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Recommended Citation

Jonathan Kahn, *Hospital Malpractice Prevention*, 27 DePaul L. Rev. 23 (1977)
Available at: <https://via.library.depaul.edu/law-review/vol27/iss1/4>

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HOSPITAL MALPRACTICE PREVENTION

Jonathan Kahn*

Liability for hospital-caused patient injuries has evoked new industry responses in malpractice prevention. In this Article, the author reviews three major judicial decisions that have shaped these responses, and discusses the significant issues that hospitals must resolve when designing programs to prevent patient injuries. Mr. Kahn concludes that as adoption of such programs becomes widespread, the failure to establish internal systems of malpractice prevention could result in further risk of liability.

Hospital liability for faulty patient care is a risk that any hospital must closely and carefully consider. In 1976 there were about one billion contacts between the nation's approximately three million hospital personnel and hospital patients. Each of these personnel performed daily at least one act that, if negligently performed, would have put a patient's life and limb in jeopardy and possibly would have resulted in hospital liability.¹ One means for dealing with the omnipresent risk of liability is a comprehensive program that seeks to reduce or eliminate "the uncertainty of financial loss resulting from risks of a fortuitous nature."² This type of program often is termed "risk management." Through it, an institution seeks, first, to identify and classify loss risks and their potential frequency and severity. Second, it acts to eliminate or avoid identified risks through loss and liability prevention efforts. Third, it undertakes to select the most effective and economical means of pre-planning for a source of funds to use in case loss elimination and reduction are not fully effective.³

This Article is concerned only with one aspect of risk management, that is, measures taken *before* an accident to reduce patient injuries from faulty care.⁴ Recent developments in hospital corporate liability

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1. Yet it should be noted that, for 1976, there probably will have been only between 40,000 and 50,000 malpractice claims filed against hospitals. Interview with James L. Groves, Risk Manager, American Hospital Association, reported in *Hospitals Cautioned to Identify Areas of Problems Before Incident Occurs*, 10 FED. AM. HOSP. REV. 37-38 (Feb. 1977).

2. 1 TOPICS IN HEALTH CARE FINANCING: RISK MANAGEMENT 3 (No. 4, 1975).

3. *Id.*

4. Such measures are being utilized increasingly by hospitals and are associated with the trend toward hospital self-insurance and formation of "captive" insurers. In 1974 and 1975, as malpractice insurance losses began to soar, some insurers began to more than double their rates, with some rates increasing tenfold. Some insurers simply stopped offering coverage. As a result, there was an alarming escalation in premiums paid. In 1974 the nation's more than 6,000

are reviewed and analyzed, with particular attention to the legal responsibilities of hospitals to supervise medical staff that are not directly employed by the hospital. Then, turning to the practical methods that hospitals could adopt to fulfill these responsibilities, specific areas that a hospital should address in designing a malpractice

hospitals (excluding those operated by the Veterans Administration) paid approximately \$350,000,000 in malpractice premiums, and, in 1976, approximately \$750,000,000. This year total outlays will climb to around \$1,000,000,000. Many hospitals began funding for full or partial self-insurance; some grouped together with other hospitals to form their own insurance companies. At the same time many of these hospitals and others began adopting patient injury prevention programs to reduce potential liability and thereby lower insurance costs. Meyer, *Medical Malpractice Insurance Crisis May End Up Improving Hospital Care*, Wall St. J., Dec. 27, 1976, at 2, cols. 2-3. Cf. Ingrassia, *Problems of Insuring Medical Malpractice Show Signs of Abating*, Wall St. J., Apr. 19, 1977, at 1, col. 1. In fact, such programs had previously been strongly endorsed in U.S. DEP'T OF HEALTH, EDUCATION AND WELFARE, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE [hereinafter cited as MEDICAL MALPRACTICE REPORT] 61-63 (1973); cf. MEDICAL MALPRACTICE REPORT APPENDIX 497, 564-65, 567-68, 571, 577-79, 580, 585, 596, 599, 600-05 (description of some of the loss control programs then in existence). Currently, hospital associations in eight states (California, Louisiana, Maryland, Missouri, New York, Ohio, Pennsylvania, Texas) are helping member hospitals implement patient injury prevention programs; three states (Indiana, Massachusetts, Michigan) have plans to develop such programs but are not utilizing the direct assistance of the state hospital association. J. ASHBY, JR. & S. PEARSON, A STUDY OF PATIENT INJURY PREVENTION PROGRAMS §§ B.1-B.4 (1976).

An informal telephone survey, taken by the DePaul Law Review in August, 1977, of fifteen Chicago metropolitan area hospitals provides empirical evidence of the trend toward adoption of malpractice prevention programs. The survey consisted of three questions: (1) Does the hospital have such a program? (2) If so, how is it organized and operated? (3) Does the hospital carry professional liability (malpractice) insurance, or is it self-insured?

Generally, the results indicate that the city's teaching or public institutions (the hospitals surveyed having between 600 and 1400 beds, except one with just over 250 beds; AMERICAN HOSPITAL ASSOCIATION, GUIDE TO THE HEALTH CARE FIELD 67-69 (1977)) have or will soon become fully or partially self-insured. Accordingly, five of the seven have patient injury prevention programs in order to obtain reimbursement under the medicare regulations for the costs of self-insurance. See note 51 *infra*. A sixth stated that eventually a self-insurance program would be necessary and that, at present, it had an informal risk management program run by the administration. The last hospital refused to say anything more than that it was in the process of setting up such a program. In addition, the organization and operation of the programs tended to vary considerably, with two of the hospitals delegating management of the program to an outside company, one maintaining an in-house risk manager, and the others adopting a wide variety of approaches.

By comparison, five of the eight generally smaller community hospitals (all eight with under 300 beds, except a large suburban hospital having over 800 beds, AMERICAN HOSPITAL ASSOCIATION, GUIDE TO THE HEALTH CARE FIELD 67-69, 73 (1977)) indicated that they could still afford their liability insurance premiums and had made no effort to establish partial or full self-insurance. Therefore, their attention had not been directed to establishing additional safety programs or reorganizing existing ones in order to comply with the medicare reimbursement regulations. Only two hospitals stated that they were funding for self-insurance. (One refused to provide any specific information.) Yet the seven responding community hospitals had some form of program to monitor medical staff performance and reduce patient injuries. Two (both having some form of self-insurance) indicated that they utilized consulting services provided by private entrepreneurs, one, on-site examinations and reviews provided by its insurance carrier.

prevention program are pointed out. Concluding is a cautionary note that the failure to undertake any such program could result in further risk of liability.

HOSPITAL CORPORATE ACCOUNTABILITY

Any injury prevention program must be operated in recognition of the legal principles underlying hospital liability for deficient patient care.⁵ In particular, two important interrelated developments in the last several years should be noted: departure from the "locality rule," and the introduction of liability for non-salaried independent staff.

The traditional rule is that liability will not be imposed upon a hospital unless it falls short of that degree of care, skill, and diligence shown by other hospitals in the same community or locality.⁶ The developing doctrine is that the trier of fact, in determining whether a hospital acted negligently, may consider not only the standards followed by other hospitals in the same locality or similar communities,⁷ but also regulations and guidelines issued by government agencies and medical and hospital associations.⁸ The new test meets the two major criticisms leveled against the older locality rule: (1) that the rule enhanced the possibility that a small group by their laxness or carelessness might establish a local standard below that which the law should require; (2) that a scarcity of doctors in the community who are qualified or willing to testify about the local standard of care deterred lawsuits against hospitals for negligent injury.⁹ The practical

5. See generally D. LOUISELL & H. WILLIAMS, 1 MED. MALPRACTICE, ¶¶ 16.01-16.08 (1973); IIA HOSPITAL LAW MANUAL: PRINCIPLES OF HOSPITAL LIABILITY (1974) [hereinafter cited as HOSPITAL LAW MANUAL]; A. HOLDER, MED. MALPRACTICE LAW 200-18 (1975); Koskoff & Nadeau, *Hospital Liability: The Emerging Standard of Care*, 48 CONN. B.J. 305 (1974); Southwick, *The Hospital as an Institution—Expanding Responsibilities Change Its Relationship with the Staff Physician*, 9 CAL. W. L. REV. 429 (1973); 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: The Hospital Responsibility for Malpractice of Physicians*, 50 WASH. L. REV. 385 (1975).

6. See, e.g., *Cooper v. Providence Hosp.*, 272 Ala. 283, 284, 130 So.2d 8, 9 (1961) (consider same community). Cf. Annot., *Locality Rule As Governing Hospital's Standard of Care to Patient and Expert's Competency to Testify Thereto*, 36 A.L.R.3d 440 (1971).

7. See, e.g., *Avey v. St. Francis Hosp. & School of Nursing*, 210 Kan. 687, 694-99, 442 P.2d 1013, 1020-22 (1968) (similar communities).

8. See, e.g., *Darling v. Charleston Community Mem. Hosp.*, 33 Ill.2d 326, 211 N.E.2d 253 (1965), cert. denied, 383 U.S. 946 (1966); *Purcell v. Zimelman*, 18 Ariz. App. 75, 500 P.2d 335 (1972); *Gonzales v. Nork & Mercy Hosps.*, No. 228566 (Super. Ct. of Cal., Sacramento County, filed Nov. 19, 1973), rev'd and remanded on other grounds sub nom. *Gonzales v. Nork*, 60 Cal. App.3d 728, 131 Cal. Rptr. 717 (1976).

9. See, e.g., *Pederson v. Dumouchel*, 72 Wash.2d 73, 77-78, 431 P.2d 973, 977 (1967). The reluctance to testify is often identified as the "conspiracy of silence." C. GREGORY & H. KALVEN, JR., *CASES AND MATERIALS ON TORTS* 149 (2d ed. 1969).

result of eliminating the locality rule is to require hospitals to meet nationally developed standards of health care.

The second area of change relates to the personnel whose activities may give rise to hospital liability. In certain jurisdictions hospitals have been insulated from liability under statutory and common law rules of governmental and charitable immunity.¹⁰ Where immunity does not apply, however, hospitals have been held financially responsible for patient injuries resulting from its personnel's acts or omissions. Causes for such liability have included deficiencies in hospital equipment,¹¹ physical condition of premises,¹² supplied drugs,¹³ and the acts or omissions of employed physicians and other employees, including nurses, interns, orderlies, and student assistants.¹⁴ The treatments, diagnoses, and occurrences that could give rise to liability under these traditional doctrines are as wide and varied as is medical practice itself.¹⁵ In recent years hospitals have been held accounta-

10. For a state-by-state analysis, see II HOSPITAL LAW MANUAL, *supra* note 5, in the chapter entitled *Immunities to Suit*.

11. IIA HOSPITAL LAW MANUAL, *supra* note 5, at § 1-1.

12. *Id.* at § 1-2.

13. *Id.* at § 1-3.

14. *Id.* at §§ 2 to 2-3, 1 MED. MALPRACTICE, *supra* note 5, at ¶¶ 16.05, 16.07.

15. 2 MED. MALPRACTICE, *supra* note 5, at Appendix A (Malpractice Case Reference List).

Cf. Stivers v. George Washington Univ., 320 F.2d 751, 753-54 (D.C. Cir. 1963) (allegation of no informed consent to performance of bilateral arteriogram); *Kapuschinsky v. United States*, 284 F. Supp. 732, 737-44 (D.S.C. 1966) (staph infection transmitted by federal employee to premature newborn in government hospital nursery), Annot., 96 A.L.R.2d 1205 (1964) (hospital's liability for exposing patient to extraneous infection or contagion); *Buzan v. Mercy Hosp., Inc.*, 203 So.2d 11, 11-13, 29 A.L.R.3d 1059 (Fla. Dist. Ct. App. 1967) (nurse's negligence in assisting operating surgeon; improper counting of sponges resulting in one being left inside patient after operation); *Edgar County Bk. & Tr. Co. v. Paris Hosp., Inc.*, 57 Ill.2d 298, 306, 312 N.E.2d 259, 263 (1974) (negligence in making hypodermic injection) (this subject is also discussed at Annot., 45 A.L.R.3d 731 (1972)); *Ball Mem. Hosp. v. Freeman*, 245 Ind. 71, 72, 196 N.E.2d 274, 275, 9 A.L.R.3d 567 (1964) (poisonous fluid labelled as novacaine and injected into patient); *Kastler v. Iowa Methodist Hosp.*, 193 N.W.2d 98, 99-100 (Ia. 1971) (patient with history of fainting spells fainted in shower, fell, and cut lip and broke jaw), Annot., 36 A.L.R.3d 1235 (1971) (hospital's liability to patient injured going to or using bathroom facilities); *D'Antoni v. Sara Mayo Hosp.*, 144 So.2d 643, 645-46 (La. App. 1962), Annot., 31 A.L.R.2d 1128, 1130-32 (1953) (forgetting to raise side rails of hospital bed); *Payne v. Garvey*, 264 N.C. 593, 594-95, 142 S.E.2d 159, 160-61 (1965) (injuries resulting from thermometer breaking and glass and mercury falling into patient's eye), Annot., 14 A.L.R.3d 1254 (1967) (defective equipment furnished by hospital for use in diagnosis or treatment of patient); *Sheehan v. North Country Community Hosp.*, 273 N.Y. 163, 165-66, 7 N.E.2d 28, 29 (1937) (hospital liable to patient for injuries received while being transported in hospital's ambulance) (subject also discussed at Annot., 21 A.L.R.2d 910, 915-16 (1952)); *Milner v. Huntsville Mem. Hosp.*, 398 S.W.2d 647, 651-52 (Tex. Ct. App. 1966) (heating pad did not have temperature locking device which would have prevented patient burns), Annot., 50 A.L.R.3d 1141 (1973) (injuries allegedly sustained from absence of particular equipment); *ZeBarth v. Swedish Hosp. Med. Ctr.*, 81 Wash.2d 12, 22-25, 29, 32, 499 P.2d 1, 8-9, 12-13, 52 A.L.R.3d 1067 (1972) (no informed consent obtained to radiation therapy used to treat Hodgkin's disease); *Kent v. Whitaker*, 58 Wash.2d 569, 570-71,

ble, not only for the negligence of employee staff physicians but also for the malpractice of independent, nonsalaried staff who had merely been given admitting and treating privileges. The emerging trend is to hold the hospital liable, regardless of the employee or nonemployee status of the physician, where the hospital has negligently failed to monitor and review medical services being provided within its walls. In other words, liability has been imposed because of the institution's negligence.

The case which sparked these twin developments is *Darling v. Charleston Community Memorial Hospital*,¹⁶ an Illinois Supreme Court decision in 1965. In that case, the facts leading to the court's decision against the hospital were simple and compelling. The plaintiff had fractured his leg playing in a college football game. He was taken to the hospital's emergency room and treated by Dr. Alexander, the on-call physician, who placed the leg in traction and in a plaster cast. Soon after, the toes, protruding from the cast, became swollen and dark in color and, eventually, cold and insensitive. Three days later, Dr. Alexander split the cast with an orthopedic saw and accidentally cut the patient's leg on both sides. Blood and other seepage oozed from the cuts. Darling was in the hospital for almost another two weeks until he was transferred to a different institution where the new treating physician was an orthopedic surgeon. Attempts were made to save the necrotic limb, but to no avail, and the leg had to be amputated eight inches below the knee. At the trial the orthopedic surgeon testified that the death of the tissue had resulted from interference to blood circulation caused by the pressure of a swelling and hemorrhaging leg against a tightly constructed plaster cast.¹⁷

Both Dr. Alexander and Charleston Community Hospital were sued. The plaintiff settled out of court with the doctor for \$40,000, and secured a judgment against the hospital in the amount of \$110,000.¹⁸ On appeal, the plaintiff argued that the hospital's negligence was established by its permitting Dr. Alexander to perform the orthopedic procedure involved in the case; by not requiring him to

364 P.2d 556, 557 (1961) (failure to prevent self-inflicted death by strangulation using plastic tube that was part of intravenous feeding apparatus after patient with known suicidal tendencies was admitted), Annot., 60 A.L.R.3d 880 (1974) (liability of hospital other than mental hospital for suicide of patient).

16. 33 Ill.2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966).

17. For a more complete summary of the testimony offered at trial than offered in the court's decision, see the appellate court's opinion at 50 Ill. App.2d 108, 200 N.E.2d 149 (1964).

18. 33 Ill.2d at 328-29, 211 N.E.2d at 255.

update his medical procedures; and by failing, through its medical staff, to supervise the case adequately, especially since the hospital had placed him on emergency duty; and by not requiring consultation by another physician once complications had developed. Moreover, the plaintiff cited the failure of the hospital's nurses to monitor his condition with sufficient care and frequency. Either the nurses were negligent in failing to report the patient's deteriorating systems to the hospital administrator, he was negligent in not reporting them to the medical staff, or the staff was negligent in not taking immediate action. Finally, the plaintiff argued that the hospital's own bylaws, state licensing regulations, and accreditation standards defined the hospital's duty to the patient, and that violation of them would result in liability for the patient's injury.¹⁹

The hospital countered with a defense based on the "locality" rule and argued that the plaintiff had not shown its conduct to be below the local standard of care. The hospital also contended that it was not an insurer of the patient's recovery, and that the only duty it owed patients relating to delivery of care by an individual physician was to exercise care in the initial selection of its medical staff. "When such care in the selection of the staff is accomplished, and nothing indicates that a physician so selected is incompetent or that such incompetence should have been discovered, more cannot be expected from the hospital administration."²⁰

In light of these opposing positions, the court characterized the issue as the significance to be afforded "evidence concerning the community standard of care and diligence, and also the effect to be given to hospital regulations adopted by the State Department of Public Health under the Hospital Licensing Act . . . to the Standards for Hospital Accreditation of the American Association, and to the bylaws of the defendant."²¹

The court said that custom is relevant in determining the standard of care because it indicates what is feasible, suggests a body of knowledge of which a party should be aware, and warns of the possible far-reaching consequences if a court requires a higher standard.²² But in response to these considerations, the court quoted the famous statement by Judge Learned Hand in *The T. J. Hooper*:²³

19. *Id.* at 329-30, 211 N.E.2d at 256.

20. *Id.*

21. *Id.* at 329-32, 211 N.E.2d at 256-57.

22. *Id.* at 331-32, 211 N.E.2d at 257.

23. 60 F.2d 737 (2d Cir. 1932).

Indeed in most cases reasonable prudence is in fact common prudence; but strictly it is never its measure; a whole calling may have unduly lagged in the adoption of new and available devices. It may never 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.²⁴

The court did not proceed to assess the protective adequacy of health care industry practices. The quotation from the Hand opinion was more in the nature of a warning. The court upheld the jury verdict and the judgment against the hospital on the ground that the evidence was sufficient for the jury to find that the hospital had been negligent.²⁵

Some courts have erroneously construed *Darling* as imposing liability on the hospital only for the negligence of doctors employed by it and not for the malpractice of staff members merely granted clinical and admitting privileges.²⁶ The fact is that the court never specifically addressed the question of liability for the negligence of non-employee physicians. The traditional rule is that a hospital can be held liable only for the negligence of its employees.²⁷ Under the

24. *Id.* at 740.

25. 33 Ill.2d at 333, 211 N.E.2d at 258. See also *Moore v. Board of Trustees*, 88 Nev. 207, 495 P.2d 605 (1972), in which the court noted:

Today, in response to demands of the public, the hospital is becoming a community health center. The purpose of the community hospital is to provide patient care of the highest possible quality. To implement this duty of providing competent medical care to the patients, it is the responsibility of the institution to create a workable system whereby the medical staff of the hospital continually reviews and evaluates the quality of care being rendered within the institution. The staff must be organized with a proper structure to carry out the role delegated to it by the governing body. All powers of the medical staff flow from the board of trustees, and the staff must be held accountable for its control of quality. The concept of corporate responsibility for the quality of medical care was forcibly advanced in *Darling v. Charleston Community Memorial Hosp.*, 33 Ill.2d 326, 211 N.E.2d 253 (1965), wherein the Illinois Supreme Court held that hospitals and their governing bodies may be held liable for injuries resulting from imprudent or careless supervision of members of their medical staffs. The role of the hospital vis-a-vis the community is changing rapidly. The hospital's role is no longer limited to furnishing of physical facilities and equipment where a physician treats his private patients and practices his profession in his own individualized manner.

Id. at 211-12, 495 P.2d at 608.

26. See, e.g., *Collins v. Westlake Community Hosp.*, 12 Ill. App.3d 847, 850-52, 299 N.E.2d 326, 328-29 (1973), *rev'd on other grounds*, 57 Ill.2d 388, 312 N.E.2d 614 (1974); *Lundahl v. Rockford Mem. Hosp. Ass'n*, 93 Ill. App.2d 461, 466-67, 235 N.E.2d 671, 674 (1968).

27. IIA HOSPITAL LAW MANUAL, *supra* note 5, at § 2-1. See, e.g., *Bulloch County Hosp. Auth. v. Fowler*, 124 Ga. App. 242, 245-47, 183 S.E.2d 586, 589 (1971) (negligence of an on-call, emergency room physician did not subject institution to liability because staff member

traditional test, the issue is the hospital's right to control the doctor's conduct in the performance of his duties.²⁸ If there is a right to control, the doctor is considered an employee; if not, an independent contractor. Generally, a hospital was not held liable for the wrongful conduct of a staff physician or surgeon because the doctor had a direct contractual relationship with the patient and, so the argument ran, the hospital had little, if any, power to control or supervise the doctor's methods in administering to his patient.²⁹

But in other recent decisions the malpractice of staff physicians, whether they are deemed employees or independent contractors, has given rise to hospital liability where the hospital is said to have breached its duty to supervise the selection, retention, and procedures of its staff. Illustrative of the trend is *Purcell v. Zimbelman*.³⁰ In that case the plaintiff was referred to Tucson General Hospital after seeing a doctor about bowel troubles. A staff general surgeon, Dr. Coy Purcell, initially diagnosed the condition as either cancer or diverticulitis of the large lower bowel, and subsequently performed a Babcock-Bacon proctosigmoidectomy or "pull-through" operation. As a result, plaintiff suffered from loss of sexual function, loss of a kidney, permanent colostomy and urinary problems. The testifying doctors were relatively unanimous in their opinion that a different operative procedure, an anterior resection, should have been performed. Two other of Purcell's patients with similar diagnoses had undergone "pull-through" operations where anterior resections were called for. These two patients, and two others, had sued the physician and the hospital. All four suits occurred prior to Purcell's treatment of the plaintiff.

The hospital claimed freedom from liability for Purcell's malpractice because he operated as an independent contractor and the hospital had no reason to believe that a specific act of malpractice would take place.³¹ In response, the court noted that the pertinent accreditation

was not an employee); *Cooper v. Sisters of Charity of Cincinnati, Inc.*, 27 Ohio St.2d 242, 253-54, 272 N.E.2d 97, 104 (1971).

28. IIA HOSPITAL LAW MANUAL, *supra* note 5, at § 2-1. Cf. W. PROSSER, HANDBOOK OF THE LAW OF TORTS 71 (4th ed. 1971); *Vanaman v. Milford Mem. Hosp., Inc.*, 272 A.2d 718, 722 (Del. 1970) (hospital would be liable for negligence of on-call, nonemployee staff surgeon acting in place of and for an unavailable salaried emergency room physician); *Mduba v. Benedictine Hosp.*, 52 App. Div.2d 450, 452-54, 348 N.Y.S.2d 527, 529-30 (1976) (dictum: hospital liable regardless of status of emergency room physician where hospital holds itself out to public as providing emergency room services and where hospital furnishes doctor; patient not bound by secret limitations contained in private contract between hospital and doctor).

29. IIA HOSPITAL LAW MANUAL, *supra* note 5 at § 2-1.

30. 18 Ariz. App. 75, 500 P.2d 335 (1972).

31. *Id.* at 83, 500 P.2d at 340-41.

standards of the American Osteopathic Association required the governing board to assume ultimate responsibility for the quality of patient care rendered in the institution and for the selection of the medical staff. The medical staff bylaws, approved by the governing board, contained a similar provision concerning the board's responsibility.³²

The court did not dispute the traditional notion that the hospital could be held vicariously liable for the physician's malpractice only if it exerted some type of control over the physician. The court found a significant element of control in the power of the modern hospital organization to indirectly affect or supervise a staff doctor's procedures through the threat of suspension or revocation of staff privileges. It pointed out that hospitals all over the country had review committees to regulate the privileges granted staff doctors and to insure that privileges were conferred only for those procedures for which the doctor was qualified. Generally, hospitals restricted or suspended privileges or required supervision when a doctor had demonstrated an inability to administer a certain type of treatment or procedure.³³

Finally, the *Zimbelman* court emphasized the importance of a hospital properly acting upon information it acquires concerning a physician's competence. Although information concerning two of the prior lawsuits had been presented to the Department of Surgery, a group of independent physicians on the professional staff, the department had not taken any action against Dr. Purcell and had not recommended to the board of trustees that his privileges be restricted or suspended.³⁴ In light of the pertinent accreditation standards and the professional staff's bylaws, the court ruled that the department had been negligent,³⁵ and that the hospital would be charged with this negligence and held liable for the resulting injuries.³⁶

The widely-publicized case of *Gonzales v. Nork & Mercy Hospitals*³⁷ squarely posed the issue of whether a hospital could be found

32. *Id.* at 84-85, 500 P.2d at 341.

33. *Id.*,

34. *Id.*

35. *Id.*

36. *Id.* at 95, 500 P.2d at 351. *Cf. Jeffcoat v. Phillips*, 534 S.W.2d 168, 172-73 (Tex. Civ. App. 1976) (holding that the hospital would not be liable for a negligently performed appendectomy by a nonemployee surgeon since there were no accreditation requirements that the hospital's governing authority screen doctors granted hospital privileges, and where the patient's mother had an on-going relationship with the doctor and knowledge of his performance as a surgeon, employing him to perform the appendectomy 16 months after he had performed a similar operation on her daughter).

37. No. 228566 (Super. Ct. of Cal., Sacramento County, filed Nov. 19, 1973).

liable despite compliance with applicable laws and hospital standards, such as those promulgated by the Joint Commission on Accreditation of Hospitals. In neither *Darling* nor *Zimbelman* were the courts faced with a situation where the hospital had complied with the relevant statutes and standards. In *Gonzales* the Superior Court of California concluded that there could be liability despite good-faith compliance.

The co-defendant, Dr. John Nork, had been trained in orthopedic surgery and had been practicing in Sacramento six years when the plaintiff, Albert Gonzales, first visited him complaining of back and neck pains resulting from a car accident. Dr. Nork performed a laminectomy on Gonzales which he admitted at trial was unnecessary and incompetently performed. The operation rendered Gonzales a partial invalid with chronic back pain and other physical and psychological difficulties.

Evidence was introduced as to about fifty operations performed by Dr. Nork on thirty-eight patients.³⁸ All of these surgeries were unnecessary or incompetently performed, or both, and most were similar to the surgery Dr. Nork had performed on the plaintiff. Thirteen of these operations had antedated Dr. Nork's work on Gonzales.³⁹ Two of Dr. Nork's other patients had sued him and the hospital prior to filing of the Gonzales complaint. Generally, Dr. Nork avoided non-surgical, conservative care, operated on the basis of inadequate or falsified diagnoses, terrorized and deceived patients to obtain their consent to surgery, avoided consultation with other doctors and discouraged his patients from doing so, falsified progress records, and illustrated a level of technical competence demonstrative of gross ignorance. Yet the hospital had no actual knowledge of Dr. Nork's crippling incompetence or his unethical practices. It was not until May 1970, when the hospital administrator heard a rumor, subsequently verified, that Dr. Nork's malpractice insurance had been cancelled, that the hospital prohibited him from operating without another supervising surgeon present. Nork did not perform further back surgery at Mercy after June 1970 and soon resigned from the staff.

The doctor was held liable for compensatory and punitive damages for conduct that, in the court's words, went "beyond depravity."⁴⁰ The hospital raised two defenses to the charge that it could be held vicariously liable for Dr. Nork's malpractice: first, that it could not be held responsible for the torts of its independent medical staff; and

38. *Id.* at 8.

39. *Id.*

40. *Id.* at 142.

second, that it not only conformed to industry standards but went beyond them.⁴¹

In response, the court ruled that the hospital could be held liable, regardless of Dr. Nork's status as an independent physician. The fact that it had complied with its statutory obligation to have a medical staff that was self-governing and independent did not immunize it from liability. The governing board was ultimately responsible for assuring that the methods employed by the staff, whether or not composed of independent physicians, reasonably could be relied upon to uncover and prevent a doctor's malpractice.⁴² The hospital's compliance with Joint Commission standards requiring it, through its medical staff, to operate a system of peer review of treatment would not provide immunity either. "Here Mercy cannot be said to have reasonably relied on its medical staff to detect fraud, because the 'peer review' of its staff was incapable of detecting fraud."⁴³ Further, the hospital had negligently failed to utilize information available to it, indicating risks to Dr. Nork's patients. In the instance of one patient, Arthur Freer, Dr. Nork had reported a postoperative complication to the hospital, and the patient had sued him and the hospital in June 1963. The case was voluntarily dismissed shortly thereafter. But no proper review of the surgery was made. In another case, the hospital's pathologist (retained by contract) failed to report his findings, as was required under the medical staff bylaws, concerning nerve fibers excised by Dr. Nork during surgery. His analysis indicated a discrepancy between the postoperative diagnosis and the preoperative diagnosis offered by Dr. Nork. During another laminectomy, a specially-trained assistant was medically necessary and required under the hospital's Department of Surgery rules and regulations to hold the nerve root retractor under the procedure being followed. Instead, a surgical nurse was left to substitute, but no notation of the

41. *Id.* at 143. Before the court issued its findings the hospital settled with the plaintiff for \$500,000 and did not appeal the judgment against it. *Gonzales v. Nork*, 60 Cal. App.3d 738, 131 Cal. Rptr. 717, 718 n.1 (1976). See also Comment, *The Hospital-Physician Relationship: Hospital Responsibility for Malpractice of Physicians*, 50 WASH. L. REV. 385, 415 n.153 (1976).

42. *Gonzales v. Nork & Mercy Hosps.*, No. 228566 (Super. Ct. of Cal., Sacramento County, filed Nov. 19, 1973), slip op. at 154-61.

43. *Id.* at 164. In particular, the Joint Commission system was criticized because it was: (1) predicated on the assumption that the doctor was reporting honestly and accurately; (2) subjective according to the personal standards of the reviewer; (3) random, bad cases being picked up only by chance; (4) infrequent; (5) uncritical and rushed; (6) made without a comparison of the doctor's progress records and nurses' notes; (7) completed without a protocol or profile of the doctor's deficiencies being made so that no common fund of knowledge was available to the hospital; and (8) performed in an atmosphere of hostility, with one witness referring to the social or club pressures on reviewers as well as economic pressures and threats of reprisal. *Id.* at 182-83.

improper departure was made by the surgical supervising nurse, a hospital employee.⁴⁴

Writing for the court, Judge Abbott Goldberg concluded:

The hospital has a duty to protect its patients from malpractice by members of its medical staff when it knows or should have known that malpractice was likely to be committed upon them. Mercy Hospital had no actual knowledge of Dr. Nork's propensity to commit malpractice, but it was negligent in not knowing. It was negligent in not knowing, because it did not have a system for acquiring knowledge; it did not use the knowledge available to it properly; it failed to investigate the Freer case, which would have given it knowledge; and it cannot excuse itself on the ground that its medical staff did not inform it

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 hospital governing board, are corporately responsible for the conduct of their medical staff Mercy is a culprit, but it is also a victim.⁴⁵

It is significant that in *Darling*, *Zimbelman*, and *Gonzales* strict liability was not imposed upon the hospitals for the failings of their medical staff. That is, the hospitals were not held liable regardless of whether they had mechanisms for reviewing and monitoring the selection, retention, and activities of hospital personnel.⁴⁶ Instead, liability was imposed where the hospitals had what the courts deemed inadequate means for detecting practices that might lead to patient injuries, and for taking prompt action upon information they had concerning actual or potential risks to a patient's health. These cases, in addition to numerous others, suggest that a hospital has a duty (1) to *acquire* and (2) to *use* information regarding risk-creating activities of hospital personnel and that it will be liable for patient injuries when it breaches this duty.⁴⁷ It is this two-fold duty involving both the

44. *Id.* at 187-93.

45. *Id.* at 194-95.

46. *Cf.* *Cunningham v. MacNeal Mem. Hosp.*, 47 Ill.2d 443, 266 N.E.2d 897 (1970) (hospital strictly liable for injury caused by blood transfusion infected with serum hepatitis). *See also* *McDonald v. Sacramento Med. Fdn. Blood Bk.*, 62 Cal. App.3d 866, 868-72, 133 Cal. Rptr. 444, 445-57 (1976) (California statute defining blood transfusion as a service rather than as a sale shielded blood donors and suppliers of contaminated blood from imposition of strict liability; statutory rule adopted in 42 states).

47. For example, in *Keene v. Methodist Hosp.*, 324 F. Supp. 233, 234-35 (N.D. Ind. 1971), a hospital was held liable for the negligent failure of an employee radiologist to bring to the attention of the attending physician, emergency room staff, or hospital administration the possibility of a patient's skull fracture and the need for further X-rays. The court noted that transmit-

acquisition and use of knowledge that provides the basis for hospital corporate accountability and necessitates the establishment of some form of risk-reporting and injury prevention mechanism.

tal of the information would probably have resulted in surgery preventing the brain damage that caused death. Tucson Med. Ctr., Inc., v. Misevech, 113 Ariz. 34, 36, 545 P.2d 958, 960 (1976) contained the dictum that if the medical staff was negligent in the exercise of its duty to supervise its members or in failing to recommend action to the hospital's governing body prior to patient's injury, the hospital may be liable. Mundt v. Alta Bates Hosp., 223 Cal. App.2d 413, 422-24, 35 Cal. Rptr. 848, 854-55 (1963), indicated that a hospital would be liable where the evidence was clearly sufficient to support the finding that, among other things, hospital nurses were derelict in their duty to observe the patient's leg and promptly report all unfavorable symptoms to the doctor in charge. Joiner v. Mitchell County Hosp. Auth., 125 Ga. App. 1, 1-5, 186 S.E.2d 307, 308-09 (1971), *aff'd*, 229 Ga. 140, 189 S.E.2d 412 (1972) imposed liability on a county hospital for negligent failure to require satisfactory proof of professional qualifications of staff physician. The fact that the doctor was licensed under Georgia law and recommended by other doctors on staff was insufficient to overcome allegation of hospital's negligence since hospital authorities knew or should have known that doctor was incompetent and unskilled. In Pettis v. State Dept. of Hosp., 336 So.2d 521, 529-32 (La. App. 1976), *aff'd as to liability issue*, 337 So.2d 527 (La. 1976), a state mental hospital was held liable for failure of nurses and attendants to inform doctors of patient's complaints of back and shoulder pain after receiving the first two electroconvulsive therapy treatments; a third and fourth set of shock treatments aggravated or caused injuries. Greenstein v. Meister, 279 Md. 301, 368 A.2d 451, 458-61 (1977), involved a post-operative patient with the following symptoms: rising pulse rate, persistent complaints of abnormal and excessive pain at site of bone graft, unusual swelling at site, complaints of feeling hot, excessive restlessness, elevated temperature, yellowish cast. The surgeon performing the graft informed the attending physician of symptoms and deceased's wife told the house physician of elevated temperature and other conditions. Antibiotics administered after delay were too late to save patient's life, and the hospital was held liable. In Kakligan v. Henry Ford Hosp., 48 Mich. App. 325, 329-33, 210 N.W.2d 463, 466-67 (1973) a violation of regulation promulgated by State Health Commission requiring a written hospital policy denoting when consultation should be held and recording of consultation was evidence of negligent procedure. The hospital in Hull v. North Valley Hosp., 159 Mont. 375, 388-91, 498 P.2d 136, 143-44 (1972), was not liable for staff surgeon's negligence in performing knee operation where the surgeon was not employed by it, where the hospital had no knowledge that a particular act of malpractice might occur, and where it reasonably relied upon information provided by its internal reviewing and monitoring process regulating the admission, conduct, and practice of medical staff. The Montana court noted, however, that the standards of hospital accreditation, state licensing regulations, and the hospital's bylaws indicated that the medical profession and other authorities regard it as desirable and feasible that hospitals assume certain responsibilities for patient care, and that the modern hospital's attempt to fulfill these duties is evidenced by the existence of the various boards, reviewing committees, and designations of privileges whose purpose is to control, supervise, and review the work within the hospital. In Foley v. Bishop Clarkson Mem. Hosp., 185 Neb. 89, 90-94, 173 N.W.2d 881, 881-84 (1970), there was a failure to take the history of a pregnant mother before delivery and failure by an intern to notify the attending physician of the patient's deteriorating condition some hours after childbirth; taking these steps probably would have led to treatment preventing the patient's death from massive "strep" infection. Violations of standards and regulations fixed by Nebraska State Department of Health and such organizations as the American Hospital Association were held admissible as proof of negligence. In Corleto v. Shore Mem. Hosp., 138 N.J. Super. 302, 305-12, 350 A.2d 534, 536-39 (1975), a motion to dismiss for failure to state a cause of action was denied where the complaint named the hospital, its board of directors, administrator, medical staff, and the treating doctor as defendants. There was an allegation that, among others, the medical staff knew or should have known that treating doctor was incompetent to perform a particular abdominal surgical proce-

MALPRACTICE PREVENTION

In many instances, the only way a hospital can acquire and use information concerning risks to patient safety is to implement formally an internal system designed to accomplish this end. The history of malpractice litigation is replete with examples of situations in which hospitals had available information indicating a possible risk to patients but either did not act upon it, or acted only after it was too late to avert the injury that gave rise to the suit. Of course, a structured system designed to detect and respond to risk-creating situations will not prevent all patient injuries from occurring. Nevertheless, such a program probably will result in fewer injuries than reliance upon an unstructured, informal system of information gathering.

Among the factors to be examined by a hospital when designing and evaluating its program to prevent patient injuries are: procedures for loss control programs outlined in various manuals and studies on the subject;⁴⁸ accrediting association standards and guidelines;⁴⁹ practices and precautions required by a hospital's bylaws, manuals,

dure. *Fiorentino v. Wenger*, 19 N.Y.2d 407, 414-15, 227 N.E.2d 296, 299 (1967), concerned a failure by a nonemployee surgeon to obtain informed consent to spinal jack operation. The court said that the hospital would not be liable for an omission to act unless it had reason to know that it should have acted within the duty it concededly had. In *Stack v. Wapner*, 368 A.2d 292, 294, 300 (Pa. Super. 1976), a patient received an intravenous injection of a drug used to induce labor by causing contractions of uterus. The labor room chart contained no notation that administration of the drug was constantly monitored as was required by current medical practice. Evidence supported the finding that failure to monitor administration of the drug led to heavy intrauterine bleeding and subsequent chain of events; patient underwent total hysterectomy and received blood transfusions, contracted infectious hepatitis, and received medication for hepatitis which resulted in partial hearing loss in both ears; nonemployee physicians and hospital liable. *Tonsic v. Wagner*, 220 Pa. Super. 468, 479-83, 289 A.2d 138, 143-45 (1972) (dissenting opinion), involved an attack upon hospital's failure to formulate rules and regulations governing standard procedure in operating room; clamp left in patient's abdomen after colectomy operation where no instrument count was taken, *rev'd and remanded on other grounds*, 458 Pa. 246, 329 A.2d 497 (1974). *Sparger v. Worley Hosp.*, 547 S.W.2d 582 (Tex. 1977), imposed liability for injuries resulting from employee nurses' failure to remove a sponge from patient's abdominal cavity after an operation, when the correct procedures for sponge count were detailed in hospital's policy and procedure manual; chief operating surgeon not liable.

48. FEDERATION OF AMERICAN HOSPITALS, *RISK MANAGEMENT MANUAL* (1977); MARYLAND HOSPITAL EDUCATION INSTITUTE, *CONTROLLING HOSPITAL LIABILITY: A SYSTEMS APPROACH* (1976); J. Ashby, Jr. & S. Pearson, *A STUDY OF HOSPITAL PATIENT INJURY PREVENTION PROGRAMS*. See also the special issues devoted to malpractice prevention, 51 *HOSPITALS* 53-74 (May 16, 1977); 10 *FED. AM. HOSP. REV.* 13-42 (1977); and Goldsmith & Bertolet, *In-Hospital Malpractice Prevention Program*, 4 *J. LEG. MED.* 11 (Sept. 1976).

49. See, e.g., JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, *ACCREDITATION MANUAL FOR HOSPITALS* (1976) and *SUPPLEMENT TO ACCREDITATION MANUAL FOR HOSPITALS* (1977); C. JACOBS & N. JACOBS, *THE PEP PRIMER: THE JCAH PERFORMANCE EVALUATION PROCEDURE FOR AUDITING AND IMPROVING PATIENT CARE* (2d ed. 1975) (manual for performing medical audit).

rules, regulations, and resolutions;⁵⁰ federal statutes, regulations and guidelines;⁵¹ state statutes requiring hospital loss control programs,⁵²

50. See, e.g., *Purcell v. Zimbelman*, 18 Ariz. App. 75, 500 P.2d 335 (1972) (hospital's professional staff bylaws put into evidence on issue of standard of care); *Gonzales v. Nork & Mercy Hosps.*, No. 228566 (Super. Ct. of Cal., Sacramento County, filed Nov. 19, 1973), slip op. at 190-93 (pathologist's violation of reporting requirements of medical staff bylaws, and employee nurse's failure to report surgeon's departure in violation of Department of Surgery rules and regulations, held to constitute negligence); *Darling v. Charleston Community Mem. Hosp.*, 33 Ill.2d 326, 211 N.E.2d 253 (1965) (hospital held not to have conformed to the requirements established by its bylaws). See also *Stack v. Wapner*, 368 A.2d 292, 297 (Pa. Super. Ct. 1976) (official hospital policy mandating patient chart entries when drug used to induce labor submitted into evidence); *Sparger v. Worley Hosp.*, 547 S.W.2d 582 (Tex. 1977) (hospital but not the chief operating surgeon held liable for injuries resulting from employee nurse's failure to remove a sponge from the patient's abdominal cavity after an operation; noted that the procedures for sponge count detailed in the hospital's policy and procedure manual not followed). Cf. *Lescoe*, *Regulation of Health Care by Medical Staff Bylaws*, 5 J. LEG. MED. 17, No. 2 (Feb. 2, 1977).

51. See, e.g., Medical Device Amendments of 1976, Pub. L. 94-295, 90 Stat. 539 (1976) (codified in scattered sections of 15, 21 U.S.C.) (relevant regulations appearing in various sections of 21 C.F.R. and 45 C.F.R. §§ 1840.1-1840.7 (1976)); Social Security Amendments of 1972, Tit. II, § 249F(b), 42 U.S.C. §§ 1320c to 1320c-19 (Supp. V 1975) (establishing unified national professional standards review organization (PSRO) program designed to conduct utilization review and to insure that medical care given to covered federal aid recipients is medically necessary and meets professionally recognized standards of quality of care); 42 C.F.R. §§ 101.1-101.2106 (1976) (PSRO regulations); OFFICE OF PROFESSIONAL STANDARDS REVIEW, U.S. DEP'T OF HEALTH, EDUCATION AND WELFARE PSRO PROGRAM MANUAL (1974); see also AMERICAN MEDICAL ASSOCIATION CRITERIA DEVELOPMENT PROJECT, SAMPLE CRITERIA FOR SHORT STAY HOSPITAL REVIEW: SAMPLE CRITERIA TO ASSIST PSROs IN QUALITY ASSURANCE (1976); Medicare Amendments to the Social Security Act of 1935, 42 U.S.C. §§ 426, 1395-1395ll (1970), as amended 42 U.S.C. §§ 1395b-1 to 1395pp (Supp. V 1975); (20 C.F.R. § 405.1011 to 405.1040) (1977) (medicare conditions of provider participation).

In particular, 20 C.F.R. § 405.451 (1977) states generally that all payments to providers must be for reasonable costs related to patient care. In response to the development of self-insurance programs by many hospitals during 1976, the Social Security Administration promulgated certain standards to clarify which self-insurance costs were reasonable and related to patient care and which, therefore, would be reimbursable under § 405.451. Cf. U.S. DEP'T OF HEALTH, EDUCATION AND WELFARE PROVIDER REIMBURSEMENT MANUAL, PART 1 §§ 2162-2162.13 (revisions effective April 1, 1977). Under § 2162.7(c) a provider will not be able to obtain reimbursement for self-insurance costs unless it has "an adequate risk management program to examine the cause of lossers and to take action to reduce the frequency and severity of them." The program must have the essential characteristics of programs required by insurers currently providing coverage against malpractice risks. "Therefore, a provider must have an ongoing safety program, professional and employee training programs, etc., to minimize the frequency and severity of malpractice and comprehensive general patient liability incidents."

See also the several law review articles discussing the extent to which physician compliance with the civil immunity clause of the PSRO amendments, 42 U.S.C. § 1320c-16(c) (Supp. V 1975), immunizes the doctor and hospital from liability; Comment, *PSRO: Malpractice Liability and the Impact of the Civil Immunity Clause*, 62 GEO. L.J. 1499, 1505-13 (1974); Note, *Federally Imposed Self-Regulation of Medical Practice: A Critique of the Professional Standards Review Organization*, 42 GEO. WASH. L. REV. 822, 837-42 (1974); Note, *The Professional Standards Review Organization: Its Impact on Medical Litigation*, 1975 UTAH L. REV. 443.

52. See, e.g., ALASKA STAT. § 19.20.075 (Cum. Supp. 1976); FLA. STAT. ANN. § 768.41 (West Supp. 1977), declared unconstitutional in *The Florida Medical Malpractice Joint Under-*

and other statutes, regulations,⁵³ and administrative determinations.⁵⁴ In attempting to establish a program that conforms to the

writing Association v. Shevin, No. 76-2792 (Leon County, Fla., Feb. 28, 1977); R. I. GEN. LAWS. § 23-16-4 (Supp. 1976). The Rhode Island statute is typical of the three and indicates the basic elements of any malpractice prevention effort:

Every hospital license[d] in this state and its insurance carrier shall cooperatively as part of their administrative functions establish an internal risk management program, which shall include at least the following components:

(1) an in-hospital grievance or complaint mechanism designed to process and resolve as promptly and effectively as possible grievances by patients or their representatives related to incidents, billing, adequacies in treatment, and other factors known to influence malpractice claims and suits. Such mechanism shall include appointment of a representative accountable to the hospital administration who shall anticipate and monitor on a day-to-day basis such grievances and administer said mechanism;

(2) the continuous collection of data by each hospital with respect to its negative health care outcomes (whether or not they give rise to claims), patient grievances, claims, suits, professional liability premiums, settlements, awards allocated and administrative costs of claims handling, costs of patient injury preventive and safety engineering activities, and other relevant statistics and information;

(3) medical care evaluation mechanisms, which shall include but not be limited to, tissue committees or medical audit committees, to review the appropriateness of procedures performed, to periodically assess the quality of medical care being provided at the institution and to pass on the necessity of surgery;

(4) education programs for the hospital's staff personnel engaged in patient care activities dealing with patient safety, medical injury prevention, the legal aspects of patient care, problems of communication and rapport with patients, and other relevant factors known to influence malpractice claims and suits.

Cf. ARIZ. REV. STAT. § 36-445 (Supp. 1977) (review of professional practices by medical staff required in order to improve patient care); MINN. STAT. ANN. § 11.692 (Supp. 1977) (state Board of Health shall publish recommendations for hospital in-service training programs designed to reduce malpractice claims).

53. In Illinois, *see, e.g.*, Abortion Act, ILL. REV. STAT. ch. 38, §§ 81-11 to -19 (1975); Birth Control Services for Minors Act, ILL. REV. STAT. ch. 91, § 18.7 (1975); Consent to Medical, Dental, or Surgical Procedure Act, ILL. REV. STAT. ch. 91, § 18.1-.5 (1975), *as amended* (Supp. 1976); Emergency Medical Treatment Act, ILL. REV. STAT. ch. 111-1/2, §§ 86-87 (1975), *as amended* (Supp. 1976); Hospital Licensing Act, ILL. REV. STAT. ch. 111-1/2, §§ 142-157 (1975), *as amended* (Supp. 1976); ILL. DEPT. OF PUBLIC HEALTH, HOSPITAL LICENSING ACT AND REQUIREMENTS (1976); Medical Practice Act, ILL. REV. STAT. ch. 91, §§ 1-16y (1975) *as amended* (Supp. 1976); Nursing Act, ILL. REV. STAT. ch. 91, § 35.32-.57 (1975), *as amended* (Supp. 1976); Physician's Assistants Practice Act, ILL. REV. STAT. ch. 91, §§ 211-229 (1975); Public Aid Code, Art. V. Medical Assistance, ILL. REV. STAT. ch. 23, § 5-5 (1975), *as amended* (Supp. 1976); Required Uterine Cancer Test Statute, ILL. REV. STAT. ch. 127, § 55.31 (1975). *See generally*, Davis v. Marathon Oil Co., 64 Ill.2d 380, 389-93, 356 N.E.2d 93, 97-98 (1976). This suit was brought by an oil bulk dealer against an oil company for injuries sustained in explosion which occurred after the dealer overfilled tanks of a service station. The court ruled that violation of administrative rules, regulations, and orders designed to protect human life or property should be considered *prima facie* evidence of negligence when they are validly adopted and have force of law. It stated that administrative regulations such as those promulgated by the Department of Law Enforcement, Division of Fire Prevention, are the result of an agency's expertise and are relevant evidence of applicable standards of care, and in so doing cited the *Darling* case.

54. Cf. *Comiskey v. Arlen*, 55 Div.2d 304, 390 N.Y.S. 2d 122, 130 (Sup.Ct. 1976) (recommendation of medical malpractice medication panel that no malpractice involved could be admitted into evidence in suit against physician and hospital).

applicable standard of care, the hospital may choose among a number of alternative approaches. Some of the issues that a hospital should consider are raised in recent books and journal articles on hospital loss control.⁵⁵ The discussion which follows examines five of the most significant issues that program planners should resolve.

Focus and Commitment

Potential liability for patient injuries is but one of the risks a hospital must consider in its risk management program.⁵⁶ Other risks include potential damage to or loss of hospital property or business⁵⁷ and potential liability for injuries to hospital personnel and visitors.⁵⁸ Focusing upon the problems of safety generally may help to eliminate risks common to patients, visitors, and employees (for example: uncovered needles left in rooms, wet or slippery floors, inadequate fire prevention and security measures) and will promote the development and utilization of procedures such as incident reporting. In short, coordination and integration of all aspects of hospital safety and security will enhance the protection afforded to patients, visitors and hospital personnel.

Another important question is the relationship between the loss reduction program and the hospital's quality assurance efforts. Already, many hospitals conduct internal assessments, audits, and reviews of the quality of care.⁵⁹ The procedures used in these programs will resemble and, in some cases, overlap with those used in loss control programs, but the emphasis in loss control is patient care improvement in order to minimize legal liability. In other words, the emphasis is upon the reduction or stabilization of hospital costs. As is true of the defensive diagnostic and treatment procedures ordered by

55. See note 48 *supra*.

56. RISK MANAGEMENT, *supra* note 2, at 5-54.

57. MED. MALPRACTICE LAW, *supra* note 5, at 189-96.

58. Safety and reporting requirements are imposed upon hospitals by the Occupational Safety and Health Act of 1970, 29 U.S.C. §§ 651-678 (1970); 29 C.F.R. §§ 1910.1-1910.1500 (1976) (OSHA standards). For a discussion of the special problems a hospital faces in creating a proper working environment for its employees, see generally, Bertz, diMonda, & Sprague, *Viewing the Hospital as a Working Environment*, 50 HOSPITALS 107, 109-112 (Oct. 16, 1976). Cf. NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH, U.S. DEP'T OF HEALTH, EDUCATION AND WELFARE VII HOSPITAL OCCUPATIONAL HEALTH SERVICES STUDY (1976).

59. Brook, Williams & Avery, *Quality Assurance in the 20th Century: Will it Lead to Improved Health in the 21st?*, in QUALITY ASSURANCE IN HEALTH CARE 1-29 (R. Egdahl & P. Gertman eds. 1976); INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMY OF SCIENCES, ASSESSING QUALITY IN HEALTH CARE: AN EVALUATION 25-55 (1976); Brook, Brutoro, & Williams, *The Relationship Between Medical Malpractice and Quality of Care*, 1975 DUKE L.J. 1197, 1199-1205.

doctors to protect themselves against malpractice liability, patient care is being evaluated primarily from a legal or financial, rather than medical or scientific, perspective.⁶⁰ In some instances, however, there may be a conflict between finance and science. For example, Michael Reese Hospital and Medical Center, in Chicago, recalled thousands of former patients who had received X-ray irradiation treatments many years before for infected tonsils and a variety of other disorders. Subsequent to the treatments, scientists had discovered that the irradiation led to a significant increase in susceptibility to thyroid cancer. The decision to recall was made, although providing notice to the patients might alert them to a possible cause of action. To date, however, there have been no successful suits against the hospital.⁶¹

Finally, the hospital must obtain participation, acceptance, and compliance with the program at all levels of its organization. *Darling v. Charleston Community Memorial Hospital* provides a good illustration of liability imposed because of, among other reasons, the failure to promptly review and report a patient's deteriorating condition. The architects of the hospital's program should stress that knowledge of risk-creating situations *before* they produce grounds for a lawsuit is the key to a successful system. In short, the ultimate success of any malpractice prevention program depends on the commitment of hospital personnel to reporting risks to patient safety. The importance of their commitment to the information gathering aspect of the program cannot be overemphasized.

Administrative Organization

A preliminary consideration in the implementation and organization of a loss control program is where control of the program will lie. There are numerous possibilities for centralizing responsibility. The hospital administrator, chief executive officer, a general assistant administrator, or specially designated risk reduction officer on the medical staff would be a logical choice. Hospital-wide committees, such as a board of trustees task force or a hospital-wide risk reduction committee composed of representatives from hospital management, medical staff, nursing staff, and legal counsel could be responsible. Finally, departmental liability control committees in, for example, the emergency room, operating rooms, and outpatient care facilities might head the organizational effort.

60. MEDICAL MALPRACTICE REPORT APPENDIX, *supra* note 4, at 38-40.

61. Kotulak, *Thyroid Tests: No Cover-up*, Chi. Tribune, Mar. 13, 1977, at 26, cols. 3-5.

One problem a hospital may face in delineating authority is conflict between the hospital administration and medical staff since the latter is usually reluctant to permit any administrative supervision of physician services in areas requiring medical judgment.⁶² An additional question is whether responsibility for the hospital's entire risk management plan should be centralized in a risk reduction committee or risk manager, who would be responsible for administering and supervising the hospital's safety and security program, the settlement and litigation of pending claims, and the purchase of insurance for injury to patients, visitors, and employees and damages to the physical plant and premises.

Risk Detection

Most hospitals utilize incident reports to document patient injuries or risk-creating situations. But these may be an inadequate source if physician-related or other types of incidents and risks are rarely reported in this way. Additional sources include (1) existing hospital systems, such as product review (standards) committee, patient representatives, pharmacy committee, infection committee, tissue committee, medical records, medical audit, nursing audit, utilization review, continuing medical education, hospital training and education programs; (2) patient complaints; (3) legal counsel; (4) insurance agents or claims adjusters; (5) malpractice summarizations and other information showing the type of incident or injury giving rise to the lawsuit against the hospital, patient diagnosis, cause of incident, personnel involved, disposition of claim, and damages awarded; and (6) solicited and unsolicited comments of hospital personnel.

The information obtained may be used to form an internal data base, and may be compared with external data to assess which procedures, treatments, and areas of the hospital are creating the greatest risk of liability. Ten or even five years ago there were no external sources based on large samples detailing the incidents of particular practices or procedures giving rise to malpractice claims since the credible data in insurer files were not systematically analyzed or widely disseminated.⁶³ But quite recently the National Association of Insurance Commissioners compiled nationwide data on individual malpractice claims closed between July 1, 1975 and July 1, 1976, and

62. Williams, *The Quandary of the Hospital Administrator in Dealing with the Medical Malpractice Problem*, 55 NEB. L. REV. 401, 403-11 (1976).

63. MEDICAL MALPRACTICE REPORT APPENDIX, *supra* note 4, at 2.

published the data in three of four planned quarterly summaries before the effort was stopped for lack of funding.⁶⁴

The last summary contains an analysis of 12,918 malpractice claim reports reported to the Insurance Commissioners through May 3, 1976.⁶⁵ In cases in which indemnity was equal to or less than \$100,000, claims against physicians and surgeons constituted 60 percent of claims paid by count and 71 percent by amount; claims against hospitals accounted for 35 percent of paid claims by count and 26 percent by amount.⁶⁶ Yet hospitals and emergency rooms were the site of 70 percent of all claims and 84 percent of indemnity dollars.⁶⁷ The summary noted:

This suggests that most malpractice claims arise from procedures performed by physicians in a hospital facility and result in the physician being named as primary defendant In many of the cases, the physician is held liable for the injury, and the claim against the hospital is closed without payment.⁶⁸

For the claim reports covered by the last summary, there is other data useful in designing a malpractice prevention program: the percentage of all claims paid and total indemnity paid according to physician or surgeon speciality,⁶⁹ the final diagnosis for which treatment was sought or rendered,⁷⁰ the operation, diagnostic, or treatment procedures leading to the claim,⁷¹ the frequency with which operation, diagnostic or treatment procedures named in the claims caused injury,⁷² and the health care practitioners and hospital employees contributing to or associated with the injury though not named as defendants.⁷³

64. Groves, *Taking Steps for Safety's Sake*, 51 HOSPITALS 60, 61 (May 16, 1977).

65. NATIONAL ASS'N OF INS. COMM'RS, MALPRACTICE CLAIMS 3 (Sept. 1976).

66. *Id.* at 12.

67. *Id.* at 14.

68. *Id.* Cf. 1 NATIONAL ASS'N OF INS. COMM'RS, MALPRACTICE CLAIMS at 10, 12 (Apr. 1976), 1 NATIONAL ASS'N OF INS. COMM'RS, MALPRACTICE CLAIMS at 19, 22 (Dec. 1976) for similar data concerning the relative importance of physician-related incidents in suits brought against hospitals.

69. 1 NATIONAL ASS'N OF INS. COMM'RS, MALPRACTICE CLAIMS at 13 (Sept. 1976).

70. *Id.* at 16-25.

71. *Id.* at 26-37.

72. *Id.* at 54 (procedural errors alleged in 83 percent of paid incidents and 88 percent of total indemnity paid; respective percentages for diagnostic errors being 31 percent and 40 percent; data excludes cases of indemnity above \$100,000).

73. *Id.* at 56. For additional statistical studies dealing with patient injuries based on smaller samples, see INSURANCE SERVICES OFFICE, AMERICAN INSURANCE ASSOCIATION, SPECIAL MALPRACTICE REVIEW: 1974 CLOSED CLAIM SURVEY (1976); MEDICAL MALPRACTICE REPORT APPENDIX, *supra* note 4, at 1-37, 41-70, 623-36.

Injury and Liability Prevention

Risks can be evaluated according to the potential liability they create and their frequency. Once the hospital has determined the severity of the potential liability arising from various risks it can take measures to reduce those risks that it feels will be the most damaging, financially and otherwise, to the hospital. These measures include immediate corrective or preventive action, continuing education or retraining programs for the personnel involved,⁷⁴ required safety orientation programs for all new employees and physicians, instruction on the use of forms to report patient injuries or risk situations, display of safety information on bulletin boards and in newsletters, and changes in criteria for admission to the medical or nursing staff. These are general injury prevention approaches. More specific solutions may be called for in light of incident reports or malpractice suits. These include counseling of personnel involved, disciplinary action, in-house education programs directed to specific personnel, changes in procedures or practices, or purchase of new equipment. Further, good hospital-patient communications may enable patients to express their frustration and anger with hospital procedures. The absence of good communications may make legal action the only vehicle available to patients for expression of dissatisfaction and resolution of grievances.

Monitoring and Evaluation

Cost-benefit analysis can be performed, looking at such variables as the number of incidents reported and claims filed, the total liability insurance premiums paid, the total liability-related payments per admission, and the total administrative costs of the program per admission. Such statistics tend to itemize and quantify the benefits of the program as compared to its costs. To help evaluate or initiate a program, the hospital may want to contract for the services of competent hospital risk management consultants. But a hospital should be cautioned that, at this point, many of the risk management consulting firms are reputed to provide inadequate services.⁷⁵ Another source of guidance is the insurance industry. Many major malpractice insur-

74. See, e.g., American Hospital Association, *Dare to Care: Reducing the Risk of Institutional Malpractice* (1976) (package multimedia program for continuing education, in-service training, and employee orientation focusing on potential risk situations that can occur in hospitals); E. BERNZWEIG, *THE NURSE'S LIABILITY FOR MALPRACTICE* (2d ed. 1975) (programmed text designed for use by nurses).

75. MALPRACTICE AND INSURANCE DIGEST 4 (No. 13, Jan. 1977).

ers survey covered hospitals, conduct seminars, and generally assist clients with their problems in patient injury prevention.⁷⁶

CONCLUDING REMARKS

There is reason to believe that a patient loss control program will result in fewer injuries and lower costs. Analogous programs in the employee safety area have resulted in lower accident rates and reduced workmen's compensation premiums. For example, this was true under hospital programs sponsored by the Ohio Hospital Association.⁷⁷ But regardless of the premium savings that might result, a hospital should be aware of the legal or evidentiary implications of a failure to institute a program designed to monitor and review the institution's quality of care. Both the case law and the widespread adoption of loss prevention programs in the hospital industry suggest the importance of having a malpractice prevention program. Testimony that a hospital has no reasonably effective, systematic program for acquiring and acting upon knowledge of risks to patients created by hospital personnel may be strong evidence, in malpractice litigation, that the hospital did not conform to the requisite standard of care. Accordingly, malpractice prevention becomes important not only as a means to enhance patient care, but also as a defensive measure significant because of its evidentiary implications.

76. MEDICAL MALPRACTICE REPORT APPENDIX, *supra* note 4, at 564-65, 567-68, 571, 577-79, 585, 596, 599.

77. Carter & Egan, *State's Safety Plan Lowers Insurance Costs*, 105 THE MODERN HOSPITAL 78 (1965).