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The Emerging Trend of Corporate Liability: Courts' Uneven Treatment of Hospital Standards Leaves Hospitals Uncertain and Exposed

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I. INTRODUCTION: WHAT IS CORPORATE LIABILITY?

Under the doctrine of hospital corporate liability, a hospital has a nondelegable, direct duty to provide adequate care to all of its patients.[1] This duty is not a product of a master-servant or a principal-agent relationship,[2] nor is hospital tort liability predicated on a showing of vicarious liability, because the hospital's liability flows directly from the hospital to its patients.[3] Consequently, a hospital may be liable for the negligent act of an independent staff physician, even if that physician is an independent contractor.[4] The corporate liability, or corporate negligence,[5] doctrine thus extends potential liability beyond the sphere of respondeat superior.

Although many courts have recognized corporate liability as an "emerging trend" throughout the country,[6] reviewing courts should consider carefully the reasons supporting the doctrine and the ways in which many courts now apply it. As health care issues play an

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1. *Thompson v. Nason Hosp.*, 527 Pa. 330, 591 A.2d 703, 707 (1991); *Elam v. College Park Hosp.*, 132 Cal. App. 3d 332, 183 Cal. Rptr. 156, 159 n.5 (1982); *Johnson v. Misericordia Community Hosp.*, 99 Wis. 2d 708, 301 N.W.2d 156, 163 (1980). See also Arthur F. Southwick, *The Hospital as an Institution—Expanding Responsibilities Change Its Relationship with the Staff Physician*, 9 Cal. W. L. Rev. 429, 440 (1973).

2. See, for example, *Pedroza v. Byrant*, 101 Wash.2d 266, 677 P.2d 166, 168-69 (1984); *Elam*, 183 Cal. Rptr. at 159. See also Barbara Werthman, *Medical Malpractice Law: How Medicine Is Changing the Law* § 1.04 at 19-25 (Lexington, 1984); Part IV (discussing the evolution of hospital liability and respondeat superior).

3. See, for example, *Pedroza*, 677 P.2d at 168-69; *Elam*, 183 Cal. Rptr. at 163-64; *Johnson*, 301 N.W.2d at 163 n.14, 164; *Tucson Medical Center, Inc. v. Misevch*, 113 Ariz. 34, 545 P.2d 958, 959 (1976). For examples of recent cases, see *Humana Medical Corp. of Ala. v. Traffanstedt*, 597 S.2d 667, 668-69 (Ala. 1992); *Thompson*, 591 A.2d at 707.

4. See, for example, *Humana*, 597 S.2d at 668-69 (citing 8 *Causes of Action* 427, 431 (1985)). In the master-servant arena, an independent contractor is a nonemployee who is not under the complete and direct control of the person who is contracting for the work to be done. See Restatement (Second) of Agency §§ 2, 220 (1958). The Restatement (Second) of Agency defines an independent contractor as "a person who contracts with another to do something for him but who is not controlled by the other nor subject to the other's right to control with respect to his physical conduct in the performance of the undertaking." Id. § 2.

5. Some courts and commentators have referred te corporate liability as corporate negligence. See, for example, *Johnson*, 301 N.W.2d at 163 n.14; *Pedroza*, 677 P.2d at 168; *Elam*, 183 Cal. Rptr. at 157.

6. See *Humana*, 597 S.2d at 668, for a listing of recent cases.

increasingly greater role in American society, courts have a greater obligation to apply articulable guidelines uniformly when determining hospital liability. Unfortunately, despite the courts' ability to rectify the existing uncertainty, they have treated corporate liability disparately thus far. The corporate liability doctrine has a useful and practical application but only when applied in limited and clearly defined circumstances.

Part II of this Note discusses hospitals' evolution into modern, health-care providing entities. An examination of the emergence of the modern hospital as a corporate institution provides the framework for the creation and application of the corporate liability doctrine. Part III examines the doctrine of corporate liability as a response to the significant changes in the modern hospital, discussing and analyzing the duties that the major cases have articulated and imposed. Part IV discusses the evolution of hospital liability from the exposure-free beginnings of charitable immunity through the present-day imposition of corporate liability. Part V analyzes the standards and guidelines courts may consider in determining the imposition of hospital corporate liability. This Part primarily explores the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)[7] guidelines as a source that courts may use to assess potential hospital corporate liability. Part VI shows that the courts have not applied the standards uniformly or consistently, primarily because they have relied on different standards at different times or have applied the same set of standards inconsistently. Thus, courts irresponsibly have allowed the corporate liability doctrine to remain imprecisely defined, leaving hospitals exposed to almost limitless liability without the reasonable ability to take preventive measures.[8] Finally, Part VII suggests a more effective method for assessing hospital liability, allowing courts to apply the standards more evenly.

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7. The Joint Commission on Accreditation of Hospitals (JCAH) is now known as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The change in name does not represent any change in the commission itself but merely reflects the fact that many different health organizations now provide care in the manner of the traditional hospital.

8. *Humana*, 597 S.2d at 668; *Thompson*, 591 A.2d at 707; *Pedroza*, 677 P.2d at 172. See Part VI for a discussion of the distinctions that courts may create by imposing this imprecisely defined liability.

II. THE MODERN HOSPITAL AS A CORPORATE INSTITUTION

Traditionally, courts viewed hospitals solely as locations for the practice of medicine by independent physicians.[9] The often-repeated phrase that hospitals do not practice medicine, doctors do,[10] reflects the traditional notion that the pre-modern hospital was a building in which doctors provided health care rather than a health-care provider in its own right.[11]

Courts no longer view hospitals as mere buildings in which physicians practice medicine,[12] but as multi-faceted institutions that furnish far more than the mere facilities for treatment. Hospitals often are used for research, teaching, diagnosis, therapy, and many other services;[13] they provide the means and the mechanisms to address comprehensive and sophisticated health-care concerns.[14]

In addition to providing complex and comprehensive medical equipment and facilities, modern hospitals have become profitable businesses.[15] Courts have described the modern hospital as a corporate institution that takes the role of a comprehensive health care center that must provide and monitor all aspects of health care.[16] Many of today's hospitals function as corporations,[17] operated and organized to make a profit.[18] Large corporations often own these private hospitals, subjecting the hospitals to corporate hierarchies and a strong profit motive.[19] Hospital companies are traded on the New York Stock Exchange and thus must be treated as market-driven,

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9. See Southwick, 9 Cal. W. L. Rev. at 429-35 (cited in note 1).

10. Id. at 566-77. Part IV of this Note discusses the evolution of hospital liability.

11. See Note, *Theories for Imposing Liability Upon Hospitals for Medical Malpractice: Ostensible Agency and Corporate Liabilty*, 11 Wm. Mitchell L. Rev. 561, 563-64 (1985). See also *Johnson*, 301 N.W.2d at 164; *Elam*, 183 Cal. Rptr. at 163-64 (quoting *Johnson*, 301 N.W.2d at 164). See generally Clark C. Havighurst, ed., *Health Care Law and Policy* 566-68 (Foundation, 1988).

12. See, for example, *Johnson*, 301 N.W.2d at 164; *Elam*, 183 Cal. Rptr. at 163.

13. See *Johnson*, 301 N.W.2d at 164; *Elam*, 183 Cal. Rptr. at 163; Southwick, 9 Cal. W. L. Rev. at 429 (cited in note 1). See also Jim M. Perdue, *Direct Corporate Liability of Hospitals: A Modern Day Legal Concept of Liability for Injury Occurring in the Modern Day Hospital*, 24 S. Tex. L. J. 773, 773 n.2 (1983) (citing Comment, *The Hospital and the Staff Physician—An Expanding Duty of Care*, 7 Creighton L. Rev. 249, 251 n.10 (1974) (discussing the Hospital Corporation of America as a $400 million per year corporation in 1973)).

14. Note, 11 Wm. Mitchell L. Rev. at 568-69 (cited in note 11).

15. See note 21 and accompanying text.

16. *Perdoza*, 677 P.2d at 169 (quoting Southwick, 9 Cal. W. L. Rev. at 429 (cited in note 1)).

17. See generally Perdue, 24 S. Tex. L. J. at 774-79 (cited in note 13) (discussing the corporate structure of hospitals in general).

18. Id. at 773. See also Paul Starr, *The Social Transformation of American Medicine*, 430-32 (Basic Books, 1982).

19. Perdue, 24 S. Tex. L. J. at 773-79 (citod in note 13).

corporate entities.[20] According to recent statistics, community hospitals throughout the country realized an annual net total revenue[21] of more than $235 billion.[22]

Because hospitals offer comprehensive medical services within a corporate structure, courts have found that the public reasonably may rely on the hospital itself as a health-care provider. The public expects to be treated and cured by the hospital rather than by particular nurses or other employees who provide patient care.[23] Accordingly, patients often believe that the various health-care practitioners within the hospital render care collectively on the hospital's behalf.[24] Courts repeatedly have found that patients at modern hospital facilities expect that the hospitals will make reasonable attempts to cure them.[25] Patients also expect that they will receive care collectively from the health-care providers within the hospital and that the various health-care providers act independently of each other, but not independently of the hospital.[26] Courts point to the increased public reliance on sophisticated, profit-generating hospitals as a major reason for imposing corporate liability.[27]

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20. See Richard B. Siegrist, Jr., *Wall Street and the For-Profit Hospital Management Companies*, in Bradford H. Gray, ed., *The New Health Care for Profit: Doctors and Hospitals in a Competitor Environment* 35 (National Academy, 1983). Examples of health-care providers whose stocks are publicly traded include Humana and Hospital Corporation of America (HCA). Some hospital stocks have performed well for shareholders over the years. Because their stocks are traded publicly, companies that are in the business of owning and operating hospitals for profit face issues such as profitability and quarterly reports to stockholders. Although many public hospitals operate in this country as well, this Noto does not address the distinctions between public and private hospitals.

21. For purposes of the study cited in this Noto, net total revenue includes net patient revenue, contributions, grants, and all other payments not made on behalf of individual patients. Net patient revenue is gross revenue less bad debts, charity, and other losses. See American Hospital Association, *American Hospital Association Hospital Statistics* xxv (American Hospital Assoc., 1992-93 ed.).

22. Id. at 204. These statistics rely on 1991 data and are compiled in a survey of American Hospital Association member hospitals. These statistics show that the hospital industry now involves huge amounts of money each year.

23. *Darling v. Charleston Comm. Memorial Hosp.*, 33 Ill.2d 326, 211 N.E.2d 253, 257 (1965) (quoting *Bing v. Thunig*, 2 N.Y.2d 656, 143 N.E.2d 3, 8 (1957)).

24. *Johnson*, 301 N.W.2d at 164. See also Gordon Davenport III, Note, Johnson v. Misericordia Community Hospital: *Corporate Liability of Hospitals Arrives in Wisconsin*, 1983 Wis. L. Rev. 453, 466.

25. See, for example, *Johnson*, 301 N.W.2d at 164 (stating that a "person who avails himself of our modern 'hospital facilities' . . . expects that the hospital . . . will do all it reasonably can do to cure him . . ."). See also *Elam*, 183 Cal. Rptr. at 163.

26. *Johnson*, 301 N.W.2d at 164 (discussing patient expectations). See also Southwick, 9 Cal. W. L. Rev. at 435 (cited in note 1).

27. *Pedroza*, 677 P.2d at 169.

III. CORPORATE LIABILITY IN RESPONSE TO THE MODERN HOSPITAL: THE DUTIES COURTS HAVE IMPOSED AND THE JUSTIFICATIONS COURTS HAVE ARTICULATED

A. Hospital Duties Under Corporate Liability

With its change in status, the hospital has seen a corresponding change in its direct duties to its patients. Hospital duties, which may give rise to corporate liability if breached, can be divided into four primary categories.[28] These classifications are based on case law that has evolved over the last twenty-five years.[29]

1. Duty to Furnish Adequate Equipment and Facilities

A hospital has a direct duty to its patients to maintain its facilities and equipment.[30] This duty is the least controversial of all the direct corporate liabilities[31] and is established by traditional tort doctrine requiring commercial entities to reasonably maintain the facilities and equipment offered to the public.[32] Courts agree that hospitals have a nondelegable duty to reasonably maintain their facilities and equipment.[33]

2. Duty to Formulate and Follow Rules and Policies

The second nondelegable duty that courts have imposed on hospitals is the requirement that hospitals formulate, adopt, and follow specific rules and regulations for patient safety.[34] Most

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28. Although some commentators have articulated six categories of corporate liability, this Note focuses on the four primary categories of corporate liability courts have established. The six categories include: (1) negligence in relationship to premises, equipment, or facilities; (2) negligence in selection or retention of physicians; (3) negligence in supervision of physicians; (4) failure to formulate medical rules or policies; (5) negligence in formulating medical rules or policies; and (6) negligence in enforcing medical rules or policies. Perdue, 24 S. Tex. L. J. at 789 (cited in note 13).

29. See *Thompson v. Nason Hosp.*, 527 Pa. 330, 591 A.2d 703, 707 (1991) (citing seminal cases).

30. Id. (citing *Candler General Hosp. Inc. v. Purvis*, 123 Ga. App. 339, 181 S.E.2d 77 (1971)).

31. Perdue, 24 S. Tex. L. J. at 789 (cited in note 13). This direct duty rarely has been the focus of the corporate liability controversy. Many courts describe corporate liability in terms of negligent selection or negligent review, or both. See, for example, *Elam*, 183 Cal. Rptr. at 158-59.

32. See Perdue, 24 S. Tex. L. J. at 789-91 (cited in note 13); Restatement (Second) of Torts § 323 (1965).

33. Perdue, 24 S. Tex. L. J. at 789-92 (cited in note 13). See, for example, *Thompson*, 591 A.2d at 707.

34. Id. (citing *Wood v. Samaritan Institution*, 26 Cal.2d 847, 161 P.2d 556 (1945)). This duty simply requires the hospital to establish some guidelines for patient care. See generally Comment, *The Hospital Physician Relationship: Hospital Responsibility for Malpractice Physicians*, 50

corporate liability litigaton does not address this duty either.[35] When a hospital fails to establish rules for its physicians or other health-care practitioners, courts may find the hospital per se negligent.[36] If hospitals have inadequate equipment or lack substantive rules, then they should be liable for any related problems that arise. The corporate liability controversies usually involve the manner and degree to which hospitals have applied the rules and regulations they have established.[37]

3. Duty to Select Physicians Properly

A more controversial nondelegable duty to patients is the requirement that hospitals select their staff physicians properly.[38] Hospitals must verify and scrutinize physicians' competence before inviting them to join hospital staffs.[39] Hospitals are responsible for any pertinent information that they knew or should have known when assessing the applications of physicians and deciding whether to appoint them to the hospital staff.[40] Institutions are liable for the malpractice of staff physicians whose original employment applications were screened negligently or inadequately,[41] even if the physicians' negligent acts occurred several years after they were hired.[42] This attenuated liability is based on the assumption that

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Wash. L. Rev. 385 (1975). The specific guidelines are not important under this duty as long as they are reasonable and clearly established. Id. The type of guidelines and the manner in which they are applied are crucial in assessing the nondelegable duties of supervision and selection. See Parts III.A.3 and III.A.4.

35. The major cases of corporate liability that focus on the controversy and inconsistency addressed by this Note do not involve failure to promulgate rules and regulations.

36. Perdue, 24 S. Tex. L. J. at 805-06 (cited in note 13).

37. See Parts III.A.3 and III.A.4.

38. For examples of cases discussing hospitals' duty to select their staff physicians properly, see *Purcell v. Zimbleman*, 18 Ariz. App. 75, 500 P.2d 335, 340 (1972); *Joiner v. Mitchell County Hosp. Auth.*, 125 Ga. App. 1, 186 S.E.2d 307, 308 (1971); *Johnson*, 301 N.W.2d at 164. See also Davenport, Note, 1983 Wis. L. Rev. at 466-72 (cited in note 24). See generally Perdue, 24 S. Tex. L. J. at 792-99 (cited in note 13).

39. *Johnson*, 301 N.W.2d at 164, 170; *Purcell*, 500 P.2d at 340; *Joiner*, 186 S.E.2d at 308-09. See also Perdue, 24 S. Tex. L. J. at 792 (cited in note 13); Note, 11 Wm. Mitchell L. Rev. at 580 (cited in note 11).

40. Perdue, 24 S. Tex. L. Rev. at 792 (cited in note 13); *Johnson*, 301 N.W.2d at 170-71.

41. Note, 11 Wm. Mitchell L. Rev. at 580 (cited in note 11). See also *Joiner*, 186 S.E.2d at 308; *Johnson*, 301 N.W.2d at 169-71; *Purcell*, 500 P.2d at 341.

42. See, for example, *Johnson*, 301 N.W.2d at 169-71. Hospitals have a duty to use reasonable care in selecting physicians to their staffs. Id. A problem has arisen in defining reasonable care. The various standards used and the courts' disparate treatment of these standards as proper indicators of negligence are discussed in Part V of this Note.

hospitals are liable for placing doctors in positions to commit negligent acts.[43]

The landmark case of *Joiner v. Mitchell County Hospital Authority*[44] squarely addressed this issue of direct hospital liability for the negligent selection of a staff physician.[45] Mrs. Joiner filed suit against Dr. Gonzalez and against Mitchell County Hospital Authority.[46] She claimed that she brought her husband to the hospital because he was suffering chest pain.[47] She further alleged that Dr. Gonzalez sent her husband home after determining that his condition was not serious and did not require hospitalization.[48] Her husband's condition worsened, and he subsequently died on the return journey to the hospital after the previous visit.[49] Mrs. Joiner claimed that the hospital negligently selected the physician Gonzalez as a member of its staff.[50] Specifically, she claimed that the hospital was negligent in failing to: (1) require adequate proof of the doctor's qualifications; (2) investigate the doctor's qualifications, character, and background; and (3) exercise care in determining his morality and professional competence.[51] The lower court granted summary judgment for the hospital, but the Georgia Supreme Court reversed the decision,[52] stating that the hospital could not absolve itself of liability by contending that the medical staff, and not the hospital, was responsible for physician selection.[53] Although the court did not determine whether the defendant hospital was liable for negligently selecting Dr. Gonzalez, the court opened the door for the application of a nondelegable duty of physician selection.[54]

The court in *Johnson v. Misericordia Community Hospital*[55] expanded and more fully articulated the nondelegable duty of the

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43. *Johnson*, 301 N.W.2d at 163-65, 170. See also I. Trotter Hardy, Jr., *When Doctrines Collide: Corporate Negligence and Respondeat Superior When Hospital Employees Fail to Speak Up*, 61 Tulane L. Rev. 85, 90-92 (1986).

44. 125 Ga. App. 1, 186 S.E.2d 307 (1971).

45. Id. As stated in the text accompanying note 155, staff physicians are independent contractors. The Court, nonetheless, held the hospital liable for negligent selection even though the patient did not claim vicarious liability for the doctor's actions. *Joiner*, 186 S.E.2d at 308.

46. Id. at 308.

47. Id.

48. Id.

49. Id.

50. Id. at 308-09.

51. Id. at 308.

52. Id. at 309.

53. Id. at 308-09.

54. Id. The court stated that the incompetence of the physician and the related negligence of the hospital in selecting the physician were issues of fact for the jury to determine. Id. at 309.

55. 99 Wis. 2d 708, 301 N.W.2d 156 (1981).

hospital to select staff physicians properly.[56] In *Johnson*, the jury found that a staff physician acted negligently when he removed a pin fragment from a patient's hip.[57] The court then found Misericordia Community Hospital directly liable for the patient's injuries because the hospital acted negligently when it selected this doctor to its staff.[58] The hospital failed to investigate the physician's background when he applied for staff privileges.[59] If Misericordia Community Hospital had inquired into Dr. Salinsky's background prior to hiring him, it would have discovered readily available information about Salinsky's questionable competence.[60]

The court defined the hospital's duty of selection in terms of foreseeability.[61] The court stated that the hospital's failure to screen prospective staff physicians' credentials gave rise to a foreseeable risk of unreasonable harm to its patients.[62] The hospital's failure to select its medical staff carefully foreseeably increased the likelihood that the selected physicians would be unqualified and subsequently would commit negligent acts.[63]

The court held that the hospital's actual knowledge of Salinsky's incompetence was not required to prove negligence.[64] Although the plaintiff offered no evidence that the hospital knew of Dr. Salinsky's incompetence when it selected him,[65] the hospital was charged with constructive knowledge of the doctor's professional problems and poor reputation because it would have obtained this information if it had conducted a proper selection inquiry using ordinary care.[66] The burden of proof, however, rests with the

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56. Id. at 170-71. See generally Davenport, Note, 1983 Wis. L. Rev. at 466-72 (cited in note 24).

57. *Johnson*, 301 N.W.2d at 157-58. The patient suffered permanent nerve damage as a result of the surgery and was partially paralyzed. Id. at 158. The jury found that Dr. Salinsky and the hospital were each 20% negligent. Id.

58. Id. at 174. Dr. Salinsky did not challenge the jury findings on appeal; the appellate court focused solely on the hospital's liability for negligently selecting this doctor to be on its staff. Id. at 158.

59. Id. at 159-61.

60. Id. at 160-62. The doctor had lied on his application, had a poor reputation among his peers, and had been sued several times for malpractice.

61. Id. at 163-64.

62. Id. at 164. See Perdue, 24 S. Tex. L. J. at 794-95 (cited in note 13). See also Davenport, Note, 1983 Wis. L. Rev. at 465-66 (cited in note 24).

63. *Johnson*, 301 N.W.2d at 164-65. See Davenport, Note, 1983 Wis. L. Rev. at 465-66 (cited in note 24).

64. Johnson, 301 N.W.2d at 172. See Davenport, Note, 1983.Wis. L. Rev. at 468-69 (cited in note 24).

65. *Johnson*, 301 N.W.2d at 172-73.

66. Id. at 172-74. Misericordia Community Hospital did not contact the hospitals that Salinsky referenced on his application. If it had, it would have discovered that this doctor never had held the consultant privileges he claimed, that he was neither board certified nor eligible to

plaintiff, who must prove that the hospital possessed constructive knowledge of the potential harm.[67]

Although the *Johnson* court articulated the modern duty of a hospital to select its physicians properly, the court also defined parameters and limits for hospital negligence based on improper physician selection.[68] The court stated that because the hospital should not be the insurer of the medical staff's competence, a hospital exercising reasonable care in selecting its staff will not be held negligent under a theory of corporate liability for acts of staff physician malpractice.[69] When the hospital fails to comply with reasonable standards of physician staff selection,[70] however, courts usually will find corporate liability for negligent selection.[71] Recent cases have distinguished between a hospital that fails to screen an applicant at all[72] and a hospital that does not use reasonable care in the screening process.[73]

Other courts also have limited corporate liability for negligent selection. These courts have stated that a plaintiff must prove both patient harm and physician negligence, even when hospital liability is

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practice orthopedic surgery, that most of his peers thought he was unqualified as an orthopedic surgeon, and that his staff privileges had been revoked at two hospitals and denied at another. Id. at 173-74. If the hospital had checked the public court files, it would have seen that seven malpractice suits were pending against him at the time it selected him. Id. at 174. See also Davenport, Note, 1983 Wis. L. Rev. at 468-69 (cited in note 24).

67. See, for example, *Thompson v. Nason Hosp.*, 527 Pa. 330, 591 A.2d 703, 708 (1991); *Purcell v. Zimbleman*, 18 Ariz. App. 75, 500 P.2d 335, 343 (1972). For all practical purposes, a hospital will be held to possess constructive knowledge. The fact that a hospital is in the best position to obtain information, coupled with the fact that the hospital has the resources and incentives to obtain such information, is the basis for imposing constructive knowledge. A hospital must have some opportunity te gain knowledge of the physician's incompetence before it may be held liable for negligent selection. See *Thompson*, 591 A.2d at 707; *Johnson*, 301 N.W.2d at 172.

68. *Johnson*, 301 N.W.2d at 174-75.

69. Id. (emphasis added). See also Davenport, Note, 1983 Wis. L. Rev. at 469-70 (cited in note 24).

70. The National Practitioner Data Bank regulations now require a hospital to check the Data Bank for any prior occurrences of physician malpractice, licensure actions, or suspensions from medical societies. See generally National Practitioner Data Bank for Adverse Information on Physicians and Other Health Care Practitioners, 45 C.F.R. § 60.1-14 (revised Oct. 1992). Accordingly, a hospital may fulfill its selection duty in certain circumstances through a proper search of the Data Bank. See Part V.B of this Note for a discussion of the Data Bank and its likely effect on the selection duty.

71. See Hardy, 61 Tulane L. Rev. at 90-91 (cited in note 43); Arthur F. Southwick, *The Hospital's New Responsibility*, 17 Clev.-Mar. L. Rev. 146, 154 (1968); Susan B. Koehn, Note, *Hospital Corporate Liability: An Effective Solution to Controlling Private Physician Incompetence?*, 32 Rutgers L. Rev. 342, 360 (1979).

72. See, for example, *Johnson*, 301 N.W.2d at 160-62, 170.

73. See, for example, *Bell v. Sharp Cabrillo Hosp.*, 212 Cal. App. 3d 1034, 1047 (1989); *Elam*, 183 Cal. Rptr. at 165.

based on a direct duty to the patient to select physicians adequately.[74] The 1992 Alabama Supreme Court case of *Humana Medical Corporation of Alabama v. Traffanstedt*,[75] for example, discussed *Johnson* and found that the doctor's negligence was an important factor in finding the hospital liable.[76] The *Humana* court used a quasi-respondeat-superior analysis by holding that the jury could not find the hospital liable without first finding the doctor negligent.[77] This holding is interesting in light of the fact that a hospital owes this duty directly to the patient. From a practical standpoint, however, the requirement that a patient show tangible harm to prove damages is reasonable.[78]

Another court found that the hospital's negligence must be a substantial factor in harming the patient.[79] Some courts also have required a causal relationship between the negligent physician selection and the subsequent patient harm.[80] The plaintiff may establish this connection by using the foreseeability doctrine.[81] Courts could construe the selection of a physician who is negligent as a substantial factor that contributes to patient harm because the doctor would not have been in a position to harm but for the initial negligent selection.[82] The courts have discretion regarding the application and limitations of corporate liability for negligent selection.[83] This judicial

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74. See, for example, *Humana Medical Corp. of Ala. v. Traffanstedt*, 597 S.2d 667 (Ala. 1992) (citing *Elam*, 183 Cal. Rptr. at 156); *Purcell*, 500 P.2d at 342.

75. 597 S.2d 667 (Ala. 1992).

76. Id. at 669. The court stated that some act of physician negligence must occur before the hospital can be held liable. Id. at 667.

77. Id. The court stated that the jury verdicts were "inherently inconsistent" because the jury found for the allegedly negligent physician's estate and against Humana Hospital. Id. If the doctor was not negligent, then the hospital itself could not be negligent.

78. The plaintiff must prove a causal connection between the plaintiff's injuries and the hospital's actions to prevail under even a corporate liablility claim. *Johnson*, 301 N.W.2d at 158; *Purcell*, 500 P.2d at 342.

79. *Thompson*, 591 A.2d at 708. See generally Judith M. Kinney, Comment, *Tort law—Expansion of Hospital Liability Under the Doctrine of "Corporate Negligence"*—Thompson v. Nason Hospital, 591 A.2d 703 (Pa. 1991), 65 Temple L. Rev. 787 (1992).

80. *Thompson* 591 A.2d at 707-08. *Fraker v. Waukesha Memorial Hosp., Inc.*, 165 Wis. 2d 392, 478 N.W.2d 67 (1991) (citing *Johnson*, 301 N.W.2d at 164). See also Davenport, Note, 1983 Wis. L. Rev. at 456 n.14 (cited in note 24).

81. See text accompanying notes 61-63.

82. Although courts may articulate a substantial factor requirement, a court wishing to impose corporate liability for negligent selection easily can show that the selection was a substantial factor. The causal connection also can be shown because it is foreseeable that if a hospital negligently screens, or does not screen at all, then the selected physicians more likely will be incompetent and, in turn, more likely to engage in malpractice. See *Johnson*, 301 N.W.2d at 154.

83. Arguably, a proper Data Bank inquiry would eliminate judicial discretion if the complaint alleges that the hospital should have checked into the physician's malpractice record or licensure record. Courts still may look beyond the requirements, however, and hold the hospital liable for any other selection-related information that the Data Bank does not mandate.

discretion, however, creates confusion and uncertainty for hospital administrators. Ultimately, a court that wants to impose corporate liability[84] may do so with impunity by merely disregarding factors and cases that limit liability and accentuating common-law duties or other liberal cases that have found liability.[85]

4. Duty to Supervise Staff Physicians Properly

After the hospital has selected its staff physicians properly, it has an ongoing duty and obligation to supervise each physician.[86] This direct, nondelegable duty may be the most controversial component of the corporate liability doctrine.[87] Two factors complicate courts' determinations of liability for breach of the duty to properly supervise: physicians are independent contractors and negligent supervision may be difficult to ascertain.[88]

The court in *Darling v. Charleston Community Memorial Hospital*[89] first recognized a hospital's responsibility for the quality of medical care provided by the physicians on its staff.[90] In *Darling*, the Illinois Supreme Court held that a hospital's failure to review and supervise its staff physicians could be construed as negligence.[91]

In *Darling*, the attending physician improperly treated a patient who came into the emergency room with a broken leg.[92] Be-

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Therefore, courts still may hold hospitals liable for not obtaining information not provided in the Data Bank.

84. See the justifications for corporate liability in Part III.B of this Note.

85. This discretion leaves room for a court te decide that the hospital should cover the costs and then work backwards to justify this result. See, for example, *Joiner v. Mitchell County Hosp. Auth.*, 125 Ga. App. 1, 186 S.E.2d 307 (1971).

86. *Elam v. College Park Hosp.*, 132 Cal. App. 3d 332, 342-44, 183 Cal. Rptr. 156 (1982); *Darling v. Charleston Comm. Memorial Hosp.*, 33 Ill.2d 326, 211 N.E.2d 253, 257 (1965).

87. See Hardy, 61 Tulane L. Rev. at 91 (cited in note 43). For cases discussing this supervisory duty, see generally *Darling*, 211 N.E.2d 253; *Elam*, 183 Cal. Rptr. 156; *Tucson Medical Center, Inc. v. Miseveh*, 113 Ariz. 34, 545 P.2d 958 (1976); *Purcell v. Zimbleman*, 18 Ariz. App. 75, 500 P.2d 335 (1972).

88. See Perdue, 24 S. Tex. L. J. at 799-806 (cited in note 13). See generally *Darling*, 211 N.E.2d 253.

89. 33 Ill. 2d 326, 211 N.E.2d 253 (1965).

90. Id. at 257. The *Darling* case is one of the most famous cases in corporate liability. Hospitals became increasingly concerned about their potential liability for the negligent acts of their independent contractor staff physicians as a great amount of academic comentary followed the *Darling* decision. See, for example, William M. Copeland, *Hospital Responsibility for Basic Care Provided by Medical Staff Members: "Am I My Brother's Keeper?"* 5 N. Ky. L. Rev. 27 (1978); Southwick, 9 Cal. W. L. Rev. at 429 (cited in note 1).

91. *Darling*, 211 N.E.2d at 257. See also Note, 11 Wm. Mitchell L. Rev. at 569 (cited in note 11); Perdue, 24 S. Tex. L. J. at 785-89 (cited in note 13); Havighurst, *Health Care Law and Policy* at 591-92 (cited in note 11).

92. In *Darling*, an eighteen-year-old boy was taken to the defendant hospital's emergency room after he suffered a broken leg in a college football game. 211 N.E.2d at 255. A hospital staff physician who was on call applied traction and put Darling's leg in a plaster cast. Id. Subse-

cause of this mistreatment, the patient lost his leg.[93] The court found that the hospital was liable for negligent supervision on two grounds.[94] First, the attending nurses did not test the circulation as often as necessary and were unaware of the deteriorating color of Darling's leg.[95] Therefore, the nurses breached a direct duty to the patient by alerting neither the attending physician nor the hospital authorities of a problem of which they should have been aware.[96] This first ground of potential hospital liability was based on the doctrine of respondeat superior because the nurses were employees and under the direct control of the hospital.[97] The second ground under which the court found the hospital negligent was the hospital's failure to review the attending physician's work or to require a consultation.[98] Thus, the court imposed direct liability on the hospital for negligent supervision of its independent contractor physician staff.[99]

This second ground of potential negligence made the *Darling* decision both novel and troubling to hospitals.[100] Since the *Darling* court first addressed this issue, many courts have expanded and explained a hospital's duty to supervise its staff physicians properly.[101] The various holdings addressing a hospital's duty to supervise its staff have examined the standards that courts should use when assessing liability and have discussed when hospitals should be held to these standards.[102] Unfortunately, some courts have imposed this

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quently, Darling suffered great pain. Id. His toes, which protruded from the bottom of the cast, became noticeably swollen and dark in complexion. Id. They later became cold and did not respond when touched. Id. Three days later, the same physician removed the cast and, in the process, cut both sides of the patient's leg. Id. See generally Havighurst, *Health Care Law and Policy* at 587-92 (cited in note 11). Nurses and other witnesses observed "blood and other seepage" as well as a stench in the room. *Darling*, 211 N.E.2d at 255. Darling subsequently was transferred to another hospital where a new doctor ultimatoly was forced to amputato the leg below the knee because of considerable dead tissue caused by a prior constriction of circulation. Id. at 255-56.

93. *Darling*, 211 N.E.2d at 255.

94. Id. at 258.

95. Id.

96. Id. See also Restatement (Second) of Agency § 229 (1958).

97. The hospital would be liable, unarguably, for the negligent acts of its employees once the master-servant relationship was established and the act was deemed to have occurred within the scope of employment. *Darling*, 211 N.E.2d at 257-58.

98. Id. at 258.

99. Id.

100. See Havighurst, *Health Care Law and Policy* at 591 (cited in note 11); Perdue, 24 S. Tex. L. J. at 790 (cited in note 13). See generally H. Ward Classen, *Hospital Liability for Independent Contractors: Where Do We Go from Here?*, 40 Ark. L. Rev. 469, 478-80 (1987).

101. See, for example, *Pedroza v. Bryant*, 101 Wash.2d 266, 677 P.2d 166, 168-70 (1984); *Purcell*, 500 P.2d at 341; *Tucson Medical Center*, 545 P.2d at 960; *Kitto v. Gilbert*, 39 Colo. App. 374, 570 P.2d 544 (1977). For a more recent application of the duty te supervise, see *Pancoast v. Northeastern Hosp.*, Phila. Cty. Rptr. LEXIS 6 (Common Pleas Ct.); *Thompson*, 591 A.2d 703.

102. See Part V of this Note.

supervisory duty inconsistently.[103] This discrepancy is understandable given the difficulty of defining a hospital's supervisory duty, which depends on the facts in a particular case as well as other factors.[104] A court's use and application of specific standards ultimately will determine its finding of liability.

B. Justifications for the Imposition of Corporate Liability on Hospitals

Courts often offer justifications for the imposition of corporate liability on hospitals for failure to meet these duties.[105] First, some courts have explained that the expanded role of the modern hospital increases its liability. Patients expect a modern hospital to address their needs directly.[106] This justification serves as the basic premise for corporate liability.[107] The weakness in this argument is that it merely asserts that the hospital deserves the liability and does not provide any corresponding policy reasons to explain or justify why courts should saddle hospitals with greater liability. Combined with other rationales, however, the arguments that support imposing greater liability on hospitals are more credible.[108]

Another justification the courts have set forth is that imposing corporate liability on hospitals provides the hospital with an added incentive to select and supervise its staff physicians carefully.[109] A hospital is likely to examine its own activities more thoroughly because it may be directly liable for harm to patients.[110] The threat of corporate liability is a useful and positive tool that gives hospitals great incentives for self-monitoring and diligent, careful operation.[111]

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103. See Part VI of this Note.

104. The mitigating factors that limit liability for physician selection also apply to the duty to supervise. See notes 74-85 and accompanying text.

105. See, for example, Keith B. Hunter, Comment, *Medical Malpractice by Emergency Physicians and Potential Hospital Liability*, 75 Ky. L. J. 633, 640 (1986) (citing Gregory G. Peters, *Reallocating Liability to Medical Staff Review Committee Members: A Response to the Hospital Corporate Liability Doctrine*, 10 Am. J. L. & Med. 115, 117 (1984)).

106. See Part II of this Note for a discussion of the role of the modern hospital as a corporato institution.

107. See text accompanying note 23. See generally *Johnson v. Misericordia Comm. Hosp.*, 99 Wis.2d 708, 301 N.W.2d 156, 164 (1981).

108. See notes 15-22 and acompanying text.

109. *Elam*, 183 Cal. Rptr. at 165. The court in *Elam* stated that "imposing the duty of care upon a hospital should have the 'prophylactic' effect of supplying the hospital with a greater incentive to assure the competence of its medical staff and the quality of medical care rendered within its walls." Id. at 164. See also Hunter, Comment, 75 Ky. L. J. at 640 (cited in note 105); Peters, 10 Am. J. L. & Med. at 117 (cited in note 105).

110. See *Elam*, 183 Cal. Rptr. at 164; *Pedroza*, 677 P.2d at 170.

111. *Pedroza*, 677 P.2d at 170. See also *Elam*, 183 Cal. Rptr. at 164; Petors, 10 Am. J. L. & Med. at 121 (cited in note 105).

The court in *Pedroza v. Byrant*,[112] for example, stated that forcing hospitals to be responsible for corporate negligence may provide them with a financial incentive to ensure the quality of their staff physicians.[113] This cost-shifting approach, however, does not guard against physician negligence adequately because hospitals do not know which standards to follow to avoid liability.[114]

A third justification that courts have articulated is that the imposition of corporate liability provides an often-needed source of compensation for the injured claimant.[115] Patients have an additional avenue of relief available when hospitals are also directly liable to patients.[116] This avenue may be the only method by which a claimant can receive compensation. Although this deep-pocket theory departs from the traditional fault-based tort system, some courts are attracted to the practical, financial considerations.[117]

A final justification that at least one court has articulated for imposing corporate liability is that a hospital is in the best position to monitor and control its staff physicians.[118] Professional practitioners can be supervised most easily and most effectively from the site where the medical care is administered.[119] The *Pedroza* court stated that a hospital is the logical place to begin addressing problems of physician incompetence.[120] The fact that a hospital may be in the best position to monitor the staff physicians, however, does not necessarily mean that the hospital automatically should be liable.

C. Criticisms of the Justifications

The courts' justifications for imposing corporate liability on hospitals have met with criticism. A counter-argument to the

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112. 101 Wash. 2d 226, 677 P.2d 166 (1984).

113. Id. at 170.

114. Hospitals receive liability without the ability te account for it. This Note argues that corporate liablity only serves as an incentive if a hospital can follow specific standards to guard against future exposure. Courts, however, have not given specific standards necessary te create a true incentive for hospitals. See the discussion in Part VI of this Note.

115. See, for example, *Pedroza*, 677 P.2d at 169. Malpractice victims may be injured beyond the negligent physician's ability to compensate through insurance or otherwise. Id.

116. Id. This avenue of relief is especially important if the negligent physician does not have medical malpractice insurance. See James B. Cohoon, Comment, *Piercing the Doctrine of Corporate Hospital Liability*, 17 San Diego L. Rev. 383, 393 n.64 (1980). The question is whether this justification is appropriate or merely appealing when an injured victim can find no other means of compensation.

117. *Thompson v. Nason Hosp.*, 527 Pa. 330, 591 A.2d 703, 709 (1991) (Flaherty, J., dissenting). See also Kinney, Comment, 65 Temple L. Rev. at 796-77 (cited in note 79).

118. *Pedroza*, 677 P.2d at 169-70.

119 Id.

120. Id. at 170 (quoting Koehn, Note, 32 Rutgers L. Rev. at 376-77 (cited in note 71)).

incentive justification is that the market provides more than an adequate incentive to select competent physicians and supervise them carefully.[121] Competition among hospitals often can be fierce, and issues such as the loss of business from bad publicity serve as a great incentive for a hospital to select and supervise its staff physicians carefully. Courts that rely on this incentive justification thus use the tort system to solve a problem that the free market could address more properly.

Some critics have maligned the contention that corporate liability provides the patient with an additional avenue of relief.[122] They argue that this justification focuses more on deep pockets than on finding the appropriate tortfeasor.[123] Traditional notions of tort liability have emphasized the concept of fault-based liability, yet corporate liability creates a quasi-strict liability system in which hospitals serve as the ultimate insurers.[124] One judge, in fact, lambasted the entire theory of corporate liability as overbroad and unnecessary.[125] The dissenting judge in the recent case of *Thompson v. Nason Hospital* stated that corporate liability is a deep-pocket theory of liability that places financial burdens on hospitals for the actions of people, specifically independent contractor staff physicians, who are not the hospital's employees.[126] The dissent implied that the traditional doctrine of respondeat superior was sufficient to protect claimants and that imposing liability without a master-servant relationship was an irresponsible search for a deep-pocket payor.[127] Although courts should consider the liability doctrine's merits, justifications, and corresponding criticisms carefully, the most important question is how the judiciary should apply the standards that define the doctrine and whether or not these standards are sufficiently clear and specific.

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121. This is because the cost of greater liability would hamper a hospital's competitiveness with respsect to other hospitals. Economists see incentives as playing a significant role in hospital and physician decisionmaking. See Harold S. Luft, *Economic Incentives and Clinical Decisions*, in Bradford H. Gray, ed., *The New Healthcare for Profit: Doctors and Hospitals in a Competitive Environment* 103, 104-05 (National Academy, 1983).

122. *Thompson*, 591 A.2d at 709 (Flaherty, J., dissenting); Cohoon, Comment, 17 San Diego L. Rev. at 400-01 n.106-07 (cited in note 116).

123. Cohoon, Comment, 17 San Diego L. Rev. at 400-01 n.106-07.

124. Although under corporate liability a hospital is not supposed to serve as an insurer, the danger of this application is ever-present. See *Johnson*, 301 N.W.2d at 174. See also *Thompson*, 591 A.2d at 709 (Flaherty, J., dissenting); David J. Slawkowski, *Do the Courts Understand the Realities of Hospital Practices*, 22 S.L.U. L. Rev. 452, 465-68 (1978).

125. *Thompson*, 591 A.2d at 709 (Flaherty, J., dissenting).

126. Id.

127. Id. Part IV of this Note discusses the evolution of hospital liability from charitable immunity te corporate liability, as well as respondeat superior liability.

IV. THE EVOLUTION OF HOSPITAL LIABILITY

Since the turn of the century, hospitals have faced increasing liability for the acts of their staff physicians.[128] Courts steadily have imposed an increasing level of liability on hospitals that has culminated in the doctrine of corporate liability. As discussed below, the evolution of hospital liability has been anything but stagnant. At one time, hosptials were exempt from liability under the charitable immunity doctrine. Since then, courts have held hospitals vicariously liable for acts of their employees under the respondeat superior and the ostensible agency doctrines to protect for the protection of reasonable patient expectations. Finally, courts have held hospitals liable for the nondelegable hospital duties articulated in the corporate liability doctrine.[129]

A. Charitable Immunity

Originally, courts treated hospitals exclusively as charitable organizations, thus giving hospitals complete immunity from liability based on the negligent acts of their staff doctors[130] and other hospital employees, such as nurses.[131] Although some courts have made the

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128. See generally Havighurst, *Health Care Law and Policy* at 581-87 (cited in note 11); Perdue, 24 S. Tex. L. J. at 783-85 (cited in note 13); Note, 11 Wm. Mitchell L. Rev. at 563-66 (cited in note 11).

129. A threshold question remains as to whether courts will extend corporate liability te third-party payors for improperly designing or administering a health-care plan. See generally *Wilson v. Blue Cross of Southern Cal.*, 222 Cal. App. 3d 660, 221 Cal. Rptr. 876 (Cal. App. Ct. 1990), and *Wickline v. California*, 192 Cal. App. 3d 1630, 239 Cal. Rptr. 810 (Cal. App. Ct. 1986), which together may raise the prospect of this extended liability.

130. *Thompson*, 591 A.2d at 706 (citing *McDonald v. Massachusetts Gen. Hosp.*, 120 Mass. 432 (1876)). The general idea of charitable immunity is that an institution, often religious, should not be exposed to liability when it serves as a charitable entity. See generally Note, 11 Wm. Mitchell. L. Rev. at 566-68 (cited in note 11). The doctrine of charitable immunity recognizes that if an institution must account for tort liability, then it will no longer be able to provide care to all without regard for their ability te pay. See generally *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 105 N.E. 92, 93 (1914). Tort doctrine in general, and hospital liability doctrine specifically, has come to reject this idea. See, for example, *Bing v. Thunig*, 2 N.Y.2d 656, 143 N.E.2d 3, 8 (1957) (stating that those who administer the public good still must be careful). In the hospital arena, the changing status of the hospital has played a significant role in the corresponding change in its liability. See, for example, *Darling v. Charleston Comm. Memorial Hosp.*, 33 Ill.2d 326, 211 N.E.2d 253, 257 (1965) (citing *Bing*, 143 N.E.2d at 8).

The fact that bospitals later argued that doctors were independent contractors did not enter into the decision-making process regarding hospital liability for physicians under the charitable immunity doctrine. The lack of employee status only became a battle cry after the courts began to impose vicarious liability on the hospitals under the doctrine of respondeat superior.

131. See, for example, *Schloendorff*, 105 N.E. at 93. Again, the immunity from liability was based not on the lack of hospital control over an independent contractor versus an employee but on the hospital's status as a charitable entity. Id.

distinction that physicians are licensed to practice medicine while hospitals are not,[132] the landmark case of *Schloendorff v. Society of New York Hospital*[133] stated that a hospital's status as a charitable organization insulates it from the negligent acts of doctors and nurses.[134] Judge Cardozo further explained that a charitable hospital[135] should not be liable for the negligent acts of its doctors and nurses because this kind of institution benefits society.[136] The court viewed practitioners as the actual providers of medical care while considering hospitals to be the mere facilities for that care.[137] The *Schloendorff* court also determined that the hospital was not in a master-servant relationship with the staff physicians.[138]

B. The Move Toward Respondeat Superior—Bridging the Gap Until Bing v. Thunig *Brings Vicarious Liability to Hospitals*

During the next forty years, charitable immunity continued to shield hospitals from any liability to their patients. Consequently, some courts applied a "captain of the ship" doctrine[139] in an effort to provide patients who had justifiable claims with at least some compensation.[140] Using this doctrine, courts could find a physician liable for the negligence of nurses under the premise that the physician is the "captain of the ship" and should take ultimate responsibility for the patients' welfare.[141] Although most modern courts have rejected this doctrine,[142] courts began to use the doctrine of respondeat superior to provide at least some compensation to patients with valid claims.[143]

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132. See the discussion in *Bernardi v. Community Hosp. Assoc.*, 166 Colo. 280, 443 P.2d 708, 711-13 (1968) (discussing *Schloendorff* and other cases).

133. 221 N.Y. 125, 105 N.E. 92 (1914).

134. Id. at 93.

135. Unlike many modern hospitals, the hospital in *Schloendorff* was not operated for profit. Id. at 92.

136. Id. at 93. See also *Thompson*, 591 A.2d at 706 (citing *Forrest v. Red Cross Hosp.*, 265 S.W.2d 80 (Ky. 1954), overruled by *Mullikin v. Jewish Hosp. Ass'n of Louisville*, 348 S.W.2d 930 (Ky. 1961)).

137. *Schloendorff*, 105 N.E. at 93. The court viewed the physician as independent of the hospital and thus did not charge the hospital with liability for the negligence of the physician.

138. Id. at 93-94.

139. See *McConnell v. Williams*, 361 Pa. 355, 365 A.2d 243, 246 (1949). For an explanation of the borrowed servant doctrine, see Restatement (Second) of Agency § 227 (1958). This doctrine served to bridge the gap between charitable immunity and respondeat superior. See Havighurst, *Health Care Law and Policy* at 585-86 n.1 (cited in note 11).

140. See *Havighurst*, Health Care Law and Policy at 585-86 n.1 (cited in note 11).

141. *McConnell*, 65 A.2d at 248.

142. See, for example, *Sparger v. Worley Hosp., Inc.*, 547 S.W.2d 582 (Tex. 1977).

143. See, for example, Note, 11 Wm. Mitchell L. Rev. at 570 (cited in note 11). See also Restatement (Second) of Agency § 2 (1958). The doctrine of respondeat superior holds an employer vicariously liable for the negligent acts of an employee. Id. The actual fault of the employee is not imputed to the employer, but the liability itself is imputed to the employer. Id.

Forty years after the charitable immunity decision in *Schloendorff*,[144] the court in *Bing v. Thunig*[145] applied the doctrine of respondeat superior to hospitals.[146] The *Bing* court expressly abandoned the prior ruling in *Schloendorff* that essentially exempted hospitals from the doctrine of respondeat superior.[147] The court in *Bing* rejected the prior distinction between administrative and medical acts that courts had considered when determining whether a hospital was liable for negligence.[148] It found that courts used this arbitrary distinction merely to exempt hospitals from respondeat superior.[149] It also held that hospitals should be subject to the same standards as all other employers[150] and should face vicarious liability for the negligent acts of their employees.[151] Thus, the court promulgated changes in hospital liability to correspond with the changes in the operation of modern hospitals.[152] It stated that the test for liability should be whether an employer-employee relationship existed and whether the employee committed the negligent act within the scope of employment.[153]

Following *Bing*, courts and commentators have expressed sound reasons for holding hospitals liable under respondeat superior.[154] Nevertheless, courts still could not hold hospitals liable for the negligent acts of their staff physicians, who usually were classified as independent contractors,[155] because the doctrine of respondeat superior does not apply to independent contractors.[156] Courts recognized

144. *Schloendorff*, 105 N.E. at 93-94.

145. 2 N.Y.2d 656, 143 N.E.2d 3 (1957).

146. Id. at 8-9.

147. Id.

148. Id. The court in *Schloendorff* had articulated a somewhat unclear rule. A nurse who filled out paperwork, an administrative act, could bring liability on the hospital for her negligent act. Conversely, a nurse providing medical care could not cause liability for the hospital because of the charitable immunity doctrine. *Bing*, 143 N.E.2d at 8-9.

149. Id. at 3-4.

150. Id. at 9. The court stated that following *Schloendorff*, a body of law developed that exempted hospitals from the "normal operation of the doctrine of respondeat superior." *Bing*, 143 N.E.2d at 3.

151. Id.

152. Id.

153. Id. (finding no reason to continue hospitals' exemption from the otherwise universal rule of respondeat superior). See generally Restatement (Second) of Agency § 2 (1958). See also id. §§ 228-29 (defining scope of employment).

154. See Arthur F. Southwick, *Hospital Liability: Two Theories Have Been Merged*, 4 J. Legal Med. 1, 4 (1983). See also Hunter, Comment, 75 Ky. L. J. at 636-38 (cited in note 105).

155. See Restatement (Second) of Agency §§ 2, 220. See also Classen, 40 Ark. L. Rev. at 472 (cited in note 100).

156. See Restatement (Second) of Torts §§ 409-442 (1966). See generally Restatement (Second) of Agency §§ 2, 220 (1958). The necessary element of control is not present with an independent contractor because an independent contractor is defined as a non-servant. Id.

this limitation and thus attempted to expand hospital liability even further to fill this gap.

C. *Ostensible Agency Pushes Hospital Liability into the Staff Physician Arena*

Courts next imposed the doctrine of ostensible agency on hospitals. Under this doctrine, a hospital may be liable for the negligent acts of independent contractor staff physicians.[157] Courts base this liability not on any actual employer-employee realtionship,[158] but on patients' reasonable expectations that their treating physicians are hospital employees.[159] By focusing on patients' reliance, courts found a way to expand hospital liability and still adhere to recognized agency doctrine.[160]

Under the theory of ostensible agency, courts require the patient to prove certain elements to trigger hospital liability.[161] The court in *Grewe v. Mount Clemens General Hospital* enumerated three elements that a patient must establish.[162] First, the patient must have relied on the belief that the physician was acting under the direct authority of the hospital.[163] Second, the patient's belief must have been caused by the hospital's negligent act.[164] Third, the patient must not be guilty of contributory negligence.[165] These required elements limit the potentially unfettered liability that otherwise is determined entirely from the patient's perspective.[166]

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157. See Restatement (Second) of Agency § 267 (1965). See also Havighurst, *Health Care Law and Policy* at 596-99 (cited in note 11); Note, 11 Wm. Mitchell L. Rev. at 573-76 (cited in note 11).

158. An employer-employee relationship and the event at issue occurring within the scope of employment-are required for the imposition of liability under the doctrine of respondeat superior. Restatement (Second) of Agency §§ 228-29 (1958). See also Classen, 40 Ark. L. Rev. at 472-74 (cited in note 100).

159. *Grewe v. Mt. Clemens General Hosp.*, 404 Mich. 240, 273 N.W.2d 429, 433-34 (1978). The hospital is imputed to have held out the doctor as an employee. See also Classen, 40 Ark. L. Rev. at 487 n.93 (cited in note 100) (citing Restatement (Second) of Agency § 267).

160. Restatement (Second) of Agency § 267 (1965).

161. *Grewe*, 273 N.W.2d at 433. See also Note, 11 Wm. Mitchell L. Rev. at 573-74 (cited in note 11).

162. *Grewe*, 273 N.W.2d at 434 (quoting *Stanhope v. Los Angeles College of Chiropractic*, 54 Cal. App. 2d 141, 128 P.2d 705, 708 (1942)). *Grewe* is a frequently cited case showing the application of the ostensible agency doctrine

163. *Grewe*, 273 N.W.2d at 434.

164. Id.

165. Id. The patient must not have known or had a reasonable opportunity to discover that the doctor was not a hospital employee. A patient's negligence undercuts the reasonableness of her reliance.

166. See id. at 433-34. The court stated that "[t]he relationship between a given physician and a hospital may well be that of an independent contractor performing services for . . . the

Other courts will not apply the ostensible agency doctrine when the hospital did not hold itself out in a way that created reasonable reliance by the patient.[167] Although courts have limited their use of the ostensible agency doctrine appropriately, they have nonetheless used this doctrine to further expand hospital liability[168] by applying accepted agency principles to the hosptial arena.[169]

By turning to corporate liability, courts have imposed yet another layer of liability on hospitals: direct liability for the negligent selection and supervision of staff physicians.[170] When determining corporate liability, courts should examine the appropriate standards and apply them consistently to provide reasonable and clear parameters to lessen what could become overwhelming liability for hospitals.

V. THE STANDARDS—WHERE COURTS MAY LOOK FOR AN INITIAL DETERMINATION OF CORPORATE LIABILITY

Courts use objective standards to determine potential hospital negligence under the corporate liability doctrine. These standards, which define the scope and extent of potential liability for hospitals, have evolved as hospitals have become modern corporations.[171] Courts can find these standards in state statutes, state regulations, and guidelines promulgated by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which probably are the most influential.[172] Although the type of standard that courts apply ultimately may be of little importance, courts should apply the same set of standards and choose these standards consistently.

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hospital. However, that is not of critical importance to the patient who is the ultimate victim of the physician's malpractice." Id.

167. See, for example, *Revitzer v. Trenton Medical Center, Inc.*, 118 Mich. App. 169, 324 N.W.2d 561, 563 (1982). See also Note, 11 Wm. Mitchell L. Rev. at 572-76 (cited in note 11).

168. See Theodore I. Kaskoff and Thomas L. Nadeau, *Hospital Liability: The Emerging Standard of Care*, 48 Conn. Bar J. 305, 310 (1974). See also Havighurst, *Health Care Law and Policy* at 596-98 (cited in note 11).

169. See Restatement (Second) of Agency § 267 (1965). Respondeat superior and ostensible agency are accepted agency doctrines.

170. See Parts III.A.3 and III.A.4 of this Note.

171. See, for example, Perdue, 24 S. Tex. L. J. at 776-78 (cited in note 13).

172 See note 7.

A. The JCAHO Guidelines

The JCAHO was organized in 1952 by the American Medical Association, the American College of Physicians, and the American Hospital Association.[173] It has two express goals: to improve overall patient care and to establish minimum standards that hospitals must follow to receive accreditation.[174] The Commission publishes and updates these standards annually in the JCAHO Accreditation Manual for Hospitals (AMH), which provides hospitals with general guidelines.[175] Although JCAHO hospital accreditation is voluntary, most hospitals seek this status by complying with the guidelines[176] because of concerns like the fierce competition in today's marketplace. Thus, JCAHO accreditation is vitally important to a hospital's economic viability.[177]

The JCAHO guidelines require a hospital to structure itself as an organized governing body with persons responsible for creating policy, ensuring quality care, and establishing internal management and planning.[178] The hospital governing body, in turn, must adopt bylaws with regard to its legal accountability and responsibility to its patients.[179] The JCAHO guidelines require a hospital governing body to develop rules and bylaws for physician staff selection[180] and supervision.[181] These guidelines also require a hospital to have a single organized medical staff responsible for the quality of the professional services, which must report their findings to the governing body.[182] Although the hospital's governing body establishes rules and regulations for the medical staff, the governing body does not have the ultimate authority; a hospital's staff physicians are not truly subordinate

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173. Perdue, 24 S. Tex. L. J. at 776-77 (cited in note 13).

174. C. Nesley Eisele, *The Medical Staff in the Modern Hospital* 181 (Houghton Mifflin, 1987).

175. See 1 *JCAHO's Accreditation Manual for Hospitals (AMH)* (1984). See generally Eisele, *Medical Staff* at 180-86. See also Perdue, 24 S. Tex. L. J. at 776-77 (cited in note 13).

176. Perdue, 24 S. Tex. L. J. at 777 (citod in note 13). See also Cohoon, Comment, 17 San Diego L. Rev. at 383-84 n.2 (cited in note 116).

177. From a competitive standpoint, JCAHO accreditation is almost mandatory. A non-accredited hospital would have a difficult time competing for the health care dollar. According to recent American Hospital Association statistics, nearly five out of every six hospitals is accredited by the JCAHO. See *1992 AHA Hospital Statistics* at 202 (reporting that 5114 out of 6634 hospitals are accredited). Hospitals must seek accreditation in order to qualify for medicare and medicaid reimbursement. See 42 U.S.C. § 1395bb (1988 & Supp. 1991).

178. JCAHO's *Accreditation Manual for Hospitals*, GB.1., at 113 (1994).

179. Id. GB.1.13 at 115.

180. Id.

181. Id. GB.1.15, 1.17, 1.19, at 115.

182. *JCAH's Accreditation Manual for Hospitals/88* MS.1 at 115 (1988).

to the governing body.[183] For example, the governing body can fire a staff physician only if other staff physicians initiate the ousting and only after consultation with the medical staff.[184] Thus, the JCAHO guidelines and the corresponding exposure to corporate liability for the failure to supervise their staff physicians adequately limit hospital administrators' freedom.[185] The governing body has the ultimate, legal responsibility for its staff physicians, but it must defer to physician autonomy to satisfy the JCAHO guidelines, which are virtually necessary to run a successful and profitable hospital.[186] Thus, the JCAHO should amend the guidelines to provide specifically for greater governing body authority.

Although the JCAHO guidelines mandate that hospitals must comply with certain broad organizational requirements, they intentionally do not require specific ways for hospitals to fulfill these requirements. In particular, the guidelines do not specify the exact manner in which a hospital must select or supervise its physicians.[187] In fact, in the 1993 version of the guidelines, the JCAHO reduced the amount and extent of specific requirements that hospitals must follow[188] in an effort to respect hospital autonomy and recognize the geographical and cultural diversity among hospitals throughout the

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183. Kirt Darr and Jonathon S. Rakich, eds., *Hospital Organization and Management* 8-10 (National Health, 4th ed. 1989). See also Basil S. Georgopoulos and Floyd C. Mann, *The Hospital as an Organization*, in Darr and Rakich, eds., *Hospital Organization and Management* at 29. Vanderbilt University School of Law Professor James F. Blumstein analogized the situation to a university, in which tenured professors work within the university framework but are not technically bound by most university decisions regarding curriculum and teaching procedures.

184. Darr and Rakich, eds., *Hospital Organization and Management* at 8-10 (cited in note 183) (discussing the power and independence of the medical staff). See generally *Patrick v. Burget*, 486 U.S. 94 (1988), for the problems that this may cause relating to physician reluctance to initiate disciplinary proceedings against other physicians because of a fear of an antitrust action. See also Alex M. Clark, *Counseling on Medical Staff Issues*, in M. Elizabeth Gee, ed., *Antitrust Health Care Enforcement and Analysis* 255 (ABA, 1992). The result is that hospitals have no ability to remove negligent doctors because they may do so only after the staff physicians have acted. Darr and Rakich, eds., *Hospital Organization and Management* at 13-15 (cited in note 183) (recognizing that hospitals are gaining a greator degree of control).

185. Darr and Rakich, eds., *Hospital Organization and Management* at 9-10 (cited in note 183). Some commentators have argued that hospitals should have the needed control over their medical staff te go along with their increasing liability exposure. See, for example, Kinney, Comment, 65 Temple L. Rev. at 798 n.97 (cited in note 79).

186. Clark, *Counseling on Medical Staff Issues* at 237-39 (cited in note 184). The physicians provide the patients; therefore, hospitals are careful to tread lightly on physician autenomy. As a result, hospital governing bodies now have little control over the physician staff despite their ultimate, legal responsibility. The rules of the medical staff are adopted by the medical staff itself, and are merely approved by the governing body. See Havighurst, *Health Care Law and Policy* at 551 (cited in note 11) (citing JCAHO Guideline MS.2.1 (1988)).

187. See generally 2 *JCAHO,AMH* at vxii-xiv (citod in noto 175).

188. Id. at xi-xii.

country.[189] A more specific set of standards, however, would allow courts to apply these standards more evenly and consistently and would allow modern hospitals to protect themselves against future liability.

B. The National Practitioner Data Bank

To reduce the overall risk of malpractice, the United States Department of Health and Human Services recently promulgated regulations establishing a National Practitioner Data Bank (Data Bank) for the purpose of documenting events of medical malpractice and physician incompetence on a national level.[190] Any entity making a payment in settlement of a malpractice claim must report the circumstances of the payment to the Data Bank.[191] The Data Bank regulations also require state licensing boards to report any disciplinary actions[192] and any adverse clinical actions taken against a health-care provider.[193]

The Data Bank regulations require a hospital to check for prior malpractice events and adverse licensing proceedings against any physician that a hospital is considering for its staff.[194] A hospital is presumed to have constructive knowledge of any information available in the Data Bank.[195] A hospital that properly checks the Data Bank may rely on the obtained information without future liability,[196] essentially creating a per se defense to negligent selection liability when a plaintiff later claims that the hospital neglected to check the Data Bank when selecting a physician to its staff.[197] Even if courts

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189. Id. at xiii.

190. National Practitioner Data Bank for Adverse Information on Physicians and Other Health Care Practitioners, 45 C.F.R. § 60.7 (1992). These regulations were promulgated by the Health Care Quality Improvement Act of 1986, Pub. L. No. 99-660, 100 Stat. 3784 (codified as amended at 42 U.S.C. §§ 11101-11152 (1988 & Supp. 1993)). These regulations were first promulgated in September of 1991 and were amended most recently on October 1, 1992. See also HHS, Division of Quality Assurance and Liability Management, National Practitioner Data Bank Guide Book 1-3 (U.S. G.P.O., 1990). Until the advent of the Data Bank, the resources for collecting data on individual physicians were the Federation of State Licensing Boards and the AMA's Masterfile. Neither resource provided the comprehensive coverage envisioned by the Data Bank. See Havighurst, *Health Care Law and Policy* at 402-03 (cited in note 11).

191. 45 C.F.R. § 60.7 (1992).

192. 45 C.F.R. § 60.8 (1992).

193. 45 C.F.R. § 60.9 (1992).

194. 45 C.F.R. § 60.10(a)(1) (1992). Additionally, hospitals must check the Data Bank every two years thereafter. 45 C.F.R. § 60.10(a)(2) (1992).

195. 45 C.F.R. § 60.10(b) (1992).

196. A hospital will not be liable for relying on the information unless it knew the information was false. 45 C.F.R. § 60.10(c) (1992).

197. This per se defense likely would cover many of the claims in *Johnson v. Misericordia Community Hospital* because the physician's prior malpractice events would have been recorded

enforce this Data Bank requirement,[198] however, they still may hold hospitals liable for negligent selection based on criteria and information not included in the Data Bank. For example, a physician's poor references or questionable educational background may influence a court's determination of whether a hospital is liable for negligent selection.[199] Thus, checking the Data Bank only provides a defense for a hospital if the alleged negligence refers to a physician's prior malpractice or adverse licensure events. Therefore, the guidelines still need further comprehensive and well-defined selection criteria.

VI. AN UNEVEN APPLICATION OF STANDARDS IN IMPOSING CORPORATE LIABILITY

When determining corporate liability for negligent physician selection and supervision, courts have relied on different standards and have imposed varying degrees of hospital duties. Unfortunately, courts have assessed hospital liability inconsistently, which has placed hospitals in a difficult and precarious situation because even diligent administrators realistically cannot determine whether their decisions regarding physician selection and supervision will result in corporate liability. Nor can a hospital administrator know what proactive steps to take to protect the hospital from liability. If a hospital is too careful in its physician selection or supervision, the hospital may face liability from the doctors who are denied staff privileges and who assert that the hospital acted improperly in deciding to deny or suspend privileges.[200]

A. Darling v. Charleston Community Memorial Hospital: *The Application of Objective Standards in the Grandfather of Hospital Corporate Liability*

Courts have examined a variety of standards when determining whether a hospital has breached its duty to patients to properly

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in the Data Bank and would have been available to the hospital. At that time, however, no data bank was available. See text accompanying notes 58-60.

198. See 45 C.F.R. § 60.10(a) (1992) (specifying what information hospitals are required to request from the Data Bank).

199. See, for example, *Joiner v. Mitchell County Hosp. Auth.*, 125 Ga. App. 1, 186 S.E.2d 387 (1971).

200. A large portion of health-care law is devoted to hospital antitrust issues. This Note does not explore the issue of peer review in conjunction with antitrust concerns. For an example of a case discussing these antitrust concerns, see *Patrick v. Burget*, 486 U.S. 94 (1988).

select and supervise staff physicians.[201] These courts have required varying degrees of compliance with a constantly fluctuating set of standards;[202] thus they fail to provide clear guidelines for hospitals to follow to avoid corporate liability.

In addition to finding a duty to supervise staff physicians properly,[203] the *Darling* court relied not on customary community standards but on objective regulations, standards, and bylaws to establish the duty.[204] Although *Darling* appeared to set the stage for future, strict judicial reliance on objective criteria in determining corporate liability,[205] this trend did not occur. The court ultimately treated objective standards the same as custom, finding that neither could prove negligence conclusively.[206] By refusing to relinquish any judicial control in favor of more uniform and predictable guidelines,[207] the

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201. See generally *Thompson v. Nason Hosp.*, 527 Pa. 330, 591 A.2d 703 (1991); 591 A.2d 703; *Bell*, 260 Cal. Rptr. 886; *Darling v. Charleston Comm. Memorial Hosp.*, 33 Ill.2d 326, 211 N.E.2d 253 (1965); *Joiner v. Mitchell County Hosp. Auth.*, 125 Ga. App. 1, 186 S.E.2d 307 (1971); *Gonzales v. Nork*, 60 Cal. App. 3d 835, 131 Cal. Rptr. 717 (1976); *Johnson*, 301 N.W.2d 156; *Pedroza v. Bryant*, 101 Wash.2d 266, 677 P.2d 166 (1984); *Elam v. College Park Hosp.*, 132 Cal. App. 3d 332, 183 Ca. Rptr. 156 (1982); *Purcell v. Zimbleman*, 18 Ariz. App. 75, 500 P.2d 335 (1972); *Van Iperen v. Van Bramer*, 392 N.W.2d 480 (Iowa 1986); *Sheffield v. Zilis*, 170 Ga. App. 62, 316 S.E.2d 493 (1984).

202. See Part VI.B of this Note

203. See notes 89-99 and accompanying text for a discussion of this portion of the court's holding.

204. *Darling*, 211 N.E.2d at 255-56. See also Havighurst, *Health Care Law and Policy* at 591 (cited in note 11).

205. The objective criteria on which the court potentially could rely included the Illinois regulations, the JCAHO standards, and the hospital bylaws that were promulgated in conformity with JCAHO standards.

206. *Darling*, 211 N.E.2d at 256.

207. Id. Some courts have held that mere licensing is enough, and others have stated that adherence to JCAHO guidelines is required. See the discussion in note 216 and accompanying text. Other courts have held that adherence to JCAHO guidelines is insufficient. See, for example, the discussion of the *Gonzalez* case in notes 220-26 and accompanying text. These different court holdings show the disparate treatment that courts have given to corporate liability cases.

The court in *Darling* pointed to universal, objective standards while simultaneously championing ultimate judicial discretion. The court quoted Learned Hand: "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 never may set its own tests, however persuasive be its usages. *Courts must in the end say what is required*; there are precautions so imperative that even their universal disregard will not excuse their omission." *Darling*, 211 N.E.2d at 257 (quoting *The T.J. Hooper*, 60 F.2d 737, 740 (2d Cir. 1932)) (emphasis added). Under the court's reasoning, any court may override even established objective standards of corporate liability. Accordingly, a hospital administrator who complies with recognized standards will nonetheless be subject to potential liability. *Darling*, 211 N.E.2d at 258. A hospital will not have an incentive to comply with established standards if the courts refuse to recognize these standards.

Thus, although *Darling* recognized that objective standards are important tools for courts to use in determining corporate liability, it left the door open for future courts to second-guess these standards and to impose standards of their own. As one commentater aptly stated, "[t]he fertile

Darling court set the stage for a long line of cases that have assessed corporate liability inconsistently.

B. The Progeny of Darling

In *Joiner v. Mitchell County Hospital Authority*,[208] the Georgia Court of Appeals rejected the defendant hospital's claim that compliance with Georgia law regarding licensing and references should absolve it of any liability for negligent selection.[209] The court rejected specific, objective standards as being dispositive and stated that although the selected physician was licensed by the state and was recommended by other doctors on the staff, the selecting hospital still could be held liable for the physician's future negligence under a corporate liability theory.[210] Thus, hospital administrators that comply with state laws on physician selection must hold their breath and hope that an appellate court does not determine, in its "expert" opinion, that their hospitals should have exercised greater diligence in the selection process. Without knowing what standards to follow, hospitals have no way to protect themselves from potentially great exposure for the future acts of their carefully hired staff physicians.

The courts in *Darling* and *Joiner* did not examine the JCAHO or similar provisions to assess a breach of duty. Later courts have considered hospital compliance with JCAHO standards when determining corporate liability.[211] In *Pedroza v. Byrant*,[212] the Washington Supreme Court applied JCAHO accreditation standards to determine a hospital's corporate liability.[213] The court apparently found that a hospital's breach of the JCAHO guidelines amounted to per se negligence; thus, courts could look to the specific JCAHO guidelines to determine whether a hospital breached a corporate

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ground first plowed by *Darling* is now growing a most diverse and hearty crop." Perdue, 24 S. Tex. L. J. at 788 (cited in note 13).

If *Darling* had not left the judicial door open so wide, then perhaps subsequent courts would have looked for established criteria that give hospital administrators the opportunity to protect themselves through compliance with the set standards.

208. 125 Ga. App. 1, 186 S.E.2d 307 (1971). See notes 44-54 and accompanying text.

209. *Joiner*, 186 S.E.2d at 308. The later case of *Purcell*, 18 Ariz. App. 75, 500 P.2d 335, cited *Joiner* and stated that state licensing and peer recommendations were not enough to shield the hospital from liability.

210. *Joiner*, 186 S.E.2d at 308. The court did not refer specifically to "corporate liability," but it clearly was referring to the doctrine.

211. See, for example, *Van Iperen v. Van Bramer*, 392 N.W.2d 480 (Iowa 1986); *Pedroza*, 677 P.2d 166; *Sheffield v. Zilis*, 170 Ga. App. 62, 316 S.E.2d 493 (1984); *Gonzales v. Nork*, 60 Cal. App. 3d 835, 131 Cal. Rptr. 717 (1976).

212. 101 Wash.2d 266, 677 P.2d 166 (1984).

213. Id. at 171.

duty.[214] Hospitals could comply with these standards, minimizing the potentially unlimited liability that a patient-sympathetic court could impose on even the most diligent hospital.

By focusing on objective standards, the *Pedroza* court moved in the right direction, but in doing so, it inadvertently emphasized a problem with the guidelines themselves from a corporate liability standpoint: courts cannot rely on the guidelines because they are too imprecise.[215] For courts to apply the JCAHO guidelines as the standard for corporate liability,[216] the guidelines must provide specific and thorough criteria. The court in *Pedroza* failed to address this issue.

Wisely, the court in *Pedroza* equated JCAHO accreditation to full compliance with hospital corporate liability duties.[217] The court stated that the JCAHO standards, along with the hospital bylaws adopted pursuant to these standards, constituted the standard of care that the hospital must follow.[218] The resulting problem is that although courts may apply these JCAHO guidelines strictly, the guidelines are too imprecise to provide consistent and comprehensive direction for hospital administrators. If all courts relied on these standards and if the standards were specific and comprehensive, then hospitals could focus squarely on compliance, thereby obviating their potential corporate liability exposure. Although the court in *Pedroza* did not go far enough to address the shortcomings of the guidelines, it nevertheless made the important decision to apply one set of uniform, national standards.[219] Unfortunately, courts throughout the country have not followed the *Pedroza* holding in this regard.

In *Gonzalez v. Nork*,[220] the Superior Court of California stated that hospital compliance with JCAHO standards alone was insufficient to insulate the hospital from corporate liability for negligent

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214. The court decided to adopt the doctrine of corporate negligence but did not reverse summary judgment against the plaintiff because the malpractice occurred entirely outside the hospital. Id. Mrs. Pedroza was treated in the physician's private office; the hospital was not involved. The court held that a "hospital's duty of care under the doctrine of corporate negligence extends only to those who are patients within the hospital." Id. at 172.

215. Id. at 169-71.

216. The JCAHO guidelines should serve as the standard. As previously stated, however, the Joint Commission must amend the guidelines to address the corporate liability problem more specifically.

217. *Pedroza*, 677 P.2d at 170-71.

218. Id. The court cited Koelln, Note, 32 Rutgers L. Rev. at 376-77 (cited in note 71), for this proposition.

219. *Pedroza*, 677 P.2d at 166.

220. 60 Cal. App. 3d 835, 131 Cal. Rptr. 717 (1976). See also Perdue, 24 S. Tex. L. J. at 801 (cited in note 13) (citing *Gonzalez v. Nork*, No. 228566C Sacramento Super. (Nov. 27, 1973), rev'd, 60 Cal. App. 3d 728, 131 Cal. Rptr. 717 (1976)).

selection.[221] *Gonzalez*, contrary *Pedroza*, scrutinized the JCAHO standards[222] and found them deficient because of their vagueness.[223] The court in *Gonzalez*, like the court in *Darling*, again quoted Learned Hand, who said that courts ultimately must decide what constitutes negligence regardless of any defined standards.[224] The court in *Gonzalez* held that courts must make the final determination regarding negligence and that hospital compliance with standards may not be enough to escape a separate judicial determination of corporate liability.[225] This decision leaves hospitals at the mercy of judicial hindsight, facing liability regardless of compliance with national industry standards. Because courts have treated compliance with JCAHO standards inconsistently, hospitals must hope that the particular court in which they appear does not ignore these accepted standards and impose corporate liability despite the hospital's actual compliance with industry guidelines.[226]

Other courts also have treated the corporate liability standards inconsistently. In a case decided after both *Pedroza* and *Gonzalez*, the Iowa court in *Van Iperen v. Van Bramer*[227] also found that a hospital's compliance with JCAHO standards, or in this case lack of compliance, was not dispositive of liability.[228] The court's holding resembled the *Gonzalez* court's decision in that both recognized that the JCAHO standards are not self-authenticating.[229] In *Van Iperen*, however, the court upheld the directed verdict for the defendant hospital despite possible non-compliance with JCAHO standards.[230] Although the court recognized that JCAHO standards may provide some evidence of

221. Perdue, 24 S. Tex. L. J. at 801. Defendant Dr. John Nork appealed from a $3.7 million judgment for the plaintiff. *Gonzales*, 131 Cal. Rptr. at 718. Mercy Hospital, a co-defendant, did not appeal the judgment. Id. at 718 n.1.

222. At the time of the decision, the standards were known as the JCAH standards.

223. Perdue, 24 S. Tex. L. J. at 802 (cited in note 13). The court recognized deficiencies in the standards but did not propose any remedial measures. Id.

224. Id. at 802-03.

225. Perdue, 24 S. Tex. L. J. at 802 (cited in note 13).

226. The JCAHO guidelines may be considered equivalent to industry guidelines.

227. 392 N.W.2d 480 (Iowa 1986). Plaintiffs appealed from a lower court judgment in a medical malpractice case. The district court directed a verdict for the defendant, St. Luke's Regional Medical Center. Id. at 481.

228. Id. at 485-86. The Iowa Supreme Court upheld a district court's directed verdict in favor of the defendant hospital even though the hospital's procedures may not have met the relevant JCAHO standards. Id.

229. Id. at 486. The court stated: "We do not believe the scope and application of the written accreditation standards upon which plaintiff relies are sufficiently clear that these documents are self-authenticating with respect to the required standard of care." Id.

230. Id.

the proper standard of care, the court declined to apply the standards exclusively when assessing the hospital's corporate liability.[231]

Thus, in some cases a hospital may comply with the guidelines but still incur liability, while in other cases a hospital may violate the guidelines but still prevail.[232] This inconsistency allows for judicial second-guessing while it reduces a hospital's realistic opportunity te protect itself through JCAHO guideline compliance. Despite the difficulties that these inconsistent holdings impose on hospitals with respect to their ability to minimize exposure, hospitals could attempt to avoid exposure to liability if all court holdings were consistently unreasonable. Nevertheless courts sometimes hold that compliance with JCAHO, or other, guidelines constitutes complete protection from corporate liability and sometimes they do not. Hospitals are left uncertain and exposed.

The Georgia Court of Appeals in *Sheffield v. Zilis*[233] upheld a lower court's summary judgment for a hospital that complied with JCAHO standards.[234] The *Sheffield* court looked to the Georgia court's decision in *Joiner* with respect to the hospital's use of reasonable care in physician selection. Although *Joiner* stated that mere compliance with objective criteria was insufficient, the *Sheffield* court arguably found that it was enough to uphold a summary judgment motion.[235]

Even within the same state, courts have continued to send conflicting signals to hospitals, creating a disincentive for hospitals to follow industry guidelines strictly.[236] This disincentive occurs because hospitals risk exposure even when they arduously follow objective standards. Courts hold themselves out as better arbiters of proper hospital care than the members of the actual medical and hospital communities. If hospitals knew that full compliance with JCAHO guidelines would protect them from liability, then they would have a greater incentive to scrutinize and comply with the guidelines. Under the present confusion, however, hospitals are left to guess and hope that a particular court will decide that their compliance is enough. By holding hospitals liable for the negligent selection or negligent

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231. Id. The court cited an earlier Iowa case, *Menzel v. Morse*, for the proposition that the standards presented in the case were "insufficient, without additional reliable interpretative data. . . ." Id. at 486 (citing *Menzel v. Morse*, 362 N.W.2d 465, 471 (Iowa, 1985)).

232. *Van Iperen*, 392 N.W.2d 480.

233. 170 Ga. App. 62, 316 S.E.2d 493 (Ga. App. 1984).

234. Id. at 495. The court stated that the JCAHO standards were the "most universally accepted standards and procedures in the United States." The court then found that the defendant hospital had followed these standards when it appointed Dr. Zilis to its staff. Id. at 494.

235. Id. The court upheld summary judgment on procedural grounds unrelated to JCAHO compliance. Nevertheless, the decision creates some confusion.

236. Compare, for example, *Sheffield*, 316 S.E.2d at 494, with *Joiner*, 186 S.E.2d at 308.

supervision of staff physicians, courts already impose liability on hospitals based on attenuated reasons.[237] The doctrine of corporate liability punishes hospitals for indirect wrongs over which they ultimately may have little or no control. If courts are going to impose this attenuated liability, they have an obligation to apply the doctrine consistently so that hospitals can protect themsselves from liability. The fact that JCAHO guidelines are intentionally broad also thwarts strict compliance with them.

C. Other Ways That Courts Have Addressed the Standards Issue-- Further Judicial Inconsistency

The Wisconsin Supreme Court, in the landmark case of *Johnson v. Misericordia Community Hospital*,[238] established a hospital duty of proper selection, but it did not create a standard of care to assess this newly imposed duty.[239] The court maintained that the established tort standard of "ordinary care under the circumstances" still served as the standard of care to assess corporate liability.[240] This holding avoids the standards issue. Instead of applying a new standard of care to a new theory of liability, the court relied on an established tort doctrine that did not address the corporate liability issue sufficiently.[241]

The court in *Elam v. College Park Hospital*[242] relied on a combination of JCAHO standards and statutory authority in rendering its decision. Although reliance on JCAHO standards would provide the needed judicial consistency, the addition of statutory authority only confuses the issue. If courts in each state consistently relied on certain JCAHO guidelines along with appropriate state statutes, then perhaps a combination of the standards would provide hospitals with a workable framework to follow. Unfortunately, courts have neglected to offer any uniformity. The frequently cited case of *Elam* provides another example of the inconsistent and uneven judicial treatment of the corporate liability issue.

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237. See Comment, 7 Creighton L. Rev. at 261 (cited in note 13).

238. 99 Wis. 2d 708, 301 N.W.2d 156 (1981). *Johnson* is discussed in notes 55-67 and accompanying text.

239. *Johnson*, 301 N.W.2d at 170.

240. Id. at 171.

241. Id. at 171-72. See Davenport, Note, 1983 Wis. L. Rev. at 467-68 (cited in note 24).

242. 132 Cal. App. 3d 332, 183 Cal. Rptr. 156 (1982).

VII. HOW COURTS SHOULD APPLY THE STANDARDS

Courts must apply the corporate liability standards evenly and consistently to give the doctrine any true credibility. Without consistent judicial application of the standards, corporate liability presents hospitals with the daunting specter of potentially limitless liability. Courts must apply a uniform set of standards to define hospitals' duties under the corporate liability doctrine.

The JCAHO guidelines are the appropriate guidelines for courts to rely on in establishing hospital duties in the area of physician selection and supervision. The guidelines are updated annually, are representative of industry changes, and are subscribed to on a national basis.[243] They also are written by and for the hospital industry, and hospitals subscribe to them on a voluntary basis.[244] The hospital community is in the best position to define and develop the specific guidelines that will safeguard hospital autonomy.[245] Accordingly, compliance with these standards should serve as a safe harbor from corporate liability. Corporate liability does not replace existing tort and contract remedies but provides additional remedies to those that have been available historically. Consequently, the doctrine should serve as a viable option only on a limited basis. Compliance with JCAHO standards should serve as the litmus test for corporate liability. Future courts should follow the *Pedroza* decision and hold that compliance with these standards alone is sufficient to protect a hospital from corporate liability.[246]

The majority of courts throughout the country now use a national standard of care to assess all types of medical malpractice.[247] The national standard, as codified in the JCAHO guidelines, is based on the knowledge and practices of the ordinary hospital, regardless of the hospital's location.[248] National standards raise the quality of all hospitals, treat all hospitals equally in the eyes of the law, provide incentives for hospitals with limited skills and resources to improve, and reflect national health plans and priorities.[249] National JCAHO

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243. See notes 61-73 and accompanying text.

244. See Part V.A of this Note (discussing the JCAHO).

245. Id.

246. See text accompanying notes 212-14.

247. See, for example, *Shilkret v. Annapolis Emergency Hosp. Assoc.*, 276 Md. 187, 349 A.2d 245, 252 (Md. App. 1975) (ruling that courts should use a national standard when assessing hospital and physician liability).

248. Id. All hospitals may maintain certain customs and practices no matter where they are or how they operate. The national standard offers a single, correct way to provide basic care.

249. National standards seem particularly appropriate in light of the new Clinton health-care plan.

standards will allow courts to apply the corporate liability doctrine in a practical and responsible manner.

Some comentators argue that courts should not use national standards because of the inherent differences in health care that exist in communities throughout the country.[250] Opponents of a national standard argue that hospitals must have flexibility in addressing health-care concerns.[251] They also argue that flexibility is necessary to handle the variety of health-care concerns that both urban and rural, as well as wealthy and poor, communities must overcome.[252]

A national corporate liability standard is indeed desirable. These proposed national standards would not regulate the health-care system itself. Hospitals need a certain amount of flexibility to determine how they may provide adequate health care in the communities in which they operate. National standards would not deny a hospital its autonomy of operation within established minimum criteria and would not mandate the specific manner in which hospitals could achieve compliance.[253] Instead, the standards would require compliance itself, rather than imposing a blueprint for how to achieve this compliance. Proper JCAHO national standards should allow hospitals needed flexibility, while still providing workable parameters for both hospitals and courts to follow. These national standards should provide a framework for hospitals and courts to follow when assessing corporate liability duties. Furthermore, the hospital community developed the JCAHO. The JCAHO, therefore, works with member

250. The locality rule is based not on the knowledge or style of the particular physician but rather on the resources and facilities available in the specific area. See *Shilkret*, 349 A.2d at 248 (citing Jon R. Waltz, *The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation*, 18 DePaul L. Rev. 408 (1969)). A health-care facility is not required to do a procedure if it does not have the resources and tells the patient that it would have performed the procedure if it had the resources. *Shilkret*, 349 A.2d at 248.

251. The locality rule has advantages and disadvantages. On the positive side, the locality rule accounts for ecenomic scarcity and considers the needs of the population in the hospital's community. The disadvantages include a lack of incentive to improve and the perpetuation of sub-par resources. For a discussion of the development of the locality rule, see Dwaine E. Fagerland, Note, *Legal Practice: The Locality Rule and Other Limitations of the Standard of Care: Should Rural and Metropolitan Lawyers Be Held to the Same Standard of Care?*, 64 N.D. L. Rev. 661, 667-75 (1988).

252. The advantages of the local standard do not outweigh the disadvantages that manifest themselves in the overall lack of consistent quality care. Local standards for cerporate liability will continue to create uncertainity and inequity in the courts' application of the doctrine.

253. For example, the national standards might require hospitals to conduct supervisory checks on staff physicians every six months. Although these investigations might be mandatory, each hospital could decide its procedure for the investigations.

hospitals to develop guidelines specific enough to address the corporate liabilty issue without eliminating hospital autonomy.[254]

Hospitals must have specific guidelines to follow so that they can take measures to eliminate their potential exposure. If hospital administrators know what procedures they must follow in selecting and supervising their staff physicians, they can eliminate future liability by strictly complying with JCAHO Guidelines. Uniform standards thus will encourage hospitals to follow the standards because full compliance will protect the hospitals from corporate liability exposure. Hospitals will spend the extra time and money to comply because the protection from exposure will merit the initial administrative efforts and financial expenditures.

This system of incentives will work only if two steps are taken. First, the courts must apply the JCAHO standards consistently and hold that full hospital compliance with these standards will create a safe harbor from liability.[255] Second, the Joint Commission must make the JCAHO Guidelines more specific. For example, the Guidelines state that hospitals must have a mechanism to evaluate the medical staff for reappointment.[256] The Guidelines specifically mention professional performance, judgement, and technical skills as factors to consider when reviewing the clinical privileges of a member of the medical staff.[257] Perhaps the Guidelines could provide greater guidance and discuss the exact mechanism and timeframe for supervision. The Guidelines might state specifically that all medical staff must be reviewed formally on a semi-annual basis by an internal peer review organization and that medical staff non-compliance with appropriate procedure will result in formal reprimand for the first offense and expulsion for the subsequent offense.[258] This specific procedure would give courts and hospital administrators the ability to

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254. The JCAHO's self-proclaimed mission is "to impose the quality of health care provided to the public. The Joint Commission developed standards of quality in collaboration with health professionals and others and stimulates health care organizations to meet or exceed the standards through accreditation and the teaching of quality improvement concepts." Joint Commission on Accreditation of Healthcare Organizations, Hospital Accreditation Statutes (1992) (mission statement). The JCAHO works with hospitals to develop standards that will benefit both the industry and the public. Recent data shows that the JCAHO Guidelines and evaluations have had a positive impact on hospital performance. See, for example, id. at 105-20. See also Richard E. Leahy, Comment, *Rational Health Policy and the Legal Standard of Care: A Call for Judicial Deference to Medical Practice Guidelines*, 77 Cal. L. Rev. 1483, 1510-13 (1989).

255. *Pedroza*, 677 P.2d at 170-71 (stating that courts should hold hospitals to the JCAHO accreditation standards).

256. 1 *JCAHO AMH*, M.S.-2.7 at 67 (1994).

257. Id.

258. Of course, notice requirements would have to be followed, and antitrust concerns might come into play.

determine whether a hospital has breached its corporate supervision duty while still providing the hospital with some lattitude as to how to set up the supervision apparatus.

Specific standards undoubtedly will strip hospitals of some of their autonomy in deciding how to select and supervise their staff physicians. This loss of autonomy, however, will be outweighed by the certainty and accountability that specific standards will provide to hospitals and to courts. The Joint Commission could fashion a specific set of JCAHO standards that still respect and provide for overall hospital autonomy of operation. By promulgating a specific set of standards that the courts could apply evenly, the Joint Commission would provide the needed framework for the proper application of the corporate liability doctrine.

Some may argue that JCAHO Guidelines are not appropriate or valuable guidelines to address liability issues. Although they may not have been designed to address liability concerns, they are the most useful standard for determining corporate liability. The hospital industry has adopted them widely on a voluntary basis. The voluntary nature of the Guidelines should allow the market forces to find the correct degree of specificity needed to address the corporate liabilty area. If the Guidelines become too onerous or inappropriate for hospitals, then the hospitals simply may drop their affiliation with the JCAHO. This, in turn, may dilute the influence and prestige of the JCAHO, causing the Commission to revise the Guidelines to reflect hospital concerns more closely in an effort to win back disgruntled members. Short of hospital withdrawal or boycott, but possibly more effective, should be the hospitals' input in deciding what specific guidelines they could or could not follow realistically from a practical and competitive standpoint. Hospital input should help the Commission to find the necessary happy medium between clarifying the corporate liability doctrine and imposing inflexible requirements on the hospital industry.

The requirements of the National Practitioner Data Bank[259] provide an example of the type of specific criteria that the JCAHO should use. The Guidelines currently defer greatly to an individual hospital's bylaws.[260] Although this deference may work best for hospitals in many areas, it does not provide adequate boundaries to circumscribe the corporate liability threat. A tension exists between standards that are too broad to guide courts and hospital

259. Part V.B of this Note discusses the Data Bank.
260. 1 *JCAHO AMH* at 66 (cited in note 175).

administrators and standards that are too narrow to allow for needed autonomy for individual hospitals. The Data Bank, however, shows that a middle ground is possible.

Proponents of the Guidelines might argue that the Guidelines already are specific enough. This contention certainly has some merit. For example, the Guidelines now require hospitals to establish a governing body that must promulage specific standards.[261] Additionally, in the area of clinical privileges, for example, the Guidelines require core elements—current licensure, relevant training or experience, and health status—and these elements must be satisfied with specific documentation.[262] These standards, therefore, may be specific enough for courts to follow.

More importantly, the courts still have the ultimate duty to render clear and uniform decisions, regardless of the Guidelines' specificity.[263] This important factor should not be forgotten amidst the discussion of the Guidelines. Accordingly, using the Guidelines is only one suggestion. If the courts develop established common-law standards within each state, perhaps the JCAHO Guidelines would be unnecessary. The responsibility ultimately lies with the courts to apply the corporate liability doctrine consistently. More specific guidelines will aid this effort, but courts still must render proper decisions.

Corporate liability has a legitimate place in the law. It may encourage hospitals to scrutinize their staff physicians more carefully, thus decreasing the instances of physician malpractice by providing direct incentives[264] to hospitals to ensure physician competence. This change should provide a direct benefit to hospital patients. Corporate liability also may provide relief to injured patients when no other avenue of compensation exists. Without the tort award that corporate liability would provide, the taxpayer ultimately would suffer the burden of providing ongoing, public care to an injured claimant whose malpractice claim falls through the cracks of the tort system. Because hospitals are highly profitable, and in the best position to prevent the malpractice that the corporate liability doctrine is designed to address, they should bear this burden, not the innocent malpractice victims and not the innocent taxpayers.

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261. Id. at 113.

262. See 2 *JCAHO AMH* § 3 at 2-11. These requirements, however, still do not specify the process needed to achieve the desired results.

263. See the discussion of the courts' inconsistent decisions in Part VI of this Note.

264. Health-care commentators increasingly are using economic models te analyze health care. Incentives are the focal point for much of this analysis. See Havighurst, *Health Care Law and Policy* at 73-98 (cited in note 11).

Corporate liability is, however, quite dangerous if the courts apply it inconsistently. Without proper judicial application, the doctrine may lead to unfettered hospital liability. Hospitals ultimately will pass this increased liability on to the patient through increased costs and fees. Courts must not hold the hospital accountable to insure any and all events that occur within hospital walls. Although courts have maintained that hospitals are not the insurers of every mishap within the hospital,[265] courts have nonetheless treated hospitals as insurers in some cases. Courts have an obligation to apply the corporate liability doctrine consistently. The hospital community, in turn, has an obligation to provide more specific guidelines for hospitals and courts to follow.

If hospitals do not believe that they can account for, or prevent liability for, negligent physician selection or supervision, then perhaps the greatest value of corporate liability will be lost.[266] Hospitals that otherwise would have an incentive to select and supervise their staff physicians carefully will not do so if they are unsure about applicable standards and potential treatment by the courts.

VIII. CONCLUSION

As it now stands, hospitals are in a quandary. If a hospital does not terminate a staff physician after receiving several complaints, then the hospital potentially exposes itself to corporate liability for negligent physician supervision. However, if the hospital terminates the physician, then the hospital is exposing itself to a potential antitrust action from the physician.[267] Until hospitals can make decisions based on greater information and with greater certainty, they will be forced to play the odds. The true losers will be the patients, who will suffer higher insurance premiums, decreased access to adequate care, and increased negligent care.

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265. See, for example, the discussion in text accompanying note 69.

266. See Part III.B (discussing the justifications for corporate liability).

267. The antitrust issues are of vital importance in this area. They affect physician peer review, for example, which is vital in overall physician selection and supervision. See generally M. Elizabeth Gee, *Antitrust Healthcare Enforcement Analysis* (ABA, 1992).