McGeorge Law Review

Volume 14 | Issue 3 Article 11

1-1-1983

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Five years ago, a student commentator writing in this Law Journal[1] assessed the prospects for the coming of hospital "corporate negligence"[2] in California and concluded that the prospects seemed excellent.[3] The prospects were indeed excellent for, in May of 1982, the Fourth District Court of Appeal decided the case of *Elam v. College*

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1. Comment, *The Hospital's Responsibility for its Medical Staff: Prospects for Corporate Negligence in California*, 8 PAC. L.J. 141 (1977).

2. The terms "corporate negligence" and "corporate liability" are used interchangeably by many courts and commentators. In the interest of uniformity, the term "corporate negligence" will usually be used in this article. "Corporate negligence" apparently stems from an effort to limit the application of charitable immunity by distinguishing between corporate negligence by employment of incompetent servants and corporate liability imposed as a result of respondeat superior. *See* Goldberg, *The Duty of Hospitals and Hospital Medical Staffs to Regulate the Quality of Patient Care: A Legal Perspective*, 14 PAC. L.J. 55, 56, n.3 (1982); *see also* Elam v. College Park Hosp., 132 Cal. App. 3d 332, 338 n.5, 183 Cal. Rptr. 156, 159 (1982).

3. Comment, supra note 1, at 163.

Park Hospital,[4] defining and applying the doctrine of corporate negligence for the first time on the appellate level in California.[5]

In *Elam*, the Court of Appeal was confronted with the following situation. Sophia Elam had filed a medical malpractice action against a podiatrist, a physician and College Park Hospital. She complained that the podiatrist had negligently performed podiatric surgery on her at College Park Hospital.[6] The podiatrist was neither an agent nor an employee of the hospital.[7] Elam herself had selected him for podiatric treatment.[8] The podiatrist had been granted podiatric surgical privileges by the governing board of the hospital.[9]

Elam asserted that the hospital had a duty to her to ensure the competence of the members of its medical staff.[10] The hospital argued that it had no such duty.[11] The trial court agreed with the hospital and granted its motion for summary judgment.[12]

The Court of Appeal reversed. It reviewed case precedent,[13] which it summarized as establishing that a hospital has a duty to protect patients from harm,[14] and then concluded as follows:

> We can perceive of no reason why this established duty of care does not encompass the duty asserted by Elam; for, as a general principle, a hospital's failure to insure the competence of its medical staff through careful selection and review creates an unreasonable risk of harm to its patients.[15]

The *Elam* decision leaves in its wake a number of very interesting questions for plaintiffs' lawyers and for hospital and physicians' attor-

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4. 132 Cal. App. 3d 332, 183 Cal. Rptr. 156, *modified*, 133 Cal. App. 3d 94a (1982).

5. In 1973, the Superior Court of Sacramento County imposed corporate liability on a hospital for retention of a physician on its medical staff in the case of *Gonzales v. Nork*, Civ. No. 228566 (Super. Ct. Sacramento County, Cal. Nov. 27, 1973), *rev'd. for failure to grant jury trial*, 60 Cal. App. 3d 728, 131 Cal. Rptr. 717 (1976), *rev'd and remanded* 20 Cal. 3d 500, 573 P.2d 458, 143 Cal. Rptr. 240 (1978); *see also*, *Eng v. Valley Memorial Hosp.*, Civ. No. 46 0898-3 (Super. Ct. Alameda County, Cal. Dec. 15, 1977), *cited in* Comment, *Piercing the Doctrine of Corporate Hospital Liability*, 17 SAN DIEGO L. REV. 383, 386, n.16 (1980), *reprinted in* SPECIALTY LAW DIGEST: HEALTH CARE 5 (August 1981).

6. 132 Cal. App. 3d at 336, 183 Cal. Rptr. at 157.

7. *Id.* at 336, 183 Cal. Rptr. at 158.

8. *Id.*

9. *Id.*

10. *Id.* at 337, 183 Cal. Rptr. at 158.

11. *Id.* at 338, 183 Cal. Rptr. at 159.

12. *Id.* at 335, 183 Cal. Rptr. at 157-58.

13. Rice v. California Lutheran Hosp., 27 Cal. 2d 296, 163 P.2d 860 (1945); Guilliams v. Hollywood Hosp., 18 Cal. 2d 97, 114 P.2d 1 (1941); Murillo v. Good Samaritan Hosp., 99 Cal. App. 3d 50, 160 Cal. Rptr. 33 (1979); Valentin v. La. Societe Francaise, 76 Cal. App. 2d 1, 172 P.2d 359 (1946).

14. *Elam*, 132 Cal. App. 3d at 340, 183 Cal. Rptr. at 160.

15. *Id.* at 341, 183 Cal. Rptr. at 161. The opinion originally published in the Official Advance Sheets imposes a duty of "careful selection, review and supervision." *Id.* at 341, 183 Cal. Rptr. at 161. The opinion was subsequently modified by removal of the duty of supervision. 133 Cal. App. 3d 94a.

neys alike. They break down into several categories, two of which can be loosely labeled as the "parties questions" and the "proof questions." The "parties questions" concern the possibility of additional defendants or even cross-defendants in corporate negligence cases. Are medical staff members who serve on peer review or quality assurance committees potential defendants or cross-defendants in a corporate negligence case? Are the committees themselves or are medical staffs *per se* potential parties? Are hospital governing bodies or individual directors or trustees likewise subject to suit? The "proof questions" concern how the plaintiff can prove his or her case against a hospital and how the hospital can defend. Are medical staff committee proceedings and records discoverable and/or admissible? Can the plaintiff use the doctrine of *res ipsa loquitur* to prove his or her case? The purpose of this article is to articulate and examine a number of the questions raised by *Elam*,[16] and even to answer a few.

BACKGROUND

A. Evolution of the Contemporary Hospital

A basic understanding of the administration and organization of hospitals in the 1980's is very important for an appreciaton of the questions raised by *Elam*, because the case applies traditional principles of corporate and tort law to an institution that is so highly regulated that it cannot operate like an ordinary corporation.

In the beginning, doctors were the hospital; they often founded, owned and ran the hospitals.[17] Today, by contrast, health care is truly big business.[18] The hospital has been transformed from merely the "doctors' workshop"[19] to a multi-faceted health center with the respon-

16. One question which will *not* be addressed in this article is just exactly what the duty entails. That question has been well covered elsewhere, although not with respect to California law. *See* Comment, *Hospital Corporation Liability: An Effective Solution to Controlling Private Physician Incompetence?* 32 RUTGERS L. REV. 342, 360-61 (1979). Perhaps the most onerous definition of a hospital's duty yet imposed is in a case decided after the foregoing comment was published. In Bost v. Riley, 44 N.C. App. 638, 262 S.E.2d 391, *disc. rev. denied*, 300 N.C. 194, 269 N.E.2d 621 (1980), the North Carolina Court of Appeals held that a hospital could breach its duty by failing to monitor and oversee the keeping of patient progress notes. The case is discussed in a case note, *Corporate Negligence of Hospitals and the Duty to Monitor and Oversee Medical Treatment* — Bost v. Riley, 17 WAKE FOREST L. REV. 309 (1981). The North Carolina appellate courts have been reluctant to apply the duty to supervise. *See, e.g.*, Cox v. Haworth, 283 S.E.2d 392 (N.C. App. 1981); Jones v. New Hanover Memorial Hosp., 286 S.E.2d 374 (N.C. App. 1982).

17. Relman, *The New Medical-Industrial Complex*, 303 NEW ENG. J. MED. 963 (1980).

18. During calendar year 1980, $247 billion was spent on health care in the United States. That represents 9.4 percent of the gross national product for that year. $100 billion (40.5 percent of the expenditure) was spent on hospital care. CALIFORNIA HOSPITAL ASSOCIATION, HOSPITAL FACT BOOK 1981-2. There is considerable debate over how health care should be provided. *Cf.* Relman, *supra* note 17; Clark, *Does the Nonprofit Form Fit the Hospital Industry?*, 93 HARV. L. REV. 1416 (1980).

19. Relman, *supra* note 17; Comment, *supra* note 16.

sibility for arranging, coordinating and providing comprehensive health care.[20] With this metamorphosis has come regulation, both from within the health care industry and by the government. The principal source of private regulation is the Joint Commission on Accreditation of Hospitals (hereinafter referred to as JCAH).[21] One might even say that the modern hospital organization is a direct descendant of the model developed initially in the early 1900's by the American College of Surgeons, the forerunner of the JCAH. Recognizing the need to develop standards for American hospitals, the American College of Surgeons inaugurated a program for hospital standardization in 1918 called, not surprisingly, the "Program for Hospital Standardization."[22] Over the years, the College developed minimum standards for hospitals which included a medical staff organization responsible for the supervision and control of professional work, conferences for the review and analysis of clinical work at regular intervals, accurate and complete medical records with sufficient data to justify the diagnosis and warrant the treatment, clinical laboratory and X-ray facilities for the determination and confirmation of the diagnosis, and elimination of fee-splitting,

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20. *See, e.g., Elam*, 132 Cal. App. 3d at 344, 183 Cal. Rptr. at 163; Southwick, *The Hospital as an Institution — Expanding Responsibilities Change Its Relationship with the Staff Physician*, 9 CALIF. W.L. REV. 429 (1973). The demise of the hospital as the "doctors' workshop" is well illustrated by considering an exerpt from a 1961 American Hospital Association publication entitled HOSPITAL ACCREDITATION REFERENCES [hereinafter referred to as 1961 ACCREDITATION REFERENCES]. The subject of trustees and the hospital administrator's presence at medical staff meetings was discussed as follows:

> Trustees should not regularly attend medical staff meetings. A medical staff meeting is predominantly on medical subjects. If it would be deemed wise for a trustee to present some subject to the medical staff, he should be granted the privilege and amenities of presentation early and then excuse himself.
>
> The business portion of medical staff meetings should be attended by the administrator as the official representative of, and the liaison officer for, the board with the medical staff. Attendance at the professional portion of the meeting should be a matter of judgment and optional. One lay administrator put it this way: "I attend all the general medical staff meetings. I love it and so does my staff. It is a wonderful chance to talk to them personally and greet them. I make sure the meeting room is clean, orderly and ready. I run the projector. I help take attendance. I make sure the coffee and snacks are ready after the meeting, answer the telephone and deliver messages to the doctors. I help wherever I can."

Id. at 96.

Today, it is still true that trustees tend to be businessmen and civic leaders who are often unfamiliar with medical matters. *See, e.g.*, Porter, *A Profile of a Hospital Trustee*, TRUSTEE 21 (Jan. 1975); R. CUNNINGHAM, GOVERNING HOSPITALS — TRUSTEES AND THE NEW ACCOUNTABILITIES 35 (1976). Certainly trustees are no longer proverbial children in their father's den, who may be allowed to speak, but then should excuse themselves and let the adults continue their business. Moreover, it is difficult to imagine the present-day hospital administrator who has spent two years in graduate school obtaining an MHA or an MBA degree and years becoming a fellow in the American College of Hospital Administrators, who "loves" making sure the doctors' "coffee and snacks are ready" and "answer[ing] the telephone and deliver[ing] the messages to the doctors." *Id.*

21. Hereinafter referred to as the JCAH.

22. 1961 ACCREDITATION REFERENCES, *supra* note 20, at vii.

which was then a wide-spread practice.[23] The American College of Surgeons continued to administer the standardization program until 1952, when the JCAH was formed.[24]

B. Hospital Regulation in the 1980's

1. The JCAH

The JCAH proved to be a worthy successor to the American College of Surgeons as administrator of the hospital standardization program, for, today, being accredited by the JCAH is nearly as important as being licensed. For example, hospitals accredited by the JCAH are automatically deemed to meet the federal Medicare conditions for participation for hospitals and, as a result, are qualified to participate in the Medicare program.[25]

The JCAH publishes extensive standards in each annual Accreditation Manual for Hospitals, among which are standards for the hospital governing body[26] and for the hospital medical staff.[27] The JCAH standards (and the Medicare Conditions of Participation) require the governing body of the hospital to delegate to the medical staff the authority to evaluate the professional competence of staff members and applications for clinical privileges.[28] The medical staff is to have the overall responsibility for the quality of all medical care provided to patients,[29] but it is also accountable to the governing body for the performance of the duties and responsibilities assigned to it.[30]

2. State Law/Administrative Regulations

In 1965, California law was amended to require hospital governing bodies to adopt rules providing for the formal organization of medical staffs.[31] Medical staffs are to be "self-governing with respect to the professional work performed in the hospital."[32] Interestingly, this requirement was not contained in the licensing laws regulating *hospitals*, but

23. *Id.*; *see also* Bowman, *Hospital Standardization Series: General Hospitals of 100 or More Beds*, 4 BULL. AM. C. SURGEONS 3 (1919).

24. 1961 ACCREDITATION REFERENCES, *supra* note 20, at vii. The need for such standards was definitely there. During the program's first year, only 12.9 percent of the hospitals surveyed met the minimum criteria. *Id.*

25. 42 U.S.C. §1395(bb)(a)(1) (1982). JCAH accreditation is also required for reimbursement by many private insurance carriers and for accreditation of physician post-graduate training programs for board eligibility.

26. JCAH, ACCREDITATION MANUAL FOR HOSPITALS 51-56 (1982) [hereinafter referred to as 1982 ACCREDITATION MANUAL].

27. *Id.* at 93-109.

28. *Id.* at 55-56; 42 C.F.R. §§405.1001-405.1040 (1980).

29. 1982 ACCREDITATION MANUAL, *supra* note 26, at 93.

30. *Id.*

31. CAL. BUS. & PROF. CODE §2282(c).

32. *Id.*

rather in the licensing laws which regulated *physicians*. The new law provided that it is unprofessional conduct for a licensed physician to practice in a hospital which did not have rules established by the governing body, including a provision for a self-governing medical staff.[33] The first mention of medical staffs in California statutes regulating hospitals occurred in 1973, when Health and Safety Code section 1250 was amended to include a reference to medical staffs.[34] The California Administrative Code was also amended to incorporate the American College of Surgeons/JCAH model into the hospital licensing regulations, which now provide that "(e)ach hospital shall have an organized medical staff responsible to the governing body for the fitness, adequacy and quality of the medical care rendered to patients in the hospital."[35] Just as under the JCAH regulatory scheme, pursuant to California law, the governing body of the hospital has the overall responsibility for the professional care rendered in the hospital, despite the fact that it is required to delegate the quality assurance function to the medical staff.[36]

3. Organization of Medical Staff

The exact organization of a hospital medical staff may vary depending largely upon the type and size of the hospital.[37] Generally speaking, however, the medical staff is organized by departments or major clinical services[38] and by committees. The departments are denominated by specialty, for example, medicine, surgery, pathology, and radiology. The committees transcend substantive specialty and relate to administrative functions within the hospital. The only committee required by the JCAH is the executive committee.[39] It is charged with accounting to the governing body for the quality assurance function delegated to the medical staff by the governing body.[40] Under the JCAH regulatory scheme, the remaining committee structure is unprescribed and, thus, is left to individual medical staffs to delineate in their bylaws;[41] but medical staff bylaws must be approved by the governing body.[42]

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33. *Id.*
34. CAL. HEALTH & SAFETY CODE §1250(a).
35. 22 CAL. ADMIN. CODE §70703(a)(1)(F).
36. CAL. HEALTH & SAFETY CODE §1250(a).
37. 1982 ACCREDITATION MANUAL, *supra* note 26, at 95.
38. *Id.* at 102.
39. *Id.*
40. *Id.* The peer review process is discussed in Comment, *Medical Peer Review Protection*, 52 TEMPLE L. REV. 552 (1979).
41. *See*, Copeland, *Hospital Responsibility for Basic Care Provided by Medical Staff Members: "Am I my Brother's Keeper?"*, 5 N. KY. L. REV. 27, 47 (1978). Copeland is an attorney and a hospital administrator. His article contains a particularly thorough examination of hospital and medical staff organization.
42. 1982 ACCREDITATION MANUAL, *supra* note 26, at 103-04.

California licensing regulations for hospitals are more specific. In addition to an executive committee, they require the medical staff to have the following committees: credentials, medical records, pharmacy and therapeutics, tissue, utilization review and infections.[43] Just as under the JCAH scheme, the hospital licensing regulations require the executive committee to act as a liason between the governing body and the other medical staff committees.[44]

B. Corporate Negligence

The doctrine of hospital corporate negligence has been widely examined. "[A] small library of legal comment"[45] on the subject has indeed been produced.[46]

To date, the courts in many states have recognized or implemented corporate negligence in one context or another.[47] In *Elam*, the court held that a hospital could be liable for breach of the duty to "insure the competence of its medical staff through careful selection and review."[48] Just what that duty entails, or might entail, is beyond the scope of this

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43. 22 CAL. ADMIN. CODE §70703(e). In small hospitals, however, the various committee functions may be performed by a committee of the whole. *Id.*

44. *Id.*

45. Goldberg, *supra* note 2.

46. In addition to Judge Goldberg's own contribution to the library, among the more recent legal comments are the following: Southwick, *supra* note 20; Slawkowski, *Do the Courts Understand the Realities of Hospital Practices?*, 22 ST. LOUIS U.L.J. 452 (1978); Copeland, *supra* note 41; Zaremski & Spitz, *Liability of a Hospital As an Institution: Are the Walls of Jericho Tumbling?*, 16 FORUM 225 (1980); Lisko, *Hospital Liability Under Theories of Respondant Superior and Corporate Negligence*, 47 U.M.K.C.L. REV. 171 (1978); Ludlam, *The Impact of the Darling Decision upon the Practice of Medicine and Hospitals*, 11 FORUM 756 (1976); Payne, *Recent Developments Affecting a Hospital's Liability for Negligence of Physicians*, 18 S. TEX. L.J. 389 (1977); Zaslow, *Vicarious Liability of a Hospital for Tortious Acts of its Independent Contractors Delivering Medical Care*, 49 PENN. B.A.Q. 466 (1978); Strodel, *The Impaired Physician — Hospital Corporate Liability*, 24 TRIAL LAWYER'S GUIDE 488 (1981); Comment, *supra* note 16; Comment, *supra* note 1; Comment, *The Hospital-Physician Relationship: Hospital Responsibility for Malpractice of Physicians*, 50 WASH. L. REV. 385 (1975); Casenote, *supra* note 16; Notes, *Wisconsin Hospital Held to Owe a Duty to its Patients to Select Qualified Physicians*, 65 MARQ. L. REV. 139 (1981); Comment, *Hospital May Be Held Liable for Permitting Incompetent Independent Physician to Operate*, 8 RUTGERS-CAMDEN L.J. 177 (1976).

47. *See* Tucson Medical Center, Inc. v. Misevch, 113 Ariz. 34, 545 P.2d 958 (1976); Elam v. College Park Hosp., 132 Cal. App. 3d 332, 183 Cal. Rptr. 156, *modified*, 133 Cal. App. 3d 94a (1982); Kitto v. Gilbert, 39 Colo. App. 374, 570 P.2d 544 (1977); Mitchell County Hosp. Authority v. Joiner, 125 Ga. App. 1, 186 S.E.2d 307 (1971), *aff'd*, 229 Ga. 140, 189 S.E.2d 412 (1972); Darling v. Charleston Community Memorial Hosp., 50 Ill. App. 253, 200 N.E.2d 149 (1964), *aff'd*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966); Ferguson v. Gonyaw, 64 Mich. App. 685, 236 N.W.2d 543 (1975); Gridley v. Johnson, 476 S.W.2d 475 (Mo. 1972); Foley v. Bishop Clarkson Memorial Hosp., 185 Neb. 89, 173 N.W.2d 881 (1970); Moore v. Carson-Tahoe Hosp., 88 Nev. 207, 495 P.2d 605 (1972); Corleto v. Shore Memorial Hosp., 138 N.J. Super. 302, 350 A.2d 534 (1975); Felice v. St. Agnes Hosp., 65 App. Div. 2d 388, 411 N.Y.S.2d 901 (1978); Bost v. Riley, 44 N.C. App. 638, 262 S.E.2d 391, *disc. rev. denied*, 300 N.C. 194, 269 N.E.2d 391 (1980); Pederson v. Dumouchel, 72 Wash. 2d 73, 431 P.2d 973 (1967); Utter v. United Hosp. Center, Inc., 236 S.E.2d 213 (W. Va. 1977); Johnson v. Misericordia Community Hosp., 99 Wis. 2d 708, 301 N.W.2d 156 (1981).

48. 132 Cal. App. 3d at 343, 183 Cal. Rptr. at 161, *modified*, 133 Cal. App. 3d 94a (1982).

article.[49] Nevertheless, any consideration of hospital corporate negligence in California would be incomplete without mention of two factors. The first is the *Nork* case,[50] which may foreshadow definitions of duty yet to come. The second is that there are restrictions both substantive and procedural placed upon hospitals in the exercise of their duty by the rights of medical staff members and applicants.[51]

1. Nork

Between 1965 and 1977, more than 60 lawsuits were filed in Sacramento County against Dr. John Nork; 51 of them were filed between 1972 and 1974 and many of those were also lawsuits against Mercy Hospitals of Sacramento. In what has come to be known as *the Nork case*,[52] Mercy paid $500,000 to settle its share of the case,[53] but not before Superior Court Judge B. Abbott Goldberg wrote an exhaustive and erudite opinion which made it clear to hospitals that they would be held responsible for failures of their quality assurance programs.

Nork was not a board-certified orthopedic surgeon, but he was nevertheless allowed to perform orthopedic surgery.[54] Evidence was introduced that he performed more than three dozen operations which were either negligently done, unnecessary, or both, and that he falsified patients' progress reports and diagnostic findings.[55] Nork's accountant testified that Nork needed money to stave off creditors and Nork himself testified that he was addicted to various drugs which affected his judgment.[56]

Judge Goldberg found that the hospital had no actual knowledge of Nork's misconduct and that it had complied with the peer review system then mandated by JCAH standards. While very sympathetic to Mercy Hospital, the judge was unexcusing. He found that the hospital

49. *See supra* note 16.

50. Gonzales v. Nork, Civ. No. 228566 (Super. Ct. Sacramento County, Cal. Nov. 27, 1973), *rev'd for failure to grant jury trial*, 60 Cal. App. 3d 728, 31 Cal. Rptr. 717 (1976), *rev'd and remanded*, 20 Cal. 3d 500, 573 P.2d 458, 143 Cal. Rptr. 240 (1978).

51. While few states accord applicants and medical staff members procedural and substantive rights which are as extensive as those accorded in California, the corporate negligence cases and comments are strangely silent on this subject. One of the few exceptions is Arthur F. Southwick's excellent article, *The Hospital as an Institution—Expanding Responsibilities Change Its Relationship with the Staff Physician*, 9 CALIF. W.L. REV. 429, 453-67 (1973). Professor Southwick also discusses applicant and member rights in his text, THE LAW OF HOSPITAL AND HEALTH CARE ADMINISTRATION, Ch. XIII, 427-65 (1978). *See also* Slawkowski, *supra* note 46, at 459-68; Comment, *supra* note 16, at 382-88.

52. *See supra* note 50.

53. Comment, *The Hospital-Physician Relationship, Hospital Responsibility for Malpractice of Physicians*, 50 WASH. L. REV. 385, 415, n.153; Ludlam, *supra* note 46.

54. Gonzales v. Nork, Civ. No. 228566, Memorandum of opinion.

55. *Id.*

56. *Id.*

57. *Id.* at 143, 148.

58. *Id.* at 166.

was not immunized from civil liability by the fact that it had complied with applicable JCAH standards,[59] nor because it functioned—as it was required to function—through the medical staff.[60] The oft-quoted closing[61] to Judge Goldberg's opinion succinctly summarizes the principle of corporate negligence.

> I have reached the conclusion that the hospital is liable with great reluctance, because I am sure that the Sisters of Mercy have done everything within their power to run a proper institution. But they like every hospital governing board, are corporately responsible for the conduct of their medical staff. I do not anticipate that they will suffer financially, because the ultimate responsibility rests on Dr. Nork. "A person . . . who by the improper exercise of a legal power, intentionally creates liability against the other, is liable to the other for the . . . creation of liability." Restatement of Torts 871 (1939). Mercy is a culprit, but it is also a victim.
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> As for the doctors on the Mercy staff, two thoughts keep going through my mind. The one is from Dr. Jones: "No one told anyone anything." The other is from Edmund Burke:
>
> > "The only thing necessary for the triumph of evil is for good men to do nothing."

2. *Physician Rights*

It should surprise no one that, in California, physicians in governmental or public hospitals[62] have both substantive and procedural constitutional due process rights in the attainment and retention of medical staff membership.[63] Applicants for membership and medical staff members in non-governmental or private hospitals[64] also have substantive and procedural rights under the common law of this State. Membership in a medical staff is deemed to be a "fundamental vested right."[65] As a result, a hospital may not materially impair or terminate that right without according the member "fair procedure."[66] Likewise,

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59. *Id.*
60. *Id.* at 157.
61. *See, e.g.*, Ludlam, *supra* note 46, at 759; Copeland, *supra* note 41, at 38.
62. For example, hospitals created and operated under the Local Hospital District Law, CAL. HEALTH & SAFETY CODE, §§32000-32492.
63. *See, e.g.*, Wyatt v. Tahoe Forest Hosp. District, 174 Cal. App. 2d 709, 345 P.2d 93 (1959); Stretten v. Wadsworth Veterans Hosp., 537 F.2d 361 (9th Cir. 1976). *Stretten* is not a medical staff case, but rather a case dealing with the termination of a physician's pathology residency. It contains a detailed analysis of due process considerations, however.
64. The distinction between "public" and "private" hospitals in California is unclear; however, it was recently summarized in Anton v. San Antonio Community Hosp., 132 Cal. App. 3d 656, 183 Cal. Rptr. 423 (1982).
65. Unterthimer v. Desert Hosp. Dist., 33 Cal. 3d 285, 296, — P.2d —, — Cal. Rptr. — (1983); Anton v. San Antonio Community Hosp., 19 Cal. 3d 802, 823, 567 P.2d 1162, 140 Cal. Rptr. 442, 453 (1977).
66. "Fair Procedure" in California is strictly a common law doctrine. Its origins can be traced to the case of James v. Marinship, 25 Cal. 2d 721, 155 P.2d 329 (1944), in which the court

applicants for medical staff membership are entitled to fair procedure in the event a medical staff committee[67] recommends against appointment.[68]

Some courts have used the terms "fair procedure" and "due process" interchangeably.[69] No doubt this stems from the fact that there is little, if any, difference between them in the extent of protection afforded an

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held that because of a labor union's monopoly-like control over the supply of labor, it could not be permitted to exercise its power in an arbitrary or unreasonable manner, injurious to others. Thus, it was required to "surrender its monopoly or else admit to membership all qualified persons." *Id.* at 732, 155 P.2d at 335. The fair procedure principles enunciated in *Marinship* were subsequently applied to membership in medical and dental professional societies on the theory that, as a practical matter, membership was required for specialty practice. Pinsker v. Pacific Coast Society of Orthodontists, 12 Cal. 3d 541, 562 P.2d 253, 116 Cal. Rptr. 245 (1974); Pinsker v. Pacific Coast Society of Orthodontists, 1 Cal. 3d 160, 460 P.2d 495, 81 Cal. Rptr. 623 (1960); Ascherman v. San Francisco Medical Society, 39 Cal. App. 3d 623, 224 Cal. Rptr. 681 (1974); Kronen v. Pacific Coast Society of Orthodontists, 237 Cal. App. 2d 289, 46 Cal. Rptr. 808 (1965). On essentially the same theory, the requirement of fair procedure was extended to hospital medical staff membership matters in the landmark case Ascherman v. St. Francis Memorial Hosp., 45 Cal. App. 3d 507, 119 Cal. Rptr. 507 (1975). The doctrine of fair procedure has now been applied to virtually all aspects of medical staff membership. *See, e.g.,* Anton v. San Antonio Community Hosp., 19 Cal. 3d 802, 567 P.2d 1162, 140 Cal. Rptr. 442 (1977) (reinstatement of staff privileges and reappointment to medical staff); Hackethal v. Loma Linda Community Hosp. Corp., 91 Cal. App. 3d 59, 153 Cal. Rptr. 783 (1979) (summary suspension and nonreappointment). It has even been extended to employment in a residency training program. Ezekial v. Winkley, 20 Cal. 3d 267, 572 P.2d 32, 142 Cal. Rptr. 418 (1977).

67. Usually is the executive committee or the credentials committee.

68. Miller v. Eisenhower Medical Center, 27 Cal. 3d 614, 626, 614 P.2d 258, 265, 166 Cal. Rptr. 826, 833 (1980).

69. *See, e.g.*, Applebaum v. Board of Directors, 104 Cal. App. 3d 648, 655, 163 Cal. Rptr. 831, (1980); Miller v. National Medical Hosp., 124 Cal. App. 3d 81, 91, 177 Cal. Rptr. 119, 125 (1981). The fair procedure analysis is somewhat analogous to the constitutional due process analysis. The former need for a state action equivalent passed with the abolition of the distinction between public and private hospitals for fair procedure purposes in Pinsker v. Pacific Coast Society of Orthodontists, 12 Cal. 3d at 554, 526 P.2d at 262, 116 Cal. Rptr. at 255, and Ascherman v. St. Francis Memorial Hosp., 45 Cal. App. 3d at 511, 119 Cal. Rptr. at 509; but fair procedure still requires a showing similar to the declaration of a property or a liberty interest in the due process analysis. Thus, to be entitled to fair procedure, the affected physician must show that his ability to fully practice his profession would be impaired by the hospital action. *Id.*

The fact that fair procedure and due process might be confused was acknowledged by the court in *Pinsker* as follows:

> It is important to note that the legal duties imposed on defendant organizations arise from the common law rather than the Constitution as such; although *Pinsker* I [v. *Pacific Coast Society of Orthodontists*, 1 Cal. 3d 160, 460 P.2d 495, 81 Cal. Rptr. 623] utilized "due process" terminology in describing defendant associations' obligations, the "due process" concept is applicable only in its broadest, nonconstitutional connotation. In an attempt to avoid confusing the common law doctrine involved in the instant case with constitutional principles, we shall refrain from using "due process" language and shall simply refer instead to a requirement of a "fair procedure."

Id. at 550 n.7, 526 P.2d at 259, 116 Cal. Rptr. at 251.

The distinction was again noted by the court in *Ascherman*, 45 Cal. App. 3d at 511 n.4, 119 Cal. Rptr. at 509, and underscored by Justice Kane in the concurring portion of his concurring and dissenting opinion, as follows:

> Bearing in mind that we are dealing with common law—not constitutional—standards of "fair procedure," we should not allow our decision to be formulated by "due process" considerations which are not only inapplicable but, in my opinion, inappropriate to the situation and the parties at bench.

Id. at 515, 119 Cal. Rptr. at 512.

The distinction between constitutional due process and common law fair procedure was most recently reiterated in Anton v. San Antonio Community Hosp., 132 Cal. App. 3d at 653-54, 183 Cal. Rptr. at 431-33.

individual.[70] Fair procedure requires that the medical staff applicant or member be given notice of the "charges" against him or her, a meaningful opportunity to respond,[71] and, if necessary, an impartial tribunal.[72] Good cause is also required to deny an application for membership[73] or to discipline or expel a member.[74]

To appreciate the significance of *Elam*, one should realize that the hospital is not entirely free to fulfill its duty to the patient to ensure "the competence of its medical staff through the prudent selection, review and continuing evaluation of the physicians granted staff privileges."[75] Rather, it must attempt to balance the physician's[76] rights against its duty to patients to ensure the competence of its medical staff. The hospital may indeed find itself between the proverbial "rock and a hard place"—being sued by the physician for expelling him from the medical staff or being sued by his patient for not expelling him, or both.

To date, no appellate court in this State has addressed the issue of physician rights in light of corporate negligence; however, the opinion of the Supreme Court in *Ezekial v. Winkley*[77] may foreshadow appel-

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70. 132 Cal. App. 3d at 657, 183 Cal. Rptr. at 433.

71. 12 Cal. 3d at 555, 526 P.2d at 263, 116 Cal. Rptr. at 255; 19 Cal. 3d at 829-30, 567 P.2d at 1178, 140 Cal. Rptr. at 458 (1977).

72. Miller v. National Medical Hosp., 124 Cal. App. 3d at 90, 177 Cal. Rptr. at 124. The JCAH requires that medical staff bylaws provide a fair hearing and appellate review mechanism for medical staff applicants and members. 1982 ACCREDITATION MANUAL, *supra* note 26, at 103-04. In the past, the JCAH has published JCAH Guidelines for the Formation of Medical Staff Bylaws, Rules and Regulations, in the form of model bylaws which set forth hearing and appellate review procedures. In 1971, the California Medical Association and California Hospital Association adopted and approved the CMA-CHA Uniform Code of Hearing & Appeal Procedures. Both the JCAH guidelines and the CMA/CHA Hearing & Appeal Procedures have been judicially noticed and tacitly approved by the California Supreme Court in a "fair procedure" case. *See Anton* 19 Cal. 3d at 811, n.5, 818-20, n.16, n.17, 828, n.27, 567 P.2d at 1165, n.5, 1171, n.16, n.17, 1177, n.27, 140 Cal. Rptr. at 445, n.5, 451, n.16, n.17, 457, n.27.

73. 27 Cal. 3d at 626, 614 P.2d at 265, 166 Cal. Rptr. at 833.

74. Hackethal v. Loma Linda Community Hosp. Corp., 91 Cal. App. 3d at 66, 153 Cal. Rptr. at 787.

Exactly what good cause entails is uncertain. It is a subject which has rarely been discussed by the courts in medical staff cases. Just as the requisites of due process depend upon the nature of the individual's rights involved, the amount of good cause required depends upon the action to be undertaken. We know, for example, that summary suspension of all or part of a member's privileges is usually justified only when immediate action (i.e., prior to a hearing) must be taken in the interest of patient care. *See, e.g.*, 91 Cal. App. 3d at 67, 153 Cal. Rptr. at 788. *Cf.* Avol v. Hawthorne Community Hosp., 135 Cal. App. 3d 101, 184 Cal. Rptr. 914 (1982). In other words, anything less than an immediate threat to patient care is insufficient good cause for summary suspension.

There is a second factor to be considered in analyzing good cause, but it has not yet been raised in any reported appellate decision in California. That factor is the nature of the hospital taking the disciplinary action. For example, what might be good cause for imposing only a consultation requirement on a member of one hospital's medical staff might be good cause for terminating the same member's privileges in another, presumably smaller, hospital which could not provide a consultant or fairly be asked to pay for one.

75. *Elam*, 132 Cal. App. 3d at 346, 183 Cal. Rptr. at 164.

76. Membership on a hospital medical staff is not limited to physicians. In *Elam*, the allegedly negligent surgery was performed by a podiatrist member of the medical staff. The term "physician" is used here only for convenience.

77. 20 Cal. 3d 267, 572 P.2d 32, 142 Cal. Rptr. 418 (1977).

late opinions yet to come. Ezekial was a surgical resident and, thus, an employee of the hospital. He challenged his dismissal from the hospital's surgical residency program. The hospital raised its potential civil liability for Ezekial's malpractice as a justification for his dismissal. The Supreme Court responded as follows:

> Finally, defendants find significance in the fact that they are civilly liable for any malpractice by plaintiff as a hospital employee, whereas they might not be responsible for the acts or omissions of independent physicians holding staff privileges. From the foregoing it is argued that defendants' interest in protecting themselves against the incompetency of residents is greater than in protecting against the mistakes and errors of staff physicians, thereby presumably creating a greater legitimate incentive to terminate summarily residents whose performance is marginal.
>
> We are sensitive to the difficulty and danger, on the one hand, of any undue restrictions on the essential ability of a hospital to discipline its professional staff thereby controlling its professional performances, while, on the other hand, malpractice liability is imposed on the hospital for its failure to exercise such control. We emphasize, however, that defendants are not precluded from dismissing plaintiff for incompetence. We hold only that, in doing so, they must afford him rudimentary procedural and substantive fairness. Moreover, the hospital is, of course, not prevented from immediately suspending a resident with pay, or placing him on noncritical duties, pending a fair determination of his competence in the residency program. Such procedures, we think, offer the hospital a practical and adequate temporary means of protecting the health and safety of its patients.[78]

QUESTIONS IN THE WAKE OF ELAM

A. The Parties Questions

1. Are Medical Staffs Potential Defendants in Corporate Negligence Cases?

Any consideration of bringing suit against a medical staff must begin with a determination of the legal status of such entities.[79] If medical staffs are independent unincorporated associations,[80] as some believe,[81]

78. *Id.* at 277-78, 572 P.2d at 39, 142 Cal. Rptr. at 425.

79. The legal status of the medical staff is subject to debate. Even within the health care industry there is argument. The Hospital Council of Southern California has taken the position that medical staffs are "non-entities." See the Council's study entitled LEGAL REPRESENTATION OF THE MEDICAL STAFF, published in Spring 1982. A copy is on file in the authors' office. The California Medical Association rejects the Hospital Council's position. Its legal counsel opines that medical staffs are legal, recognized organizations. *See* 26 CMA NEWS 1 (October 29, 1982). It is somewhat ironic that liability can be imposed on a medical staff only if the medical staff is a legal entity (capable of being sued), which is exactly what the CMA is contending.

80. Witkin defines an unincorporated association as "a group of persons who have joined

then they are subject to being sued.[82] If they are not unincorporated associations,[83] then they are not subject to suit and the inquiry ends there.

If the medical staff is an entity capable of being sued, then its potential liability as an entity should turn on the determination of whether it has any *duty* directly to hospital patients to ensure the competence of its own members. The concept of duty is somewhat amorphous. Dean Prosser put it best:

> Its artificial character is readily apparent; in the ordinary case, if the court should desire to find liability, it would be quite as easy to find the necessary "relation" in the position of the parties toward one another, and hence to extend the defendant's duty to the plaintiff. The statement that there is or is not a duty begs the essential question—whether the plaintiff's interests are entitled to legal protection against the defendant's conduct. It is therefore not surprising to find that the problem of duty is as broad as the whole law of negligence, and that no universal test for it ever has been formulated. It is a shorthand statement of a conclusion, rather than an aid to analysis in itself. It is embedded far too firmly in our law to be discarded, and no satisfactory substitute for it, by which the defendant's responsibility may be limited, has been devised. But it should be recognized that "duty" is not sacrosanct in itself, but only an expression of the sum total of those considerations of policy which lead the law to say that the particular plaintiff is entitled to protection.[84]

Despite its limitations, there is no substitute for the concept of duty. It is the key to the analysis of corporate negligence and its present and potential effect.

The result in *Elam* was the product of the court's extending the previously existing limits of the duty owed by a hospital to its patients to include the duty to ensure the competence of its medical staff. In so

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together for some common purpose." 6 B. WITKIN, SUMMARY OF CALIFORNIA LAW, *Corporations*, §36, at 4347 (8th ed. 1974). A statutory nonprofit association is defined as an "unincorporated association of natural persons for religious, scientific, social, literary, educational, recreational, benevolent, or other purpose not that of pecuniary profit." CAL. CORP. CODE §21000.

81. The California Supreme Court, in dicta, has referred to one medical staff as an unincorporated association. Anton v. San Antonio Community Hosp., 19 Cal. 3d at 809, 567 P.2d at 1164, 140 Cal. Rptr. at 444; *see also* St. John's Hosp. Medical Staff v. St. John Regional Medical Center, Inc., 245 N.W.2d 472 (S. Dak. 1976); Corleto v. Shore Memorial Hosp., 238 N.J. Super. 302, 350 A.2d 534 (1975).

82. CAL. CIV. PROC. CODE §388(a).

83. For those taking this position, see, e.g., Horty & Mulholland, *The Legal Status of the Hospital Medical Staff*, 22 ST. LOUIS U.L.J. 485 (1978); Comment, *supra* note 5. The authors have also taken the position that medical staffs are not unincorporated associations. *See* Loveridge, *The Hospital Medical Staff and its Legal Status*, 2 CALIFORNIA HEALTH LAW NEWS 14 (July 1982); G. Loveridge, The Legal Status of the Hospital Medical Staff (unpublished manuscript) (copy on file in the authors' office).

84. W. PROSSER, LAW OF TORTS §54, at 325-26 (4th ed. 1971).

doing, the *Elam* court held itself true to the spirit of Professor Prosser. It not only applied a conventional "test" for duty, but it also considered other factors, including public policy, which led it to conclude that Elam was "entitled to protection" from the Hospital's conduct.[85]

The "test" utilized by the *Elam* court begins with the provisions of section 1714 of the California Civil Code,[86] which imposes liability for injuries caused by failure to exercise ordinary care under the circumstances and then balances the factors of foreseeability of harm to the plaintiff, the degree of certainty that the plaintiff will be harmed, the moral blame attributable to the defendant's conduct, the burdensomeness to the defendant and the consequences to the community of imposing a duty and the availability, cost and prevalence of insurance.[87] As a practical matter, any court that *wants* to find a medical staff duty directly to hospital patients should have little trouble doing so. If a court does nothing more than to apply the same "test" used by the *Elam* court, it may well find that the medical staff, as an independent entity,[88] has a duty directly to patients to ensure the competence of its members. That result would be largely determined by the emphasis placed on the factor of foreseeability by the court.[89] In other words, if the medical staff fails to ensure the competence of its own members by making inappropriate recommendations or by not making appropriate recommendations to the governing body for member appointment or discipline, then injury to the plaintiff is highly foreseeable because governing bodies rarely disapprove medical staff recommendations.[90] Standing alone, however, that analysis is incomplete. A proper analysis of the medical staff duty question should track the *Elam* court's examination of hospital duty by including the same basic factors of public policy and practicality and taking into account the overall regulatory scheme which dictates responsibilities within the hospital.

As discussed above, the operation of a hospital is highly regulated.[91] The responsibilities of the governing body with respect to the quality of

85. *Id.* at 325.

86. Section 1714(a) provides in relevant part as follows:

> Every one is responsible, not only for the result of his willful acts, but also for an injury occasioned to another by his want of ordinary care or skill in the management of his property or person . . . .

87. 132 Cal. App. 3d at 339-40, 183 Cal. Rptr. at 160. The test employed by the *Elam* court is substantially the same test established by the Supreme Court in J-Aire Corp. v. Gregory, 24 Cal. 3d 799, 598 P.2d 60, 157 Cal. Rptr. 407 (1979).

88. *See supra* note 78.

89. 132 Cal. App. 3d at 340, 183 Cal. Rptr. at 160.

90. A 1979 "confidential survey of medical staff coordinators at major southern California hospitals" indicated the hospital governing bodies accept and comply with medical staff executive and credentials committee recommendations virtually 100% of the time. *See*, Comment, *Piercing the Doctrine of Corporate Hospital Liability*, 17 SAN DIEGO L. REV. 383, 394, n.70 (1980).

91. *See supra* notes 25-36 and accompanying text.

care rendered in the hospital are clearly set forth by statute,[92] regulation[93] and accreditation standards.[94] The duty of the medical staff is equally plain. The legislators, bureaucrats and private regulators have made the *governing body* responsible to hospital patients, that is, imposed a duty on the governing body to ensure the competence of the medical staff, and they have made the medical staff responsible *to the governing body*, not to hospital patients, for the competence of its members. Thus, the question of whether the medical staff owes a duty directly to hospital patients has been circumscribed by the extensive regulatory scheme which dictates the internal responsibilities within hospitals.

The lack of medical staff duty to hospital patients is also solidly grounded in considerations of public policy and practicality. In addition to acknowledging the regulatory scheme which makes the governing body responsible to hospital patients for the competence of the medical staff,[95] the *Elam* court also found that the public looks to the *hospital* for total health care.

> Further, [imposition of a duty on the hospital to exercise responsible care to ensure the competency of the medical staff] is consonant with the public's perception of the modern hospital as a mutlifaceted, health-care facility responsible for the quality of medical care and treatment rendered. The community hospital has evolved into a corporate institution, assuming "the role of a comprehensive health center ultimately responsible for arranging and coordinating total health care." The patient treated in such a facility receives care from a number of individuals of varying capacities and not merely treated by a physician acting in isolation. The patient relies upon the effectiveness of this "highly integrated system of activities . . . ." Consequently, "[t]he concept that a hospital does not undertake to treat patients, does not undertake to act through its doctors and nurses, but only procures them to act solely upon their own responsibility, no longer reflects the fact. The complex manner of operation of the modern-day medical institution clearly demonstrates that they furnish far more than mere facilities for treatment. They appoint physicians and surgeons to their medical staffs, as well as regularly employing on a salary basis resident physicians and surgeons, nurses, administrative and manual workers and they charge patients for medical diagnosis, care, treatment and therapy, receiving payment for such services through privately financed medical insurance policies and government financed programs known as Medicare and Medicaid. Certainly, the person who avails himself of our modern

92. *See supra* notes 31-34 and accompanying text.
93. *See supra* notes 35-36 and accompanying text.
94. *See supra* notes 26-30 and accompanying text.
95. 132 Cal. App. 3d at 332, 341-44, 183 Cal. Rptr. at 161.

> 'hospital facilities' (frequently a medical teaching institution) expects that the hospital staff will do all it reasonably can to cure him and does not anticipate that its nurses, doctors and other employees will be acting solely on their own responsibility."[96]

In addition, the medical staff is an unlikely defendant since it lacks assets to satisfy damages arising from patient injuries caused by failure to ensure a competent medical staff. Generally, the assets of a medical staff are little more than accrued dues. Individual members of the medical staff may of course be joined in an action against the medical staff[97] but satisfaction of any judgment against the medical staff should ordinarily be limited to its assets.[98]

Last and very important is the fact that imposition of a medical staff duty directly to hospital patients would have what might be termed a "chilling effect" on participation in peer review, in contravention of both law and regulations that require physicians to belong to medical staffs in order to practice in hospitals and public policy which encourages physicians to play an active role in health care.[99] It bears noting that the *Elam* court acknowledged that imposition of a duty of care on the hospital should supply incentive for the hospital to assure medical staff competence and quality care.[100] The disincentive to medical staff membership and active participation which would result from imposition of a duty of care on the medical staff is no less clear.

Finally, no discussion of the potential of the medical staff as a defendant is complete without mention of the case of *Corleto v. Shore Memorial Hospital*.[101] In *Corleto*, a New Jersey trial court judge allowed a medical staff to be named as a defendant in a malpractice case alleging, *inter alia*, its peer review failure by allowing a physician to perform surgery whom it knew or should have known to be incompetent to do so.[102] The case is prefaced on the court's characterization of the medical staff as an unincorporated association under New Jersey

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96. *Id.* at 344-45, 183 Cal. Rptr. at 163 (quoting Johnson v. Misericordia Community Hosp., 301 N.W.2d 156, 164 (Wis. 1981)).

97. CAL. CIV. PROC. CODE §388(b).

98. CAL. CORP. CODE §24002; *cf.* Steuer v. Phelps, 41 Cal. App. 3d 468, 116 Cal. Rptr. 61 (1974).

99. The extent of encouragement to physicians to participate in peer review activities is evident in the various immunities granted them for their participation. *See, e.g.*, CAL. CIV. CODE §§43.7, 47; CAL. EVID. CODE §§1156, 1157.

100. 132 Cal. App. 3d at 345, 183 Cal. Rptr. at 163-64.

101. 350 A.2d 534 (N.J. Super. 1975).

102. The medical staff's motion to dismiss for failure to state a claim was denied by the trial court judge. Under New Jersey law, an order denying a motion to dismiss is not appealable as of right, but may be appealed with leave of the appellate division. N.J. R. CT. 2:2-2, 2:2-3. The medical staff and other defendants sought leave to file an appeal, filed a brief, but did not have oral argument. The appellate division denied leave to appeal without issuing an opinion. See Horty & Mulholland, *supra* note 83, at 486.

law[103] and, thus, subject to suit; but it is completely devoid of any discussion of the medical staff's duty to the injured patient. The case was settled before trial.[104] It has been widely and deservedly criticized[105] and should not be of any influence whatsoever on a California court considering the potential liability of a hospital medical staff.

2. *Are Medical Staffs Potential Cross-defendants in Corporate Negligence Cases: Will Hospitals and Their Medical Staffs Cross-complain against Each Other to Shift or Allocate Responsibility for Quality Assurance Failures?*

The medical staff's duty to the hospital to perform the quality assurance functions delegated to it is established, again, in the regulatory scheme.[106] Thus, under principles of both tort and agency law,[107] the medical staff could well be named as a cross-defendant in a cross-complaint by the hospital which is itself being sued for corporate negligence. This, however, will probably never happen.

These suits would be fruitless, if not counter-productive, for several reasons. First, as noted above, medical staffs lack sufficient assets to make these suits economically viable.[108] Second, medical staffs do not currently carry their own insurance separate and apart from hospital insurance. Third, these suits would undoubtedly prove to be disastrous to the relationships between the hospital governing body, administration and medical staff.

3. *Are Individual Medical Staff Members Who Serve on Quality Assurance Committees Potential Defendants in Corporate Negligence Cases?*

In its opinion, the *Elam* court made several references[109] to a law review comment in which the student-author proposes that liability for failure to assure competent care should be imposed directly upon the physicians who had actual notice of the malpracticing physician's incompetence.[110] The *Elam* court, however, did not address the question

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103. 350 A.2d at 539.
104. Horty & Mulholland, *supra* note 83, at 497; Hollowell, Corleto: *A Paper Tiger*, THE HEALTH LAWYER 1 (Summer 1982).
105. *See, e.g.*, Horty & Mulholland, *supra* note 83; Zaslow, *A New Reason for Liability: Hospital Medical Staff Membership*, 5 J. LEGAL MED. 20 (Feb. 1977); Comment, *supra* note 5, at 396-97.
106. *See supra* notes 29-30, 35 and accompanying text.
107. An agent is generally liable to his principal for loss suffered by the principal because of the agent's breach of duty. *See* RESTATEMENT (SECOND) OF AGENCY §401 (1958).
108. *See supra* note 97 and accompanying text.
109. 132 Cal. App. 3d at 337, 345-46, 183 Cal. Rptr. at 159, 164.
110. Comment, *supra* note 5.

of individual member liability for peer review failures, since none was alleged.

The student-commentator supports his "better solution"[111] on the basis that it is a logical alternative to corporate negligence,[112] which he sees as being essentially unfair to the hospital since only the medical staff has the requisite ability to avert future malpractice.[113] Implicit in the comment is the assumption that a cause of action will lie against individual members, and that is certainly doubtful.

The question of individual member liability for quality assurance failures must be analyzed as another duty question under the law of torts,[114] and also as a question of agency law. Simply stated, the first question is whether individual committee members have a duty directly to hospital patients to exercise reasonable care to ensure the competency of the medical staff.[115] The answer is that they do not. All of the reasons which compel the conclusion that the medical staff *per se* has no duty to patients apply equally to the individual member. Here, however, it would be difficult to find a duty even if one wanted to find one. Recall that the court in *Elam* applied a balancing test of a handful of factors to begin its duty analysis. The most important of the factors was forseeability. Whereas, it is foreseeable that, if the medical staff as an entity failed in its delegated quality assurance task, a plaintiff patient would get hurt, the same is not true of individual members of quality assurance committees. Individual committee members alone cannot fail to make the proper recommendations or make the improper recommendation that will ultimately be approved by the hospital's governing body and be put into effect.

Similarly, the whole regulatory scheme, fixing in the governing body the responsibility for medical staff competence, compels a finding of no duty. Finally, if imposing a duty directly to patients on the medical staff *per se* may be said to have a chilling effect on medical staff participation in quality assurance activities, then to impose that duty upon individual committee members would absolutely freeze those activities

111. *Id.* at 397.

112. *Id.* at 398.

113. *Id.* at 399.

114. The student-commentator reaches his conclusion without any analysis of the individual member's duty.

115. The duty, or lack thereof, discussed here has nothing whatsoever to do with a physician's common law (and ethical) duty to report suspected misconduct or wrongdoing. There is no mandatory reporting statute in California, as there is in at least fifteen other states. There is, however, a fiduciary duty on physicians to protect their patients which includes "a duty to make full and fair disclosure of all facts which materially affect their rights or interests." O'Kane v. Board of Registered Nursing, 3 Civ. 19616, April 1, 1982, at 16; *see also* Garlock v. Cole, 199 Cal. App. 2d 11, 15, 18 Cal. Rptr. 393, 396 (1962).

within the hospital because physicians would refuse to serve on quality assurance committees.

When they sit on medical staff committees, medical staff members act as agents or subagents of the hospital. If committee members owe no duty directly to patients, then it is unlikely that they will have direct liability to the patient under the law of agency. Generally, the law of agency provides that, although a third person may suffer loss or injury as a result of an agent's failure to perform his duties to his principal, if that breach of duty to the principal is unaccompanied by any act or omission of the agent which breaches a duty owing to the third person, no cause of action accrues in favor of the latter against the agent.[116] In other words, a patient would not have a personal action against a committee member unless he could show that the committee member owed a *duty* to him in addition to whatever duty the committee member owed to the hospital.

In addition to the foregoing duty and agency analysis, there is one final obstacle to be overcome by a plaintiff seeking to impose liability on individual committee members: the immunity conferred by California Civil Code section 43.7.[117] Even if there is duty owed by individual committee members directly to patients, section 43.7 defines the standard of care they must exercise to be nothing more than an absence of malice! Section 43.7 protects medical staff members from liability arising out of their participation in the peer review process, as long as they act without malice, make a reasonable effort to obtain the facts of the

116. In United States Liab. Co. v. Haidinger-Hayes, Inc., 1 Cal. 3d 586, 463 P.2d 778, 83 Cal. Rptr. 418 (1970), the Supreme Court stated the proposition in traditional nonfeasance/misfeasance terms:

> [Agents] are not responsible to third persons for negligence amounting merely to nonfeasance, to a breach of duty owing to the [principal] alone; the act must also constitute a breach of duty owed to the third person.

Id. at 595, 83 Cal. Rptr. at 423, 463 P.2d at 775.

Section 343 of RESTATEMENT (SECOND) OF AGENCY and section 2343 of the California Civil Code should not be co. ñused with the principle articulated by the Supreme Court in *Haidinger-Hayes*. They both involve liability based upon the agent's duty to a third person. *Haidinger-Hayes* establishes the absence of an agent's duty to a third person and the resulting absence of liability.

117. Section 43.7 provides in relevant part as follows:

> There shall be no monetary liability on the part of and no cause of action for damages shall arise against . . . a duly appointed member of a committee of a professional staff of a licensed hospital (provided the professional staff operates pursuant to written bylaws that have been approved by the governing board of the hospital) . . . or any member of any peer review committee whose purpose is to review the quality of medical or dental services rendered by physicians and surgeons, dentists or dental hygienists, which committee is composed chiefly of physicians and surgeons, dentists, or dental hygienists, of any member of the governing board of a hospital in reviewing the quality of medical services rendered by members of the staff if such committee or board member acts without malice, has made a reasonable effort to obtain the facts of the matter as to which he or she acts, and acts in reasonable belief that the action taken by him or her is warranted by the facts known to him or after such reasonable effort to obtain facts. . . .

matter as to which they act and act in a reasonable belief that the action taken by them is warranted by the facts.[118]

4. Are Medical Staff Peer Review Committees Potential Parties in Corporate Negligence Cases?

Consideration of medical staff peer review committees as potential parties in corporate negligence cases begins and ends with the status of such entities. Whereas there is considerable debate over the status of a medical staff per se,[119] it is simply untenable to assert that committees of the medical staff are anything other than organizational units of the hospital or of the medical staff. In short, they have no status as a legal entity which would enable them to be sued.

5. Are Individual Members of the Hospital's Governing Body Potential Defendants in a Corporate Negligence Case?

In addition to naming the medical staff as a defendant in his malpractice case, the plaintiff in the New Jersey case of *Corleto v. Shore Memorial Hospital*[120] named the individual members of the hospital's governing body.[121] Their motion to dismiss, along with the medical staff's,[122] was overruled. Owing to the critical reaction, however, one might think that each trustee had been held liable for thousands of dollars in damages.[123]

Individual members are indeed potential defendants in a corporate negligence case;[124] the likelihood of success is quite another matter. The question should be analyzed in accordance with established principles of corporate, agency and tort law.[125] Ordinarily, members of hospital governing bodies (directors) should not become personally liable

118. The nature and extent of the immunity conferred by section 47.3 was recently recounted in Long v. Pinto, 126 Cal. App. 3d 946, 179 Cal. Rptr. 182 (1981). The potential liability of peer review participants, as well as various immunities, are discussed in Comment, *The Legal Liability of Medical Peer Review Participants for Revocation of Hospital Staff Privileges*, 28 DRAKE L. REV. 692 (1978-79).

119. *See supra* note 79.

120. 350 A.2d 534 (N.J. Super. 1975).

121. 350 A.2d at 535.

122. *See supra* note 102.

123. *See, e.g.*, T. MULROY, HOSPITAL LIABILITY REVISITED: HOW GOVERNING BOARDS CAN PROTECT THEMSELVES AND IMPROVE PATIENT CARE (1980) and comments discussed therein at 1-9. While implying that the *Corleto* decision has or might have engendered panic by hospital directors (and their attorneys), *Id.* at 3, Mulroy opines that, "unless the doctrine [expressed in *Corleto*] is hereafter repudiated by a significant appellate tribunal, hospital directors would be well advised to treat it with respect as the existing law of the land." *Id.* at 11.

124. One member of a hospital's board of trustees has been named in some of the consolidated cases entitled Katie Cichy v. William Miofsky, M.D., set for trial in early 1983 in the Superior Court of Sacramento County. They are, *inter alia*, corporate negligence cases.

125. One commentator has analyzed potential director liability in terms of the nature of the hospital entity: for-profit private, nonprofit private and nonprofit public charitable. Hackler, *Hospital Trustees' Fiduciary Responsibilities: An Emerging Tripartite Distinction*, 15 WASHBURN L.J.

to patients for the failure of their corporation to ensure the competence of its medical staff through careful selection and review. As prescribed in *Elam*, corporate negligence arises out of the failure of a hospital to adequately review the performance of medical staff members or to properly evaluate applicants for membership. The role of the governing body in the review process is normally limited to reviewing the recommendations of the medical staff. In fact, as repeatedly noted above, the governing body is required by accreditation standards, statutes and regulations to delegate to the medical staff the authority to evaluate the professional competence of staff members and applicants for membership. Directors are entitled to rely on such recommendations, unless they have some knowledge which places doubt on the efficacy of the reports.[126] Consequently, a hospital may be found to have breached its duty to an injured patient despite the fact that the directors fully complied with their standard of care to the corporation.

The standard of care for directors of corporations in California is essentially the same, regardless of whether the particular corporation is commercial, for-profit, nonprofit mutual benefit or nonprofit public benefit.[127] This general standard has three elements: a director must perform his or her duties in good faith, in a manner that the director believes is in the best interest of the corporation and with such care, including reasonable inquiry, as an ordinarily prudent person in a like position would use under similar circumstances.[128] This standard, which has been called the "business judgment rule," protects directors from liability for honest mistakes.[129] It applies regardless of whether or not directors are compensated for their services. It also applies to the performance of directors while acting on board committees.[130] The requirement that a director act in good faith is a subjective requirement. It is ordinarily used to describe that state of mind denoting honesty of purpose, freedom from intention to defraud, and faithfulness to one's duty or obligation.[131]

The director's exercise of that degree of skill and attention which an ordinary prudent person in a similar position of responsibility would use under similar circumstances generally involves such things as attendance of board meetings and adequate review of agenda and re-

422 (1976). He does not specifically address the question of director or trustee liability for hospital corporate negligence.

126. CAL. CORP. CODE §§309(b), 523(b), 7231(b).

127. *Id.* §§309, 5231 & 7231.

128. *Id.* §§309(a), 5231(a), 7231(a).

129. BALLENTINE & STERLING, CALIFORNIA CORPORATION LAWS §102.01 (4th ed. 1982).

130. *Id.*

131. *Id.*; *see, e.g.*, Efron v. Kalmanovitz, 249 Cal. App. 2d 187, 192, 57 Cal. Rptr. 248, 251 (1967).

ports.[132] It also includes the obligation to make reasonable inquiry. In other words, directors must, if put on notice by an unusual event or report, make such additional inquiries as an ordinary prudent person in the director's position would make in similar circumstances.[133]

A standard of care only makes sense in conjunction with the duties to which it attaches. While it is true that the law provides that the activities and affairs of a corporation shall be conducted and all corporate powers shall be exercised by or under the direction of the governing body,[134] it is also true that the law permits governing bodies to delegate the management of the activities of the corporation to various persons or committees, as long as the governing body retains the ultimate control and direction.[135] In reality, very few, if any, hospital governing bodies manage the day-to-day activities of their corporations. Consequently, the ability of a director to rely on reports from his or her delegates is very important.

Generally, a director of a corporation does not incur personal liability for the torts of the corporation merely by reason of his or her membership on its governing body. If, however, a director commits or participates in the commission of a corporate tort, he may be found liable to injured third persons.[136] In other words, directors are personally liable to third parties for their own torts which are the proximate cause of the injury.[137]

In light of the acknowledged limitations of the concept of duty, the question is not so much whether a hospital director has a personal duty to the hospital patient to ensure the competence of the members of the medical staff, but rather whether society would be served by creating such a duty. To date, only the court in *Corleto v. Shore Memorial Hospital*[138] has concluded that society would be served by the imposition of personal liability.

The imposition of personal liability on a director for the failure of a hospital to ensure the competency of its medical staff is in reality both unwarranted and unnecessary. Hospital directors lack the expertise to make independent evaluations of the medical care rendered by medical

132. BALLENTINE & STERLING, *supra* note 138, §102.01.

133. *Id.*

134. CAL. CORP. CODE §300(a).

135. *Id.*

136. Wyatt v. Union Mortgage Co., 24 Cal. 3d 773, 785, 598 P.2d 45, 52, 157 Cal. Rptr. 392, 399 (1978); *see also* United States Liab. Ins. Co. v. Haidinger-Hayes, Inc., 1 Cal. 3d at 595, 463 P.2d at 775, 83 Cal. Rptr. at 423.

137. *See, e.g.*, Golden v. Anderson, 256 Cal. App. 2d 714, 64 Cal. Rptr. 404 (1967) (interference with contractual relations); Price v. Hibbs, 225 Cal. App. 2d 209, 37 Cal. Rptr. 270 (1964) (conspiracy to defraud).

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

staff members. The various requirements of delegation to the medical staff are based on the concept that only the medical staff has the competence to review the quality of medical care provided at the hospital. Furthermore, the relationship between an individual director and a prospective hospital patient is remote. A patient looks to the hospital as a whole for his or her health needs, not to individual directors. In short, the criteria used by the *Elam* court to expand the hospital's duty to its patients simply do not support the creation of a director's independent duty to patients.[139]

Lastly, it appears that California Civil Code section 43.7[140] will act to shield directors from personal liability in most cases. It protects them so long as they act without malice, make a reasonable effort to obtain the facts of the matter as to which they act, and act in a reasonable belief that the action taken by them is warranted by the facts.[141] The standard of care described in Civil Code section 43.7 is remarkably similar to the standard of care for directors described in the Corporations Code.[142] For instance, acting "in good faith" is the equivalent to acting "without malice;" acting in a manner that the director believes is in the best interest of the corporation is similar to acting in a reasonable belief that the action taken is warranted by the facts; and acting with such care, including reasonable inquiry, as an ordinary prudent person in a like position would use under similar circumstances is similar to making a reasonable effort to obtain the facts of the matter as to which they act. Thus, directors who meet the standard of care they owe their corporations should also meet the standard of care, if any, owed to patients. They will not be found liable for honest mistakes, or for reasonably relying on medical staff recommendations.[143]

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139. The foregoing analysis assumes that the directors do not have special knowledge of a physician's incompetence to practice or otherwise actively participate in a knowing decision to appoint or reappoint an incompetent physician to the medical staff. For example, if a medical staff recommended to the board that a physician be appointed to the staff despite the fact that the physician was incompetent (perhaps the physician was a known drug abuser, but the director knew or believed that the physician would donate a new wing to the hospital if appointed to the medical staff) and the board accepted the staff's recommendation, then a court could properly find that the director participated or directed the corporate tort, thereby imposing personal liability on the director.

140. For the text of section 43.7(b) see *supra* note 124.

Subsection (e) of Civil Code section 43.7 expressly denies to hospitals the same immunity it confers on trustees; however, on March 2, 1983, a bill was introduced into the Assembly that, if passed, would apparently contradict subsection (e) by conferring immunity on hospitals for any act or proceeding when individual medical staff committee members would have immunity under section 43.7(b). *See* A.B. 1261, 1983-84 Cal. Leg. Reg. Sess.

141. CAL. CIV. CODE §43.7.

142. CAL. CORP. CODE §§309(a), 5321(a), 7231(a).

143. After the *Corleto* decision, a great deal of literature was published for hospital directors, both warning them about their potential liability and advising them how to avoid the perceived pitfalls. *See, e.g.*, T. MULROY, HOSPITAL LIABILITY REVISITED: HOW GOVERNING BOARDS CAN PROTECT THEMSELVES AND IMPROVE PATIENT CARE (1980); R. CUNNINGHAM, GOVERNING HOS-

B. *The Proof Questions*

1. *How Can a Plaintiff Prove a Claim that the Hospital Breached its Duty of Using Reasonable Care in the Selection and Retention of the Members of its Medical Staff?*

As discussed above, the hospital delegates to its medical staff the responsibility for evaluating applications for membership and the professional competence of staff members, that is, the responsibility for selection and retention of medical staff members. Thus, to defend itself against a charge of corporate negligence, the hospital will want to show that the various medical staff committees did their job. The plaintiff will need to show that they did not.

a. *Section 1157 of the California Evidence Code Prevents the Discovery of Medical Staff Committee Records in Corporate Negligence Cases.*

Useful, if not indispensible, sources of information about whether or not the medical staff committees did their job are medical staff committee records and the testimony of the committee members. However, the discovery of the proceedings and records of medical staff committees that are performing quality assurance functions is prohibited by section 1157 of the Evidence Code.[144] Section 1157 was enacted in 1968 upon the theory that external access to peer investigations conducted by medical staff committees would inhibit effective physician participation in peer review activities.[145] Apparently it came in response to a mal-

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PITALS: TRUSTEES AND THE NEW ACCOUNTABILITIES (1976); A. BERNSTEIN, A TRUSTEE'S GUIDE TO HOSPITAL LAW (1981). By and large, these publications urge directors to become more actively involved in the operation of the hospital. While that might be good for the hospital, the more actively involved they become, the more directors run the risk of being accused of participating in the hospital's tort.

144. Section 1157 provides as follows:

> Neither the proceedings nor the records of organized committees of medical or medical-dental staffs in hospitals having the responsibility of evaluation and improvement of the quality of care rendered in the hospital or medical or dental review or dental hygienist review or chiropractive review committees of local medical, dental, dental hygienist, or chiropractic societies shall be subject to discovery. Except as hereinafter provided, no person in attendance at a meeting of any such committee shall be required to testify as to what transpired thereat. The prohibition relating to discovery or testimony shall not apply to the statements made by any person in attendance at such a meeting who is a party to an action or proceeding the subject matter of which was reviewed at such meeting, or to any person requesting hospital staff privileges, or in any action against an insurance carrier alleging bad faith by the carrier in refusing to accept a settlement offer within the policy limits.
>
> The prohibitions contained in this section shall not apply to medical, dental, dental hygienist, or chiropractic society committees that exceed 10 percent of the membership of the society, nor to any such committee if any person serves upon the committee when his own conduct or practice is being reviewed.

145. Matchett v. Superior Court, 40 Cal. App. 3d 623, 629, 115 Cal. Rptr. 317, 320 (1974).

practice case[146] in which the court ordered production of hospital records dealing with medical staff disciplinary proceedings against a physician.[147] It is based on a legislative judgment that confidential treatment of committee records will enhance the quality of the in-hospital medical practice[148] and is aimed directly at malpractice actions in which a present or former hospital staff doctor is a defendant.[149]

Section 1157 itself carves out three exceptions to its broad prohibition against discovery. The first provides that the immunity does not apply to the "statements made by any person in attendance at such a meeting who is a party to an action or proceeding the subject matter of which was reviewed at such meeting. . . ."[150] This exception was the subject of judicial interpretation in the case of *Schulz v. Superior Court*.[151] In *Schulz*, the plaintiff asserted that the foregoing statutory exception applies whenever a staff doctor and a hospital are named as defendants in a malpractice case.[152] The appellate court disagreed, saying that such a conclusion ". . . would not only achieve an absurd result, but would render sterile the immunity provisions of the statute."[153] The court specifically held that the exception does not apply to malpractice proceedings in which a doctor or a hospital has been made a party, but rather it applies to permit discovery in suits by doctors claiming arbitrary or wrongful exclusion from hospital staff privileges.[154]

The *Schulz* decision makes somewhat redundant the second exception, that the prohibition relating to discovery does not apply to any person requesting hospital staff privileges.[155] This exception was interpreted to also apply to contract physician disputes in *Roseville Community Hospital v. Superior Court*.[156] The third, and very narrow, exception provides that the prohibition relating to discovery shall not apply "in any action against an insurance carrier alleging bad faith by the carrier in refusing to accept a settlement offer within the policy limits."[157]

Eight years before the *Elam* decision, the question of the discovery of medical staff committee records in a hospital corporate negligence case

146. Kenney v. Superior Court, 255 Cal. App. 2d 106, 63 Cal. Rptr. 84 (1967).
147. 40 Cal. App. 3d at 629, 116 Cal. Rptr. at 320; Holbrook, *Medical Malpractice Litigation: The Discoverability and Use of Hospitals' Quality Assurance Committee Records*, 16 WASHBURN L. REV. 64, 70 (1976).
148. 40 Cal. App. 3d at 629, 115 Cal. Rptr. at 320.
149. *Id.*
150. CAL. EVID. CODE §1157.
151. 66 Cal. App. 3d 440, 136 Cal. Rptr. 67 (1977).
152. *Id.* at 445, 136 Cal. Rptr. at 70.
153. *Id.*
154. *Id.* at 446, 136 Cal. Rptr. at 70.
155. CAL. EVID. CODE §1157.
156. 70 Cal. App. 3d 809, 139 Cal. Rptr. 170 (1977).
157. CAL. EVID. CODE §1157.

was squarely addressed in *Matchett v. Superior Court*.[158] Matchett was a plaintiff in a medical malpractice action. He alleged that, while a patient in the hospital, he suffered injuries resulting from the doctor's negligent treatment and from the negligence of the hospital in admitting and retaining the doctor on its staff without adequate inquiry or control over his competence.[159] In short, it contained a corporate negligence cause of action against the hospital indistinguishable from the cause of action upheld in *Elam*.

Matchett sought pretrial discovery of hospital and medical staff committee records, including records of the credentials committee, the medical executive committee and the tissue committee.[160] The hospital refused to produce the records, claiming that they were protected by section 1157.[161] Matchett argued that the exception relating to persons requesting staff privileges applied, in that his lawsuit charged the hospital with negligent selection or retention of a "person requesting hospital staff privileges."[162] The appellate court disagreed. It held that the protection provided by section 1157 applied even though the hospital was also named as a defendant.[163] After observing that section 1157 might ". . . seriously jeopardize or even prevent the plaintiff's recovery,"[164] the court went on to state that "[s]ection 1157 represents a legislative choice between competing public concerns. It embraces the goal of medical staff candor at the cost of impairing plaintiffs' access to evidence."[165]

In summary, Evidence Code section 1157 and the relatively few cases that have construed it[166] clearly limit the discoverability of medical staff committee proceedings, thereby preventing plaintiffs from obtaining important evidence which they might need to prove that a hospital negligently selected or retained a physician on its staff.

b. Placing the Burden of Explanation on the Hospital—Res Ipsa Loquitur

The doctrine of *res ispa loquitur* may regain for some plaintiffs the ground they lost by their inability to discover medical staff committee

158. 40 Cal. App. 3d 623, 115 Cal. Rptr. 317 (1974).
159. *Id.* at 626, 115 Cal. Rptr. at 318.
160. *Id.*
161. *Id.* at 627, 115 Cal. Rptr. at 319.
162. *Id.* at 628, 115 Cal. Rptr. at 320.
163. *Id.* at 629, 115 Cal. Rptr. at 320.
164. *Id.* at 629, 115 Cal. Rptr. at 320-21.
165. *Id.*
166. In addition to *Matchett, Schulz* and *Roseville Community Hosp.*, see also, County of Kern v. Superior Court, 82 Cal. App. 3d 396, 147 Cal. Rptr. 248 (1978), Henry Mayo Newhall Memorial Hosp. v. Superior Court, 81 Cal. App. 3d 626, 146 Cal. Rptr. 542 (1978) and American Mutual Liability Insurance Company v. Superior Court, 38 Cal. App. 3d 579, 113 Cal. Rptr. 561 (1974).

records because of Evidence Code section 1157. Under present law, *res ipsa loquitur* is known as a presumption affecting the burden of producing evidence.[167] The *res ipsa loquitur* doctrine is not simply a technical evidentiary rule of uncertain but ancient ancestry.[168] It grows out of a concern for fairness. An example of that concern can be found in the following comments of the California Supreme Court:

> "The increasing use of *res ipsa loquitur* exemplifies the growing recognition of the courts of the special obligations which arise from particular relationships." In cases in which "the particular defendant is in a position of some special responsibility toward the plaintiff or the public," the doctrine protects the dependent party from unexplained injury at the hands of one in whom he has reposed trust. "In an integrated society where individuals become inevitably dependent upon others for the exercise of due care, where these relationships are closely interwoven with our daily living, the requirement for explanation is not too great a burden to impose upon those who wield the instruments of injury *and whose due care is vital to life itself*."[169]

It is not difficult to find a description of a hospital's duty to its patients within the foregoing quotation. In fact, while *res ipsa loquitur* has not been applied to a corporate negligence case in California, it has been used in cases involving hospitals in traditional medical malpractice cases such as those based upon nursing staff negligence.[170] More importantly, it has been used in hospital malpractice cases to assist plaintiffs in proving that hospitals breached their traditional duty to protect patients from harm.[171]

In California, it is ordinarily a question of fact whether particular circumstances justify application of the *res ipsa loquitur* doctrine.[172] The doctrine, therefore, will be available for use in a corporate negligence case, if a plaintiff can show that the basic *res ipsa loquitur* conditions have been met.

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167. CAL. EVID. CODE §646.

168. Kenney v. Superior Court, 255 Cal. App. 2d at 106, 63 Cal. Rptr. at 84.

169. Bardessono v. Michels, 3 Cal. 3d 780, 788-89, 478 P.2d 480, 485, 91 Cal. Rptr. 760, 765 (1970) (citations omitted, emphasis added).

170. *See, e.g.*, Cline v. Lund, 31 Cal. App. 3d 755, 107 Cal. Rptr. 629 (1973); Sanchez v. Bay General Hosp., 116 Cal. App. 3d 776, 172 Cal. Rptr. 342 (1981); Annot., Res Ipsa Loquitur *in Action against Hospital for Injury to Patient*, 3 A.L.R.3d 1315 (1966). For a discussion of *res ipsa loquitur* in medical malpractice, see Comment, Res Ipsa Loquitur: *Its Place in Medical Malpractice Litigation*, 8 U.S.F.L. REV. 343 (1973).

171. *See, e.g.*, Vistica v. Presbyterian Hosp., 67 Cal. 2d 465, 432 P.2d 193, 62 Cal. Rptr. 577 (1967); Meier v. Ross General Hosp., 69 Cal. 2d 420, 445 P.2d 519, 71 Cal. Rptr. 903 (1968); GinNon Louie v. Chinese Hosp. Association, 249 Cal. App. 2d 774, 57 Cal. Rptr. 906 (1967). The "three traditional corporate or institutional duties" of hospitals have been summarized as maintenance of building and grounds, maintenance of equipment and selection and supervision of employees. *See* A. SOUTHWICK, THE LAW OF HOSPITAL AND HEALTH CARE ADMINISTRATION 399-409.

172. *See, e.g.*, Newing v. Cheatham, 15 Cal. 3d 351, 360, 540 P.2d 33, 39, 124 Cal. Rptr. 193, 199-200 (1975).

The conditions for its application are established by the "*Ybarra-Newing* formulation."[173] They are as follows:

> . . . (1) the accident must be of a kind which ordinarily does not occur in the absence of someone's negligence; (2) it must be caused by an agency or instrumentality within the exclusive control of the defendant; (3) it must not have been due to any voluntary action or contribution on the part of the plaintiff.[174]

Most patients will have little difficulty proving the second and third conditions of the *Ybarra-Newing* formulation. Proving the first condition, that is, that the injury is of a type which ordinarily does not happen unless someone is negligent, will be more difficult. It will probably require expert testimony.[175] In hospital corporate negligence, the injury to the patient is not what the physician does or fails to do to the patient, that is, the professional malpractice. Rather, the negligence is the fact that an incompetent physician was allowed to, and did treat, the patient.[176]

In summary, it is possible that the doctrine of *res ipsa loquitur* may be applied in corporate negligence cases in California, thereby placing the burden of explanation on hospitals to show that their medical staff committees were not negligent in the performance of their peer review activities.[177] The protection from discovery provided by Evidence Code section 1157 may play a large part in the resolution of this question, since if the burden of explanation is not shifted to "those who wield the instruments of injury and whose due care is vital to life itself,"[178] the plaintiff may not be able to obtain evidence to prove his case.

4. Do California Evidence Code Sections 1156 or 1157 Prohibit a Hospital from Introducing Medical Staff Committee Records in Its Own Defense?

The use of medical staff peer review records by a hospital in its own

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173. Sanchez v. Bay General Hosp., 116 Cal. App. 3d at 783, 172 Cal. Rptr. at 346. The term "*Ybarra-Newing* formulation" refers to the cases of Ybarra v. Spangard, 25 Cal. 2d 486, 154 P.2d 687 (1944), and *Newing v. Cheatham*.

174. *Id.* at 786, 172 Cal. Rptr. at 346.

175. *See, e.g.*, 15 Cal. 3d at 359-60, 540 P.2d at 39, 124 Cal. Rptr. at 199. In medical malpractice cases, expert testimony is required if the medical procedure at issue is special, unusual, complex or otherwise beyond a layperson's common knowledge. See B. WITKIN, CAL. EVIDENCE 69-71 (2d ed. 1982 Supp.)

176. Some of the consolidated cases entitled *Katie Cichy v. William Miofsky, M.D.*, set for trial in early 1983 in the Superior Court of Sacramento County, include causes of action in which the plaintiffs allege that they are entitled to recover damages from the hospital solely because they were patients in operating rooms in which Miofsky was permitted to practice anesthesiology. They claim damages not from any malpractice Miofsky may have committed against them, but only arising out of the fact that he attended them as an anesthesiologist.

177. *Cf.* Montes v. Hartford Hosp., 16 Conn. Supp. 441, 226 A.2d 798 (1966); Richards v. Grace-New Haven Community Hosp., 137 Conn. 508, 79 A.2d 353 (1951).

178. Bardessono v. Michels, 3 Cal. 3d at 789, 478 P.2d at 485, 91 Cal. Rptr. at 765.

defense may be important to rebut a *prima facie* case of corporate negligence or if *res ipsa loquitur* is used to shift the burden of producing evidence to the hospital. The ability of a hospital to use such records is not without question. Evidence Code section 1157, does not expressly affect the admissibility of medical staff committee records; it merely protects them from discovery. The specific question of their admissibility has thus far escaped judicial decision.

If Section 1157 does not prevent the admissibility of committee records and if they are not otherwise rendered inadmissible by the hearsay rule or any other rule of evidence, they could be used by the hospital in its defense.[179] If so, the hospital has an obvious advantage, since it would not have to produce the records before trial. It is unlikely that the courts would endorse such an unfair practice. More likely, the court would order a hospital to disclose to the plaintiff all records the hospital intended to use at trial, in effect, forcing the hospital to waive Evidence Code section 1157 protection as a condition to being permitted to introduce medical staff records at trial.[180]

If, on the other hand, the committee records are inadmissible as well as undiscoverable, they will not be available to help or hurt either party at trial. The party with the burden of producing evidence obviously will be in a difficult position.

The admissibility question is further clouded by the relationship between sections 1156 and 1157 of the Evidence Code. Section 1156 allows discovery of the records of medical staff committees which engage in research and medical or dental study for the purpose of reducing morbidity and mortality, but it expressly makes those records inadmis-

179. In November of 1982, the California Hospital Association issued a bulletin to its members urging them to resist "the temptation" to waive section 1157 protection for committee records and to continue to assert the position that sections 1156 and 1157 prohibit the discovery or admissibility of committee records, either offensively or defensively.

180. Almost all of the states, in addition to California, that recognize the theory of corporate negligence have some type of evidentiary privilege exempting medical staff committee records from discovery. Arizona's statute is particularly interesting. As described and applied by the Arizona Supreme Court in Tuscon Medical Center, Inc. v. Misevch, 113 Ariz. 34, 545 P.2d 958, it permits the statements and information considered by a committee to be subpoenaed, while protecting from discovery the reports and minutes of the committee. It distinguishes between purely factual, investigative matters and materials that are the product of reflective deliberation or policy-making processes. It allows candid and conscientious evaluations to be protected, but it also allows for the discovery of factual matters that form the basis of the committee's decision.

The Arizona solution seems to be a fair compromise for plaintiffs and hospitals alike. It permits a court to review the process while protecting the discussions of the participants. It is also a solution which medical staff members might accept since it protects their deliberations from disclosure. A California court might arrive at such a solution simply by interpreting section 1157 in such a way as to find that the factual investigative materials were neither the proceedings nor the records of a medical staff committee. Stranger things have happened. Alternatively, it may be time to amend sections 1156 and 1157 to resolve some of the conflicts and ambiguities which presently exist. The risks of the legislative process cannot be any greater than the risks of the judicial process.

sible as evidence in any action or before any administrative body, agency, or person.[181] The provisions of sections 1156 and 1157 are apparently in conflict since the committees researching morbidity and mortality (section 1156 committees) are also committees having the responsibility for evaluation and improvement of the quality of care rendered in a hospital (section 1157 committees). The questions are whether section 1157 supersedes or controls section 1156, making all records undiscoverable, and whether section 1156 makes all records inadmissible.

Section 1156 was enacted in 1965 and became operative on January 1, 1967. As noted above, section 1157 was enacted in 1968, apparently in response to the decision in *Kenney v. Superior Court*[182] which permitted a malpractice plaintiff to discover hospital medical staff records which might reveal information bearing on the competency of the defendant doctor.[183] The *Kenney* court remarked that the committee records might be useful to the plaintiff even if they were inadmissible, since they might point the way to admissible evidence.[184] Their admissibility will be determined by regular evidentiary rules. Consequently, the focus of section 1157 on discoverability may well be a result of the legislature's decision to reverse the narrow holding in *Kenney*.

If Evidence Code section 1157 does not prohibit the admissibility of committee records, then the records are subject to being subpoenaed and used at trial. The protection provided by section 1157, therefore, is limited. It protects the records from discovery, thereby preventing a plaintiff from using the information in the preparation of his or her

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181. Section 1156 provides as follows:
(a) In-hospital medical or medical-dental staff committees of a licensed hospital may engage in research and medical or dental study for the purpose of reducing morbidity or mortality, and may make findings and recommendations relating to such purpose. Except as provided in subdivision (b), the written records of interviews, reports, statements, or memoranda of such in-hospital medical or medical-dental staff committees relating to such medical or dental studies are subject to Sections 2015 and 2036, inclusive, of the Code of Civil Procedure (relating to discovery proceedings) but, subject to subdivisions (c) and (d), shall not be admitted as evidence in any action or before any administrative body, agency, or person.
(b) The disclosure, with or without the consent of the patient, of information concerning him to such in-hospital medical or medical-dental staff committee does not make unprivileged any information that would otherwise be privileged under Section 994 or 1014; but, notwithstanding Sections 994 and 1014, such information is subject to discovery under subdivision (a) except that the identity of the patient may not be discovered under subdivision (a) unless the patient consents to such disclosure.
(c) This section does not affect the admissibility in evidence of the original medical or dental records of any patient.
(d) This section does not exclude evidence which is relevant evidence in criminal action.

182. 255 Cal. App. 2d 106, 63 Cal. Rptr. 84 (1967).
183. *Id.* at 108-09, 63 Cal. Rptr. at 86-87.
184. *Id.* at 109, 63 Cal. Rptr. at 87.

case, but it does not, at least on its face, protect the records from being used at trial. The confidentiality of records protected by section 1157, therefore, may be somewhat illusory.

By contrast, section 1156 expressly declares that the records of morbidity and mortality committees are inadmissible. Neither the hospital nor a malpractice plaintiff can introduce such records over an objection. It may be argued that sections 1156 and 1157 should be read together to make all peer review medical staff committee records nondiscoverable and inadmissible.[185] This argument is based generally on the idea that the difference in language between section 1156 and section 1157 reflects a growing sophistication in the evolution of the medical staff peer review process. The committees described in section 1156, according to the argument, are really the same committees that are described in section 1157, that is, committees engaged in research and study for the purpose of reducing morbidity and mortality are equivalent to committees having the responsibility of evaluation and improvement of the quality of care rendered in the hospital. Section 1157 was enacted, the argument concludes, to complete the process begun with section 1156, to close the discovery "loophole."

This argument might very well be right. If it is right, then medical staff committee records are inadmissible and will not be available for use by hospitals in defending *Elam* claims.

IV. Conclusion

The decision by the *Elam* court to expand the duty of a hospital to its patients to include the exercise of reasonable care in the selection and retention of members of its medical staff came as no surprise to most lawyers in the health care field. When, as they inevitably must, the courts of this state address the "parties questions" and the "proof questions" raised in this article, their answers may prove to be surprising. Whatever the answers, and regardless of whether they adopt the reasoning and analysis set forth above, their impact will alter the organizational structure of California hospitals in the 1980's and, perhaps, beyond.

185. For example, the California Hospital Association apparently takes this position. *See supra* note 189.