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Negligence: *Strubhart v. Perry Memorial Hospital*: Taming the Monster of Corporate Negligence or Creating an Unpredictable Form of Hospital Liability?

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I. Introduction

Since the turn of the century, medical technology has advanced with herculean strides.[1] The increasing complexity of healthcare issues accompanying these advances has called upon the legal community to keep in step.[2] At the same time, hospitals have evolved into modern, healthcare-providing businesses,[3] facing ever-expanding liability.[4]

This trend of increasing hospital liability has culminated in the widely adopted and loosely defined doctrine of corporate negligence.[5] However, an uneven and inconsistent application of the doctrine's precepts has produced an evolving creature,[6] not unlike Dr. Frankenstein's "monster," which was assembled from mismatched members and sewn into one body.[7] Many courts and commentators accept corporate liability as encouraging a higher quality of patient care.[8] The

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1. *See* ARTHUR SOUTHWICK, THE LAW OF HOSPITAL AND HEALTHCARE ADMINISTRATION 539 (2d ed. 1988).

2. For a discussion of policies and legal doctrines arising in the midst of medical advancement, see CLARK C. HAVIGHURST, HEALTH CARE LAW AND POLICY 581-87 (1988).

3. *See* PAUL STARR, THE SOCIAL TRANSFORMATION IN AMERICAN MEDICINE 430-32 (1982) (describing the shift in the public perception of hospitals to that of sophisticated businesses, providing multiple health services); *see also* William B. Smith, *Hospital Liability for Physician Negligence (Law and Medicine)*, 251 JAMA 497, 497-98 (1984) (noting that as hospital equipment became more complex, more powerful, and more sophisticated, the hospitals exposure to the risk of liability increased accordingly).

4. *See* Elam v. College Park Hosp., 183 Cal. Rptr. 156, 159 (Cal. Ct. App. 1982) (acknowledging that the community hospital has assumed the role of a comprehensive health center ultimately responsible for arranging and coordinating total health care); *see also* David D. Griner, Note, *Paying the Piper: Third-Part Payor Liability for Medical Treatment Decisions*, 25 GA. L. REV. 861, 896-97 (1991) (explaining that the public's perception of the modern hospital as a comprehensive health facility promoted the application of corporate negligence to hospitals).

5. *See generally* Cassandra P. Priestley, *Hospital Liability for the Negligence of Independent Contractors: A Summary of Trends*, 50 J. MO. B. 263 (1994) (describing the almost unanimous acceptance of the jurisdictions considering corporate negligence and the variety of forms it has taken).

6. *See* Gerry Gressel, Note, Albain v. Flower Hospital: *Halting the Expansion of Hospital liability for Negligence of Physicians in Ohio*, 19 N. KY. L. REV. 393, 402-03 (1992). The author notes the inconsistency in refusing to broadly define a hospital's independent duty while insisting that hospital administrators are qualified to supervise employee physicians). *Id.* at 402.

7. *See* MARY SHELLEY, FRANKENSTEIN (New Am. Library ed. 1965) (1818).

8. *See* John F. Bales & Lisa A. Demarco, *Selected Topics in Medical Malpractice Litigation, in* HEALTH CARE LAW 1993, at 381, 471-85 (PLI Commercial Law & Practice Course Handbook Series No. 669, 1993), *available in* Westlaw, 669 PLI/Comm 381 (describing the holdings of some of the courts of jurisdictions deciding the issue of corporate negligence). For a review of some of the jurisdictions accepting corporate negligence, see Insinga v. Labella, 543 So. 2d 209, 214 (Fla. 1989).

doctrine's unpredictability, though, has left hospitals confused and exposed to a greater risk of liability.[9]

On February 14, 1995, the Supreme Court of Oklahoma followed this trend and formally adopted corporate negligence as a viable theory of hospital liability.[10] According to this ruling, a hospital owes an independent duty to its patients to ensure that only competent physicians are granted staff privileges.[11] Further, once staff privileges are granted, a hospital has a duty to take reasonable steps to ensure patient safety when it knows or should have known that a physician has demonstrated a pattern of incompetent behavior.[12] As a result, the court adopted a more limited version of the corporate negligence doctrine than has been applied in other jurisdictions.[13]

This note will first explore the development of hospital liability, from the origins of charitable immunity through the present-day imposition of corporate responsibility. Second, the facts of *Strubhart v. Perry Memorial Hospital Trust Authority*[14] will be presented, as well as an analysis of the court's holdings. Third, the limited form of corporate liability adopted will be examined and supported as an evenhanded and timely expansion of existing hospital liability theories. Finally, alternative guidelines by which a hospital's standard of care may be defined will be discussed and evaluated.

II. Historical Evolution of the Corporate Negligence Doctrine

For the greater part of a century,[15] the doctrine of charitable immunity released hospitals from accounting for tort liability.[16] Public policies affirming the hospital's role as a nonprofit charity, however, grew outdated as hospitals developed into

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9. *See* David H. Rutchik, *The Emerging Trend of Corporate Liability: Court's Uneven Treatment of Hospital Standard Leaves Hospitals Uncertain and Exposed*, 47 VAND. L. REV. 535, 571 (1994).

10. Strubhart v. Perry Memorial Hosp. Trust Auth., 903 P.2d 263, 266 (Okla. 1995).

11. *Strubhart*, 903 P.2d at 276.

12. *Id.* Hospitals shall be held liable by a showing that the staff physician's negligence was foreseeable, *id.* at 277, evidenced by a pattern of incompetence which puts the hospital on notice to take reasonable steps to protect patients, *id.* at 278. The court declined, however, to place a strict duty on hospitals to cancel privileges whenever a physician's incompetence is called into question. *Id.* (citing Albain v. Flower Hosp., 553 N.E.2d 1038, 1045-46 (Ohio 1990)).

13. *Id.* at 278.

14. 903 P.2d 263 (Okla. 1995).

15. The charitable immunity doctrine was first applied in McDonald v. Massachusetts Gen. Hosp., 120 Mass. 432 (1876), and was expressly rejected in Oklahoma in Gable v. Salvation Army, 100 P.2d 244 (Okla. 1940). The *McDonald* court based the doctrine on a trust fund theory that donations should not be diverted to award damages from the intended purpose of freely administering charity. Thompson v. Nason Hosp., 591 A.2d 703, 706 (Pa. 1991).

16. *See* Schoendorff v. Society of New York Hosp., 105 N.E. 92, 93 (N.Y. 1914) (reasoning that if a hospital must account for tort liability, then its ability to provide care without regard for a patient's ability to pay would be hindered); *see also* Priestley, *supra* note 5, at 263 (outlining four theories as the basis for charitable immunity).

sophisticated businesses.[17] Courts eventually rejected this doctrine, favoring instead respondent superior.[18]

Although respondent superior, the "master-servant" doctrine, exposed hospitals to the risk of vicarious liability for employees' acts,[19] an important exception remained. The current law viewed non-employee physicians as independent contractors,[20] solely liable for injuries to patients under their care.[21] However, courts, with the guidance of agency law, devised a theory to bridge the gap in hospital responsibility whenever patients look to the hospital, rather than any specific physician, as their primary health care provider.[22]

In *Weldon v. Seminole Hospital*,[23] a minor girl was treated in the local emergency room by her family physician. The family doctor unsuccessfully attempted to extract a bead that was lodged in the girl's ear. Eventually, the girl was transferred to a specialist in Oklahoma City, where the bead was removed. However, believing that the family physician's earlier attempts had caused the permanent damage to the girl's hearing, the parents sued the family doctor and the local hospital. This action against the hospital was based upon theories of respondeat superior, ostensible agency, and the hospital's independent acts of negligence.[24]

The Supreme Court of Oklahoma held in favor of the hospital.[25] The theory of respondeat superior failed because the family doctor, who had staff privileges, was not an employee of the hospital. Further, the court rejected an application of ostensible agency. Relying on a two-part test,[26] the court refrained from extending the theory of ostensible agency to render a hospital liable in the event of a

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17. *See* Rutchik, *supra* note 9, at 539-40.

18. *See, e.g.*, Gable v. Salvation Army, 100 P.2d 244 (Okla. 1940) (rejecting charitable immunity theory's application to hospitals); *see also* Bing v. Thunig, 143 N.E.2d 3, 8 (N.Y. 1957) (abandoning charitable immunity in holding hospital vicariously liable for employee negligence).

19. For an interesting discussion of the application of the theory of respondeat superior to hospital liability, see Arthur F. Southwick, *Hospital Liability: Two Theories Have Been Merged*, 4 J. LEGAL MED. 1, 4 (1983).

20. *See* RESTATEMENT (SECOND) OF AGENCY §§ 2, 220, 223 (1958); *see also* Pedroza v. Bryant, 677 P.2d 166, 169 (Wash. 1984) (explaining court's tendency to classify staff physicians as independent contractors).

21. *See* W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 71 (5th ed. 1984); *see also* RESTATEMENT (SECOND) OF TORTS §§ 409-42 (1966) (describing independent contractors as an exception to the doctrine of respondent superior, because they are not under the control of the employer).

22. *See, e.g.*, Capan v. Divine Providence Hosp., 430 A.2d 647, 649 (Pa. Super. Ct. 1980) (holding hospital liability when patient looked to hospital and not to specific physician for care upon admission to the emergency room); *see also* 1 STEVEN E. PEGALIS & HARVEY F. WACHSONAN, AMERICAN LAW OF MEDICAL MALPRACTICE § 3-27 (Supp. 1990) (supporting ostensible agency theory in certain situations, especially in the emergency room).

23. 709 P.2d 1058 (Okla. 1985).

24. *Weldon*, 709 P.2d at 1059.

25. *Id.* at 1061.

26. The following test was applied: (1) whether the patient sought treatment primarily from the hospital and (2) whether the hospital paid the doctor a salary. *Id.* at 1060 (citing Adamski v. Tacoma Gen. Hosp., 579 P.2d 970, 975 (Wash Ct. App. 1987)).

preexisting doctor-patient relationship.[27] Nevertheless, the court affirmed the general rule of hospital liability for the negligence of emergency room physicians, regardless of their status as independent contractors.[28] Additionally, the court concluded that the hospital had no independent duty to supervise the individual decisions of staff physicians.[29]

The increasing labor pains of expanding hospital liability signaled the birth of the new doctrine of corporate negligence.[30] First introduced in *Darling v. Charleston Community Memorial Hospital*,[31] the Illinois Supreme Court established the concept that a hospital had an independent responsibility to supervise the medical treatment provided by its medical staff.[32] Hospital liability was not founded on respondeat superior but on the hospital's breach of a duty owed directly to the patient.[33] The court's ambiguity, however, concerning the required standard of care has led to years of confusion, with some jurisdictions expanding corporate liability to impute to a hospital the duty to ensure that only qualified physicians practice within its walls.[34]

The jurisdictions deciding the issue have almost unanimously adopted the doctrine,[35] yet its application has been uneven.[36] Some courts have utilized the doctrine of corporate negligence to impose upon a hospital as many as six independent duties owed to those patients treated by staff physicians.[37] Other courts

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27. *Id.* at 1059.

28. *Id.* (distinguishing Smith v. St. Francis Hosp., 676 P.2d 279 (Okla. Ct. App. 1983) based on Weldon receiving treatment from her family doctor whereas Smith had no preexisting relationship with the emergency room staff physician).

29. *Id.* at 1061.

30. *See* Judith M. Kinney, Comment, *Tort Law-Expansion of Hospital Liability Under the Doctrine of "Corporate Negligence,"* 65 TEMPLE L. REV. 787, 787-90 (1992); *see also* Priestly, *supra* note 5, at 264-70 (describing how the theories permitting greater hospital liability culminated in the doctrine of corporate liability).

31. 211 N.E.2d 253 (Ill. 1965) There, an 18-year-old boy was taken to the emergency room after suffering a broken leg. The staff physician who was on call put the boy's leg in a cast that subsequently cut off circulation to the knee, requiring that portion of the leg to be amputated.

32. *Darling*, 211 N.E.2d at 257. The court recognized that the medical community already condoned a hospital's accountability as shown by the Standards for Hospital Accreditation and the hospital's bylaws. *Id.*

33. *Id.* at 258; *see also* Rosemary D. Welsh, *Negligent Credentialing: Ohio Expands Hospital Liability in the Wake of "Surgery of Love,"* 63 U. CIN. L. REV. 607, 616 (1994) (noting the doctrinal origins of corporate negligence as distinct from vicarious liability). *But see* Blanton v. Moses H. Cone Memorial Hosp., 354 S.E.2d 455, 458 (N.C. 1987) (adopting corporate negligence as an extension of respondeat superior, rather than a distinct independent duty).

34. *See* Mitchell J. Nathanson, *Hospital Corporate Negligence: Enforcing the Hospital's Role of Administrator*, 28 TORT & INS. L.J. 575, 579 (1993); *see also* Gressel, *supra* note 6, at 400 (scrutinizing the trend of adopting a form of corporate negligence which could give rise to strict hospital liability).

35. *See* Strubhart v. Perry Memorial Hosp., 903 P.2d 263, 275 n.13 (Okla. 1995) (explaining that at least twenty-two states have adopted corporate negligence in some form).

36. *See* Bales & Demarco, *supra* note 8, at 471-85 (showing the inconsistencies in cases adopting, rejecting, and limiting corporate negligence).

37. Some commentators have listed six duties including: (1) negligence in relationship to premises, equipment, or facilities; (2) negligence in selection or retention of physicians; (3) negligence in

have limited its scope by imposing fewer duties,[38] by requiring that the underlying physician negligence have been foreseeable,[39] or by adopting what some commentators have labeled a "quasi-respondeat-superior" analysis.[40]

In *Strubhart v. Perry Memorial Hospital Trust Authority*,[41] the Supreme Court of Oklahoma joined those states advocating corporate negligence, yet followed *Albain v. Flower Hospital*[42] in limiting the type of independent duties imposed.[43] Despite the conservative approach in reshaping the doctrine, the majority failed to define the "pattern of incompetent behavior" by a staff physician which would impose an independent duty upon the hospital. Thus, future applications of the *Strubhart* decision could possibly breathe new life into the unpredictable "monster" of corporate liability.

III. Statement of the Case

Gayla Tearney was admitted to Perry Memorial Hospital to give birth under the care of Dr. Richard Seal, the patient's private physician who had staff privileges at the hospital.[44] After a difficult labor and delivery with forceps at 1:30 a.m., Dr. Seal stayed with the baby for about an hour before leaving the hospital.[45]

The physician returned at 7:00 a.m. and resumed personal care of the baby. However, by late morning or early afternoon, the baby had gone into hypovolemic

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overseeing physicians; (4) failure to devise medical rules or policies; (5) negligence in devising medical rules or policies; (6) negligence in enforcing medical rules or policies. Jim M. Perdue, *Direct Corporate Liability of Hospitals: A Modern Day Legal Concept of Liability for Injury Occurring in the Modern Day Hospital*, 24 S. TEX. L.J. 773, 773 n.2 (1983).

38. *See* Albain v. Flower Hosp., 553 N.E.2d 1038, 1046 (Ohio 1990) (refusing to impose upon a hospital a duty to supervise or monitor the activities of staff physicians, based on the rationale that physicians and not hospitals are licensed to practice medicine).

39. *See* Johnson v. Misericordia Community Hosp., 301 N.W.2d 156, 163-64 (Wis. 1981).

40. *See* Rutchik, *supra* note 9, at 545 (citing Humana Medical Corp. of Ala. v. Traffanstedt, 597 So. 2d 667 (Ala. 1992) (holding that the hospital can not be liable absent a showing that the attending staff physician was also negligent)).

41. 903 P.2d 263 (Okla. 1995).

42. 553 N.E.2d 1038 (Ohio 1990). *See supra* note 38 and accompanying text. The *Albain* court held that "the independent duty of the hospital is limited to the exercise of due care in the granting of staff privileges, and the continuation of such privileges, to independent private physicians." *Albain*, 553 N.E.2d at 1046.

43. *Strubhart*, 903 P.2d at 278 (citing *Albain*, 553 N.E.2d at 1046).

44. *Id.* at 266.

45. *Id.* The subsequent chain of command was the following: (1) Dr. Seal, who, although, had returned home would resolve any disputes between Ms. Kennedy and Nurse Bowles in caring for the baby; (2) Ms. Kennedy, a medical student; (3) Nurse Bowles, a hospital employee; and (4) a nurses aid, who was assigned to take the baby's vital signs every fifteen minutes. At 3:45 a.m. and at 4:00 a.m., Nurse Bowles, concerned about the baby's condition, called Kennedy, who concluded that the baby was "fine."

shock,[46] most probably as the result of the improper delivery by forceps, and had to be transferred to a hospital in Oklahoma City.[47] The baby died later that day.[48]

Strubhart, as the representative of Geoffrey Tearney's estate, brought a suit against Perry Memorial Hospital for negligence in causing the baby's death.[49] Although the judge had previously dismissed any theory of liability based on corporate negligence,[50] the jury awarded the decedent's estate $800,000.[51] The trial court judge, however, granted a new trial based upon the estate's refusal to remit $500,000 of the verdict and because the hospital was prejudiced by the admission of certain evidence.[52]

The court of appeals affirmed the trial court's decision for a new trial and held that Strubhart had not adequately preserved the issue of whether corporate negligence is a viable liability doctrine in Oklahoma.[53] The Supreme Court of Oklahoma in part overruled the lower court, opening the door to evaluate corporate negligence as a theory of recovery.[54] The present discussion focuses on the resolution of this issue.

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46. "Hypovolemia is an abnormally low volume of blood circulating in the body, which usually follows a severe blood loss which may occur as a result of internal bleeding. It is a dangerous condition that can lead to shock and death." *Id.* at 267 n.2 (citing AMERICAN MEDICAL ASS'N STAFF, AMERICAN MEDICAL ASSOCIATION ENCYCLOPEDIA OF MEDICINE 564 (1989)).

47. *Id.* at 267.

48. *Id.*

49. *Id.* at 266. The plaintiff originally brought suit against the hospital, Dr. Seal, Ms. Kennedy, the Oklahoma College of Osteopathic Medicine and Surgery. *Id.* at 268. The latter three claims were dismissed before trial, after a settlement with Dr. Seal for $150,000. *Id.*

50. *Id.*

51. *Id.*

52. *Id.* at 269. This evidence consisted of prior alleged bad acts of Dr. Seal which included, but was not limited to, Dr. Seals reluctance to transfer patients to specialized facilities, incidents when his failure to transfer resulted in infants' deaths, violations of hospital policy, and sending a patient home without protecting an incision with antibiotics and requiring her to undergo an additional surgery. *Id.* at 267-68. This evidence was admitted, not to show the hospital's negligence in screening and reviewing the competency of Dr. Seal, but rather to prove that the hospital employees were negligent and to impute their negligence to the hospital based on respondeat superior. *Id.* at 267. the trial judge reconsidered his earlier admission of this evidence and

> was of the view that the overwhelming nature of this testimony made it appear to the jury that the hospital was responsible for the actions of Dr. Seal or . . . made the hospital responsible for insuring some action to be taken by hospital personnel to prevent the treatment of the infant.

Id. However, the court also provided guidance for the admission of testimony supporting the theory of corporate negligence on retrial.

> Testimony about a doctor's prior conduct is admissible if the hospital, through its personnel, knows or should know with the exercise of ordinary care of the prior conduct, and the prior conduct of the doctor is such that a hospital exercising ordinary care would take steps to either monitor or discipline the doctor.

Id. at 273. "[S]uch episodes . . . of prior conduct might include the fact the doctor has previously been sued for malpractice or experienced untoward results in prior cases." *Id.*

53. *Id.* at 269. The court of appeals affirmed the trial court's decision by a 2-1 vote. *Id.* at 269.

54. *Id.* at 271-74.

Justice Lavender, as author of the majority opinion, recognized an independent duty which hospitals owe directly to patients who are treated by staff physicians.[55] The court imposed a duty of ordinary care on hospitals to ensure that only competent physicians are granted staff privileges. Further, once staff privileges are granted, a hospital must take "reasonable steps to ensure patient safety when it knows or should know[56] the staff physician has engaged in a pattern of incompetent behavior."[57] Limiting the hospital's duty to the exercise of due care in granting and renewing staff privileges, the majority presented three reasons for adopting the doctrine of corporate negligence.

First, the public's perception of modern hospitals as businesses which provide and coordinate comprehensive health care supports the imposition of a direct duty on the hospital to the patient-consumer to meet an adequate standard of care in fulfilling this administrative role.[58] Second, the existing law in Oklahoma foreshadowed the further expansion of hospital responsibility, and now it was time to continue this trend. Third, failure to impose this independent duty would permit a hospital to ignore the incompetence of staff physicians, thereby increasing the likelihood of patients being injured by such incompetence.[59]

Distinguishing this form of liability from respondeat superior,[60] the majority adopted an approach similar to that of *Albain v. Flower Hospital*[61] and rejected making hospitals insurers of patient safety.[62] However, the majority in *Strubhart* parted with the *Albain* court by refusing to place a strict duty on hospitals to terminate staff privileges whenever a doctor's competence is called into question.[63] Rather, a hospital may fulfill its independent duty by taking "some reasonable or

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55. *Id.* For a discussion of additional duties which courts have imposed under the umbrella of corporate negligence, see *supra* note 37.

56. The court repeatedly set forth the standard that the hospital "should know." On the other hand, the court was ambiguous when stating that "the hospital can only be held liable if it had reason to know it should have acted. Therefore, knowledge, either actual or constructive, is an essential factor in determining whether the hospital exercises reasonable care or was negligent." *Strubhart*, 903 P.2d at 278. However, the "reason to know" standard is distinct from the "should know" standard. According to the *Restatement of Torts*, an actor has reason to know a fact, when the actor "has information from which a person of reasonable intelligence or of the superior intelligence of the actor would infer that such fact exists." RESTATEMENT (SECOND) OF TORTS § 12(1) (1965). In contrast, the term "should know" means that "a person of reasonable prudence and intelligence . . . would ascertain the fact in question in the performance of his duty to another . . . ." *Id.* § 12(2). The comment to this section provides that "these two phrases . . . differ in that 'reason to know' implies no duty of knowledge on the part of the actor, whereas 'should know' implies that the actor owes another the duty of ascertaining the fact in question."

57. *Strubhart*, 903 P.2d at 275. However, the court emphasized that this "pattern of incompetence" may consist of a single prior episode, if it is "so egregious on the part of the doctor that the hospital should know it is dealing with an incompetent." *Id.* at 277 n.14.

58. *Id.*

59. *Id.* at 278.

60. *Id.* at 276. For a discussion of the views of respondeat superior in Oklahoma law, see I. Trotter Hardy, Jr., *When Doctrines Collide: Corporate Negligence and Respondeat Superior When Hospital Employees Fail To Speak Up*, 61 TUL. L. REV. 85, 85-88 (1986).

61. 553 N.E.2d 1038 (Ohio 1990).

62. *Strubhart*, 903 P.2d at 276.

63. *Id.* at 277.

appropriate steps."[64] Adopting this form of corporate negligence as a viable theory of recovery upon retrial, the court remanded the case back to the trial court for a new trial.[65]

IV. Reasons for Adopting the Corporate Negligence Doctrine

Although corporate negligence has gained widespread acceptance in the legal community, not all have welcomed the doctrine's debut with open arms. Some critics have argued that this new form of liability focuses more on targeting deep pockets than on extracting a judgment from the appropriate tortfeasor.[66] Other skeptics have lambasted the doctrine based on practical arguments, predicting escalating health care costs, borne predominantly by patients.[67]

In *Strubhart*, the court was similarly conflicted over the issue.[68] Three considerations, however, persuaded the majority to adopt a variation of corporate negligence. Though each of the arguments has weaknesses, when taken together, these reasons support the doctrine's imposition.

A. Public's Perception of the Modern Hospital[69]

Wary of creating an epidemic of health care litigation, some courts have excused hospitals from any responsibility for the negligent acts of staff physicians, reasoning that "hospitals don't practice medicine, physicians do."[70] However, this oft-quoted adage no longer reflects the current public perception of healthcare facilities.[71] The modern hospital has voluntarily assumed the role of a profit-producing business,[72] aggressively marketing itself as an administrator[73] and a provider of comprehensive health care.[74]

The *Strubhart* court accurately defined the modern hospital as a "corporate institution."[75] Like other corporations, hospitals in the United States funnel billions

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64. *Id.* at 278.

65. *Id.* at 279.

66. *See* James B. Cohoon, Comment, *Piercing the Doctrine of Corporate Hospital Liability*, 17 SAN DIEGO L. REV. 383, 400-01 nn.106-07 (1980).

67. *See* Thompson v. Nason Hosp. 591 A.2d 703, 709 (Pa. 1991) (Flaherty, J., dissenting) (claiming that corporate negligence would be a monumental and ill-advised change in the law).

68. The majority's victory in adopting the corporate negligence doctrine was marginal, decided by a 5-4 vote. *Strubhart*, 903 P.2d at 279.

69. "The doctrine of corporate negligence reflects the public's perception of the modern hospital as a multifaceted health care facility." *Id.* at 275.

70. *See* Hannola v. City of Lakewood, 426 N.E.2d 1187, 1190 (Ohio Ct. App. 1980) (quoting the trial court judge's reasoning).

71. *Id.* at 1190.

72. *See* Kashishian v. Port, 481 N.W.2d 277, 282 (Wis. 1992) (observing the hospital's attributes as a business).

73. *See* Nathanson, *supra* note 34, at 592.

74. *See* McClellan v. Health Maintenance Org. of Pa., 604 A.2d 1053, 1058 (Pa. Super. Ct. 1992) (citing Thompson v. Nason Hosp., 591 A.2d 703, 706 (Pa. 1991)).

75. *Strubhart*, 903 P.2d at 275.

of dollars each year into marketing strategies,[76] targeting prospective patients and companies whose insurance policies include the hospital in their health care plan.[77] Modern hospitals recruit staff physicians who are key admitters of inpatients and devise programs to generate referrals to specialists.[78] Further, hospitals charge patients for many medical services, collecting from them, if necessary, by legal action.[79]

Aware of this corporate structure, the public has come to rely on hospitals to provide administrative services.[80] Of course, the law must not bend when merely pressured to conform to public expectation. Rather, the law must adapt when a potential tortfeasor aggressively assumes a new role and public policy dictates that the new role should include legal duties.

B. Promoting Hospital Responsibility and Awareness in the Role of Healthcare Coordinator[81]

Recognizing the modern hospital as a comprehensive healthcare corporation, the majority in *Strubhart* concluded that hospitals must bear the legal responsibility associated with this new role.[82] Addressing the significance of responsibility, Lyndon Baines Johnson advised that "[t]here are plenty of recommendations on how to get out of trouble cheaply and fast. Most of them come down to this: Deny your responsibility."[83] Because expanded hospital liability is neither cheap nor fast, some opponents of corporate negligence have, likewise, rejected the doctrine.[84]

Although the dissent in *Strubhart* was silent in rejecting the doctrine,[85] other critics contend that corporate liability would necessarily accelerate the upward spiral of health care costs[86] and would excessively burden the courts with increased malpractice litigation.[87] The defect in this argument is threefold. First, corporate

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76. *See Kashishian*, 481 N.W.2d at 282.

77. *See* JULIANN B. SULLIVAN, THE DEVELOPMENT OF AN INHOSPITAL CENTER FOR WOMEN'S HEALTH 59-60 (1994).

78. *Id.* at 16-22.

79. *See* Frank M. McClellan, *Tort Liability of Physicians, Hospitals, and Other Health Care Providers*, C972 ALI-ABA 1, 25 (1994).

80. *See* Nathanson, *supra* note 34, at 592. For instance, hospitals generally investigate credentials before granting staff privileges, often spending 20 hours or more verifying the information for one physicians. Mary T. Koska, *Credentialing Program Demise a 'Disappointment'*, HOSPS. & HEALTH NETWORKS, Feb. 20, 1992, at 72, *available in* Westlaw, 1992 WL 3256171, at *1-2. In addition, hospitals coordinate peer review programs and institute bylaws ensuring patient safety. *See* Moore v. Burt, 645 N.E.2d 749, 751-55 (Ohio Ct. App. 1994); *see also* Corrigan v. Methodist Hosp., 158 F.R.D 70, 72 (E.D. Pa. 1994) (acknowledging that hospitals have bylaws and a duty to formulate, adopt, and enforce adequate rules and policies).

81. *Strubhart*, 903 P.2d at 276.

82. *Id.*

83. *See* Priestley, *supra* note 5, at 263 (quoting Lyndon Baines Johnson (Sept. 30, 1967)).

84. *See* Thompson v. Nason Hosp., 591 A.2d 703, 709 (Pa. 1991) (Flaherty, J., dissenting) (claiming an adoption of the doctrine will boost health care costs already burdening the public).

85. *Strubhart*, 903 P.2d at 279 (Hodges, J., dissenting).

86. *See Thompson*, 591 A.2d at 709.

87. *See* Brian Cox, *Medical Providers Exposure to Liabilities*, NAT'L UNDERWRITER PROP. &

negligence is fault-based.[88] The threat of increased insurance costs, therefore, creates an incentive to alter hospital conduct to avoid liability.[89] If courts provide hospitals with a clear standard of care, health care costs need increase only to the extent that is required to maintain the increased standard.

Second, the prospect of gaining a reputation as "the malpracticing hospital" would prompt hospitals to adjust their behavior, terminating or reducing the staff privileges for physicians reasonably known to be incompetent.[90] Third, the hospital must bear the responsibility when breaching the duties associated with the administrative role it has assumed, independent of economic and efficiency considerations.[91]

Therefore, corporate negligence places legal responsibility on the party who both has actively assumed a role performing the required duties and has the ability to improve their performance to avoid liability. The practical result of imposing this form of liability could be greater caution in screening and coordinating peer reviews of physicians before granting or renewing staff privileges.

Corporate negligence, as adopted by the *Strubhart* court, does not require a hospital to bear all responsibility for the negligence of staff physicians.[92] Rather, this doctrine requires that a hospital bear responsibility only when a patient is injured because of the hospital's negligence in granting or continuing to extend staff privileges to physicians reasonably known to be incompetent. The *Strubhart* form of corporate negligence does not encompass hospital liability for the negligent acts of those physicians who have not previously exhibited a "pattern of incompetent behavior."[93]

In effect, the *Strubhart* holding recognized the hospital's role as an administrator in overseeing peer review, but not as a supervisor which would second-guess all physicians' medical decisions.[94] Of course, advocates of expanded hospital liability could argue that the hospital's role as a provider and protector of patient care does in fact include the responsibilities of making policies and supervising all medical decisions taking place within its walls. Nevertheless, the policy of promoting

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CASUALTY-RISK & BENEFITS MGMT., Nov. 22, 1993, at 2, *available in* Westlaw, 1993 WL 3029396, at *2.

88. *Strubhart*, 903 P.2d at 275.

89. *See* Pedroza v. Bryant, 677 P.2d 166, 170 (Wash. 1984) (theorizing that imposing corporate negligence would have economic incentives, which would keep down the rising costs of insurance).

90. *See* Stephen D. Sugarman, *Doctor No*, 58 U. CHI. L. REV. 1499, 1522-23 (1991). Addressing the "incentives to police the conduct of independent contractor physicians," the author noted that "[a] hospital does not want to gain the reputation that its patients are more commonly the victims of malpractice than patients elsewhere." *Id.*; *see also* Pauline Martin Rosen, *Medical Staff Peer Review: Qualifying the Qualified Privilege Provision*, 27 LOY. L.A. REV. 357, 392 (1993). "The hospital has an interest in protecting its own reputation and ensuring quality patient care; indeed it is legally obligated to prevent incompetent doctors from practicing at its facilities." *Id.*

91. *See* Jackson v. Power, 743 P.2d 1376, 1382-84 (Alaska 1987) (applying analogy of responsibility of the common carrier to justify imposing a responsibility on the hospital when undertaking to operate a new program as an integral part of its health care enterprise).

92. *Strubhart*, 903 P.2d at 277.

93. *Id.* at 278.

94. *Id.*

hospital responsibility is tempered by permitting liability only to expand commensurate to the hospital's expanded role.

C. Precedent of Increasing Hospital Liability Proportionate to Hospital Role[95]

During the last fifty-five years, Oklahoma courts have systematically dismantled the stronghold of hospital immunity.[96] In *Strubhart*, the majority acknowledged the trend of hospital liability, citing cases in which the Oklahoma Supreme Court had imposed a duty upon the hospital to ensure the competence of staff physicians in certain situations.[97] The majority correctly recognized that it was time to adopt corporate negligence.

The majority cited *Weldon v. Seminole Municipal Hospital*[98] as foreshadowing the adoption of corporate negligence in some form.[99] In that case, the court cited *Darling v. Charleston Community Memorial Hospital*,[100] the decision first recognizing an independent duty of hospitals to their patients. In determining whether the hospital had neglected to properly supervise the diagnosis and course of action by a staff physician, the *Weldon* court "looked to a hospital's role and the amount of control it possesses over the care rendered to a patient."[101] The staff physician was the patient's family doctor and had an established doctor-patient relationship. As a result, the court concluded that the hospital did not have a duty to oversee the doctor's independent medical decisions.[102]

The court in *Weldon* acknowledged the doctrine of corporate responsibility but refrained from applying it to the facts of that case. However, the hospital's negligence in granting or continuing the doctor's staff privileges was not at issue. Further, the evidence did not indicate that the staff physician had demonstrated a

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95. *Id.* at 275.

96. Charitable immunity was abolished in Oklahoma in 1940. Gable v. Salvation Army, 100 P.2d 244, 244 (Okla. 1940). The modern-day hospital has continually redefined its role, and courts, consequently, have enlarged the boundaries of hospital liability. When the hospital achieved profit-producing status and exercised control over its employees, the courts applied respondeat superior. *See* Smith, *supra* note 3, at 447; SHERYL L. RAY, EVALUATING OKLAHOMA HOSPITALS' CRITERIA FOR ASSESSING RECOVERING PHYSICIANS RISKS 11 (1992). As the hospital further grew into the role of primary healthcare provider and established the emergency room, courts permitted patients to recover under ostensible agency. *See, e.g.*, Smith v. St. Francis Hosp., 676 P.2d 279 (Okla. Ct. App. 1983) (estopping hospital from denying responsibility for the alleged negligence of its independent contractors in the emergency room as ostensible agents). For a more recent case applying agency theory, see Weldon v. Seminole Mun. Hosp., 709 P.2d 1058, 1059-60 (Okla. 1985).

97. *Strubhart*, 903 P.2d at 275 (citing Weldon v. Seminole Mun. Hosp., 709 P.2d 1058, 1061 (Okla. 1985) (affirming the theory of ostensible agency but holding the hospital not liable when a preexisting doctor-patient relationship is proved); Hillcrest Medical Ctr. v. Wier, 373 P.2d 45, 48 (Okla. 1962) (holding the hospital must exercise ordinary care when patient is left by private physician in the general care of hospital personnel)). At each phase in hospital development, the courts have responded by applying a theory of liability suitable to the evolving role of the hospital.

98. 709 P.2d 1058 (Okla. 1985).

99. *Strubhart*, 903 P.2d at 276 n.12.

100. 211 N.E.2d 253 (Ill. 1965).

101. *Weldon*, 709 P.2d at 1061.

102. *Id.*

pattern of prior incompetence. Thus, the application of corporate negligence in *Strubhart* did not contradict the court's reasoning in previous cases.

The doctrine of corporate negligence may be viewed as an expansion of hospital liability analogous to the expanded liability adopted in previous cases. Ostensible agency and respondeat superior were both accepted based upon the expanding role of the hospital.[103] Therefore, corporate negligence may be interpreted as both a distinct doctrine as well as a natural progression of the policies supporting Oklahoma precedent.

V. Ramifications of Applying the Strubhart Form Of Corporate Negligence

The scope of the corporate negligence doctrine is determined by the dimensions of the burdens of proof, the duties imposed, and the guidelines defining these duties.

A. Scope of Duties Imposed

In general, courts have divided the duties embodying this doctrine into the following four categories: (1) a duty to use reasonable care in granting and in continuing staff privileges; (2) a duty to use reasonable care in the maintenance of safe and adequate facilities and equipment; (3) a duty to formulate, adopt, and enforce adequate rules and policies which ensure quality care for patients; and (4) a duty to oversee and supervise all staff physicians who practice medicine within the facility.[104] In *Strubhart*, the form of corporate negligence adopted encompassed only the first category of these duties.[105] The majority remained silent concerning the second category, suggested but did not impose the third,[106] and expressly rejected the fourth.[107]

The majority's failure to address the duty of safely maintaining hospital facilities and equipment is negligible.[108] The *Strubhart* majority's failure to formally adopt the third category of duties was possibly more calculated. Upon a showing that the hospital formulated safety rules and policies, an injured patient may be barred from recovery.[109] However, an injured patient may still not recover damages, even when proving that the hospital failed to meet this standard of care.[110] Therefore, the

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103. For a discussion of the development of ostensible agency, see Nathanson, *supra* note 34, at 576. For a discussion of the development of respondeat superior, see Priestly, *supra* note 5, at 263-64.

104. Thompson v. Nason Hosp., 591 A.2d 703, 707 (Pa. 1991).

105. *Strubhart*, 903 P.2d at 276.

106. *Id.* at 277 n.14 (citing *Thompson*, 591 A.2d at 707).

107. *Id.* at 277.

108. Traditional tort law long ago imposed premises liability upon all commercial entities. RESTATEMENT (SECOND) OF TORTS § 323 (1967). Courts, in turn, have imposed this form of liability upon hospitals since the abolition of charitable immunity. *See* Flagiello v. Pennsylvania Hosp., 208 A.2d 193, 194-96 (Pa. 1965) (recognizing that the court's desire to hold hospitals accountable for improperly maintained facilities was a strong force behind abolishing charitable immunity).

109. *Strubhart*, 903 P.2d at 277 n.14 (citing Thompson v. Nason Hosp., 591 A.2d 703, 707 (Pa. 1991)).

110. Because the form of corporate negligence imposed did not expressly include the duty to formulate, adopt, and enforce rules and policies which ensure the safety of patients. *Id.* at 75-76.

court denied that the hospital owes its patients the duty to formulate safety rules, yet also noted that a hospital's formulation of such rules could be a defense to liability. Consequently, the court narrowed the circumstances giving rise to hospital liability, while also providing hospitals with an incentive to formulate rules and policies which ensure that only competent doctors are selected and retained on staff.

Similarly, the majority indicated that the hospital's duty might be satisfied by requiring some type of supervision of the physician in certain circumstances, yet refused to impose the supervision of staff as a hospital duty in all individual cases.[111] However, the court suggested that a hospital may be liable in some cases in which the staff physician was not incompetent at all.[112] The court noted that a hospital should be required to take reasonable alternative action in individual cases where the prior incompetence of the staff doctor is not an issue, if the hospital personnel:

> 1) knows that a staff physician's diagnosis or treatment is below medical standards, or 2) the diagnosis or treatment is so obviously negligent as to lead any reasonable person to anticipate substantial injury would result to the patient from following the doctor's course of treatment.[113]

Confusingly, the court's view that the hospital could be liable in such circumstances contradicts the court's express holding that the hospital is not "required to constantly supervise and second-guess the activities of its physicians, beyond the duty to remove a known incompetent."[114] By explicitly rejecting this fourth category of duties, the majority shut the door on the prospect of strict hospital liability for the negligent acts of staff physicians.[115] Imposing a duty upon hospitals to adequately supervise and oversee the staff, however, does not necessarily lead to unbounded liability.[116] Outlining adequate guidelines for supervision might have served to prevent the possibility of the reckless expansion of hospital liability[117] rather than eliminating the duty to supervise staff.

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111. *Id.* at 277.

112. *Id.* at 278 n.15.

113. *Id.*

114. *Id.* at 276.

115. *Id.* (citing Albain v. Flower Hosp., 553 N.E.2d 1038, 1045-46 (Ohio 1990)); *see also* Purcell v. Zimbleman, 500 P.2d 335, 343-45 (Ariz. Ct. App. 1972) (holding hospital is on notice when pattern of incompetence is discoverable but has no duty to monitor all medical decisions). *See generally* Patratos v. Markakis, 637 N.E.2d 13, 14-15 (Ohio Ct. App. 1993) (placing no duty on hospital to constantly supervise all medical decisions of all the staff).

116. *See* Corrigan v. Methodist Hosp., 158 F.R.D. 70, 72-74 (E.D. Pa. 1994) (recognizing that hospitals in Pennsylvania may be sued for negligently failing to oversee its staff doctors). For a justification of imposing this duty as part of corporate negligence, see Nathanson, *supra* note 34, at 591-92 (citing Mark Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 451 (1988)).

117. *See* Coleman v. Bessemer Carraway Methodist Ctr., 589 So. 2d 703, 704 (Ala. 1991) (looking to JCAH and hospital bylaws to create a clear standard of care for supervising staff physicians); *see also* Pedroza v. Bryant, 677 P.2d 166, 168-70 (Wash. 1984) (applying the JCAH guidelines to objectively define the parameters of supervising staff physicians).

B. Scope of Burdens of Proof

Relying on the *Strubhart* decision, a court could require a plaintiff to prove the following: (1) the hospital owed a duty to the patient, determined by whether the patient's injury was foreseeable in light of the hospital's failure to exercise due care in selecting and retaining medical staff;[118] (2) the patient was injured;[119] and (3) the hospital's breach was the proximate cause of the patient's injury, determined by whether the injury would not have happened "but for"[120] the hospital's negligence and whether the doctor was proven to be negligent.[121]

According to these requirements, a plaintiff would be restricted from suing the hospital when the staff physician alone was negligent. The consequences of imposing these burdens of proof, especially that of foreseeability, could be to keep strict liability for staff negligence at arms length, regardless of the types of duties assumed by the hospital. Likewise, courts imposing more duties upon the hospital have generally required greater burdens of proof.[122]

C. Scope of Guidelines

In *Strubhart*, the majority identified a hospital's standard of care to fulfill its duty of investigating a medical staff applicant's qualifications.[123] However, the court did not clearly define the guidelines for determining what constitutes a pattern of physician incompetence once a physician has been granted staff privileges.[124] Those guidelines mentioned to illustrate how a hospital satisfies the duty could be interpreted as contradictory.

For instance, the majority identified three types of behavior by staff physicians which would trigger the hospital's duty. First, if the hospital knew or should have known about a physician's "pattern of incompetent behavior," then the hospital would be under a duty to take "reasonable action."[125] Depending on the facts of

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118. *Strubhart*, 903 P.2d at 273 (citing Purcell v. Zimbleman, 500 P.2d 335, 342-44 (Ariz. Ct. App. 1972)). Foreseeability is generally proven by showing the hospital had actual or constrictive knowledge of the incompetence, by a pattern or particularly egregious episode of physician negligence. *See* Tucson Medical Ctr. v. Misevch, 545 P.2d 958, 960 (Ariz. 1976) (finding that hospital must know or should have known to be liable); Albain v. Flower Hosp., 553 N.E.2d 1038, 1046 (Ohio 1990) (requiring actual or constructive knowledge). Johnson v. Misericordia Community Hosp., 301 N.W.2d 156, 172 (Wis. 1981) (requiring proof of foreseeability).

119. *See* JOHN W. WADE ET AL., PROSSER, WADE, AND SCHWARTZ'S CASES AND MATERIALS ON TORTS 131 (9th ed. 1994).

120. *Strubhart*, 903 P.2d at 276.

121. *See* Humana v. Traffanstedt, 597 So. 2d 667, 670-73 (Ala. 1992) (requiring some underlying negligent act of the doctor or other staff member); *see also* Elam v. College Park Hosp., 183 Cal. Rptr. 156, 160 (Cal. Ct. App. 1982) (holding that attending staff physician must have been negligent to find hospital liable). *But see* Browning v. Burt, 613 N.E.2d 993, 993-95 (Ohio 1993) (holding claims against doctor and hospital to be separate, thus, no doctor negligence need be shown to find hospital liable).

122. *See* Thompson v. Nason Hosp., 591 A.2d 703, 707 (Pa. 1991) (holding that plaintiff must show that the negligence was a substantial factor in the patient's injury).

123. *Strubhart*, 903 P.2d at 276.

124. *Id.* at 277.

125. *Id.*

the individual case, reasonable action might include total termination of staff privileges, "lesser steps than total or full termination," or no steps toward limitation of privileges.[126]

Second, "one prior episode of physician misconduct" may be so egregious that the hospital should know that it is dealing with an incompetent physician.[127] In such a case, the hospital would be under a duty to take "reasonable steps to ensure patient safety" with regard to the physician's staff privileges.[128] However, the court failed to suggest what "reasonable steps" the hospital could take to avoid liability.

Third, the majority suggested that a hospital may be liable in some situations in which the staff physician was not incompetent at all.[129] The hospital could be under a duty to "take reasonable alternative action" if the physician's treatment is known to be "below acceptable medical standards" or is "obviously negligent."[130]

The majority left the issue of whether a hospital has met its standard of care in the hands of the jury,[131] but neglected to impose an objective standard by which it may be measured. At the most, the majority mentioned that a hospital has a duty to reveal a pattern of incompetence through its peer review process.[132] However, the majority stopped short of defining the steps to be taken once incompetence is discovered.

In an attempt to avoid "putting a straightjacket on hospitals,"[133] the majority has exposed hospitals to the risk of inconsistently imposed liability. Just as a straightjacket restrains those who may do harm to themselves or others,[134] objective yet flexible guidelines must be imposed to bind against unfettered liability.

D. Application of Strubhart

Combining the variables of duties, burdens of proof, and guidelines, the *Strubhart* form of corporate negligence permits the construction of a doctrinal framework of odd proportions. The majority narrowly restricted the duties which may be imposed, moderately defined the burdens of proof, and yet provided a shifting plumbline by which to measure the standard of care. Because of the fact-specific guidelines,[135] courts in the future could rely on *Strubhart* to liberally impose hospital liability for cases concerning negligence in staff selection or retention.

In applying this form of corporate negligence to the facts of *Strubhart*, the plaintiff will have little difficulty proving Dr. Seal's negligence in establishing

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126. *Id.*
127. *Id.*
128. *Id.*
129. *Id.* at 278 n.15.
130. *Id.* at 278.
131. *Id.* at 277.
132. *Id.*; *see* MARCIA MILLMAN, THE UNKINDEST CUT: LIFE IN THE BACKROOMS OF MEDICINE 26-42 (1978); *see also* SPENCER VIBBERT, THE DOCTOR WATCHERS *passim* (1991) (describing the policing of medicine in the United States).
133. *Strubhart*, 903 P.2d at 277.
134. *See* TABOR'S CYCLOPEDIA MEDICAL DICTIONARY 1636 (15th ed. 1985).
135. *Strubhart*, 903 P.2d at 277.

proximate cause.[136] The more critical issue will be in establishing a pattern of incompetence of Dr. Seal or that the hospital knew or had reason to know of his incompetence.[137] The result at retrial, then, would turn on what guidelines the court uses to measure both Dr. Seal's medical competence and the hospital's administrative competence.

VI. Alternative Guidelines in Determining a Consistently Imposed Standard of Care

"Accountability to the public, through assurance of competent care to patients by physicians and other health care professionals is a paramount responsibility of organized medicine."[138] The form of corporate negligence adopted in *Strubhart* is a step in the direction of greater hospital accountability to patients. However, the majority neglected to specify a new standard of care proportional to this new form of liability.[139]

Whether this lack of specificity will create uncertainty for Oklahoma hospitals remains to be seen. Hospitals' complaints about uncertain liability may be more justifiable in states adopting a more expansive form of corporate negligence. For instance, in Pennsylvania, a hospital owes a duty to its patients to supervise all medical decisions of staff physicians practicing medicine within the facility.[140] Not surprisingly, the hospitals in these states may not be sure how to protect themselves against liability when an otherwise competent staff doctor injures a patient.

Additionally, unlike Oklahoma, some states have adopted a version of corporate liability which imposes upon hospitals the duty to formulate and enforce rules and policies to ensure patient safety. Quite naturally, the hospitals in these states might complain about the uncertainty of liability when failing to have adequate bylaws, policies, or committees.

In comparison, the duty imposed on Oklahoma hospitals under the doctrine of corporate negligence is limited to granting staff privileges to competent doctors and to taking reasonable steps when a staff physician has engaged in a pattern of incompetent behavior.[141] Thus, the lack of specific guidelines which a hospital

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136. The hospital's defense had previously focused on proving the doctor's negligence, and medical experts had testified that Dr. Seal's standard of care fell below the accepted standard. *Id.* at 268. The accepted standard is the practice ordinarily employed in similar situations. *Id.* at 278 n.17 (citing Rogers v. Baptist Gen. Convention, 651 P.2d 672, 674 (Okla. 1982) (rejecting locality rule)).

137. The plaintiff produced no witnesses to show medical mismanagement, and only one expert witness had labeled Dr. Seal as a "problem doctor." *Id.* at 268. Justice Lavender indicated that at least one of these episodes was clearly not relevant to Dr. Seal's competence as a physician. *Id.* The court may have been following the reasoning of Albain v. Flower Hosp., 553 N.E.2d 1038, 1046 (Ohio 1990) (disregarding non-technical physician negligence such as tardiness in proving hospital liability).

138. Council on Mental Health, *The Sick Physician: Impairment by Psychiatric Disorders, Including Alcoholism and Drug Dependence*, 223 JAMA 684, 684 (1973).

139. The court preferred to leave the standard of care as a matter to be determined according to the circumstances by the jury. *Strubhart*, 903 P.2d at 276.

140. *See* Thompson v. Nason Hosp., 591 A.2d 703, 707-08 (Pa. 1991).

141. *Strubhart*, 903 P.2d at 276.

could apply to avoid liability may not create the same degree of uncertainty as those jurisdictions adopting a broader form of corporate negligence. Nevertheless, the *Strubhart* decision failed to define "pattern of incompetence" and provided no clear path of "reasonable steps" for a hospital to follow in responding to physician incompetence. Instead, the court left these issues to be determined on a case-by-case basis.[142]

As in *Strubhart*, other courts have attempted to enact a fact-specific system of accountability.[143] In *Gonzalez v. Nork*,[144] the California Superior Court rejected an application of guidelines by the Joint Commission on Accreditation of Hospitals (JCAH, now the JCAHO),[145] leaving the decision to the courts.[146] However, the practical effect of such flexibility has been that, even if hospitals diligently have met national standards for accreditation, they are still exposed to the risk of liability. Some commentators have even advised that the type of standard applied may be irrelevant as long as the same standards are applied consistently.[147]

Elam v. College Park Hospital,[148] a more recent decision out of the California courts, determined that the standards of care arose from both the state statutes and the national standards of accreditation, as well as the hospital's role as a comprehensive health center.[149] Likewise, the courts of other jurisdictions have looked to the JCAHO for guidance in establishing a standard of care.[150] Other courts have applied some of the elements of the JCAHO's guidelines, such as hospital bylaws[151] or peer reviews[152] as the standard of care.

In the future, courts applying the *Strubhart* doctrine of corporate negligence will be afforded discretion in determining the standard of care for a narrow category of duties. The result could be inconsistency in the manner in which the courts impose

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142. *Id.* at 277.

143. *See, e.g.*, Johnson v. Misercordia Community Hosp., 301 N.W.2d 156, 171 (Wis. 1981) (holding the standard of care for corporate negligence is the traditional standard of tort law, ordinary care under the circumstances).

144. No. 228566 (Cal. Super. Ct. Sacramento County 1973) (criticizing the JCAH standards but not adopting any remedial standards as a substitute).

145. The Joint Commission on Accreditation of Hospitals (JCAH) is now known as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). For the 1995 manual containing these guidelines, see 1 JOINT COMM'N ON ACCREDITATION FOR HEALTHCARE ORGS., ACCREDITATION MANUAL FOR HOSPITALS (1994).

146. Rutchik, *supra* note 9, at 563.

147. *See* Rutchik, *supra* note 9, at 555.

148. 183 Cal. Rptr. 156 (Cal. Ct. App. 1982).

149. *See* William B. Smith, *Hospital Liability for Physicians Negligence*, 251 JAMA 448 (1984) (citing *Elam*, 183 Cal. Rptr. at 163)).

150. *See* Rodriques v. Miriam Hosp., 623 A.2d 456, 459 (R.I. 1993) (finding hospital not liable when adhering to guidelines of hospital bylaws and JCAH, regardless of doctor negligence); Bays v. St. Lukes Hosp., 825 P.2d 319, 323 (Wash. Ct. App. 1992) (noting that evidence of JCAH noncompliance could be admissible for showing breached standard of care when proving hospital liability).

151. *See* Pedroza v. Bryant, 677 P.2d 166, 170-71 (Wash. 1984) (applying JCAH and hospital's own bylaws as standard).

152. *See* Moore v. Burt, 645 N.E.2d 749, 755 (Ohio Ct. App. 1994) (holding negligently performed peer review as breach of standard of care).

hospital liability.[153] One alternative is adopting the JCAHO's guidelines as the new standard of care. Although some courts have criticized these guidelines as too vague, the JCAHO standards comprise an objective framework by requiring, for example, hospital bylaws, an administrative governing board, and peer reviews.[154]

However, the scope of the JCAHO standards is broader than the duties imposed in *Strubhart*. Thus, if a court were attempting to create a standard of care proportional to the duty imposed under corporate responsibility, only the JCAHO guidelines addressing the hospital's discipline of incompetent doctors would be applicable. Alternatively, the court could adopt the JCAHO standards and expand the doctrine of corporate negligence to include a broader range of duties. For example, in the future courts could impose upon hospitals the duties to establish rules and policies ensuring patient care or to oversee and supervise the independent medical decisions of staff physicians.

With regard to these types of guidelines, the majority only mentions that a hospital may be liable if a pattern of incompetence develops which the hospital should have become aware of through its peer review process.[155] Because peer review programs are mandated in almost every state by statute,[156] courts could interpret *Strubhart* as imposing a standard of care as defined by state statutes. In addition, Justice Lavender notes the opinion's accord with title 63, section 1-707b of the Oklahoma Statutes.[157]

This statute, however, requires only that the governing board of each hospital adopt standards for use in determining staff privileges.[158] It does not provide a uniform standard of care for all hospitals. Until a uniform standard is developed, applying the *Strubhart* doctrine of corporate negligence could expose hospitals to inconsistent judgments and patients to increased insurance premiums.[159]

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153. One significant contributor to this problem is the inconsistency in how hospitals deal with impaired physicians. One study predicts that 14-15% of physicians at some point in their career will be impaired, either mentally or due to substance addition. RAY, *supra* note 96, at 7. Some courts have resolved the dilemma of protecting patients and rehabilitating physicians by meeting JCAHO standards and using a Psychiatrist's or other health professional's evaluations in determining whether staff privileges should be reinstated. *See* Rembis v. Anderson, No. 90-35852, 1991 WL 206319, at *2 (W.D. Wash. Oct. 15, 1991).

154. *See* Rutchik, *supra* note 9, at 566-70. Other suggestions are application of the National Practitioner Data Bank (NPDB). *Id. But see* RAY, *supra* note 96, at 41 (reporting that 84% of Oklahoma hospitals surveyed claim that the NPDB has not altered the process used by hospitals in dealing with physician incompetence).

155. *Strubhart*, 903 P.2d at 277.

156. Murray S. Monroe, *Health Care: Current Antitrust Issues*, 20 N. KY. L. REV. 365, 389 (1993) (noting that at that time 38 states had statutes providing for peer review).

157. *Strubhart*, 903 P.2d at 277.

158. *Id.*

159. *See* Rutchik, *supra* note 9, at 562-64 (discussing the probable consequences of inconsistent standards of care for corporate negligence).

VII. Conclusion

The trend of expanding hospital liability has reached its current zenith in the doctrine of corporate negligence. In *Strubhart v. Perry Memorial Hospital*, Oklahoma joined the growing number of jurisdictions imposing this independent duty on hospitals to protect patients from the acts of negligent physicians. However, the *Strubhart* majority created a plateau of hospital liability by limiting the scope of these duties to encompass only the exercise of due care in granting and continuing staff privileges.

Despite this restriction, the majority failed to lay clear boundaries in establishing a new standard of care proportional to this new duty. Without clear guidelines, courts in the future could struggle with this issue, possibly leaving the apparent plateau of hospital liability to fade into a mirage.

One solution may be to look to the national standards for disciplinary actions of incompetent doctors, as set forth by the JCAHO. These annually updated standards provide objective yet flexible guidelines by which to measure the hospital's standard of care. Such guidance could enable courts to both protect patients against the negligence of known incompetents and protect hospitals against the risk of uncertain liability.

However, without specific guidelines, Oklahoma courts must let the jury decide whether the hospital has met its standard of care in taking "reasonable action"[160] to protect patients from injury by habitually negligent or otherwise incompetent staff physicians. In *Strubhart*, a divided Oklahoma Supreme Court may have attempted to tame the "monster" of hospital liability, but in the end, the creature merely assumed the conflicted nature of its creator.

Jeannie Pinkston

160. *Strubhart*, 903 P.2d at 277.