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PLAYING DOCTOR: WHO CONTROLS THE PRACTICE OF MEDICINE?

The health care industry has changed dramatically over recent decades.¹ The autonomy that physicians once enjoyed in making health care decisions and rendering medical treatment² has been


² See, e.g., Schloendorff v. Society of New York Hosp., 105 N.E. 92, 93-94 (N.Y. 1914) (hospital had no right of control over physician because professional skill and learning rendered physician independent contractor), overruled by Bing v. Thunig, 143 N.E.2d 3 (1957). In Schloendorff, the court distinguished between administrative and medical acts and limited the hospital's liability to administrative acts, which do not require medical judgment. Id. at 132. Moreover, the court held that a charitable hospital is shielded from liability for the actions of its employed physicians and nurses in the treatment of patients because as licensed professionals they were regarded as independent contractors. Id. at 131-32, 135; see also Mark A. Hall, Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment, 137 U. PA. L. REV. 431, 445-47 (1988) (physicians have essentially controlled practice of medicine since beginning of century). See generally ELIOT FREIDSON, PROFESSIONAL DOMINANCE: THE SOCIAL STRUCTURE OF MEDICAL CARE (1970) (discussing professional autonomy and dominance over performance of health care in United States and noting legally supported monopoly over medical practice).

The nature of medical work has always required independent professional judgment. See ELIOT FREIDSON, PROFESSION OF MEDICINE 162-64 (1970). "[J]udgment as such cannot be objectified because it is at least in part a matter of opinion: it would not be wise to create formal codes or rules placing one opinion, theory, or school over another." Id. at 162; see also Carmichael v. Reitz, 95 Cal. Rptr. 381, 393 (Ct. App. 1971). In Carmichael, the court stated that "'[t]he physician's services depend upon his skill and judgment derived from his specialized training, knowledge, experience and skill." Id.

In Mount Sinai Hosp. v. Zorek, 271 N.Y.S.2d 1012, 1016 (N.Y.C. Civ. Ct. N.Y. County 1966), the court held that

[o]nly the treating physician can determine what the appropriate treatment should be for any given condition. Any other standard would involve intolerable second-guessing, with each case calling for a crotchety Doctor Gillespie to peer over the shoulders of a supposedly unseasoned Doctor Kildare. The diagnosis and treatment of a patient are matters peculiarly within the competence of the treating physician.

Id.; see also Rosane v. Senger, 149 P.2d 372, 374 (Colo. 1944) (corporation hospital powerless to direct doctor's medical actions as it is not licensed to practice medicine); Herman v. Baker, 15 N.E.2d 365, 370 (Ind. 1938) (corporation or licensed individual may not control manner and means of physician’s performance of his professional duties, nor may a physician accept such direction), overruled by Harris v. YWCA, 237 N.E.2d 242 (Ind. 1968);
severely curtailed by increased governmental intervention, the fear of malpractice litigation, and the growth in contract and corporate medical practices. In reaction to the increasing public concern over health care costs, hospitals have also exerted greater control over the manner in which treatment is rendered. Consequently, while courts have acknowledged the diminishing control of physicians over treatment decisions, the increase in hos-


See infra notes 17, 21-26 and accompanying text.

*See infra note 31 (autonomy threatened by institutional accountability arising from expanded malpractice liability).

See Jeffrey F. Chase-Lubitz, Note, The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry, 40 Vand. L. Rev. 445, 455-58 (1987) (organization of contract and corporate medical practice by business viewed as threat to autonomy of independent physicians). After the Civil War, corporations in the railroad, mining, and lumber industries contracted with independent physicians to render medical services to employees. Id. at 456 & n. 70. In addition, practitioners’ services were marketed directly to the public through for-profit medical service companies for a fixed rate each month. Id. at 456-57. The contract and corporate practice arrangements included management review of the fee structure, length of hospital stay, and required second opinion before surgery, shifting a degree of physician control to corporate management. Id. at 456. As organized health services and contract medicine policy decisions increasingly were made by nonprofessional individuals, physician autonomy diminished, giving rise to “myriad concerns” within the medical profession. Id.

* See Pedroza v. Bryant, 677 P.2d 166, 169 (Wash. 1984) (quoting Arthur F. Southwick, The Hospital as an Institution: Expanding Responsibilities Change Its Relationship with the Staff Physician, 9 Cal. W.L. Rev. 429, 431-35 (1973)). The Washington Supreme Court observed that 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.’” Id.; see also Ybarra v. Spangard, 154 P.2d 687, 691 (Cal. 1944) (hospitals today have evolved into highly integrated health care centers).

The doctrine of charitable immunity has gradually eroded as hospitals have come to be viewed as profit centers operated by private corporations. See Restatement (Second) of Torts § 895(E) (1965 & Supp. 1977); see also President & Directors of Georgetown College v. Hughes, 130 F.2d 810, 827-28 (D.C. Cir. 1942) (landmark case viewing hospital as corporation and abolishing doctrine of charitable immunity).

* Compare Virginia Hosp. Ass'n v. Kenley, 427 F. Supp. 781, 783-84 (E.D. Va. 1977) (21-day limitation on Medicaid funding for hospital stays reasonable because it does not control physicians’ decisions) and Sarchett v. Blue Shield of Cal., 729 P.2d 267, 275 (Cal. Ct. App. 1987) (subjecting attending physician’s recommendation to retrospective review by insurer not violative of public policy) with American Medical Ass’n v. Weinberger, 395 F. Supp. 515, 523-24 (N.D. Ill. 1975) (issuing preliminary injunction against Medicaid regulations because of chilling effect of conditioning reimbursement on committee’s 24-hour review of medical necessity of admission). Generally, however, the passing of control from the community practitioner to the boards and administrators of hospitals is widely acknowl-
pitals' control over the selection, manner, and method of doctors' services has resulted in a trend imposing greater liability on hospitals for the actions of physicians using their facilities.

Until recently, hospital liability for a physician's negligence arose solely under the theory that an employer was accountable for the conduct of its agent, servant, or employee, and an exemption from liability existed for the acts of physicians characterized as independent contractors. However, recognizing the increase in the...
degree of control exercised by a hospital in administering medical care, several jurisdictions have expanded the scope of hospital liability under a corporate negligence theory. Recently, in Thompson v. Nason Hospital, the Supreme Court of Pennsylvania further extended this theory of liability to circumstances where the treatment was rendered by a non-employee staff physician over whom the hospital had no control.

This Note will discuss how today's heightened economic concerns and increased hospital control over a physician's professional conduct has led to an expanded theory of corporate hospital negligence. Part One will discuss recent external controls that infringe upon the autonomy of the physician and increase a hospital's role in the treatment of patients. Part Two will review the changes in the nature and theories of hospital liability concurrent with their changing role in treatment decisions. Finally, Part Three will consider the legal and financial ramifications of extending hospital liability at the expense of qualitative health services.

I. EXTERNAL CONTROLS ON THE MEDICAL FIELD

The shift in the control of treatment decisionmaking from physicians to hospitals is a result of a changing health care env-

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1 See supra note 8 and accompanying text; Charles Perrow, Goals and Power Structures, in The Hospital in Modern Society 119, 124-39 (Eliot Freidson ed., 1963) (recognizing increased administrative power in hospitals over doctors, internal administration, and network of organizations involved with health care).

2 See Darling v. Charleston Community Memorial Hosp., 211 N.E.2d 253, 258-61 (Ill. 1965) (recognizing doctrine of hospital corporate liability which imposes on hospital nondelegable duty of care to patient separate from that of private physician), cert. denied, 383 U.S. 946 (1966). In Darling, the basis for liability was the hospital's failure to fulfill a duty owed directly to the patient. Id. When a hospital is not held liable for the tortious conduct of private physicians granted staff privileges, it may lack the incentive to supervise the medical care. See Paul E. Williamson, Notes, Medical Malpractice-An Unwarranted Operation: The North Carolina Supreme Court Excises the Doctrine of Hospital Corporate Negligence, 23 Wake Forest L. Rev. 825, 833 (1988). Several jurisdictions have expanded hospital liability in order to correct this situation by adopting the concept of corporate negligence. See 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, 776-80 (1983) (examining organizational structure of hospital and evolution of corporate negligence). But see James B. Cohoon, Comment, Piercing the Doctrine of Corporate Hospital Liability, 17 San Diego L. Rev. 383, 400-01 (1980) (corporate hospital liability disregards realities of medical practice, making adoption of doctrine unsound).

3 See id. at 708; see also infra notes 76-78 and accompanying text (discussing Thompson).
environment fueled by economic considerations. Specifically, governmental funding regulations, the structure of health care networks, and the proliferation of malpractice litigation have eroded the physician’s professional autonomy and have increased the necessity of hospital control.

16 See Clark C. Havighurst, Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships, 1984 Duke L.J. 1071, 1077-81 (financial health developments rework hospital-physician relationships because of such influences as prospectively determined patient payment systems, increased numbers of physicians, increased antitrust litigation by physicians denied admitting privileges, and expansion of legal doctrine allowing for hospital liability). Increasing cost restraints are diluting the Hippocratic ideal that “all care should be provided that is of any conceivable benefit, regardless of the cost.” See Hall, supra note 2, at 435-38. For example, the Medicare prospective payment system based on diagnosis related groups that has been implemented in hospitals has caused hospital administrators to increase their monitoring of physician medical care. See J. Timothy Philipps et al., Meeting the Goals of Medicare Prospective Payments, 88 W. Va. L. Rev. 225, 234 (1985); see also Symposium, The Dark Side of Health Care Containment Emerging Legal Issues in Managed Care, 14 Seton Hall Legis. J. 1, 1 (1990). “During the past several years, the financing and delivery of health care in the United States have been dramatically altered due to substantial changes in the economy of the market place.” Id.

17 See infra notes 21-26 and accompanying text; see also 103 Cong. Rec. E269-01 (daily ed. Feb. 11, 1992). Congress considered comprehensive health care plans because of urgent need for market reform; this year 14% of gross national product will be spent on health care and yet 36 million Americans will be without coverage. Id. In an effort to reduce Federal health care spending, the Honorable James A. McDermott of Washington has introduced the State-Based Comprehensive Care Act of 1992, which authorizes funding to support a state health care plan that “provides for the development and implementation of appropriate cost-control mechanisms, which may include insurance market reforms, medical malpractice liability reforms, managed care plans, low income cost-sharing protections” and meets “appropriate standards as established by the State.” Id. It is submitted that if the State-Based Comprehensive Care Act of 1992 is enacted, the Government Funding Plan will further infringe on the physician’s professional autonomy by delegating the establishment of the standard of medical care to the state.

18 See infra notes 27-30 and accompanying text.

19 See infra notes 31-39 and accompanying text.

20 See Symposium, Hospitals and the Disruptive Health Care Practitioner—Is the Inability to Work With Others Enough to Warrant Exclusion?, 24 Duq. L. Rev. 377, 377-82 (1985). The legal climate towards health care has diluted the physician’s dominance over medical treatment decisions as federal and state regulatory schemes, expanded theories of hospital liability, and legal developments have become involved in the health delivery system. Id. It appears that practitioners have “lost control of what used to be their sacred and familiar territory. In a very short span of years, the legal system has moved from a posture of benign indifference about health matters, to an attitude of active intervention in all aspects of health care delivery.” Id. at 379; see also Kenneth R. Wing, American Health Policy in the 1980’s, 38 Case W. Res. L. Rev. 608, 635-39 (1986) (physician’s treatment decisions directly impact overall medical costs because significant portion of services delivered in hospitals are ordered by doctors). In an effort to contain costs, the response has been changes in hospital administration and the growth of alternative delivery systems that may “dilute the traditional autonomy of physicians; their role in determining who gets what kind and what level of service may be thereby reduced.” Id. at 636.
For example, in *Rust v. Sullivan*, the Supreme Court determined that Department of Health and Human Services regulations prohibiting title X physicians from discussing information concerning abortion as a method of family planning did not impermissibly infringe on the doctor-patient relationship. The majority held that "[t]he financial constraints that restrict an indigent woman's ability to enjoy the full range of constitutionally protected freedom of choice are the product not of governmental restrictions on access to abortion, but rather of her indigency." By upholding the direct regulation of dialogue between a pregnant woman and her doctor, the Court restricted a physician's ability and obligation to provide a full range of information, medical alternatives, and professional advice to the patient. Consequently, hospitals receiving government funding are forced to exert greater control over the substance of a physician's treatment advice in order to protect those funds.

In addition, the structure of employer-sponsored health plans has increased hospital control. Corporate health care networks establish fee structures and regulate referrals between doctors as well as the nature of tests and procedures which will be compen-

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22 Public Health Service Act, § 1008, 84 Stat. 1506 (1970), amended by 42 U.S.C. §§ 300-300a-6 (1988). The Public Health Services Act authorizes the Secretary to “make grants to and enter into contracts with public or non-profit private entities to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services.” 42 U.S.C. § 300a (1988). Section 1008 of the Public Health Service Act states that “[n]one of the funds appropriated under this subchapter shall be used in programs where abortion is a method of family planning.” Id. § 300a-6.
23 *Rust*, 111 S. Ct. at 1777.
24 *Id.* at 1778 (quoting Harris v. McRae, 448 U.S. 297, 316 (1980)).
25 *Id.* at 1783 (Blackmun, J., dissenting). The dissent vigorously objected to the Governor's attempt to control a physician's professional judgment and dialogue with a woman. *Id.* at 1785 (Blackmun, J., dissenting). The dissent feared the effect of such a restriction and warned that governmental regulations which "'confine the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession,' cannot endure.” *Id.* at 1786 (Blackmun, J., dissenting) (quoting Planned Parenthood v. Danforth, 428 U.S. 52, 67 n.8 (1976)).
26 See supra notes 21-25 and accompanying text.
27 See Lisa Belkin, *Doctors View Health Plans As Eroding Their Autonomy*, N.Y. Times, Nov. 12, 1991, at A1, B6. An increasing number of employers are participating in health care networks in an effort to contain rising hospital costs in a weakened economy. *Id.* As a result, more individuals are enrolling in the network and more doctors are feeling compelled to join because of financial necessity. *Id.*
sated. Thus, hospitals are imposing more restrictive guidelines that attempt to maximize compensation. However, while these group-practice prepayment structures achieve substantial savings for the participating corporations, the medical treatment rendered has become less individualized.

Finally, the threat of malpractice litigation has resulted in increased control of decisionmaking by hospitals in an attempt to insulate themselves. Courts have imposed greater liability on hospitals in order to reflect their participation in the decisionmaking process. Accordingly, courts have created a corporate negligence theory for hospitals to buttress traditional theories of hospital liability.

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28 Id.; see also Robert F. Blomquist, Health Maintenance Organizations and State DRG Hospital Cost Control Programs: The Need for Federal Preemption, 10 Am. J.L. & Med. 1, 5-7 (1984) (noting such comprehensive health service systems monitor enrollees' hospital length of stay, require annual prepayment fees, integrate physicians' practices and facilities, and compensate physicians on non-episodic bases).

29 See supra notes 27-28 and accompanying text.

30 See Note, The Role of Prepaid Group Practice in Relieving the Medical Care Crisis, 84 Harv. L. Rev. 887, 921-27 (1971). Prepaid group practice plans have provided strong incentives to minimize costs. Id. For example, the comprehensive benefits offered by these networks appear to reduce a patient's incentive to hospitalize and serve as a disincentive to doctors to recommend hospitalization. Id. at 923-24. As physicians' remuneration is inversely proportional to allocable hospital services, the incentive to economize has resulted in decreased medical costs. Id. at 925. However, this "reversed financial incentive" system to economize might interfere with the independent, professional medical decision of the physician and potentially undermine the appropriate care of the patients. See Philip C. Kissam & Ronald M. Johnson, Health Maintenance Organizations and Federal Law: Toward a Theory of Limited Reformmongering, 29 Vand. L. Rev. 1163, 1180-83 (1976). But see Chase-Lubits, supra note 5, at 480 ("HMO's cost-control incentive . . . translates into better health for HMO members" because "HMO's find it more profitable to keep members healthy by treating them during the early stages of illness when treatment is less expensive"). The patient-doctor relationship may also deteriorate as physicians become increasingly controlled by employers and network governing boards. See id. at 480-81. Further, the clinical services offered by these plans foster an impersonal atmosphere that may erode the traditionally individualized nature of the doctor-patient relationship thereby affecting the quality of care. See Kissam & Johnson, supra, at 1181.

31 See Hall, supra note 2, at 457-61 (expanded hospital malpractice liability imposing institutional accountability for patient care intrudes upon domain of physician's treatment authority). However, "[d]espite the courts' overwhelming acceptance of the concept of direct institutional responsibility for patient care, they have resisted essentially any expansion of institutional authority." Id. at 460.

32 See Southwick, supra note 6, at 452-53 (legal developments holding hospital liable for failing to monitor quality of treatment rendered by doctors have increased).

33 See infra notes 56-80 and accompanying text.
II. Theories of Hospital Tort Liability

Tort law imposes liability on individuals who unreasonably interfere with the rights of others. The primary purposes for imposing liability for tortious conduct have been to compensate the injured party and to provide an incentive to prevent the occurrence of similar harm. The endeavor to find a standard of reasonable care to use when imposing liability on hospitals requires the courts to balance the conflicting rights and obligations of the parties against the interests of society. Traditionally, hospital tort liability was founded on principles of negligence, which require the existence of a duty, breach of that duty, proximate cause, and injury before culpability can attach. The theories under which a hospital may be subject to tort liability are respondeat superior, ostensible agency, and more recently, the corporate negligence doctrine.

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34 W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 1, at 6 (5th ed. 1984).
35 See id. § 4, at 20. The primary function of tort law is the allocation of losses and compensation for injuries arising out of human activities. Id. at 20-23; see also Cohoon, supra note 13, at 398-99 (imposing liability on hospitals compensates plaintiff for negligence of physicians).
36 See KEETON ET AL., supra note 34, § 4, at 25-26. In addition to compensation, the field of torts is concerned with providing an incentive to prevent future injury and punishing the wrongdoer. Id.; see also Cohoon, supra note 13, at 398-99 (imposing liability on hospitals provides incentive for hospitals to act with reasonable care); Perkes, supra note 8, at 573 (holding hospital liable for physician's misconduct creates strong inducement for assuring competent medical care); Gregory G. Peters, Note, Reallocating Liability to Medical Review Committee Members: A Response to the Hospital Corporate Liability Doctrine, 10 AM. J.L. & MED. 115, 121-22 (1984) (imposing liability on hospitals is response in part to low quality of medical treatment, theorizing hospital is in best position to control physician incompetency).
37 See KEETON ET AL., supra note 34, § 3, at 16; see also Koehn, supra note 9, at 388 (conflicting social interests must be weighed to decide extent of liability imposed on hospitals for quality of medical treatment administered by independent staff physicians).
39 See Note, Theories for Imposing Liability upon Hospitals for Medical Malpractice: Ostensible Agency and Corporate Liability, 11 WM. MITCHELL L. Rev. 561, 568-78 (1985) (courts have moved away from traditional rule of non-liability of hospitals and applied tort law theories to impose upon hospitals duty of care to patients); see also Jeffrey S. Leonard, Note, Independent Duty of a Hospital To Prevent Physicians' Malpractice, 15 ARIZ. L. Rev. 953, 953-54 (1973). Courts and legislatures have recognized that the contemporary realities and needs of our society have not been addressed by the traditional analyses of the hospital-patient relationship. Id. at 953. This has resulted in an "increased recognition of a duty owed by hospitals to their patients with respect to the quality of medical care offered,
A. Doctrine of Respondeat Superior

In holding an employer vicariously liable for the negligent acts of an employee under the doctrine of respondeat superior, courts have utilized a right-of-control test which determines whether an individual was an employee based upon the right of the employer to control the individual’s work. Historically, the right-of-control test barred the application of respondeat superior to hospitals, vis-a-vis physicians, based upon the belief that the practice of medicine required a unique skill: a doctor’s independent, professional judgment and freedom to make clinical decisions. With the

even in the absence of a master-servant relationship between the physician and the hospital.” Id. at 954.

Under the doctrine of respondeat superior, “a master is subject to liability for the torts of his servants committed while acting in the scope of their employment.” See Restatement (Second) of Agency § 219(1) (1958). Traditionally, hospitals were liable for the administereic acts but not medical acts of its personnel. See Bing v. Thunig, 143 N.E.2d 3, 8-9 (N.Y. 1957) (negligence of nurse resulting in injury to patient during surgical procedure imputed to hospital under doctrine of respondeat superior). The court in Bing observed that a hospital was a place that administers medical treatment through its staff. Id. Thus, the court abandoned the distinction between administerial and medical acts, and applied the doctrine of respondeat superior. Id. at 666; see also William H. Payne, Recent Developments Affecting a Hospital’s Liability for Negligence of Physicians, 18 S. Tex. L.J. 389, 390-94 (1977) (most states impose liability on hospitals for negligence of physician committed within scope of employment).

The Restatement (Second) of Torts sets forth the foundation of the ostensible agency doctrine and provides:

One who employs an independent contractor to perform services for another which are accepted in the reasonable belief that the services are being rendered by the employer or by his servants, is subject to liability for physical harm caused by the negligence of the contractor in supplying such services, to the same extent as though the employer were supplying them himself or by his servants.


See supra note 39.

See Newton County Hosp. v. Nickolson, 207 S.E.2d 659, 662 (Ga. Ct. App. 1974). A hospital is liable for injuries sustained by a patient during treatment rendered by a physician if the doctor is employed as a servant. Id. The test is whether the employer has the “right to direct the time, the manner, the methods, and the means of the execution of the work.” Id. (emphasis omitted) (quoting Banks v. Ellijay Lumber Co., 200 S.E. 480, 481 (Ga. Ct. App. 1938)); see also Reynolds v. Swigert, 697 P.2d 504, 508 (N.M. Ct. App. 1984) (right of hospital to control work of doctor determined whether physician is independent contractor or employee on basis of respondeat superior).

See Symposium, supra note 16, at 6-7.
increasing availability of hospital malpractice insurance, courts rejected the exemption from respondeat superior, and eliminated the distinction between medical and administrative acts by imposing liability on hospitals for all services performed by their employees within the scope of employment.43 However, a critical distinction was made between employee-physicians and independent practitioners.44

 Courts have held that an independent staff physician is not an employee of a hospital, and therefore the hospital is not legally responsible for the negligence of such a physician.45 Furthermore, while a hospital merely provides the necessary equipment and services to care for the patient and has no right to exercise control over the private physician's performance, the duty to provide a reasonable level of care rests solely with the independent practitioner.46

 Notable exceptions to this independent practitioner rule involved situations where the risk of negligent treatment was foreseeable by the hospital,47 where the health care provider con-

43 See Bing, 143 N.E.2d at 7 (hospitals protected against financial loss from litigation with easily obtainable insurance). In Bing, the court determined that the medical acts as well as the administrative acts of a physician could be imputed to the hospital based on the practitioner's employment status. See Symposium, supra note 16, at 7; see also Cohoon, supra note 13, at 401 nn.106-07 (hospital's insurance coverage generally greater than that of independent physician and consequently viewed as best strategic target for ensuring recovery).

44 See Stewart v. Midani, 525 F. Supp. 843, 849 (N.D. Ga. 1981). The Stewart court enunciated eight factors to use as evidence of a hospital's control over a physician: (1) the right to direct the work; (2) whether the physician contracted to administer a service or to complete a task; (3) the employer's right to control the time of the work; (4) the employer's authority to inspect the work; (5) who provides the equipment; (6) the power to end the contract; (7) the degree of skill of the worker; and (8) the method of compensation. Id.


47 See, e.g., Heddinger v. Ashford Memorial Community Hosp., 734 F.2d 81, 85-86 (1st Cir. 1984) (hospital liable for negligent delay of treatment by attending physician where risk was clearly foreseeable “whether the doctors were employees of [hospital] . . . or were, as the hospital asserts, independent contractors”); Fiorentino, 227 N.E.2d at 299 (hospital held liable where it knew malpractice action would occur by independent practitioner).
tracted to provide a particular medical service, where the hospital represented the physician to the public as its agent, or where the corporate facility's duty to the patient was considered nondelegable. Under this framework of exceptions, a trend in favor of imposing legal responsibility on a hospital for the actions of independent staff physicians has emerged.

B. Doctrine of Ostensible Agency

In the absence of an employer-employee relationship between the hospital and the physician, an increasing number of jurisdictions have adopted the theory of ostensible agency under which hospital liability is imposed for the malpractice of an independent contractor physician whom the patient reasonably believes to be under the hospital's authority. This doctrine has been applied to establish the existence of an agency relationship between a hospital and an emergency room physician where the hospital has held itself out as a full-care facility.

Under the theory of ostensible agency, a patient treated in an emergency room has no duty to inquire as to the physician's contractual status since the patient generally draws no distinction between the corporate entity and its staff. Thus, where the hospital places the independent contractor in a position where a reasonable

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48 See, e.g., Irving v. Doctors Hosp. of Lake Worth, Inc., 415 So. 2d 55, 58-59 (Fla. Dist. Ct. App.) (hospital liable for independent contractor physician's negligent diagnosis and treatment under estoppel theory since hospital contractually undertook to provide emergency room services), petition denied, 422 So. 2d 842 (Fla. 1982); Giusti v. C.H. Weston Co., 108 P.2d 1010, 1012-15 (Or. 1941) (hospital association not shielded from liability where hospital employed independent contractor physician to perform its contract with high school).

49 See supra note 39; infra text accompanying notes 52-55.

50 See supra note 39; infra text accompanying notes 56-80.

51 See generally Classen, supra note 11, at 472-73 (discussing courts' increasing willingness to hold hospitals vicariously liable for independent contractor physicians).

52 See supra note 39 and accompanying text.

53 See, e.g., Paintsville Hosp. Co. v. Rose, 683 S.W.2d 255, 256-58 (Ky. 1985) (hospital liable for negligence of non-employee physician who rendered emergency room treatment to patient who looked to hospital for medical care); Mduba v. Benedictine Hosp., 384 N.Y.S.2d 527, 528-30 (3d Dep't 1976) (where emergency room physician under contract with hospital failed to administer blood to patient in time, hospital liable for doctor's negligence because it controlled manner in which doctor operated emergency room and held itself out to public as facility for emergency treatment).

person would believe that the physician has the authority to act, liability will be imposed on the institution for the physician's negligence based on the doctrine of ostensible agency.\(^5\)

C. Doctrine of Corporate Negligence

A number of jurisdictions have expanded the scope of a hospital's liability to include the negligent acts of independent staff physicians under the theory of corporate liability or corporate negligence.\(^6\) This doctrine has its genesis in \textit{Darling v. Charleston Community Memorial Hospital}.\(^7\) In \textit{Darling}, the court held that the hospital owed an independent, nondelegable duty of care directly to its patients to ensure that physicians practicing within its facilities were competent.\(^8\) The \	extit{Darling} court's corporate responsibility theory redefined a hospital's legal obligation toward its patients by holding that a hospital may independently be held responsible for an injured patient's treatment.\(^9\)

The view espoused in \textit{Darling} has been accepted in many American jurisdictions.\(^10\) State courts adopting the \textit{Darling} approach have based their application of corporate liability on several underlying duties which a hospital owes a patient.\(^11\) The duties identified by the courts, each of which limit a hospital's responsibility to situations involving foreseeable and preventable risks, have been: (1) the duty to use reasonable care in maintaining the facility and furnishing medical equipment;\(^12\) (2) the duty to exercise reasonable care in selecting and retaining competent medical staff;\(^13\) (3) the duty to provide the proper overall supervision of the

\(^{5}\) See supra note 39.

\(^{6}\) See id.


\(^{8}\) Id. at 257. Although the court acknowledged a separate duty of care, it stopped short of defining that duty by merely stating that it is "both desirable and feasible that a hospital assume certain responsibilities for the care of the patient." Id.; see supra note 39.

\(^{9}\) \textit{Darling}, 211 N.E.2d at 257.

\(^{10}\) See Havighurst, supra note 16, at 1079.

\(^{11}\) See infra notes 62-66 and accompanying text.


\(^{13}\) See, e.g., Mitchell County Hosp. Auth. v. Joiner, 189 S.E.2d 412, 414 (Ga. 1972) (hospital has duty to exercise reasonable care to investigate background of physician permitted to serve on its staff); Johnson v. Misericordia Community Hosp., 391 N.W.2d 156, 163-71
quality of patient care services\textsuperscript{64} and (4) the duty to promulgate and enforce medical rules and policies to ensure the quality of patient care.\textsuperscript{65}

Implicit in each of these underlying obligations has been the threshold requirement of actual or constructive knowledge and proximate cause of compensable harm.\textsuperscript{66} In addition, compliance with guidelines established by the Joint Commission on Accreditation of Hospitals,\textsuperscript{67} the hospital's bylaws,\textsuperscript{68} and general licensing

\textsuperscript{64}See, e.g., Purcell v. Zimbelman, 500 P.2d 335, 343 (Ariz. 1972) (hospital liable for breach of duty to supervise staff where hospital has knowledge of professional incompetence); Bost v. Riley, 262 S.E.2d 391, 396-97 (N.C. Ct. App.) (hospital owes duty to patient to make a reasonable effort to monitor and oversee medical treatment), cert. denied, 269 S.E.2d 621 (N.C. 1980).


\textsuperscript{66}See Reynolds v. Mennonite Hosp., 522 N.E.2d 827, 829-30 (Ill. App. Ct.) (absent knowledge of incompetence of physician or proof of proximate cause of patient's injury, hospital not liable for surgeon's misdiagnosis of patient's condition), appeal denied, 530 N.E.2d 264 (Ill. 1988); see also Perkes, supra note 8, at 572 ("liability has been premised on the hospital's failure to oversee the care of its patients and ensure their safety since the hospital either knew or should have known of these negligent acts"); Lisa R. Rohm, West Covina and Its Progeny: Have the California Courts Barricaded the Avenue of Relief Provided for Victims of Hospital Corporate Negligence?, 22 CAL. W. L. REV. 317, 324 (1986) (for plaintiff to prevail in action for breach of hospital's independent duty of care, "a plaintiff must show that the defendant hospital's negligent selection or retention of an incompetent staff physician caused the plaintiff harm").

\textsuperscript{67}See Joint Commission on Accreditation of Hospitals, Accreditation Manual for Hospitals 94 (1984) [hereinafter JCAH]. The JCAH promulgates national standards of operating criteria for hospitals which are voluntarily adopted by hospitals seeking to acquire or retain accredited status. \textit{Id.} at xvi; see also Gary F. Loveridge & Betsy S. Kimball, \textit{Hospital Corporate Negligence Comes to California: Questions in the Wake of Elam v. College Park Hospital}, 14 PAC. L.J. 803, 807 (1983) (accreditation by JCAH nearly as important as being licensed). The standards place emphasis on the selection/retention process, delineation of staff privileges, and periodic appraisals of each physician staff member. See Koehn, supra note 9, at 369-70. Therefore, the standards could be used to determine whether the hospital's conduct is fulfilling its duty of care to patients. \textit{Id.; see also} Pederson v. Dumouchel, 431 P.2d 973, 979 (Wash. 1967) (enunciating standard of care under JCAH for corporate hospital negligence).

\textsuperscript{68}See Purcell, 500 P.2d at 341 (hospital's own bylaws relevant in defining its legal obligation toward patient for medical treatment rendered); Pedroza v. Bryant, 677 P.2d 166, 171 (Wash. 1984). In Pedroza, the court maintained that "[h]ospitals are required by statute and regulation to adopt bylaws" to govern medical staff functions, and because "bylaws are based on national standards . . . their use in defining a standard of care for hospitals is appropriate." \textit{Id.}
standards has enabled hospitals to fulfill their duty of care to patients according to defined standards, and has also provided for regulated supervision of medical practices and procedures.

Because jurisdictions have imposed corporate hospital liability on health care facilities based on different underlying duties, no clear boundaries have emerged to define the scope of the corporate practice of medicine. While some courts view corporate negligence as no more than an application of common law tort analysis, other courts treat corporate liability as a novel doctrine upon which to base hospital responsibility.

A recent trend broadening the scope of the corporate negligence doctrine includes a duty to monitor, oversee, and control the ongoing medical treatment rendered by a non-employee staff physician. Moreover, liability has been imposed on a hospital for the unfavorable consequences of medical care prescribed by an independent contractor physician. Specifically, in Thompson v. Nason Hospital, the Supreme Court of Pennsylvania affirmed the lower court's broad construction of the doctrine of corporate negligence which imposed liability "for [the] adverse effects of treatment... approved by doctors although the doctors were not employees of the hospital." Justice Flaherty, in a strong dissent, argued that the application of corporate negligence was no more than a deep-pocket theory of legal responsibility applied to hospitals holding them liable as "guarantors of the quality of care af-

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69 See Marrese v. Interqual, Inc., 748 F.2d 373, 394-95 (7th Cir. 1984) (statutory schemes establishing comprehensive peer reviews assure public "that medical practices and procedures within the State are being closely monitored and reviewed"), cert. denied, 472 U.S. 1027 (1985). Additionally, hospital licensing regulations enable a hospital to fulfill its duty to use reasonable care in selecting qualified physicians. Id. at 394.

70 See Pedroza, 677 P.2d at 170-71 (under corporate negligence doctrine, hospital's duty of reasonable care should be defined and guided by both accreditation standards of JCAH and hospital's bylaws).

71 See supra notes 62-66 and accompanying text; infra notes 72-73 and accompanying text.


73 See, e.g., Pedroza, 877 P.2d at 168-70 (expressly adopting doctrine of corporate negligence as enunciated by other jurisdictions to hospitals in Washington, acknowledging role of hospital as corporate entity makes institution responsible for quality of health care rendered).

74 See Thompson v. Nason Hosp., 591 A.2d 703, 706-08 (Pa. 1991); see also infra notes 76-78, 80 and accompanying text (detailed discussion of Thompson).

75 Thompson, 591 A.2d at 706-08.


77 Id. at 706.
forded by independent staff members.\textsuperscript{78}

It is submitted that such an overbroad adoption of corporate liability has sidestepped the fundamental tort law premise that a duty requires some degree of knowledge. In the absence of a clearly defined duty, the imposition of liability thrusts tort law into the area of evaluating a doctor's professional judgment with the benefit of hindsight only, subjecting the hospital to liability for neither foreseeing nor preventing the risk of injury.\textsuperscript{79} Such a burden exceeds the realm of corporate negligence as established in \textit{Darling}.\textsuperscript{80}

III. Ramifications of an Overbroad Application of Corporate Negligence

Extending a hospital's liability to acts performed by a private physician in the exercise of independent professional judgment and exposing the hospital to liability for unforeseen injurious results thwarts the purpose of tort liability.\textsuperscript{81} Instead of serving as an incentive for hospitals to prevent the occurrence of negligence, this view of corporate liability compels hospitals to act as guarantors against patient injuries.\textsuperscript{82}

\begin{itemize}
  \item \textsuperscript{78} Id. at 709 (Flaherty, J., dissenting); infra note 82.
  \item \textsuperscript{80} See \textit{Darling}, 211 N.E.2d at 256-58 (corporate liability applied where attending physician was employee placed on emergency room duty and subject to supervision). Subsequent decisions by the Illinois appellate courts have constricted the holding in \textit{Darling}, rejecting the imposition of liability upon hospitals except for their own negligence. See, e.g., \textit{Reynolds v. Mennonite Hosp.}, 522 N.E.2d 827, 829-30 (Ill. App. Ct.) (recognizing specific and narrow factual basis of corporate negligence, and holding that unless occurrence of malpractice foreseeable, no duty exists to monitor ongoing medical care provided by staff physician), appeal denied, 530 N.E.2d 264 (Ill. 1988); \textit{Pickle v. Curns}, 435 N.E.2d 877, 881 (Ill. App. Ct. 1982) (recognizing that although hospital owes duty of reasonable care to patient for known condition, hospital is not insurer).
  \item \textsuperscript{81} See generally \textit{Cohoon}, supra note 13, at 398-401 (placing liability on hospitals that lack knowledge to enable them to recognize or prevent occurrence of future malpractice thwarts objective of imposing tort liability).
  \item \textsuperscript{82} See \textit{Thompson}, 591 A.2d at 709-10 (Flaherty, J., dissenting). "The opinion of the majority adopts an entirely new concept of liability, i.e., 'corporate liability,' to be applied to hospitals in order to hold them liable as guarantors of the quality of care afforded by independent staff members." \textit{Id.} at 709 (Flaherty, J., dissenting). It is submitted that the court, in hindsight, should not impose liability on a hospital for the failure to intervene in the doctor/patient relationship when there is no clearly known or foreseeable risk of injury to the patient and no evidence in the record that the physician on staff was incompetent to perform the procedure in question.
\end{itemize}
Public policy does not require a hospital to act as an insurer for all treatment rendered on its premises, and to assume that such a policy exists would constitute an unprecedented deviation from existing tort law. Far-reaching ramifications would result from such a broad application of the theory of corporate liability.

Expanded liability would increase hospital insurance and administrative costs, resulting in higher costs to the public for medical services. In addition, hospitals suspecting inadequate service within their institutions and wishing to act would encounter an array of legal barriers that would thwart administrative efforts to react, and ultimately to render timely supervision. In essence, hospitals would find themselves torn between the popular mandate of providing cost-effective professional services and the significant increase in costs that would accompany the supervision and control of qualified physicians.

**Conclusion**

The hospitals' increased control of the manner in which a doctor renders treatment has also broadened their exposure to liability for the actions of their physicians. Traditional tort doctrine has

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83 See Peters, supra note 36, at 128-38.
84 See supra notes 34-39 and accompanying text.
85 See Thompson, 591 A.2d at 709-10 (Flaherty, J., dissenting); infra notes 86-89 and accompanying text.
86 See Koehn, supra note 9, at 378-79; Thompson, 591 A.2d at 709 (Flaherty, J., dissenting). This new concept of liability 'reflects a deep pocket theory of liability, placing financial burdens upon hospitals for the actions of persons who are not even their own employees.' Id. "At a time when hospital costs are spiraling upwards to a staggering degree, this will serve only to boost health care costs that already too heavily burden the public." Id.
87 See Miller v. Indiana Hosp., 930 F.2d 334, 335-36 (3rd Cir. 1991) (hospital facing disciplinary action against staff physician may face protracted litigation by physician based on legal theories such as antitrust, due process, and civil rights); Gordon v. Lancaster Osteopathic Hosp. Ass'n, 489 A.2d 1364, 1368-72 (Pa. Super. Ct. 1985) (counter legal forces already in place restrain hospitals from acting hastily).
88 See David J. Slaflkowski, *Do the Courts Understand the Realities of the Hospital Practices?*, 22 St. Louis U. L.J. 452, 462-65 (1978). "In applying a variety of theories by which hospitals may be held liable for the acts of independent physicians, courts repeatedly have overlooked conditions which may make the imposition of such liability anomalous." Id. at 465. "A hospital's administration may be placed in the position of knowing of a doctor's incompetence but not having enough proof to remove him." Id.; see also Ascherman v. St. Francis Memorial Hosp., 119 Cal. Rptr. 507, 509 (.Ct. App. 1975) (substantively, hospitals must act reasonably in denying/terminating physician's staff privileges).
been expanded to include a new theory of liability for hospitals based on corporate negligence. However, the extension of corporate negligence to the negligent acts of a non-employee physician, with no requirement that the hospital have knowledge or control of these acts, unnecessarily expands the scope of hospital liability. The application of the corporate negligence doctrine should be limited to those situations in which a hospital can foresee that a doctor using its facilities is utilizing treatment methods that deviate from standard medical care and can control the physician's activities.

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