., 159 Mont. 375, 385-86, 498 P.2d 136, 141 (1972).

However, this interpretation necessarily renders *Darling* inconsequential because the doctrine of respondeat superior would dictate hospital liability in such a circumstance. Comment, *The Hospital-Physician Relationship: Hospital Responsibility for Malpractice of Physicians*, 50 WASH. L. REV. 385, 414 (1975).

Most commentators agree that Dr. Alexander was not a hospital employee and thus the doctrine of respondeat superior was not the basis for hospital liability. *See, e.g.*, O'Sullivan & Wing, *The Hospital-Based Physician: Current Status and Significance*, J. LEGAL MED., May-June, 1973, at 20, 23; Southwick, *The Hospital as an Institution—Expanding Responsibilities Change Its Relationship with the Staff Physician*, 9 CAL. W.L. REV. 429, 447 (1973); Zaslow, *A New Reason for Liability*, *supra* note 6, at 21.

50. *See* text accompanying notes 10-12 *supra*.

51. This delegation by the governing body to the medical staff is authorized by

comes an "agent" or "arm of the hospital."[52] If the staff negligently performs these duties, the hospital is legally responsible.[53]

A critical examination of both the duty to supervise medical care and the duty to select and retain only competent staff physicians will illustrate that not only are hospitals not the most logical defendants but also, in terms of public policy, hospitals are not the most desirable defendants.

Duty to Supervise Medical Care

The governing body[54] of a hospital has the ultimate responsibility for the quality of patient care rendered in a hospital.[55] The presumption is that "[p]resent day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. . . . Certainly, the person who avails himself of 'hospital facilities' expects that the hospital will attempt to cure him, not that its [staff physicians,] nurses or other employees will act on their own responsibility."[56] However, the board of trustees and the administration of a hospital are composed primarily of laymen from the community that is served by the hospital.[57] The lay members of the governing body are medically and legally in-

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the Joint Commission on Accreditation of Hospitals (JCAH). *See* ACCREDITATION MANUAL, *supra* note 2, at 53.

This delegation creates further confusion regarding the legal basis for corporate hospital liability. This delegation would seem to dictate, and the JCAH so acknowledges, that the medical staff, not the corporate hospital, has the overall responsibility for the quality of all medical care provided to patients. *Id.* at 81.

52. *See* Mitchell County Hosp. Auth. v. Joiner, 229 Ga. 140, 142, 189 S.E.2d 412, 414 (1972); Southwick, *The Hospital as an Institution—Expanding Responsibilities Change Its Relationship with the Staff Physician*, 9 CAL. W.L. REV. 429, 437 (1973) (the medical staff is an agent of the corporate hospital); Comment, *The Hospital-Physician Relationship: Hospital Responsibility for Malpractice of Physicians*, 50 WASH. L. REV. 385, 413-14 (1975) (the medical staff is an arm of the corporate hospital).

53. *See* Purcell v. Zimbelman, 18 Ariz. App. 75, 81, 500 P.2d 335, 341 (1972); Copeland, *Hospital Responsibility for Basic Care Provided by Medical Staff Members: "Am I My Brother's Keeper?"*, 5 N. KY. L. REV. 27, 39 (1978); Southwick, *The Hospital as an Institution—Expanding Responsibilities Change Its Relationship with the Staff Physician*, 9 CAL. W.L. REV. 429, 453 (1973); Comment, *The Hospital-Physician Relationship: Hospital Responsibility for Malpractice of Physicians*, 50 WASH. L. REV. 385, 414 (1975).

54. The governing body of a hospital is ordinarily the board of trustees or board of directors. *See* Moore, *Medical Staff—Corporate Accountability*, 43 INS. COUNSEL J. 110, 110 (1976); Southwick, *The Hospital's New Responsibility*, 17 CLEV.-MAR. L. REV. 146, 146 (1968).

55. *See* Horty & Mulholland, *The Legal Status of the Hospital Medical Staff*, 22 ST. LOUIS U.L.J. 485, 490 (1978); Moore, *Medical Staff—Corporate Accountability*, 43 INS. COUNSEL J. 110, 114 (1976).

56. Bing v. Thunig, 2 N.Y.2d 656, 666, 143 N.E.2d 3, 8, 163 N.Y.S.2d 3, 11 (1957).

57. ACCREDITATION MANUAL, *supra* note 2, at 47; O'Sullivan & Wing, *The Hospital-Based Physician: Current Status and Significance*, J. LEGAL MED., May-June, 1973, at 20, 23; Note, *Physician-Hospital Conflict: The Hospital Staff Privileges Con-*

capable of passing judgment on the quality of medical treatment rendered by trained physicians.[58]

Because it is illogical to presume lay trustees and administrators are competent to supervise the medical activities of physicians,[59] the overall responsibility for the quality of medical care is delegated to the organized medical staff.[60] Under *Darling* and its progeny, hospitals must blindly trust their medical staffs to carry out this delegated duty.[61] The *Darling* and *Pederson* cases[62] are sobering illustrations that a hospital's faith in its medical staff may be unrewarded.

Additionally, when a hospital is held liable under the corporate negligence doctrine, the hospital's customary remedies may be severely limited. For example, because implied indemnity principles apply in the medical malpractice area as in traditional tort law,[63] the hospital clearly can proceed against the individual negligent doctor for indemnification subsequent to paying a judgment entered against it. However, as a practical matter, this remedy is of little value to a hospital in the numerous cases in which the judgment greatly exceeds the uninsured or minimally insured physician's personal assets.[64]

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troversy in New York, 60 CORNELL L. REV. 1075, 1077 (1975); 8 RUT.-CAM. L.J. 177, 181 n.27 (1976).

58. Lescoe, *Regulation of Health Care by Medical Staff Bylaws*, J. LEGAL MED., Feb., 1977, at 17, 18; Rapp, *Darling and Its Progeny: A Radical Approach Toward Hospital Liability*, 60 ILL. B.J. 883, 885 (1972). *Cf.* Appleman, *The Darling Case—A "Real" Tiger?*, 1975 INS. L.J. 714, 716-17 (only physicians who have spent many years in the practice of medicine are competent to judge whether another physician has acted with due care).

59. Comment, *The Hospital-Physician Relationship: Hospital Responsibility for Malpractice of Physicians*, 50 WASH. L. REV. 385, 413 (1975).

60. ACCREDITATION MANUAL, *supra* note 2, at 81; 8 RUT.-CAM. L.J. 177, 181 n.27 (1976).

61. *See* Mills, *Corleto in Perspective*, J. LEGAL MED., Feb., 1977, at 3, 3.

In Purcell v. Zimbelman, 18 Ariz. App. 75, 500 P.2d 335 (1972), the department of surgery was delegated the duty of supervising the surgical doctors. The staff was negligent in not taking any action against Dr. Purcell or recommending to the board of trustees that action be taken. *Id.* at 81, 500 P.2d at 341. The hospital was held liable for the staff's breach of their delegated duty.

62. *See* text accompanying notes 17-30 *supra*.

63. *See* Oster, *Medical Malpractice Insurance*, 45 INS. COUNSEL J. 228, 228 (1978). *See also* Greenstone, *Spreading the Loss—Indemnity, Contribution, Comparative Negligence and Subrogation*, 13 FORUM 266, 275-76 (1977-78).

64. The decision of whether or not to procure malpractice insurance is a personal one for every physician. However, hospitals in several jurisdictions now have legislative or judicial authority to require staff physicians to maintain professional liability insurance as a condition of staff membership. *E.g.*, Pollock v. Methodist Hosp., 392 F. Supp. 393 (E.D. La. 1975); Holmes v. Hoemako Hosp., 117 Ariz.

Duty to Select and Retain Only Competent Staff Physicians

The governing body of a hospital has the authority and responsibility for appointing members of the medical staff.[65] Obviously, the task of processing and evaluating the applications of physicians applying to the hospital for privileges must necessarily be delegated to the medical staff.[66] The lay members of the board of trustees and directors are not qualified to evaluate the credentials of physician applicants. Accordingly, when a physician applies to a hospital for staff privileges, the application procedure typically involves three steps.[67] Initially, all applications are sent directly to the hospital's credentials committee. Composed of staff physicians, the committee reviews and evaluates the applicant's standing in the medical community, primarily by referring to the completed application form and the accompanying letters of reference.[68] The file then is forwarded to the staff executive committee for further study of the applicant's medical qualifications. Once these two committees agree that the applicant should be granted staff privileges, their recommendation is forwarded to the hospital governing board for final ratification.[69]

Because the ultimate determination of whether a physician applicant receives staff privileges rests with the board of directors or trustees, it might reasonably be assumed that the board independently reviews, studies, and investigates the applications for admission referred to it by the medical staff. In fact, the board simply "rubber-stamps" the recommendations of the credentials committee and the executive committee.[70] Whomever the com-

403, 573 P.2d 477 (1978); CAL. HEALTH & SAFETY CODE § 1319 (West 1979). *Cf.* Jones v. State Bd. of Medicine, 97 Idaho 859, 555 P.2d 399 (1976), *cert. denied*, 431 U.S. 914 (1977); Schneider v. Liggett, 223 Kan. 610, 576 P.2d 221, *appeal dismissed*, 439 U.S. 808 (1978) (state statute requiring professional liability insurance as a condition for rendering medical services within the state is not violative of due process or equal protection). *But see* McGuffey v. Hall, 557 S.W.2d 401 (Ky. 1977) (state statute requiring physicians to acquire malpractice insurance as a condition to practicing medicine within the state is unconstitutional).

65. ACCREDITATION MANUAL, *supra* note 2, at 53; Moore, *Medical Staff—Corporate Accountability*, 43 INS. COUNSEL J. 110, 110 (1976).

66. *See* ACCREDITATION MANUAL, *supra* note 2, at 53.

67. Note, *Physician-Hospital Conflict: The Hospital Staff Privileges Controversy in New York*, 60 CORNELL L. REV. 1075, 1076 (1975).

68. *Id.*

69. *Id.* at 1077.

70. Through a 1979 confidential survey of medical staff coordinators at major Southern California hospitals, the author has learned that the hospital board accepts and complies with the credentials and executive committees' recommendations in virtually 100% of all cases. A typical example was found in a San Diego area hospital. In the 13 years that the medical staff coordinator had been employed by the hospital, the board had never failed to comply with committee recommendations. The board does no independent investigation. The committees

mittees approve to the board are granted staff privileges.[71] Thus, the responsibility for deciding who is accorded privileges actually rests squarely upon members of the medical staff. Therefore, it is not logical to subject the hospital to primary liability for the negligent recommendations of the staff concerning initial staff appointments.

The *Darling* line of cases effectively requires hospitals to monitor appointments to their medical staffs and, if warranted, to revoke or restrict privileges which previously have been granted.[72] Yet under current medical practice, hospitals are not free to withhold or reduce staff privileges at will.[73] Procedural due process considerations severely limit a hospital's power to unilaterally terminate any physician's opportunity to pursue his livelihood through the use of hospital facilities.[74]

For example, the California Supreme Court recently held that a physician may not be removed from or denied reappointment to a hospital medical staff absent the minimum requirements of procedural due process.[75] In an analogous case, the New Jersey rule—that a hospital must accord a physician a full hearing before rejecting his initial application for staff appointment—was con-

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reject one or two applications per month and these rejected applications are not even sent to the board for its assent.

Even more surprising is that the committees themselves do little investigation. They rely primarily on the completed hospital application form and the accompanying letters of reference. If the applicant fails to admit to prior instances of misconduct or malpractice, there is a substantial chance that the committee will not check the hospitals with whom the doctor was previously associated to determine if the application's questions were answered honestly.

The author contends that because staff members accept the delegated duty to screen physician applicants, they should perform the task diligently or risk personal liability.

71. *See id.*

72. Slawkowski, *Do the Courts Understand the Realities of Hospital Practices?*, 22 ST. LOUIS U.L.J. 452, 460 (1978).

73. *Id.*

74. *See* Hirsh, *A Fish Without Water: Hospital Admitting Privileges*, CASE & COMMENT, July-Aug., 1979, at 18, 18; Comment, *Hospital Medical Staff Privileges: Recent Developments in Procedural Due Process Requirements*, 12 WILLAMETTE L.J. 137, 139-50 (1975-76).

For further discussion of the conditions of modern medicine which make the effect of expulsion from a hospital medical staff potentially disastrous for a physician, see Moore v. Board of Trustees, 88 Nev. 207, 495 P.2d 605, *cert. denied*, 409 U.S. 879 (1972) (dissenting opinion).

75. Anton v. San Antonio Community Hosp., 19 Cal. 3d 802, 567 P.2d 1162, 140 Cal. Rptr. 442 (1977).

firmed.[76] These cases signify that hospitals must be prepared for potential litigation whenever attempts are made to terminate the privileges of a suspected or known malpractitioner.[77] Although courts may have been unwilling to interfere with the negative decisions of a hospital board during the early development of the corporate negligence doctrine, this basic assumption is no longer valid.[78]

One Proposed Solution

This Comment has thus far suggested that holding a hospital liable for the negligent performance of one of its independent contractor physicians is confusing and insensitive to the realities of hospital structure. At least one court has placed "the responsibility for medical staff function directly on the medical staff," rather than imposing a fictional duty of control upon the hospital.[79] In *Corleto v. Shore Memorial Hospital*,[80] a malpractice suit was filed against a staff physician who negligently performed abdominal surgery on plaintiff's decedent.[81] The plaintiff also named the hospital and the *entire medical staff* as defendants on the ground that they knew or should have known that the doctor was not competent to perform such a surgical procedure. The New Jersey court, acknowledging the doctrine of corporate hospital liability, denied the hospital's motion to dismiss the complaint for failure to state a cause of action. In addition, the court denied the 141-member medical staff's motion to dismiss.[82] The court held that a cause of action may exist against an entire medical staff when any staff physician is negligent.[83]

The imposition of liability upon the medical staff for the misconduct of a staff member appears to be more logical than corpo-

76. Garrow v. Elizabeth Gen. Hosp., 155 N.J. Super. 78, 382 A.2d 393 (1977), *modified*, 79 N.J. 549, 401 A.2d 533 (1979).

77. Slawkowski, *Do the Courts Understand the Realities of Hospital Practices?*, 22 St. Louis U.L.J. 452, 464 (1978).

78. Hirsh, *A Fish Without Water: Hospital Admitting Privileges*, Case & Comment, July-Aug., 1979, at 18, 18.

79. Mills, *Corleto in Perspective*, J. Legal Med., Feb., 1977, at 3, 4.

80. 138 N.J. Super. 302, 350 A.2d 534 (1975).

81. Plaintiff's complaint alleged that his decedent was subjected to malpractice which led to the decedent's death. *Id.* at 305, 350 A.2d at 535. The court, in deciding whether to grant or deny the defendants' motion to dismiss, assumed the allegations of the complaint could be substantiated at a future trial. *Id.* at 309, 350 A.2d at 538.

82. *Id.* at 312, 350 A.2d at 539.

83. Corleto v. Shore Memorial Hosp., 138 N.J. Super. 302, 309, 350 A.2d 534, 539 (1975); Williams, *The Quandary of the Hospital Administrator in Dealing with the Medical Malpractice Problem*, 55 Neb. L. Rev. 401, 416 (1976); Zaslow, *A New Reason For Liability*, *supra* note 6, at 20.

rate hospital liability.[84] However, this theory also has defects. The *Corleto* theory of staff responsibility overlooks the practicalities of hospital organization and medical practice in much the same manner as the *Darling* line of cases.[85] For example, in the *Corleto* hospital, it is highly unlikely that all 141 physicians knew of, or even had heard of, one another. It is also improbable that, as a group, these physicians were aware of the misconduct of any given staff physician. Every physician on a medical staff cannot be responsible for monitoring the practice of each of his colleagues.[86]

The plaintiff's attorney may have named the entire medical staff simply as a tactic to coerce settlement.[87] If this was his intention, he succeeded. The case was settled out of court before the claim of staff negligence was litigated on the merits.[88]

A BETTER SOLUTION

Those few doctors whose practices bring them into frequent professional contact with the offending physician or the particular doctors who serve on mandatory hospital review committees are more likely to notice instances of negligence than are the members of the entire medical staff. All hospitals accredited by the Joint Commission on Accreditation of Hospitals are required to establish and maintain various committees to review specific aspects of the practice of medicine within the institution.[89]

84. Mills, *Corleto in Perspective*, J. LEGAL MED., Feb., 1977, at 3, 4.

85. *See* Zaslow, *A New Reason For Liability*, *supra* note 6, at 22.

86. *Id.*

87. Horty & Mulholland, *The Legal Status of the Hospital Medical Staff*, 22 ST. LOUIS U.L.J. 485, 500 (1978).

The author submits that this tactic of naming the entire medical staff should be considered abuse of process. The names of individual physicians and review committee members easily can and should be acquired through fundamental attorney investigation. *See* Zaslow, *A New Reason For Liability*, *supra* note 6, at 22.

88. *See* Horty & Mulholland, *The Legal Status of the Hospital Medical Staff*, 22 ST. LOUIS U.L.J. 485, 485-87 (1978). The procedural aspects of *Corleto* are instructive. Plaintiff alleged the medical staff was negligent for failing to protect the patient from a known incompetent surgeon. The medical staff moved to dismiss urging that an unincorporated association is not amenable to suit under local statute. The effect of the court's denial of the staff's motion to dismiss was that the case proceeded through discovery towards trial. While both parties were preparing for trial, the insurance company representing the staff physicians settled with the plaintiff for the full amount of the policy limits. Therefore, the plaintiff discontinued the suit and there was never a trial on the merits as to the liability of the medical staff. *Id.* at 486-87.

89. *See generally* ACCREDITATION MANUAL, *supra* note 2, at 87-96. Each medi-

Because actual notice should be the primary consideration in establishing the liability of passive staff physicians,[90] the logical alternative to the corporate negligence doctrine would be to hold liable those medical committee members who are responsible for processing and assessing the credentials of hospital staff applicants and those physicians who are charged with review, analysis, and evaluation of clinical performance.[91] A doctor does not become grossly incompetent overnight. Even though some major act of malpractice finally brings him and his work into legal question, evidence at trial typically demonstrates that there has been a pattern of negligence developing for years.[92] The committee members who previously reviewed such acts of negligence and intimate co-workers who were silently aware of his carelessness have actual knowledge sufficient to hold them judicially responsible for their inaction. In addition, this knowledge is seldom communicated to the governing body so as to put the hospital on actual notice.[93] Yet the doctrine of corporate hospital liability focuses liability on the hospital.[94]

There are two primary purposes behind imposing liability for

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cal committee is organized for a definite purpose. For example, a tissue review committee is established to review the results and complications of surgery performed in the hospital. A utilization committee, among other things, serves to detect abnormal patterns of medical practice and services within the hospital. These and other committees are composed of members of the medical staff and they meet on a regular basis to carry out their assigned functions.

90. *See* text accompanying notes 84-86 *supra.*

91. *See* Horty & Mulholland, *The Legal Status of the Hospital Medical Staff*, 22 ST. LOUIS U.L.J. 485, 498 n.67 (1978); Zaslow, *A New Reason For Liability*, *supra* note 6, at 22.

92. Williams, *The Quandary of the Hospital Administrator in Dealing with the Medical Malpractice Problem*, 55 NEB. L. REV. 401, 405 (1976).

93. *See id.* at 406.

94. Veracious judges candidly admit the corporate hospital's duty of control is purely fictional. For example, in the tragic case of Gonzales v. Nork, Civil No. 228566 (Super. Ct. Sacramento County, Cal. Nov. 27, 1973), *rev'd for failure to grant jury trial*, 60 Cal. App. 3d 728, 131 Cal. Rptr. 717 (1976), *rev'd and retransferred to Court of Appeals for disposition on the merits*, 20 Cal. 3d 500, 573 P.2d 458, 143 Cal. Rptr. 240 (1978), Dr. John Nork was found to have operated needlessly and negligently on more than a score of patients. Much evidence was introduced demonstrating that many medical staff members were aware of Dr. Nork's flagrant incompetence and failed to report known instances of gross misconduct to the hospital board.

Although the court conceded that Mercy Hospital had no actual knowledge of Dr. Nork's propensity to commit malpractice, Judge Goldberg looked to other jurisdictions to conclude that Mercy Hospital was liable under the doctrine of corporate hospital liability:

> I accept the reasoning of the courts of Arizona, *Purcell v. Zimbelman*, 500 P.2d, 335, 341 (Ariz. App. 1972); Georgia, *Mitchell County Hospital Authority v. Joiner*, 189 S.E.2d, 412, 414 (Ga. 1972); Illinois, *Darling v. Charleston Community Memorial Hospital*, 211 N.E.2d, 253, 257 (Ill. 1965); Nebraska, *Foley v. Bishop Clarkson Memorial Hospital*, 173 N.W.2d, 881, 844 (Neb. 1970); New York, *Fiorentino v. Wenger*, 227 N.E.2d, 296, 299 (N.Y. 1967); and

tortious conduct: to compensate the plaintiff and to provide an incentive to the tortfeasor to act with due care in the future.[95] When hospitals are held liable for the misconduct of independent contractor physicians, the first aim is served; but, because only the medical staff has the knowledge and training to recognize and prevent the occurrence of future malpractice, subjecting hospitals to liability appears unnecessary.[96]

The imposition of corporate liability arguably creates an incentive upon hospitals to prevent the occurrence of negligence within their walls.[97] However, because the duties of selection and supervision are rightfully delegated to the medical staff and because staff knowledge is rarely imparted to the hospital administration, this prophylactic effect clearly would be greater if the appropriate staff members were threatened with liability for their own lack of due care.[98]

If the law merely holds the hospital liable for the negligence of the staff for failing to carry out its delegated duties, there is no more than a moral impetus on the staff members to discharge their obligations ambitiously.

CONCLUSION

A lawyer's fiduciary duty to his client mandates that all appro-

Nevada, *cf. Moore v. Board of Trustees of Carson-Tahoe Hosp.*, 495 P.2d, 605, 608 (Nev. 1972). . . .

> I have reached the conclusion that the hospital is liable with great reluctance, because I am sure that the Sisters of Mercy have done everything within their power to run a proper institution. But they, like every other governing board, are corporately responsible for the conduct of their medical staff. . . .
>
> As for the doctors on the Mercy staff, two thoughts keep going through my mind. The one is from Dr. Jones: "No one told anyone anything." The other is from Edmund Burke: "The only thing necessary for the triumph of evil is for good men to do nothing."

Id. at 194-95.

95. *See* W. PROSSER, THE LAW OF TORTS § 4, at 23 (4th ed. 1971).

96. Slawkowski, *Do the Courts Understand the Realities of Hospital Practices?*, 22 ST. LOUIS U.L.J. 452, 465 (1978).

97. Roemer, *Controlling and Promoting Quality in Medical Care*, 35 LAW & CONTEMP. PROB. 284, 297 (1970); Comment, *The Hospital's Responsibility for its Medical Staff: Prospects for Corporate Negligence in California*, 8 PAC. L.J. 141, 149 (1977). *But see* Warren, *The Discipline of Physicians*, J. LEGAL MED., Sept.-Oct., 1974, at 43, 44 (even with the new interest sparked in administrators and boards of trustees by the *Darling* case, hospitals are still lax with regard to supervision and selection of staff physicians).

98. *See* Williams, *The Quandary of the Hospital Administrator in Dealing with the Medical Malpractice Problem*, 55 NEB. L. REV. 401, 416 (1976).

priate potential defendants be named in the complaint to ensure that sufficient monetary recovery can be realized in the event legal liability is found.[99] However, the "shotgun" approach of naming the errant physician, the hospital, and the entire medical staff should be judicially disfavored.[100] Basic investigation can and should provide a plaintiff's attorney with the names of all medical staff and committee members who potentially were derelict in the performance of their delegated duties of staff selection and supervision.[101]

Liability for failure to assure quality medical care should be fixed directly on the medical staff. In the usual case, only physicians have the ability and training to recognize another physician's negligence.[102] However, to allow the plaintiff to name the entire medical staff as a defendant is excessive and clearly extends beyond the reasonable expectations not only of medical staff members, but also of injured hospital patients. The most logical defendants are those physicians who are on actual notice of the primary defendant's incompetency.[103]

The legal basis underlying the fictional duty of control espoused by courts adopting the doctrine of corporate hospital liability is unclear. These courts have ignored basic procedural and organizational realities of hospital and medical practice that make the imposition of corporate liability unsound.[104] Judicial attempts to force hospitals to respond in damages for the actions of independent contractor physicians on medical staffs will continue to create doctrinal inconsistencies, procedural due process conflicts, and an unrealistic depiction of physician-hospital function and interaction.[105] Moreover, compelling hospitals to assume this fictional

99. Mills, *Corleto in Perspective*, J. LEGAL MED., Feb., 1977, at 3, 3.

100. Those patients who recklessly institute a malpractice action, either without probable cause or with some ulterior motive, should not be afforded the protection given by the judicial process to legitimate claims. Comment, *Physician Countersuits: Malicious Prosecution, Defamation and Abuse of Process as Remedies for Meritless Medical Malpractice Suits*, 45 U. CINN. L. REV. 604, 622 (1976). The impact of groundless medical malpractice claims on the courts and society is enormous. Birnbaum, *Physicians Counterattack: Liability of Lawyers for Instituting Unjustified Medical Malpractice Actions*, 45 FORDHAM L. REV. 1003, 1016 (1977). There are many doctors who believe that the medical malpractice insurance crisis has been caused largely by overzealous and unethical attorneys who institute meritless malpractice suits solely for their settlement value. *Id.* at 1004, 1006. A recent physician survey concluded that many baseless claims are settled rather than litigated because of the fear of purely sympathetic judgments by juries. *Id.* at 1008.

101. *See* Zaslow, *A New Reason For Liability*, *supra* note 6, at 22.

102. Appleman, *The* Darling *Case—A "Real" Tiger?*, 1975 INS. L.J. 714, 716-17.

103. *See* Zaslow, *A New Reason For Liability*, *supra* note 6, at 22.

104. Slawkowski, *Do the Courts Understand the Realities of Hospital Practices?*, 22 ST. LOUIS U.L.J. 452, 465 (1978).

105. *See id.* at 468.

duty of control will serve to increase the cost of health care to the public because of higher hospital insurance costs.[106] Finally, although it may be desirable to hold hospitals liable under the policy of maximum compensation to injured plaintiffs,[107] common sense, logic, and the practicalities of modern hospital operation dictate that holding liable those physicians who have been delinquent in reporting known incompetent doctors is the best way to encourage and assure the quality medical care to which the public is entitled.

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106. *See id.* The doctrine of corporate hospital liability effectively causes a hospital to become an insurer of the performance of its staff physicians. Comment, *The Hospital and the Staff Physician—An Expanding Duty of Care*, 7 CREIGHTON L. REV. 249, 261 (1974).

107. Injured plaintiffs are often eager to pursue the most heavily insured defendant under the "deep pocket" theory. Even when the negligent staff physician carries normally adequate insurance coverage, the hospital's coverage is much greater and is attractive to severely injured patients. Stanczyk, *The Hospital Dilemma—To Staff or Not To Staff*, 25 FED'N INS. COUNSEL 138, 148 (1974-75).