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The 1960s was an event-filled decade in the history of the United States. It was a time during which many people took to the streets to express opposition to the war in Vietnam, protest the denial of civil rights, and encourage full participation in society for African-Americans. It was also a period when much attention was given to law as a vehicle to bring about substantial changes to improve life in a variety of areas.

Consider two important national changes brought about by 1960s legislation and their respective purposes. First, the enactment of important civil rights laws provided true equal treatment of minorities with respect to public accommodations and voting. Second, the establishment of the Medicare and Medicaid programs increased the availability of health services to the elderly and the poor by providing funds to pay for the health care services they needed. These changes prompted many to see law as an instrument for social justice.

The 1960s were also a period in which there was considerable debate about the proper role of the judiciary, both at the federal level and in the states. Some criticized the courts for what they termed "judicial activism," changing law by court decision rather than deferring to the legislative process as the vehicle for change. Others believed that bringing change through court action was the best tradition of the judiciary; many legal principles and doctrines, now subject to challenge, had been created by the courts.

The decision in *Darling v. Charleston Community Memorial Hospital*[1]

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1. 211 N.E.2d 253 (Ill. 1965). The Darling case involved a young man who was brought to the local hospital after sustaining a broken leg. He remained under the care of a

should be seen as one powerful example of a change in the law of health care. The decision introduced a broadened view of the standard of care to which hospitals were to be held. The Illinois Supreme Court quoted with approval the following language from a New York Court of Appeals decision:

> The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact. Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. They regularly employ on a salary basis a large staff of physicians, nurses and interns, as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such services, if necessary, by legal action. Certainly, the person who avails himself of 'hospital facilities' expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility. . .
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> The Standards for Hospital Accreditation, the state licensing regulations and the defendant's bylaws demonstrate that the medical profession and other responsible authorities regard it as both desirable and feasible that a hospital assume certain responsibilities for the care of the patient.[2]

The Illinois Supreme Court in *Darling* reviewed the evidence presented at trial and concluded that it was sufficient to support a finding of negligence on at least one of the bases for hospital liability submitted to the jury. The hospital could be found liable based on the nurses' negligence under the theory of *respondeat superior*. Moreover, the hospital could be liable for its failure to require "consultation with or examination by members of the hospital surgical staff skilled in such treatment; or to review the treatment rendered to the plaintiff and to require consultants to be called in as needed,"[3] as called for by accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), state licensing regulations, and hospital bylaws. Thus, *Darling* recognized the hospital as being liable for failing to intervene when a physician's patient care was substandard and harmful. Additionally, this Illinois Supreme

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physician, who had applied a cast to the leg in the emergency room, for seventeen days before being transferred to a hospital in St. Louis, where his leg was amputated. Hospital nurses had noted on several occasions his complaints of pain and an offensive odor emanating from his leg.

2. *Darling*, 211 N.E.2d at 257 (quoting Bing v. Thunig, 143 N.E.2d 3, 8 (N.Y. 1957)).

3. *Id.* at 258.

Court decision left no doubt that the doctrine of charitable immunity, a judge-made doctrine, was no longer part of Illinois law.[4]

WHAT WERE THE SEQUELAE TO THE *DARLING* DECISION?

Focusing on Illinois first, *Darling* apparently laid a foundation for later decisions resulting in greater exposure to liability for health care providers, particularly hospitals. Illinois courts have been relatively liberal in applying the apparent agency doctrine, allowing cases to go to juries for trial.[5] In addition, the *Darling* decision is cited with approval in *Jones v. Chicago HMO Ltd.*,[6] where the *Darling* rationale became the basis for imposing liability on a managed care plan for departing from the standard of care by assigning an excessive number of plan members to one of its primary care physicians.

Elsewhere across the nation, courts in most jurisdictions have recognized the concept of institutional liability, thus widening the liability exposure of hospitals, particularly in the context of practitioner credentialing and oversight of physician performance.[7] This expansion of hospital liability has had a number of effects. First, the cost of liability insurance coverage for participants in the health care industry has risen substantially because of increased liability exposure.[8] Second, it has caused many hospitals to give increased attention to credentialing and review of practitioner performance. One might observe that the *Darling* decision and its progeny have prompted many hospitals to perform in the manner in which JCAHO has long sought to have them perform. This change, in turn, stimulated JCAHO to adopt more stringent standards that have raised the bar regarding the expectations of the staff, board of directors, and hospital administration concerning improving the quality of care and protecting patients from harm.

The delivery of health services and the manner in which they are funded have changed considerably since *Darling*, but they are given scant attention when looking at liability. As a result of major changes in health services

4. *Id.* at 260. For a brief, useful discussion of the charitable immunity doctrine, see John D. Blum, *Feng Shui and The Restructuring of the Hospital Corporation: A Call for Change in the Face of the Medical Error Epidemic*, 14 HEALTH MATRIX 5, 7-8 (2004).

5. *See* Petrovich v. Share Health Plan, 719 N.E.2d 756 (Ill. 1999); Malanowski v. Jabamoni, 688 N.E.2d 732 (Ill. App. Ct. 1997).

6. 730 N.E.2d 199 (Ill. 2000).

7. *See* Johnson v. Misericordia Cmty. Hosp., 301 N.W.2d 156 (Wis. 1981).

8. See GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES, GAO-03-702 (2003), *available at* www.gao.gov; CONG. BUDGET OFFICE, LIMITING TORT LIABILITY FOR MEDICAL MALPRACTICE (2004), *available at* www.cbo.gov, for an in-depth discussion of the factors contributing to increasing liability premiums and for statistics and graphics relating to the magnitude of the premium increases.

delivery and payment during the last thirty years, the medical profession has been consolidated; physicians now practice almost always as participants in entities or groups to which they have surrendered a degree of autonomy that physicians in traditional private practice possessed in the past. Physicians tied to organizations heavily influenced by managed care find that their opportunity to act in what they believe to be the best interests of the patients they serve has been compromised by managed care requirements.

Managed care itself has changed substantially from when it was highly touted as the solution to rapidly rising health care costs. In the past, through capitation, the primary care physician was incentivized to control costs by limiting access to both physician specialists and expensive diagnostic and treatment procedures. Today, capitation is largely history, and although the extent to which prior authorizations and "management" of care exist under health plans is difficult to measure, managed care organizations continue to function in ways not generally seen as consumer-oriented.

Nevertheless, *Darling* has been positive from the consumer perspective. During the late 1960s and 1970s, an increasing acceptance of the responsibility of all industries and the desire to give greater protection to consumer interests prompted the adoption of federal consumer protection legislation.[9] Changes that benefit consumers, however, do not come without cost. In some instances costs are shifted; in others, costs are increased to the collective public. In health care, when liability is imposed on a provider in circumstances that formerly did not lead to liability, costs are shifted from the injured patient to the provider and insurer.

Since *Darling* and similar decisions, a number of negative reactions to consumer (patient) interests are apparent. Depending on the standard used to establish that a "malpractice crisis" is present, there have been at least three and, perhaps at least double that number of crises since the *Darling* decision.[10] In the view of some insurers, there has been a continuing

9. *See, e.g.*, Federal Cigarette Advertising and Labeling Act, 15 U.S.C. §§ 1331-1341 (2000 & West. Supp. 2004); Poison Prevention Packaging Act of 1970, 15 U.S.C. §§ 1471-1474, 1476 (2000); Consumer Credit Protection Act, 15 U.S.C. §§ 1601-1693r (2000 & West Supp. 2004); Consumer Product Safety Act, 15 U.S.C. §§ 2051-2084 (2000 & West. Supp. 2004); Toxic Substances Control Act, 15 U.S.C. §§ 2601-2692 (2000 & West. Supp. 2004).

10. William M. Sage describes four crises: the 1960s disequilibrium, the 1970s crisis of availability, the 1980s crisis of affordability, and the most severe crisis, the 1990s and beyond, which he describes as the "perfect storm." William M. Sage, *The Forgotten Third: Liability Insurance and the Medical Malpractice Crisis*, 23 HEALTH MATRIX 10, 12-13 (2004). The Insurance Information Institute states that the current "medical malpractice crisis did not appear overnight" and that "previous crises occurred in the early 1970s and the

malpractice crisis for more than forty years. A "malpractice crisis" is marked by allegedly unjustified increases in the volume of litigation and the size of awards against health care providers, leading to the need for substantial increases in insurance premiums.

It should have been no surprise that a malpractice crisis arose soon after the Medicare and Medicaid legislation went into effect. When millions of persons gained access to health care that they formerly could not afford, their use of health care services increased substantially. Simple logic dictates that when the volume of health care services rendered rises, there will be a corresponding increase in the number of services that result in patient injury, a percentage of which will be the result of substandard performance in the administration of health care services. That, in turn, will lead to an increase in litigation, awards, and, of course, an increase in liability insurance premiums.

For many physicians and critics of the liability system, it is the financial aspect of malpractice liability insurance that is most burdensome.[11] However, these critics ignore the costs malpractice causes to those harmed: to their finances, to their enjoyment of life, and even to loss of life itself. Perhaps these critics should give more consideration to those injured by health care providers. The Institute of Medicine's (IOM) oft-cited report, *To Err is Human: Building a Safer Healthcare System*, addressed the quality of patient care and patient safety provided by hospitals.[12] The IOM reported that large numbers of avoidable hospital patient deaths, between 44,000 to 98,000 per year, occurred due to medical errors.[13] This range is

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1980s." ROBERT P. HARTWIG & CLAIRE WILKINSON, MEDICAL MALPRACTICE INSURANCE 2 (Insurance Information Institute Insurance Issues Series, Vol. 1, No. 1. June 2003). Kenneth E. Thorpe reports that "by many accounts, the United States is in the midst of its third 'crisis' in medical malpractice." Kenneth E. Thorpe, *The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms*, HEALTH AFFAIRS, January 21, 2004, at W4-20, *available at* http://www.healthaffairs.org.

11. According to the Congressional Budget Office, even large savings in medical malpractice insurance premiums will have only a small direct impact on health care spending because malpractice costs account for less than 2% of spending. CONG. BUDGET OFFICE, *supra* note 8, at 2. Hartwig and Wilkinson report that, according to A.M. Best, a total of 335 companies wrote $6.1 billion in net medical malpractice premiums in 2001. HARTWIG & WILKINSON, *supra* note 10, at 7. Physicians account for approximately 52% of estimated medical malpractice premiums, followed by hospitals at 32%, and the remaining 16% consisting of nursing homes and managed care organizations. *Id.* The GAO reports that "physician-owned and/or operated insurance companies . . . insure approximately 60 percent of all physicians in private practice in the United States." GEN. ACCOUNTING OFFICE, *supra* note 8, at 6. While that heightens the physicians' awareness of their financial responsibility and losses, it apparently has not prompted the physicians to strive to reduce error, and thus liability claims.

12. INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTHCARE SYSTEM (2000).

13. *Id.* at 26. The findings in the IOM report are contentious, in part because they are

widely accepted by those working in the malpractice policy area. Despite all of the complaints by physicians and insurers that greedy malpractice attorneys and runaway juries are the root cause of the health care system's fragile economic condition, the IOM report indicates that health care service providers, physicians, and insurers are held accountable for only a modest fraction of the harm they cause.

The existence of past and present medical malpractice "crises" has not gone unnoticed by government. In response to the "crisis" of the early 1970s, the federal government during the Nixon Administration created a commission to study and to provide recommendations to address the malpractice problem.[14] The commission recommended changes not only in the judicial system, but also within the medical community itself, including better education and stronger powers for states to respond to incompetent providers.[15]

In the late 1960s and early 1970s many states adopted legislation to affect the malpractice crisis.[16] Joint underwriting arrangements, limits on contingent fees, caps on recovery for non-economic damages,[17] changes in the statutes of limitation, and other such mechanisms were responses to the malpractice crisis.[18] Good Samaritan statutes, directed primarily at

based upon extrapolation from previous studies completed in New York, Utah, and Colorado. Some believe the IOM report overestimates the number of deaths, while other believe it underestimates the number of deaths because it looks only at patients in the hospital setting and not in other health care settings, such as long-term care and physician office-based care. *See* Keith Myers, *Medical Errors: Causes, Cures, and Capitalism*, 16 J.L. & HEALTH 255, 258 (2001-02).

14. U.S. DEP'T OF HEALTH, EDUC., AND WELFARE, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE (1973).

15. *Id.* at 27-38, 51-65.

16. According to the Insurance Information Institute, aggressive campaigns to reform state laws governing medical malpractice lawsuits began in the 1970s, with every state except for West Virginia passing some reforms. HARTWIG & WILKINSON, *supra* note 10, at 2.

17. Capping non-economic damages is a particularly contentious aspect of the medical malpractice reform debates. The evidence is inconclusive as to whether caps actually lower health care spending. While most commentators analyze the cost savings to insurers and providers, few examine the effects of capping non-economic damages on the injured patient. The use of caps abandons the traditional tort law concept of placing the costs on the party that can better absorb the cost and instead shifts the costs of the patient's loss to the patient's family members.

18. According to the GAO, "since the medical malpractice crisis of the mid-1970s, all states have enacted some change in their laws in order to reduce upward pressure on medical malpractice premiums," including statutes regarding limits on damages, evidence of collateral source payments, joint and several liability, limits on attorney's contingency fees, reducing the statute of limitations, requiring periodic payment of damages rather than lump sum payments, expert certification (certificates of merit), arbitration, advanced notice of claim, and insurance bad faith claims. GEN. ACCOUNTING OFFICE, *supra* note 8, at 41-43.

emergency care situations, provided some protection to physicians and other health care providers from liability.[19] With each new "crisis," caused in part by unsuccessful insurance company investment strategies endangering reserves, one or two new proposals were added to previously-used measures to handle the liability problem.

There are basically two camps in the conflict over the liability situation. The first consists of insurers, health plans, and most providers, worried about the financial impact of liability on them as health care industry participants.[20] Organized medicine, America's Health Insurance Plans, and liability insurers have great weight in the both the federal and state legislative arenas and seek to reduce their financial responsibility and accountability. They decline to acknowledge their contributions to the crisis, such as underestimating liability risks in the 1990s, the increasing expense of reinsurance, and the mergers and withdrawals from the market that have reduced competition and led to captive audiences that cannot price-shop.[21] The physicians and other providers focus their attention on limiting liability exposure and expenses rather than assessing their own contribution to adverse patient outcomes. Together, the groups spend large sums of money promoting "malpractice reform," which consists of changes in the law to reduce liability exposure and the financial expense associated with it.[22]

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19. For a list of state Good Samaritan Statutes, see Terrence J. Centner, *Tort Liability for Sports and Recreational Activities: Expanding Statutory Immunity for Protected Classes and Activities*, 26 J. LEGIS. 1, 4-7 (2000), and Daniel P. Connaughton & John O. Spengler, *Automated External Defibrillators in Sport and Recreation Settings: An Analysis of Immunity Provisions in State Legislation*, 11 J. LEGAL ASPECTS OF SPORT 51, 57-60 (2001). As early as the 1970s, physicians were allegedly fearful that rendering care as a "good Samaritan" would impose financial liability. However, the Secretary's Commission on Medical Malpractice found widespread misperception, but "no factual basis for the commonly-asserted belief that malpractice suits are likely to stem from rendering emergency care at the scene of accidents." U.S. DEP'T OF HEALTH, EDUC., AND WELFARE, *supra* note 14, at 16.

20. Even during the malpractice "crisis" of the 1970s, physicians were deeply concerned about the financial impact of liability. The Nixon report found that "many doctors are convinced that the contingent fee system is the very root of today's malpractice problem, and a number of them have proposed its outright abolition as the most effective way to solve the problem." U.S. DEP'T OF HEALTH, EDUC., AND WELFARE, *supra* note 14, at 32. The commission, however, found that the "contingency fee system discourages lawyers' acceptance of meritorious low-recovery cases." *Id.* at 33. It arguably follows that the contingency fee system, at times, insulates physicians from being held accountable when they have committed malpractice.

21. Kenneth E. Thorpe, *supra* note 10, at W4-22 – W4-24.

22. It is difficult to accurately know how much money is spent promoting malpractice reform. It is known, however, that during the 2004 election cycle, the health sector (which includes health professionals, health services and HMOs, and pharmaceuticals and health supply companies) contributed over $113 million to political parties, candidates, and

The members of the second camp are organizations and individuals concerned with the number of injuries resulting from the administration of health care services. From their perspective, the most important issue is reducing the volume and extent of harm to patients, thereby reducing the injury and risk of liability. They seek accountability and transparency in the system.

Additionally, physicians have mixed feelings toward the health care industry. Obviously, most physicians have little in common with the American Trial Lawyers Association (ATLA). On the other hand, physicians also have problems with the way in which health plans and large physician employers, such as universities, impose practice mechanisms that are often based on strict time allocations for administering specific services. Physicians assert that their professional judgment is being restricted. They are also disturbed by the way in which some services are organized because they weaken or destroy the bond that in the past marked the trust relationship between physicians and patients. Patients are often stripped of the opportunity to maintain relationships with physicians because they are forced to change health plans or their current health plan no longer includes physicians or physician groups with which the patient has had a good relationship.

Another consideration is the defensive practice of medicine, often alleged to be a major cause of higher health care costs. The defensive practice of medicine has been defined "as poor practice (a deviation from what the physician believes is sound practice and which is generally so regarded) induced by a threat of liability."[23] Thus, the argument goes, physicians perform or order unnecessary procedures for their patients because of fear of liability; they are concerned that if the patient has a poor result, the failure to provide such a procedure would be deemed malpractice.

Consider two evident flaws in this argument. First, a specific instance of

political action committees (PACs). Lawyers and lobbyists contributed over $190 million and the finance, insurance, and real estate sector contributed over $306 million. THE CTR. FOR RESPONSIVE POLITICS, 2004 ELECTION OVERVIEW: TOTALS BY SECTOR (2004), *at* http://www.opensecrets.org (last visited Feb. 27, 2005). A significant portion of these contributions was likely directed toward influencing legislation on issues other than medical malpractice, such as prescription drug plans and Medicare reimbursement. Nevertheless, entities and individuals receiving the monies will likely keep in mind the other interests of the donors.

23. Nathan Hershey, *The Defensive Practice of Medicine: Myth or Reality*, 1 THE MILBANK MEMORIAL FUND Q. 69, 72 (1972). For further historical articles regarding the defensive practice medicine, see L.R. Tancredi & J.A. Barondess, *The Problem of Defensive Medicine*, 200 SCIENCE 879 (1978); The Duke Law Journal Editorial Board and Staff, *The Medical Malpractice Threat: A Study of Defensive Medicine*, 1972 DUKE L.J. 939, 942 (1971).

possible defensive practice would require the physician to admit to providing the patient with unneeded, inappropriate, and possibly risk-creating procedures. How many physicians are prepared to describe specific instances of such behavior in their practice? Second, if health plans implemented hospital peer review and utilization review with evidence-based practice standards, would not most instances of defensive practice come to light and lead to reprimand (or worse) for the physician? We would be more accepting of allegations that defensive medicine takes place to a substantial extent if physicians would talk of their own conduct, rather than merely state that defensive practice is done by many of their peers.

It is paradoxical that some physicians are of two minds on the subject of unnecessary procedures. Physicians suggest that they provide unnecessary procedures, which increase health care costs, but also complain that health insurers, through their coverage rules, prevent them from providing needed referrals or services to their patients because of the insurers' desire to restrain costs.

Finally, the *Darling* decision is worthy of a program such as this Colloquium. This decision highlighted the process of change in the health care industry from the horse and buggy era by making clear the responsibility of institutions to the public they serve and the role they play in the delivery of services ordered and provided by physicians.