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1981

Judicial Recognition of Hospital Independent Duty of Care to Patients: Hannola v. City of Lakewood

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Recommended Citation

Note, Judicial Recognition of Hospital Independent Duty of Care to Patients: Hannola v. City of Lakewood, 30 Clev. St. L. Rev. 711 (1981)

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JUDICIAL RECOGNITION OF HOSPITAL INDEPENDENT DUTY OF CARE TO PATIENTS: *HANNOLA v. CITY OF LAKEWOOD*

I. INTRODUCTION

ON MARCH 27, 1980, the Court of Appeals for the Eighth Judicial District of Ohio announced its decision in *Hannola v. City of Lakewood*,¹ establishing that a hospital owes its patients an independent duty of care to see that its physicians are both carefully selected and responsibly retained on the medical staff. Of equal importance, the decision established that a hospital which holds itself out as the provider *ab initio* of services such as emergency medical care has a special responsibility to look at the quality of those services. Thus, according to the *Hannola* decision, the hospital stands as the party responsible to the patient should those services be rendered negligently by a physician who is *not* an employee. This Note will examine the court's rationale in *Hannola* and the previous leading Ohio case on emergency room care, *Cooper v. Sisters of Charity*.² This Note will similarly examine "control" tests of employment, the concept of apparent authority and the series of cases on independent duty of care which have been decided in the eleven years between *Cooper* and *Hannola*. It is the conclusion of this Note that the *Hannola* decision is more consistent with the realities of employment and service in the health care industry, and that the public policy arguments presented by the court require significant modifications in decisional rationale for medical negligence cases.

II. BACKGROUND: THE LAW BEFORE *COOPER*

Medical care today is a complex enterprise, and hospitals are frequently multimillion dollar institutions,³ but this has not always been so. The economic changes which have occurred in the health services industry are paralleled by developments in medical negligence law and, in general, the former have preceded the latter. At the beginning of the twentieth century, hospitals were largely charitable institutions, offering themselves as repositories for the seriously ill. They were the "doctor's work-shop" and not the service institutions of today, and were afforded charitable immunity for their torts.⁴

¹ *Hannola v. City of Lakewood*, 68 Ohio App. 2d 61, 426 N.E.2d 1187 (8th Dist. 1980), *cert. denied*, No. 80-804 (Ohio Sup. Ct., Sept. 12, 1980).

² 27 Ohio St. 2d 242, 272 N.E.2d 97 (1971).

³ The statement is probably modest. One study pegged the volume of investor-owned hospital income at \$10 billion for 1979, and rising steadily. 12 FED'N AM. HOSP. REV. 20 (1979).

⁴ An excellent overview of the charitable immunity doctrine and its role in

As individual hospitals grew in size during post-Civil War industrialization and expansion of urban centers, the number of employees of hospitals also grew. Some, inevitably, were less careful than others, and injuries to patients or visitors occurred. But for their charitable immunity, hospitals could have been made to answer for employee torts, since the principles of vicarious liability—holding an employer or “master” responsible for the torts of his employee or “servant”—were well-established.⁵ The problem with charitable immunity was that hospital employees were protected from suit whether they were rendering health care—the original purpose of the hospital—or performing some nonmedical act which might in another business subject them to liability.

This problem was resolved in 1914 by Justice Cardozo’s famous opinion in *Schloendorff v. Society of New York Hospitals*.⁶ In *Schloendorff*, Justice Cardozo pronounced that there should be a modification in the charitable immunity doctrine to permit a degree of accountability by the hospital when one of its servants caused injury while acting in a non-charitable function. The distinction Justice Cardozo proposed is no longer the law of New York, and has been subject to unremitting criticism;⁷ still, it was novel for the time. Since the charitable purpose of the hospital was to care for the sick, liability should not attach when an employee tort occurred in that context. Thus, Justice Cardozo spoke in terms of both medical acts and administrative acts for which a hospital might be sued as any other employer. He specifically noted that physicians and nurses were medical actors, and did not conform to accepted criteria for “servants.”⁸ Therefore, their negligent acts would not be imputed to the hospital.

The idea that physicians and nurses were “special” survived the *Schloendorff* opinion, although the original distinction blurred in other jurisdictions. In Indiana, it took on a curious twist: Since the hospital was a charitable *res*, it could not practice medicine, as licensed physicians could. Therefore, it could not, by definition, ever be vicariously liable for the negligence of physicians, even if physicians received wages

health care appears in Note, *Independent Duty of a Hospital to Prevent Physician Malpractice*, 15 ARIZ. L. REV. 953, 954-56 (1973).

⁵ In the context of this Note the following notions pertain: A servant is in the service of a master, and performs work for him, and is controlled by the master, or is subject to his control. An independent contractor contracts with an employer to work, but the employer does not control the work, nor does he have the right to control it. A master is liable for the torts of his servants committed within the scope of the servant’s employment. RESTATEMENT (SECOND) OF AGENCY §§ 2, 2(1), 2(3), 219(1) (1957).

⁶ 211 N.Y. 125, 105 N.E. 92 (1914).

⁷ Overruled in 1957 by *Bing v. Thunig*, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957).

⁸ 211 N.Y. 125, 105 N.E. 92 (1914).

from the hospital, because the physician (servant) was performing an act which the hospital (master) could not.⁹

In other models of negligence law, recognition of the special character of the provider of health services appeared. In some jurisdictions, nurses lost their protection as "special" people and reverted to mere employee status.¹⁰ Other cases held that a hospital might be liable for a physician's negligence if it knew he was incompetent to perform his duties, or if the hospital attempted to dictate to him how care should be given.¹¹

It became clear, early on, that courts would not permit the physician and hospital to mutually shield each other from liability. In passing on the question of liability for physician negligence where the patients were referred thereto by the hospital, the Oregon Supreme Court held that the hospital, too, was liable. In *Giusti v. C.H. Weston Co.*,¹² a hospital executed a contract with third parties to furnish medical care to a group. The members of the group who sought care were referred to the subject physician. The court held that while the negligence of the physician might ordinarily be personal to him, the hospital here assumed a role closer to that of employer than disinterested party, and that this role would subject the hospital to suit also.¹³ This result took on special significance where a corporation set up employee accident plans utilizing the services of local hospitals, as in *Jenkins v. Charleston General Hospital*.¹⁴ While the defendant-physician in *Jenkins* was otherwise an independent contractor, he became an agent of the hospital when he treated injured workers of a company with whom the hospital had contracted.¹⁵

By these decisions the breakdown of classical negligence concepts *vis-a-vis* physicians began. There had been no showing of the hospitals' knowledge of physician incompetence, nor proof that the hospital dictated treatment methods to him. Nevertheless, the courts "found" agency.

It was not surprising that other "agency" relationships were deduced by courts from what had theretofore been clearly independent choses. Preeminent among these cases is *Stanhope v. Los Angeles College of Chiropractic*,¹⁶ and it appears to be the first example of apparent authority used as a decisional rationale. The plaintiff was injured in an auto accident, and a decision was made to take X-rays of his back. For

⁹ *Herman v. Baker*, 214 Ind. 308, 15 N.E.2d 365 (1938).

¹⁰ *Piedmont Hospital v. Anderson*, 65 Ga. App. 491, 16 S.E.2d 90 (1930).

¹¹ *Black v. Fischer*, 30 Ga. App. 209, 117 S.E. 103 (1923).

¹² 165 Or. 525, 108 P.2d 1010 (1941).

¹³ *Id.* at 530, 108 P.2d at 1013.

¹⁴ 90 W. Va. 230, 110 S.E. 560 (1922).

¹⁵ *Id.* at 233, 110 S.E. at 561.

¹⁶ 54 Cal. App. 2d 141, 128 P.2d 705 (1942).

this purpose, he was taken to a private physician, who maintained an office in the defendant hospital. There was no indication that the physician was not an employee or functionary of the hospital, although evidence was presented that clearly affirmed his independent contractor status. The physician failed to obtain the proper films, and the plaintiff was not adequately treated. The hospital was estopped from invoking the physician's independent contractor status in their defense. The court held that the patient's testimony that he knew he was in a hospital, and his belief that he was being attended by hospital employees while in the radiologist's office, was enough to create an ostensible agency.¹⁷

In another case, *Senaris v. Haas*,¹⁸ the relationship between physician and hospital was not obvious to the plaintiff until after the tort, but an agency relationship was still "found." An anesthesiologist practiced in a single hospital in company with six other anesthesiologists. The anesthesiologist billed patients for his services, but obtained all of his drugs from the hospital, maintained an office there and was subject to on-call duty by the hospital. These contacts were sufficient to make him an agent of the hospital, and his fault was attributed to it.¹⁹

Apparent authority—the creation of "ostensible" agents—did not fare well everywhere. In *Dickinson v. Mailliard*,²⁰ an emergency room physician in Iowa worked in only one hospital, was a full-time staff member and had no other practice. The physician was not distinguishably an independent contractor. Nevertheless, he was not considered an agent of the hospital when he negligently treated the plaintiff.²¹ In a similar situation, a physician who was a member of a partnership which had contracted with the defendant hospital to supply emergency room services was clearly an independent contractor, even though the patients he served had no indication that he was not a hospital employee.²²

Other changes were occurring in the courts' treatment of medical negligence cases. The stirrings of enterprise liability were felt in the famous case of *Ybarra v. Spangard*,²³ where all the members of a surgical team were held accountable for an injury which was clearly the result of improper positioning during surgery. Yet, if there was the assumption that the hospital was a guarantor of results for all acts within its walls, there were plenty of cases which demonstrated that no

¹⁷ *Id.* at 147, 128 P.2d at 708.

¹⁸ 45 Cal. 2d 811, 292 P.2d 915 (1955).

¹⁹ *Id.* at 831, 292 P.2d at 925.

²⁰ 175 N.W.2d 588 (Iowa 1970).

²¹ *Id.* at 595.

²² *Pogue v. Hospital Authority of DeKalb County*, 120 Ga. App. 230, 170 S.E.2d 53 (1969).

²³ 25 Cal. 2d 486, 154 P.2d 687 (1945).

matter how gross the negligence of the attending physician, the hospital would not be held accountable for his torts absent proof of actual knowledge or "control."²⁴

The *Schloendorff* case fostered innovative thought about medical negligence law. With time, it created a muddle for the New York courts as they decided which acts were administrative and which were medical. In 1957, the courts, having been through enough gymnastics, overruled *Schoendorff* in *Bing v. Thunig*.²⁵ *Bing* accomplished two major feats. First, it removed physicians and nurses from their protected position.²⁶ Second, it recognized that the hospital was a full-service institution, and not the charitable shelter of yore.²⁷

The *Bing* decision provoked an incisive look at the "new" hospital, which was more like a business than a charity. This new perspective did not change the postulate that an individual physician's negligence might not necessarily impute to the hospital. However, in a series of cases decided in the interim between *Bing* and *Cooper*,²⁸ courts began to examine how the hospital held itself out to the public.

Typical of this focus was *Vanaman v. Milford Memorial Hospital*.²⁹ In *Vanaman*, an injured child was negligently treated by an emergency room physician, and a painful and serious infection resulted. The treating physician was not a hospital employee, but he was a staff physician who took his turn in the emergency department. He received no money from the hospital. All billing of patients was done by the physician under his name. In a novel opinion, the Delaware Supreme Court looked at the facts from the *patient's* viewpoint and perceived that the physician had the appearance of a hospital employee.³⁰ The court declared that the representations and omissions of the hospital would have to be considered in making decisions about agency, and that the matter of the physician's source of income could not alone determine his relationship with the hospital.³¹

It is this new factor—the hospital's representations to the public—which assumes an important role in subsequent cases, including *Hannola*. What the hospitals say and do with respect to their physicians,

²⁴ See, e.g., *Clary v. Hospital Authority*, 106 Ga. App. 134, 126 S.E.2d 470 (1962) (use of improper equipment to perform elective bronchoscope exam in infant, where hospital staff had knowledge of plans to proceed, and where, after seriously injuring child, no indication was given to parents of injury; *held*, negligence not to be imputed to hospital).

²⁵ 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957).

²⁶ *Id.* at 660, 143 N.E.2d at 9, 163 N.Y.S.2d at 9.

²⁷ *Id.* at 558, 143 N.E.2d at 7, 163 N.Y.S.2d at 6.

²⁸ 27 Ohio St. 2d 242, 272 N.E.2d 97 (1971).

²⁹ 272 A.2d 718 (Del. 1970).

³⁰ *Id.* at 722.

³¹ *Id.*

especially in those instances where serious matters of competence are in question, become increasingly fundamental considerations. The balance of this discussion, then, will consider how two separate Ohio courts considered hospital representations and decided two similar fact situations very differently. The difference between those decisions represents another recognition by the courts of the changing role of the hospital, and the concomitant changing responsibility which must be accepted for assuring quality medical care.

III. INDEPENDENT CONTRACTORS AND "CONTROL" TESTS— THE *COOPER* CASE

The Ohio Supreme Court settled the question of hospital liability for emergency room physician negligence with the 1971 case of *Cooper v. Sisters of Charity*.³² The thrust of *Cooper* was that emergency room physicians are independent contractors, absent some manner of classical "control" by the hospital.³³ This argument was employed by the hospital defendant in the *Hannola* case as justification for dismissing the case against the hospital, even if the emergency room physician was negligent.³⁴

An analysis of the *Cooper* opinion suggests, however, that the Ohio Supreme Court did not consider all the facts of the pecuniary relationships in the case when arriving at its decision. A further argument can be made that the *Cooper* opinion is no longer timely because of society's changed expectations of hospital emergency service. Thus, it is appropriate that the law should also change.

In *Cooper* the decedent had been riding a bicycle when struck by a truck.³⁵ Later that day the decedent complained of a slight headache, and vomited periodically after the accident. His mother accompanied him to the Good Samaritan Hospital emergency room where he was seen by one Dr. Hansen.³⁶ The patient was given a cursory physical examination. Certain key tests, including ophthalmoscopic examination of the eyes and neurologic examinations, were not undertaken. A skull X-ray, however, revealed no sign of fracture.³⁷ Dr. Hansen discharged

³² 27 Ohio St. 2d 242, 272 N.E.2d 97 (1971).

³³ *Id.* at 254, 272 N.E.2d at 104. "Appellee Dr. Hansen was an employee of appellee Emergency Professional Service Group, and was not under the control of the hospital." *Id.*

³⁴ Brief for Appellant at 9, 10, 13, *Hannola v. City of Lakewood*, No. 80-804 (Ohio Sup. Ct., filed May 28, 1980).

³⁵ 27 Ohio St. 2d at 242, 272 N.E.2d at 97.

³⁶ *Id.* at 243, 272 N.E.2d at 98. Plaintiff made out an issue of apparent authority here, although it is evident that she also raised the question of traditionally-manifested agency. *Id.* at 249, 272 N.E.2d at 104.

³⁷ The combined body of evidence—headache, vomiting and subsequent instability of gait, pointed to a closed head injury, since there was no X-ray

the boy, and told Cooper's mother to put him to bed, but to be sure he could be awakened every hour for a few hours. She was told to bring him back to the hospital if she could not awaken him.³⁸ The child did not fall asleep at home; he remained alert until early the next morning, when he became restless and suddenly died.³⁹ An autopsy was performed, and the cause of death was determined to be hemorrhage, with intracranial pressure damage; a basilar skull fracture was also found.⁴⁰

Mrs. Cooper brought wrongful death actions against Dr. Hansen, the emergency room physician and the Sisters of Charity of Cincinnati, Inc., doing business as Good Samaritan Hospital. Also joined as defendants were an unincorporated association of Good Samaritan staff physicians, the Emergency Professional Service Group and that group's director, Dr. Weber.⁴¹ The theory put forward by the plaintiff to hold the hospital liable was that "the Sisters of Charity had represented to appellant [plaintiff], and to the public, that the persons rendering medical care in the emergency room were doing so on behalf of the hospital. . . ."⁴²

The case proceeded to trial, and at the close of plaintiff's evidence, a defense motion for a directed verdict as to all defendants was sustained.⁴³ Much of the trial judge's opinion goes to fact questions on the issue of decedent's probability of survival.⁴⁴ The trial court's conclusion of law stated (without more) that the defendant Emergency Professional Services Group controlled the rendering of "professional medical services available at the emergency room and rendered to plaintiff's decedent,"⁴⁵ and that the Sisters of Charity did not control these services.

evidence (at the initial examination) of a fracture or "open" injury. The omitted tests would arguably have pointed to an increase in intracranial pressure, which was determined at autopsy to be the cause of death. While the condition is extremely dangerous, it is not uniformly fatal, and surgical decompression by means of burr holes in the skull is often life-saving. Unfortunately, it is frequently difficult to assess the likelihood of survival after the patient's death, as is apparent from the *Cooper* opinion. *Id.* at 253, 272 N.E.2d at 103. See generally W. COLLINS, J. VANGILDER, J. VENES & J. GALICICH, *Neurological Surgery*, in *PRINCIPALS OF SURGERY* 1635-41 (Schwartz ed. 1974) [hereinafter cited as *Neurological Surgery*].

³⁸ 27 Ohio St. 2d at 244, 272 N.E.2d at 98. The object of this regimen was to ascertain levels of consciousness, which—in some instances—*gradually* fade with increasing intracranial pressure. *Id.* See *Neurological Surgery*, *supra* note 37, at 1636. In this instance, the exception proved to be the rule, and there was a rapid turn of events with immediate death.

³⁹ 27 Ohio St. 2d at 244, 272 N.E.2d at 99.

⁴⁰ *Id.*

⁴¹ *Id.* at 245, 246, 272 N.E.2d at 99.

⁴² *Id.* at 246, 247, 272 N.E.2d at 100.

⁴³ *Id.* at 248, 272 N.E.2d at 101.

⁴⁴ *Id.* at 247, 248, 272 N.E.2d at 102.

⁴⁵ *Id.* at 249, 272 N.E.2d at 104.

The bulk of the Ohio Supreme Court opinion and the syllabus of the case focus on the trial issue of decedent's survival and the evidence required to overcome a summary judgment on this question.⁴⁶ On the matter of Good Samaritan's liability for Dr. Hansen's negligence, the court was parsimonious in its pronouncement: "Appellee Dr. Hansen was an employee of appellee Emergency Professional Service Group, and was not under the control of the hospital."⁴⁷ The court appears to refer, in this section, to traditional master-servant control standards. On the more precise issue of apparent authority, arising from plaintiff's claim of the hospital's representations about its emergency service,⁴⁸ the opinion is no more protracted: "[T]he practice of medicine by a licensed physician in a hospital is not sufficient to create an agency by estoppel, as alleged by appellant. Nowhere is induced reliance shown by the appellant, as required by *Johnson v. Wagner Provision Co.* (1943), 141 Ohio St. 584, 26 O.O. 161, to establish such a relationship."⁴⁹ Neither of these conclusions appear in the syllabus of the case.⁵⁰

The initial point of departure from the *Cooper* case with those which have come after it (including *Hannola*) is that the defendant, Dr. Hansen, was a member of an "unincorporated association."⁵¹ Ohio law permitted physicians to form professional corporations in 1971.⁵² The opinion notes that this association was formed in 1965 to run the emergency depart-

⁴⁶ *Id.* at 242, 253-54, 272 N.E.2d at 97, 104.

⁴⁷ *Id.* at 254, 272 N.E.2d at 104.

⁴⁸ *Id.* at 246, 247, 272 N.E.2d at 100.

⁴⁹ *Id.*

⁵⁰ The absence of these conclusions from the syllabus was a point of law raised by the plaintiff in the *Hannola* case. Brief for Appellees at 22, *Hannola v. City of Lakewood*, No. 80-804 (Ohio Sup. Ct., May 28, 1980). Under the syllabus rule, the quotations set forth there are considered dicta, and not to be construed as a holding of the court. *Cassidy v. Glossip*, 12 Ohio St. 2d 17, 231 N.E.2d 64 (1967).

⁵¹ 27 Ohio St. 2d at 245, 272 N.E.2d at 99.

⁵² OHIO REV. CODE ANN. § 1785.02 (Page 1978), provides for the incorporation of individuals who are licensed by the state to perform professional services. The courts specifically include physicians (and specifically excluded lawyers) under this statute, as construed by *Cleveland Clinic v. Sombrio*, 6 Ohio Misc. 48, 215 N.E.2d 740 (C.P. Cuyahoga County 1966). Physicians acting as the agents or officers of professional associations (professional corporations) of physicians organized under § 1785.02, and who are negligent within the scope of their agency to the association, impute their negligence to the association under vicarious liability principles. *Lenhart v. Toledo Urology Assoc.*, 48 Ohio App. 2d 249, 356 N.E.2d 749 (1975); *accord*, *Zimmerman v. Hogg & Allen*, 22 N.C. App. 544, 207 S.E.2d 267, *rev'd on other grounds*, 286 N.C. 24, 209 S.E.2d 795 (1974); *see also* *O'Neill v. United States*, 281 F. Supp. 259 (N.D. Ohio 1968), *aff'd*, 410 F.2d 888 (6th Cir. 1969) (professional employee of a professional association is still liable to his patients for his own negligence, and his affiliation with the association does not subject a stockholder of the association to more than the stockholder's limited liability under general corporation law principles).

ment⁵³ and that the association members were also Good Samaritan staff members in 1965 and subsequent thereto. The "agreement" of the association with the hospital was *oral*, and never reduced to writing.⁵⁴ The function of Dr. Weber, the "director," was to schedule physicians to serve; if a particular person did not show up at the assigned time, hospital personnel were to call Dr. Weber and he would find a substitute.⁵⁵ His duties, then, were much less than either a corporate officer or a professional partnership member.

The court stated that Dr. Hansen was not controlled by the hospital because he was employed by the Emergency Professional Services Group,⁵⁶ and was paid by them.⁵⁷ However, the Group did not bill patients directly—the hospital billed its emergency patients, and then paid the Group, which in turn paid Hansen.⁵⁸ Yet, if this was true, the unincorporated association was not a profit-making enterprise⁵⁹ for that would have made it a *de facto* partnership, and all the members of the association would have been subject to suit.⁶⁰ The Group, if anything, was an illusion. It is apparent that Hansen's entire income derived from the emergency practice, and the Group functioned as a bookkeeping middleman between the provider of services (Hansen) and the purchaser of those services (Good Samaritan).⁶¹ It is this set of facts which render the court's use of traditional employment tests inappropriate.

⁵³ Brief for Appellants at 56, *Hannola v. City of Lakewood*, No. 80-804 (Ohio Sup. Ct., May 28, 1980).

⁵⁴ *Id.* at 57.

⁵⁵ *Id.* at 59-60.

⁵⁶ 27 Ohio St. 2d at 254, 272 N.E.2d at 104.

⁵⁷ *Id.* at 247, 272 N.E.2d at 101.

⁵⁸ *Id.*

⁵⁹ OHIO REV. CODE ANN. § 1745.01 (Page 1978), sets forth the statutes dealing with unincorporated associations, and specifically provides that one may sue and be sued. The leading case construing this section, *Lyons v. American Legion*, 172 Ohio St. 331, 175 N.E.2d 733 (1961), held that one might have a judgment satisfied from the assets of the association, or from assets of an individual member thereof, but not both. This result obtains only in the instance of a not-for-profit association; the court noted that an association-for-profit is nothing more or less than a partnership, whose members are liable, as partners, for the torts of members acting within the partnership business. UNIFORM PARTNERSHIP ACT §§ 13, 15 (1969).

⁶⁰ UNIFORM PARTNERSHIP ACT §§ 13, 15 (1969) (partners jointly and severally liable for the tortious acts of partners occurring within scope of partnership business).

⁶¹ The fact that the defendant physician was a member of one hospital did not preclude his membership in another, nor did it bar him from working there. It was common at one time to have "circuit riding" emergency room physicians who worked at several hospitals. This arrangement is less common as a result of the emergence of emergency room professional corporations which usually negotiate an "exclusive" contract with a particular hospital.

*Avellone v. St. John's Hospital*⁶² and *Councell v. Douglas*⁶³ were used by the court as authority for the proposition that liability is imputable to the party who has control of another in an employment setting. *Councell* enumerates the definitive test of vicarious liability in Ohio:

The relationship of principal and agent or master and servant is distinguished from the relationship of employer and independent contractor by the following test: Did the employer retain control of, or the right to control, the mode and manner of doing the work contracted for? If he did, the relationship is that of principal and agent or master and servant. *If he did not but is interested merely in the ultimate result to be accomplished, the relationship is that of employer and independent contractor.*⁶⁴

Since this test will disclose whether one of two individuals is a servant's master (as opposed to an independent contractor's employer), it should also identify where the liability of the servant should lie.⁶⁵ In the *Cooper* case, however, there was no master, and no servant. This follows from the test, because no one was "controlling" Dr. Hansen. Thus, it is patently inconsistent for the court to call him an employee of the Emergency Professional Services Group by the *Councell* definition of employee. Accordingly, it is inconsistent to say he is an independent contractor with respect to the hospital. The *Councell* test produces that result *even if* Dr. Hansen was paid a salary by the hospital and served only the hospital. This result follows because the hospital would not have control, nor the right to control, the "mode and manner of doing the work contracted for."⁶⁶ That is the analytical error in the *Cooper* opinion—the control test of employment *does not work* for medical negligence cases.

The *Cooper* court's reliance on *Avellone* was similarly inappropriate. The cited passage from *Avellone* notes that

we are not deciding that persons working in a hospital, such as doctors and nurses, under circumstances where the hospital has

⁶² 165 Ohio St. 467, 135 N.E.2d 410 (1956).

⁶³ 163 Ohio St. 292, 126 N.E.2d 597 (1955).

⁶⁴ *Id.* (emphasis added).

⁶⁵ A servant is an agent employed by a master to perform service, and whose conduct is controlled or "subject to the right to control" by the master. RESTATEMENT (SECOND) OF AGENCY § 2 (1957). If the servant commits a tort while acting within the ambit of his employment, the master is liable (vicariously) and must answer to a third party. RESTATEMENT (SECOND) OF AGENCY § 219(1) (1957). See *Burks v. Christ Hospital*, 19 Ohio St. 2d 128, 249 N.E.2d 829 (1975); *Burns v. Ellens*, 459 S.W.2d 203 (Mo. 1970); *French v. Fisher*, 362 S.W.2d 926 (Tenn. 1962).

⁶⁶ 163 Ohio St. 292, 126 N.E.2d 597 (1955). There is no avoiding the implication of the test by assuming that a right to control may exist even when unexpressed by the superior party; "control" is an incident of contract, and contracts are built on the clear and present intentions of the parties, not on their unvoiced thoughts.

no authority or right of control over them, can bind the hospital by their negligent actions. *See* *Schloendorff v. Society of New York Hospitals*, 211 N.Y. 125, 101 N.E. 92, 52 L.R.A., N.S., 505.⁶⁷

Justice Cardozo's rationale in the *Schloendorff* opinion, and the *Avellone* court's apparent rationale in referring to it, was to point out that two types of activity go on in hospitals: medical and administrative. In the original *Schloendorff* opinion, Justice Cardozo held that hospitals could not be held accountable for negligence done by medical actors.⁶⁸

While the *Avellone* court cited the law as it stood, the *Cooper* court erred in invoking *Avellone* as a basis for a control test, since the *Schloendorff* opinion on which *Avellone* relied was expressly overruled one year after it was decided (and fourteen years before *Cooper*) in *Bing v. Thunig*.⁶⁹ In *Bing*, the physician-patient relationship was set out in a different light:

The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact. Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. *They regularly employ on a salary basis a large staff of physicians, nurses and interns, as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such services, if necessary, by legal action. Certainly, the person who avails himself of hospital facilities expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility.*⁷⁰

The *Bing* court went further in its opinion to clarify exactly what the rule of *respondeat superior* liability should mean in the context of hospital services:

Hospitals should, in short, shoulder the responsibilities borne by everyone else. There is no reason to continue exemption from the universal rule of *respondeat superior*. *The test should be, for these institutions, whether charitable or profit-making, as it is for every other employer, was the person who committed the negligent injury-producing act one of its employees and, if he was, was he acting within the scope of his employment.*⁷¹

⁶⁷ 27 Ohio St. 2d at 254, 272 N.E.2d at 104, *citing* *Avellone v. St. John's Hospital*, 165 Ohio St. 467, 478, 135 N.E.2d 410, 417 (1956).

⁶⁸ 211 N.Y. 125, 105 N.E. 92 (1914). If the "administrative/medical" liability dichotomy seems to the reader reminiscent of the "governmental/proprietary" immunity dichotomy, it is probably not coincidental.

⁶⁹ 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957).

⁷⁰ *Id.* at 660, 143 N.E.2d at 10, 163 N.Y.S.2d at 8 (emphasis added).

⁷¹ *Id.* (emphasis added).

The distinction between the *Bing* test of *respondeat superior* liability and the *Councill* test explains why the control test fails in medical negligence cases. The *Bing* court repeatedly noted that physicians employed by hospitals might subject the hospitals to liability for their negligent acts if such acts were done within the scope of their employment. The *Bing* case *never* suggested that hospitals "controlled" their physician-employees; rather, *Bing* looks to the incidents of employment, much as the Restatement definition of an independent contractor looks to the incidents of "contractorship."⁷²

"Employment," by the *Bing* definition, has special connotations when the employee is an emergency department physician. His employer is not the patient he sees. In private practice, the doctor and patient might come together in a freely-made contract which either might dissolve. The physician is not bound, legally or ethically,⁷³ to accept the patient. In the emergency room, the patient has *no choice* which physician shall aid him, and the physician must see any and all patients. The patient does not solicit information about the physician's reputation; he looks for a hospital which furnishes emergency services by means of the physician. In the latter instance it appears that the physician is employed by the hospital, and the patient is purchasing his services from the hospital.

What has just been described is the alternate theory of liability for emergency room malpractice cases, apparent authority.⁷⁴ It should not be confused with the *Bing* employment theory, which applies when the

⁷² "In determining whether one acting for another as a servant or an independent contractor, the following matters of fact, *among other things*, are considered . . . (a) The extent of control which, by the agreement, the master may exercise over the details of the work. . . ." RESTATEMENT (SECOND) OF AGENCY § 220(2) (1957) (emphasis added).

⁷³ "A physician may choose whom he will serve . . . [But] [h]aving undertaken the care of a patient, he may not neglect him, and unless he has been discharged he may discontinue his services only after giving adequate notice." JUDICIAL COUNCIL, AMERICAN MEDICAL ASSOCIATION, PRINCIPLES OF MEDICAL ETHICS § 5 (1971).

⁷⁴ When one actor deals with another actor, and a principal makes "manifestations to such third persons" (i.e., the first actor) as would create or change a legal relationship between the principal and the "third person," the principal has clothed the second actor—the agent, if you will—with apparent authority. RESTATEMENT (SECOND) OF AGENCY § 8 (1957). The reader will note that this definition does not quite constitute an "estoppel;" indeed, agency by estoppel is distinctly different, as this latter doctrine requires not only a detrimental change of position by the third person, but also necessitates that the wronged party have reliance on some proveable manifestations of apparent authority. RESTATEMENT (SECOND) OF AGENCY § 27 (1957). The confusion engendered here is made worse by the tendency of the courts to blur the two ideas into one.

In the context of the present discussion, the merging of apparent authority and agency estoppel doctrines is desirable, if not scholarly. The author reaches that conclusion from considering that the usual concepts of master/servant and principal/agent do not work in the medical legal context, and it is useless to force

plaintiff can demonstrate—after the fact—some notorious exchange of promises or money between physician and hospital. Apparent authority applies when there is no obvious legal separateness between physician and hospital. It follows from the facts in *Cooper* that an apparent authority theory could be raised by the plaintiff. There was no indication that Dr. Hansen was not an employee of the hospital; and the hospital, not Dr. Hansen, solicited the patient's business. There was no suggestion that Cooper might obtain the services of other physicians, and the fact that he saw Dr. Hansen was a result of a hospital decision to grant Hansen privileges.⁷⁵ Of course, it is obvious that a patient expects to find physicians in a hospital emergency room, and neither knows nor cares whether they are independent contractors or employees.⁷⁶

The *Cooper* trial court did not address apparent authority directly,⁷⁷ but the Ohio Supreme Court opined that an important element of that theory was lacking:⁷⁸ The plaintiff did not make a showing of "induced

apparent authority and agency by estoppel into the same nonfunctional framework. For the present discussion, then, the term apparent authority will define the following situation: A third party (a patient) will seek treatment from a physician; the patient will assume, based on demonstrable indications, that the physician is an employee of X, the hospital. In fact, the physician may be an employee of Y, or is self-employed. In a determination of whether the negligence of the physician should be imputed to X, the trier of fact must determine (in addition to the usual proofs regarding the personal negligence of the physician) whether the indications given the patient came from X; whether they were reasonable so as to engender the conclusion; whether the patient relied on those indications or elected to retain the physician based on those indications or elected to retain the physician based on some other consideration; and whether this construed to his detriment. In considering the latter two conditions reference will be made to the "disclosure" test. See note 83 *infra* and accompanying text. If, prior to making his treatment choice, it had been revealed to the patient that the physician was in fact *not* an employee of X, but was self-employed (an independent contractor), would that revelation have made any difference? The disclosure test is deceptive—it is susceptible of incorrect application because the courts which have invoked it for medicolegal decisions have failed to put themselves in the perspective of the patient who must make the choice. The court of appeals decision in *Hannola*, however, represents a correct application of the test. *Hannola v. Lakewood*, 68 Ohio App. 2d 61, 64, 426 N.E.2d 1187, 1189 (8th Dist. 1980).

⁷⁵ It is *only* by the mechanism of privilege that a physician is able to render services in a hospital; absent this, he has no standing as a professional there. Only the controlling body of the hospital may grant privileges, a fact which is easily overlooked. Medical staff organizations may make recommendations as to an individual physician, but the statutory authority for operation of the hospital quite plainly reserves this power to the governing body as a nondelegable duty. OHIO REV. CODE ANN. § 3701.71 (Baldwin 1976); OHIO LEGIS. SERV. S-429 (Baldwin 1981).

⁷⁶ *Hannola v. City of Lakewood*, 68 Ohio App. 2d 61, 65, 426 N.E.2d 1187, 1190 (8th Dist. 1980) (the court may not disregard the human factors in considering fact questions going to apparent authority).

⁷⁷ 27 Ohio St. 2d at 249, 272 N.E.2d at 100.

⁷⁸ *Id.* at 254, 272 N.E.2d at 104.

reliance" which must be proven according to *Johnson v. Wagner Provision Co.*⁷⁹ The *Johnson* court stated:

The doctrine of agency by estoppel, as it might be invoked by a plaintiff in a tort action, rests upon the theory that one has been led to rely upon the appearance of agency to his detriment. It is not applicable where there is no showing of induced reliance upon an ostensible agency.⁸⁰

The conceptual problem of detrimental reliance goes beyond the idea that the plaintiff received negligent treatment at a particular emergency room with an "ostensible agent" physician in attendance. The *Cooper* court recognized this when it stated that there was no "induced reliance" by the plaintiff. What the court seems to say is that if Cooper knew Dr. Hansen was not a hospital employee, that knowledge would have caused him to decide whether to stay and accept treatment or go somewhere else. If this was true, there would be no detrimental reliance on an ostensible agency, and therefore no grounds to rely on apparent authority as a plaintiff's theory.

This scenario, however, bears no resemblance to the real world. Even if the patient had a detailed explanation of the liability of hospital and physician and a writing reiterating it,⁸¹ his decision to stay or go would not reflect an objective choice. Even if the suffering and stress of the moment could be set aside,⁸² he still would rely on the agency—ostensible or factual—to his detriment.⁸³

Classically, a plaintiff would not be able to invoke apparent authority

⁷⁹ 141 Ohio St. 584, 49 N.E.2d 925 (1943).

⁸⁰ *Id.* (syllabus ¶ 4).

⁸¹ The reader may be sure, however, that in the hypothetical case there would not be an attempt to get the patient to affirm the hospital's disclaimer of liability as a condition to treatment; that sort of conduct is looked on quite severely by the courts, as it should be. *Meiman v. Rehabilitation Center of California*, 60 Cal. 2d 92, 383 P.2d 441, 32 Cal. Rptr. 33 (1963). See also *Belshaw v. Feinstein*, 258 Cal. App. 2d 711, 65 Cal. Rptr. 788 (1968) (where there is no alternative to the care to be provided by a private physician, the provider cannot use that fact as a basis for bargaining away his liability under a contract).

⁸² The court of appeals in *Hannola* opined that these concerns cannot be disregarded by the fact finder, and also noted that they form part of the calculus of a captive contract situation, in addition to being patently offensive to public policy. 68 Ohio App. 2d 61, 426 N.E.2d 1187 (8th Dist. 1980).

⁸³ This construct is more eloquently set forth in the case of *Gasbarra v. St. James Hospital*, 85 Ill. App. 3d 32, 406 N.E.2d 544 (1979). The alternative choice made available to the patient—that of leaving the emergency room and going to another emergency room—is made not quite moot by the court. Realistically (they assume), unless there is some ominous portent to the label "independent contract," a patient would always elect to stay where he was. 406 N.E.2d at 554-55. This would seem to eliminate the doctrine of apparent authority as a viable theory of liability in emergency room medical malpractice cases. However, as will be apparent, when the issue is considered in the context of the *Hannola*

as a basis for recovery once he knew that there was no actual agency between hospital and physician. However, in the emergency department context, it is not the fact (quantity, if you will) of disclosure which matters, so much as the *quality* of disclosure. That is, the patient needs to know whether the physician is *competent* to be a practitioner of emergency medicine, what his physician-peers think of him and how the hospital came to grant him privileges. Obviously, the hospital is not likely to reveal that information even if it collects it. Similarly, the patient is usually in no condition to make any but the simplest decisions—and a comatose patient cannot make even those decisions. These facts suggest that there will always be detrimental reliance on the hospital's representations by an emergency room patient, because the hospital will not provide him with the facts he needs to make an informed choice of treating physicians, or because he is physically unable to make any choice, and the hospital thus subjects him to the mercy of his choice of health provider.

The *Cooper* opinion, in sum, reflects both an unwise use of the control test in its discussion of employment relationships and a shallowness of interpretation of the disclosure requirements of the apparent authority doctrine.⁸⁴ It is not readily applicable to later cases, for the unincorporated association "employment" vehicle has given way to the professional association or corporation,⁸⁵ for which general corporate prin-

fact situation, an important element is present in the calculus which is not considered by the *Gasbarra* court.

What must be considered is what hospital "employment" implies to the patient. Simply put, if the hospital is perceived as being able to put an *imprimatur* on the emergency room physician, disclaimer of employment status may suggest disclaimer of *imprimatur* to the patient. In those instances, the patient would be well-advised to seek other treatment, if he is able. The unfortunate fact is that most of the cases on which the theory of independent duty of care to patients is based have been *precisely* the type of situations where the hospital had resoundingly disclaimed any knowledge of the physician's ability. See, e.g., *Purcell v. Zimbelman*, 18 Ariz. App. 75, 500 P.2d 335 (1972).

⁸⁴ There is no notion in the *Cooper* opinion that anything like the disclosure test presented here was employed by the court, and it does not directly follow from the *Johnson v. Wagner Provision Co.* opinion. At best, the *Cooper* court's inquiry into the question of detrimental reliance was superficial.

⁸⁵ This is not to suggest that physician corporations are the only means by which emergency services can be furnished by a hospital, although the corporate form is certainly attractive. Teaching institutions, for example, rely heavily on interns and residents, who typically receive salaries for their labors and are thus clearly employees. In the small, isolated hospital, and where professional corporations are either not permitted by statute or are not in vogue, the practice of each staff member taking his turn "on call" persists. The disadvantages of this method should be obvious; frequently, the physician is at home, or at least not physically in the hospital, and in the time required for him to arrive a critically ill patient might expire. There is also the very real problem that one might have a semi-retired general practitioner dealing with a problem which is essentially surgical, and which requires quick hands and a keen eye. The outcome could predictably be disastrous.

ciples provide suitable decisional rationales.⁸⁶ The members of the unincorporated associations, as staff members of the hospital, were subject to the "control" of the privilege-granting function of the hospital,⁸⁷ but the fact did not alter the hospital's lack of responsibility for their negligence. In contrast, the corporate form of emergency medical services would clearly seem to exempt the hospital from any physician liability.⁸⁸

The *Cooper* case stands as one instance where the bureaucratic structure between hospital and physician served to insulate the hospital from liability for the physician's negligence. This result has been rejected in some jurisdictions⁸⁹ and upheld in others.⁹⁰ A consideration of later cases must also account for public policy considerations which have arisen and the theory of an independent duty of care owed by the hospital to the patient. To reach this point, we must first consider the most famous medical negligence case of the twentieth century, *Darling v. Charleston Community Memorial Hospital*,⁹¹ the changes it produced in how hospitals view themselves, and what courts will expect of them as a result of this case.

⁸⁶ Some such doctrines, like "borrowed servant," are not unique to corporation law, and were applied to malpractice cases before "corporate medicine" became popular. *E.g.*, *Beadles v. Metayka*, 135 Colo. 366, 311 P.2d 711 (1957). Conversely, the appearance of the corporate form of practice may hasten the demise of such artificial doctrines as "captain of the ship," (*Ybarra v. Spangard*, 25 Cal. 2d 486, 154 P.2d 687 (1944)), which are as ill-suited to medical malpractice cases as the control test of *Councell*. Unfortunately, the "captain of the ship" doctrine has been revived in Ohio. *Baird v. Sickler*, 69 Ohio St. 2d 652, ____ N.E.2d ____ (1982).

⁸⁷ The question of whether the granting of privileges to a physician is equivalent to hospital control (in the *Councell* sense) over the physician is best deferred to the later discussion of the intercorporate contract in the *Hannola* case, between the professional corporation furnishing emergency medical services and the hospital. In the author's opinion the analogy is one which strains to achieve its goal, and for which better rationales could be substituted.

⁸⁸ Consonant with this statement, of course, is the presumption that there would exist no "holding out" situations so as to suggest apparent authority problems and an agency between hospital and physician. See note 74 *supra* and accompanying text. By way of illustration, if a hospital has operated a physical medicine and rehabilitation unit, hiring one or two physicians, physical therapists, and buying equipment, the entire department might remove itself bodily from the building, set itself up under the corporate shield and otherwise carry on business as usual. The hospital would no longer bear the burden of liability for negligence in that type of treatment.

⁸⁹ *Vanaman v. Milford Memorial Hospital*, 272 A.2d 718 (Del. 1970) (professional corporation).

⁹⁰ *Bulloch County Hospital Authority v. Fowler*, 124 Ga. App. 242, 183 S.E.2d 586 (1971) (partnership).

⁹¹ 50 Ill. App. 2d 253, 200 N.E.2d 149, *aff'd*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966).

IV. THE *DARLING* CASE AND INDEPENDENT DUTY OF CARE

The apparent authority theory may permit a plaintiff to recover in an emergency room medical malpractice case if he can show he did not know the physician was not an employee of the hospital and if he was induced to rely on the ostensible agency between the two. This theory is of no value if the patient knew that the two were separate legal entities. The argument can be made, however, that this result is not quite fair because the patient was not able to freely choose his physician, as he would have been able to do in a private practice setting. The legal concept which embodies his social policy idea is that of an independent duty of care. This means that in certain endeavors the hospital has a responsibility to act directly in the best interests of the patient, regardless of what other relationships may exist between patient and physician, or hospital and physician. Thus, the patient is to be protected from errant nurses,⁹² drug-addicted physicians,⁹³ grossly incompetent surgeons⁹⁴ and ill-conceived experimentation.⁹⁵ While the concept of independent duty of care does not seem to have a single origin, much of the interest in the idea is traceable to the *Darling*⁹⁶ case. Curiously enough, it is in the misinterpretation of the court's holding that the case has had its greatest impact.⁹⁷

The *Darling* facts are plainly gruesome. The plaintiff injured his leg at a football practice and was taken to the Charleston Community Memorial Hospital emergency room. A general practitioner—Dr. Alexander—was “on call” to that department and attended Darling. Dr.

⁹² Utter v. United Hospital Center, 236 S.E.2d 213 (W. Va. 1977).

⁹³ Purcell v. Zimbelman, 18 Ariz. App. 75, 500 P.2d 335 (1972).

⁹⁴ Gonzales v. Nork, No. 228856 (Cal. App. Dep't Super. Ct., Sacramento County, Nov. 23, 1973), *rev'd and remanded*, Gonzales v. Nork, 60 Cal. App. 3d 728, 131 Cal. Rptr. 717 (1976), *rev'd and transferred to court of appeals for decision on the merits*, 20 Cal. 3d 500, 573 P.2d 458, 143 Cal. Rptr. 240 (1978).

⁹⁵ Fiorentino v. Wenger, 19 N.Y.2d 407, 227 N.E.2d 296, 280 N.Y.S.2d 373 (1967).

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

⁹⁷ If the reader is not familiar with the medicolegal literature he may wonder at the observation. However, it is a nearly predictable result for a case so widely commented on. An attempt to list the articles it has engendered would be beyond the scope of the present discussion; a good starting point, however, is the case annotation following a reprint of the decision at 14 A.L.R.3d 873 (1967).

The greatest source of confusion has surrounded the status of the defendant physician, i.e., was he an employee of the hospital or an independent contractor? According to plaintiff's counsel, he was a general practitioner taking his turn at emergency room duty who was called by the hospital when young Darling was brought in. Appleman, *The Darling Case—A “Real” Tiger*, 1975 INS. L.J. 714, 715. Recalling the example of previous cases, the hospital would not be liable for the physician's negligence under a vicarious fault theory if employment is the linchpin of vicarious liability. See note 65 *supra* and accompanying text.

Alexander obtained an X-ray and determined that the plaintiff had suffered a fracture. Then, in violation of medical staff rules which required consultation by emergency department staff in orthopedics cases,⁹⁸ the physician casted the injured leg and admitted the boy to the hospital. Within hours after the cast was applied, the patient complained of considerable pain. The toes of the casted leg turned dark, swelled, lost sensation and turned cold.⁹⁹ Two days later the cast was removed; a witness present testified that "there was a stench in the room . . . the worst he had smelled since World War II."¹⁰⁰ The patient was transferred to another hospital, but, predictably, the leg had to be amputated below the knee. The surgeon performing the amputation testified that the cause of the "stench" and the attendant problems was gangrenous degradation of the tissues of the leg, which occurred when circulation of blood was cut off by the pressure of the swollen leg against the unyielding plaster cast.¹⁰¹

Plaintiff proceeded against the hospital's nurses on a vicarious liability theory, and against the physician on traditional negligence grounds. The unique theories of the case, however, were advanced against the hospital in its own right. First, the hospital was alleged to have been negligent because it failed to see that the nurses in its employ followed care plans for fracture patients, by which the nurses were supposed to report when an attending physician failed to take action to correct the deteriorating condition of a patient.¹⁰² Second, the hospital was alleged to have been negligent because it failed to insist that the attending physician follow the rules which the medical staff had compiled, which required that consultation with a specialist be obtained in cases such as fractures.¹⁰³ The plaintiff did *not* allege an independent duty of care running to the patient to be achieved by an independent monitoring of physician quality of care, or by "peer review."¹⁰⁴

The hospital argued it was unable to prevent the tort, and that it was powerless under the laws of Illinois to "forbid or command any act by a physician or surgeon in the practice of his profession. . . ."¹⁰⁵ The best

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

⁹⁹ *Id.* at 328, 211 N.E.2d at 255.

¹⁰⁰ *Id.*

¹⁰¹ *Id.* at 329, 211 N.E.2d at 256.

¹⁰² *Id.*

¹⁰³ *Id.*

¹⁰⁴ The mistake has frequently been made, and seems to follow from the court's frequent use of terms like "failure to exercise adequate supervision" in the opinion. It is only apparent after several readings of the opinion and by a comparison with other materials which more fully illuminate the fact situation. See e.g., Rapp, *Darling and its Progeny: A Radical Approach to Hospital Liability*, 60 ILL. B.J. 883 (1972).

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

the hospital could do, and the limit of its duty, it said, was to "use reasonable care in selecting medical doctors. When such care in the selection of the staff is accomplished, and nothing indicates that a physician so selected is incompetent or that such incompetence should have been discovered, more cannot be expected from the hospital administration."¹⁰⁶ As to the matter of responsibility for the misconduct of the nurses, this was held to be attributable to the physician; when the nurses followed the doctor's orders, the hospital could not control what the former did.¹⁰⁷

The trial strategy of the plaintiff in disproving these contentions was deceptively simple. In essence, he argued that the hospital was licensed by the State of Illinois, a member of the American Hospital Association, and accredited by the Joint Commission on the Accreditation of Hospitals (JCAH).¹⁰⁸ As a result of these affiliations, the hospital developed

¹⁰⁶ *Id.*

¹⁰⁷ *Id.*

¹⁰⁸ The American Hospital Association is a trade organization admitting to membership both short term (acute care) and long term (rehabilitative care) hospitals; it sets out for its members hospital standards relative to physical plant, safety and (minimally) personnel. The Joint Commission on Accreditation of Hospitals ("Joint Commission" or "JCAH") is predominantly concerned with quality of care within the hospital, and less with the physical plant. Membership in the American Hospital Association is a prerequisite to Joint Commission membership; in addition, a hospital seeking the initial accreditation of the Joint Commission must demonstrate that it offers a wide variety of services to the public, including emergency care, radiology, pharmacy, pathology and quality care review. It must provide for the availability of other services, such as nuclear medicine, if not furnished therein. Further, it must maintain a clinical service in either medicine, obstetrics-gynecology, pediatrics or surgery (and if surgery, anesthesia service as well). These last requirements are deceptively simple, for they also require that the hospital have all the necessary backup in terms of nurses, laboratory and special care units to support the clinical services.

A stated minimum of six full-time beds must be maintained, although it is an extreme rarity that so small a hospital would qualify for Joint Commission accreditation since the economies of scale would make the setup unworkable. Initial accreditation is usually accompanied by on-site inspection by Joint Commission officials, who then issue an approval for two years, one year or deny approval. If approved for two years, interim re-inspection by the hospital must be performed, and the results submitted to the Joint Commission. Unannounced surveys may occur at any time, and if a hospital is found "not in substantial compliance" with standards, approval may be revoked for a single service, or for the entire hospital; this ban is effective for a minimum of six months, during which time the hospital is supposed to correct its stated deficiencies. JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS 13-19 (1976).

When a particular clinical service loses accreditation, the effect on the medical staff is chilling. Insurers such as Blue Cross and the Medicare/Medicaid reimbursement offices learn of the Joint Commission sanction very quickly, as the decisions are made public in Joint Commission publications. This can prove to be a great inconvenience for the patient; if he is admitted for elective care to an institution where Joint Commission approval has been suspended as to one service (the one furnishing the care), his insurer may elect not to pay.

bylaws for its medical staff, a policy and procedure manual for its nurses and certain internal rules of conduct. The avowed purpose of these rules, and the justification for their existence under state law was to improve the quality of care in the hospital. Since the state gave the hospital governing body the power to permit its medical staff to write its own code of conduct (bylaws), and gave other clinical departments similar power, it was not unreasonable that the hospital should be required to see that its departments followed their own rules, and that it should answer when a breach of these rules resulted in an injury to the patient.¹⁰⁹

The court of appeals affirmed an award for the plaintiff,¹¹⁰ and in its affirmation of this decision the Illinois Supreme Court laid the foundation for much of the subsequent discussion of independent duty of care: "The Standards for Hospital Accreditation, the state licensing regulations and the defendant's bylaws demonstrate that the medical profession and other responsible authorities regard it as both desirable and feasible that a hospital assume certain responsibilities for the care of the patient."¹¹¹

¹⁰⁹ Appleman, plaintiff's counsel in *Darling*, gives a glimpse into the defense dilemma in recounting his examination of the Charleston Memorial Hospital administrator. See note 97 *supra* and accompanying text. If the administrator denied that the nurses told him Darling's condition was deteriorating and untreated, then the nurses were at fault, and as employees of the hospital their negligence was imputable to the hospital since it had been shown that extant rules required reporting to the administrator of such occurrences. If the administrator said the nurses *did* tell him, then he was at fault, and his negligence, as an employee, was imputable to the hospital, since evidence had been adduced that rules of the hospital required that he then inform the chief of the medical staff, which he did not do.

¹¹⁰ 50 Ill. App. 2d 253, 200 N.E.2d 149 (1964), *aff'd*, 33 Ill. 326, 211 N.E.2d 253 (1965).

¹¹¹ 33 Ill. 2d 325, 330, 211 N.E.2d 253, 257 (1965). The reader should particularly note the phrase "and other responsible authorities," which refers inclusively to the Joint Commission on Accreditation of Hospitals. *Id.* In a preceding reference to Joint Commission standards, the court observed:

In the present case, the regulations, standards and by-laws which the plaintiff introduced into evidence, performed much the same function as did evidence of custom. This evidence aided the jury in deciding what was feasible and what the defendant knew or should have known. It did not conclusively determine the standard of care and the jury was not instructed that it did.

Id. at 330, 211 N.E.2d at 257. Despite the language of the court, the standards of the Joint Commission have been accepted as more than custom, and legitimized as decisional constructs. They are as much standards of care as the testimony of physicians would be in regard to medical procedures, and it is unfortunate that some courts have failed to recognize them as such.

The court's holding, "that a hospital assume certain responsibilities," must not be seen as too sweeping. In the context of *this case* it meant that Charleston Community Memorial Hospital must follow the rules which it had set up for its own functioning, and which ostensibly provide quality care. The court did *not* include independent checks of physician performance as manifested by credential

Though the *Darling* court did not address the matter of hospital liability for selection or retention of its medical staff of incompetent physicians, this issue had been alluded to by an earlier Illinois decision. In *Dayan v. Wood River Township Hospital*,¹¹² it was noted that hospitals which were negligent in selecting staff members might themselves be liable if the physician injured a patient.¹¹³ However, if the issue of hospital liability for physician conduct was not reached by the *Darling* court, it was certainly addressed by legal commentators. A typical pronouncement of the extreme reformers was an observation by Southwick:

The case indicates that the law should finally and forcefully reject the antiquated, rather meaningless notion that a corporation cannot practice medicine; the law should recognize that the realities of modern medicine of highest quality require collective concern and action. Institutionalization of medicine results in institutionalization of responsibility for the patient's welfare.¹¹⁴

Other writers were more conservative:

Darling v. Charleston Community Memorial Hospital held that a hospital's duty of care is to be determined not only by an examination of what other hospitals in the community do, but also by reference to what the hospital says it should do in its by-laws and in other standards applicable to the hospital.¹¹⁵

In the interim between the *Darling* decision and the *Hannola* decision, those reforms which have been made have not been so sweeping as suggested by Southwick, but they have been significant. Unfortunately, reform has not prevented some singular cases of medical negligence and incompetence, which have reflected a breach of internal hospital standards and dereliction of a duty owed to patients.¹¹⁶

validation and supervision. Later cases, building on the *Darling* foundation, have held that hospitals *should* exercise this independent duty of care, but the reader should note that Joint Commission standards relating to this duty have preceded the courts into the area; holdings of courts have reflected the trend, not created it.

¹¹² 18 Ill. App. 2d 263, 152 N.E.2d 205 (1958). The *Dayan* court was not the first to propose this theory. In *Rosane v. Senger*, 112 Colo. 363, 149 P.2d 372 (1944), the Colorado Supreme Court declared that no hospital could ever be liable for the negligence of physicians, even if they were employees, *unless* "it employs those whose want of skill is known, or should be known to it. . . ." *Id.* at 364, 149 P.2d at 374.

¹¹³ *Dayan v. Wood River Township Hospital*, 118 Ill. App. 2d at 269, 152 N.E.2d at 208.

¹¹⁴ Southwick, *The Hospital's New Responsibility*, 17 CLEV.-MAR. L. REV. 146, 161 (1968).

¹¹⁵ Rapp, *Darling and its Progeny: A Radical Approach to Hospital Liability*, 60 ILL. B.J. 883, 892-93 (1972).

¹¹⁶ One of these, *Utter v. United Hospital Center, Inc.*, 236 S.E.2d 213 (W. Va. 1977), evinces a similar fact situation to *Darling*. *Utter* fell from a ladder, sustain-

One case concerned an attempt by one Dr. Moore to regain privilege revoked for incompetence. In *Moore v. Board of Trustees of Carson-Tahoe Hospital*,¹¹⁷ Moore, a Board-certified obstetrician-gynecologist,¹¹⁸ sought to regain his medical and surgical privileges at the defendant hospital. A district court denied his request, and the Nevada Supreme Court affirmed the denial.¹¹⁹ A series of events were involved in the medical process which apparently culminated in Dr. Moore attempting to induce spinal anesthesia in a patient while not wearing surgical gloves—after repeatedly handling the needle with his bare hands.¹²⁰ Two days later, he was barred from performing a scheduled operation, and a hearing to cancel his privileges followed.

As in *Darling*, the court found that medical staff bylaws, established by the hospital, governed the plaintiff's conduct.¹²¹ Significantly, the court went a bit further: "The delegated power to establish admission standards for medical staff members impliedly includes the power to

ing multiple injuries, and his right arm was put in a cast from shoulder to hand. Within forty-eight hours, his arm was "swollen, black, very edematous and that there was a foul-smelling drainage emitting therefrom; that he maintained a high temperature and was sometimes delirious." *Id.* at 215.

The treating physician was notified by the nurse, but he did nothing. At that point, the nurses did not contact the chief of staff, although their nursing manual required them to do so.

The West Virginia court had no difficulty attributing liability to the hospital, noting that the hospital is charged with knowledge in the delivery of medical services. *Id.* at 216, citing *Duling v. Bluefield Sanitarium*, 149 W. Va. 567, 142 S.E.2d 754 (1965).

¹¹⁷ *Moore v. Board of Trustees of Carson-Tahoe Hospital*, 88 Nev. 207, 495 P.2d 605, cert. denied, 409 U.S. 879 (1972).

¹¹⁸ "Board certified" in this discussion means that Dr. Moore had passed the examination in clinical medicine given by the American Board of Obstetrics and Gynecology, Inc. This is not an inconsequential feat, and a physician who is Board certified in a specialty is *prima facie* considered to be among the best qualified of the practitioners in that specialty. The circumstances of the *Moore* case suggest that his incompetence was induced, not that competence was never acquired.

¹¹⁹ 495 P.2d at 606.

¹²⁰ A dissenting opinion by two justices calls this an isolated incident, and notes that "every professional man errs from time to time." They miss the point of the "incident." Moore's act was so egregious that first year medical student would know better than to do what he did. The likely outcome of his blundering, for the patient, was bacterial meningitis arising from penetrating the spinal canal with the contaminated needle. The fact that the patient did not succumb was due either to Moore's failure to actually penetrate the canal, or, more probably, the prompt administration of antibiotics by other physicians. DRIPPS, ECKENHOFF & VANDAM, INTRODUCTION TO ANESTHESIA 78-81 (1977). The dissent's colloquy also points to a major problem in medical negligence cases: the failure of lawyers to adequately explain, and of judges to study, the medical facts and consequences, prior to applying decisional rules to those facts.

¹²¹ See note 108 *supra* and accompanying text.

continue to regulate membership after admission."¹²² That this regulation meant individual monitoring of physician performance was not left to speculation:

Today, in response to demands of the public, the hospital is becoming a community health center. The purpose of the community hospital is to provide patient care of the highest possible quality. To implement this duty of providing competent medical care to the patients, it is the responsibility of the institution to create a workable system whereby the medical staff of the hospital *continually reviews and evaluates the quality of care* being rendered within the institution.¹²³

An extension of this idea appeared four years later in the Supreme Court of Arizona. In *Tucson Medical Center, Inc. v. Misevch*,¹²⁴ a hospital sought to block discovery of a massive collection of incident reports and medical review committee minutes concerning the repeated negligent conduct of an anesthesiologist whose negligence, while under the influence of alcohol, caused the death of a plaintiff's wife. The action was declined in lower court, and taken on appeal to the Arizona Supreme Court, which remanded and ordered that discovery be allowed.¹²⁵ In passing on the disquieting facts of the case, the court specifically noted the utility and probative value of Joint Commission on Accreditation of Hospitals regulations and their use in formulating rules by which a continuing quality review of physicians could occur.¹²⁶ If the medical staff was negligent in seeing that the review process was implemented, or that deficiencies in individual physicians were not corrected, then the hospital was corporately liable for the negligence of the medical staff.¹²⁷

This judge-made rule, that the medical staff is the agent of the governing body, was developing simultaneously in other jurisdictions. In *Joiner v. Mitchell County Hospital Authority*,¹²⁸ the Georgia Court of Appeals made it clear that the governing body could not disassociate itself from the medical staff on grounds of medical ignorance when questions of an independent duty of care to the patient arose.¹²⁹ Plaintiff took her husband to defendant's emergency room after he complained of chest pains. After a cursory examination, the physician on duty (not a hospital employee) told the patient that his condition was not serious,

¹²² 88 Nev. at 208, 495 P.2d at 607.

¹²³ *Id.* at 211, 495 P.2d at 608 (emphasis added).

¹²⁴ 113 Ariz. 34, 545 P.2d 958 (1976).

¹²⁵ *Id.*

¹²⁶ 113 Ariz. at 36, 545 P.2d at 960.

¹²⁷ *Id.* at 37, 545 P.2d at 960.

¹²⁸ 125 Ga. App. 1, 186 S.E.2d 307 (1971), *aff'd sub nom.*, Mitchell County Hospital Authority v. Joiner, 229 Ga. 140, 189 S.E.2d 412 (1972).

¹²⁹ 186 S.E.2d at 209.

and that he should return home. He did, but his condition worsened, and he died within two hours. Plaintiff's wrongful death action was rebuffed at the lower court, which granted summary judgment for the hospital. In reversing for plaintiff, the court of appeals noted:

The Authority seeks to absolve itself from liability in that it leaves the screening of candidates for the admission to the medical staff of the hospital to the existing members of said staff, which is composed of doctors already admitted thereto. This is not defensive, as these members of the staff are agents of the Hospital Authority, and it is responsible for any default or negligence on its part in properly selecting new members of this staff.¹³⁰

The Georgia Supreme Court, in affirming, formed that holding into a test of liability for the defendant hospital:

If the physician was incompetent, and the Authority knew or from information in its possession such incompetency was apparent, then it cannot be said that the Authority acted in good faith and with reasonable care in permitting the physician to become a member of its staff.¹³¹

Having the medical staff as agent of the governing board was a concept adopted for osteopathic hospitals in *Purcell v. Zimbelman*.¹³² There was strong evidence of notice of Purcell's incompetence as a surgeon; he had been sued by four patients prior to the subject case, and all five actions concerned the same type of surgical error.¹³³ The hospital was accredited by the American Osteopathic Association which prescribed that the governing board had to accept responsibility to select medical staff members who "are professionally competent and will offer optimum patient care. . . ."¹³⁴ There was testimony from outside experts and from a medical staff member that the custom in osteopathic hospitals so accredited was to establish review committees and examine privileges, and to make recommendations on the termination or refusal of privileges. The explanation offered in the case of the errant surgeon was that two of his cases which resulted in suit had been presented to the surgical review committee, but nothing happened and no recommendations were made to the governing body. Since the governing body did not know about Dr. Purcell's propensity to be incompetent, they were not negligent in failing to curtail or remove his privileges.¹³⁵ This argu-

¹³⁰ *Id.* at 307, 308.

¹³¹ 189 S.E.2d at 414.

¹³² 18 Ariz. App. 75, 500 P.2d 335 (1972).

¹³³ *Id.* at 81, 500 P.2d at 340.

¹³⁴ *Id.* at 83, 500 P.2d at 341.

¹³⁵ *Id.* This argument had been advanced successfully in a similar case, *Hull v. North Valley Hospital*, 159 Mont. 375, 498 P.2d 136 (1972), where the Montana

ment was rejected by the court, utilizing a theory similar to that used in the *Joiner* case.¹³⁶ The medical staff, after all, was the agent of the governing board, and they were to make recommendations on the qualifications of individual physicians. If they were negligent in making recommendations, then their negligence was directly imputable to the governing board.¹³⁷

The Ohio Supreme Court was not unmindful of the trend toward a new doctrine of hospital liability when it decided *Khan v. Suburban Community Hospital*.¹³⁸ The plaintiff had been a practicing surgeon at the defendant hospital, but was advised his privileges would be terminated when new medical staff bylaws were adopted. There was never a question of lack of competence on his part; his foreign medical training made it difficult to gain admission to the certification examination which would qualify for the new privileges.¹³⁹ He sued to regain his privileges, but the trial court found that they had been removed via a proper hearing and the denial should stand. The court of appeals reversed, reasoning that while the criteria imposed by the board were not unreasonable, a test of outcome should override such criteria where, as in the instant

Supreme Court acknowledged that the governing body of a hospital could act to curtail a physician's privileges; but the court also noted that the hospital's governing body could not act unless and until it had been notified by the medical staff. Absent such notification it was not negligent for the governing body to do nothing.

¹³⁶ *Purcell v. Zimbelman*, 18 Ariz. App. at 83, 500 P.2d at 341.

¹³⁷ *Id.* A different approach to the question of medical staff negligence was taken by the plaintiff in *Corleto v. Shore Memorial Hospital*, 138 N.J. Super. 302, 350 A.2d 534 (1975). As in the previous cases, the defendant physician was alleged to have been grossly incompetent, and to have a history of negligent acts which the hospital was aware of or should have been aware of. The unique feature of the case was that the entire medical staff of the hospital—some 141 physicians—were joined as defendants by referring to them as an incorporated association. This action engendered a veritable firestorm of criticism. See e.g., Note, *Hospital May Be Held Liable for Permitting Incompetent Independent Physician to Operate*, 8 RUT.-CAM. L.J. 177 (1977); see also Zaslow, *A New Reason for Liability: Hospital Staff Membership*, 5 J. LEGAL MED. 20 (1977).

The case did not live up to expectations, however; the published proceeding was a denial of an interlocutory motion to dismiss, and before trial the physician's insurance company settled—therefore, the question was not passed on. See Horty and Mulholland, *The Legal Status of the Hospital Physician*, 22 ST. LOUIS U.L.J. 485, 487 (1978). These authors argue persuasively that the joinder of the entire staff would never have worked, since the staff did not meet the requirements of an unincorporated association. *Id.* at 499. They also note that a claim based on hospital liability for individual medical staff failure to recommend credential changes is neither prohibited, nor unreasonable. *Id.* at 498 n.67.

¹³⁸ 45 Ohio St. 2d 39, 340 N.E.2d 398 (1976).

¹³⁹ Although plaintiff had extensive surgical experience and training in the English-speaking world, the American Board of Surgery would not let him sit for the examination. Whether he would have passed it was never considered, although it seems likely that he would have. This seems to represent less an attempt to engage in a restraint of trade than an attempt at "restraint of trade."

case, plaintiff had satisfactorily performed general surgery for four years at defendant's hospital.¹⁴⁰ In reversing the court of appeals, the Ohio Supreme Court noted that the power of the governing body of the hospital, which derives from statute, must be controlling:

The great weight of case authority in the United States is that a board of trustees of a private hospital has the authority to appoint and remove members of the medical staff of the hospital and to exclude members of the medical profession in its discretion from practicing in the hospital. And, the action of hospital trustees in refusing to appoint a physician to its medical or surgical staff, or declining to renew an appointment that has expired or changing the requirements for staff privileges, is not subject to judicial review.¹⁴¹

Significantly, the court, citing *Darling* and *Joiner*, recognized the reason for this power: "[H]ospital governing boards are responsible for upgrading the standards of health care to be maintained in a hospital."¹⁴² Thus, the Ohio court seems to have laid the groundwork for an independent duty of care doctrine with the recognition that hospitals must be free to curtail the privileges of those physicians who cannot provide quality care to their patients.

The latest case to expand independent duty of care also serves as an example of the grossest type of hospital failure. In *Johnson v. Misericordia Community Hospital*,¹⁴³ a surgeon applied to the defendant hospital for privileges in orthopedic surgery. He listed several hospitals as references; two had never heard of him, and his privileges had been cancelled at the others. He was given full privileges at Misericordia with no investigation by the hospital administration, and even became chief of the medical staff. Plaintiff-patient sued the surgeon after he performed an operation on plaintiff's hip which resulted in severe damage including permanent muscle atrophy.

The hospital's principal defense was that while it might have had a moral duty to recruit competent medical staff members, it had no legal duty to do so. The defendant-hospital cited provisions of the Wisconsin Administrative Code which spoke to the ability of the governing body to exercise its privilege function.¹⁴⁴ The court of appeals, sustaining a verdict against the hospital, was not impressed:

¹⁴⁰ 45 Ohio St. 2d at 44, 340 N.E.2d at 402.

¹⁴¹ *Id.* at 44, 340 N.E.2d at 402. This is not *strictly* true because the court made it clear that any action to change a physician's privileges must conform to due process requirements, and to the rules of the hospital. *Id.*

¹⁴² *Id.* at 44-46, 340 N.E.2d at 402-03.

¹⁴³ 97 Wis. 2d 521, 294 N.W.2d 501 (1980).

¹⁴⁴ *Id.* at 530, 294 N.W.2d at 506.

Misericordia consciously disregarded the welfare of patients who came to the hospital for treatment. One of the basic tenets of a hospital's existence is to provide optimal patient care. When a hospital negligently fails to exercise reasonable care in selecting physicians for appointment to its staff, it fails in its responsibility to patients and violates the very purpose for which it was established. *Patients necessarily rely on hospitals to monitor the quality of care rendered in their facilities.*¹⁴⁵

This position is the pinnacle of contemporary thought on the responsibility of the hospital to the public. It is judicial recognition that a hospital must make an effort to provide quality medical care since patients expect and deserve quality care from a hospital.

Darling makes clear that a hospital must follow its own internal rules and guidelines in carrying out its duty to its patients. However, it has since become evident that this alone will not suffice: An incompetent physician could remain on the staff and harm many patients. The case which proved that this could happen was *Gonzales v. Nork*.¹⁴⁶ In the words of the trial judge, the case was a "Grand Guignol of horror."¹⁴⁷ The defendant-physician, Dr. John Nork, was not a drug addict, mentally ill, or a sociopath; he was simply a horrible blunderer.¹⁴⁸

The particular aspect of the case which startled medico-legal commentators was that the defendant hospital, operated by the Sisters of Mercy of Sacramento, California, was a member in good standing of the Joint Commission on the Accreditation of Hospitals. For all the years that Dr. Nork had been bungling surgeries, the Joint Commission had surveyed and resurveyed the hospital, always giving it highest marks for quality

¹⁴⁵ *Id.* at 565, 294 N.W.2d at 523 (emphasis added).

¹⁴⁶ See text accompanying note 94 *supra*.

¹⁴⁷ The choice of words by Judge B. Abbott Goldberg, sitting as the trier of fact, was unfortunately appropriate. In the course of trial, evidence was adduced pointing to Dr. Nork's grossly negligent treatment of thirty-eight patients, on whom fifty unnecessary operations had been performed. The human suffering caused by him is staggering. Note, *Hospital Liable for Surgeon's Admittedly Unnecessary Operations*, 29 THE CITATION 18-19 (1974); S. LAW & S. POLAN, PAIN AND PROFIT: THE POLITICS OF MALPRACTICE 216-17 (1978) [hereinafter cited as PAIN AND PROFIT] (quoting the trial court opinion of *Gonzales v. Nork* and Sisters of Mercy, No. 228856 (Superior Court of Sacramento County, Cal., Nov. 23, 1973).

¹⁴⁸ PAIN AND PROFIT, *supra* note 147, at 217, quoting the trial court opinion of *Gonzales*. The defense of drug addiction which Dr. Nork offered was overcome by the testimony of his wife and seventeen co-workers who had both intimate contact with him and the training to permit them to detect such a problem. This point is important to an understanding of the case: Dr. Nork was not substance-addicted—he was a horrible incompetent, whose incompetence was known to some who did not speak, and unknown to others who should have made it their business to discover his faults.

of care.¹⁴⁹ The adherence of Mercy Hospital to Joint Commission standards was never disputed. However, as Dr. Nork's full history of conduct unfolded, it became clear that compliance with these standards could not itself serve as a defense.

In attacking the hospital's position that it had no basis to assume that Dr. Nork would negligently treat the plaintiff,¹⁵⁰ a group of thirteen former patients of Dr. Nork were presented by Gonzales' counsel. Each one had been needlessly operated on by Dr. Nork, and each left the hospital in a worse condition than when he entered. In one case, a tissue sample from the patient was noted by the hospital pathologist¹⁵¹ as "a mass of white fibrotic material . . . 12 mm in diameter . . . bundles of

¹⁴⁹ The reader may imagine the effect that the case had on the Joint Commission. With its honor and reputation at stake, it sent a high ranking officer and nationally known surgeon, Dr. Reed Nesbitt, to testify at the trial about accreditation procedures. His testimony, unfortunately, confirmed that safeguards built into the existing surveillance programs were incapable of detecting incompetent physicians like Dr. Nork. *Id.* at 229.

¹⁵⁰ The position taken by the hospital becomes virtually transparent considering the facts of the *Gonzales* case, which resembled in many details other of Dr. Nork's surgical misadventures. Mr. Gonzales was a gardener who consulted Dr. Nork in November, 1967, with complaints of low back pain. After only a cursory physical examination, Dr. Nork rendered a provisional diagnosis of what in lay terms would be called a "slipped disk." He placed Mr. Gonzales in traction for one week, which resulted in a dramatic improvement in symptoms—an outcome which should have indicated that the provisional diagnosis was in error. Next, although there was no justification for it, Dr. Nork ordered that a myelogram, a special X-ray view of the spine, be taken. The radiologist who interpreted it found absolutely no indication of a disc problem; Dr. Nork stated that *he* saw one, and suggested surgery. When Gonzales declined, Nork alternately cajoled and threatened him until he succumbed. The operation lasted longer than it should have, and required far more blood than necessary, because Dr. Nork had to perform two ancillary operations for bone grafts to complete the repair of the vertebral column. Mr. Gonzales' postoperative recovery was stormy and long, and when finally discharged, he was in worse pain than when he first consulted Dr. Nork.

Unhappily, the story does not end there. Mr. Gonzales could no longer work because of his constant pain, and he came, in time, to distrust all physicians. As a result, when he developed testicular cancer, he did nothing. When the pain of that disease became unbearable, and he sought assistance, he had passed the point where a cure could be hoped for. PAIN AND PROFIT, *supra* note 147, at 217-29, quoting the trial court opinion of *Gonzales*.

¹⁵¹ Since its inception more than twenty-five years ago, the Joint Commission has included among the standards for pathology services that all tissue removed from a surgical wound would be examined by a physician pathologist and a diagnosis rendered to be entered in the patient's chart. This standard seems to have originated as an early attempt to check unnecessary surgeries: If a tissue committee saw that a surgeon was taking out too many healthy gall bladders, for example, the suggestion might be made that he should employ greater diagnostic acumen before recommending surgery. JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS 139 (1976).

myelinated nerve fibers. . . ."¹⁵² Dr. Nork had cleanly severed one of the main nerve trunks leading from the spinal cord to the voluntary muscles, *instead* of performing his stated operation, removal of vertebral bone to reduce pressure on the spinal cord.¹⁵³ *Despite* the existence of a Medical Audit and Tissue Committee at Mercy Hospital which was directed to report and review findings of "all tissue with discrepancies between preoperative and postoperative diagnoses,"¹⁵⁴ no action was ever taken against Dr. Nork. Indeed, there is no indication that the Committee ever took notice of Nork's incompetence, even though the Hospital's pathologist was repeatedly confronted with the evidence.¹⁵⁵

Drawing on the wisdom of *Darling*, *Moore* and *Purcell*, Judge Goldberg found that Mercy Hospital had breached its duty to Mr. Gonzales by not removing Dr. Nork from its staff.¹⁵⁶

I have reached the conclusion that the hospital is liable with great reluctance, because I am sure that the Sisters of Mercy have done everything within their power to run a proper institution. But they, like every hospital governing board, are corporately responsible for the conduct of their medical staff.¹⁵⁷

¹⁵² PAIN AND PROFIT, *supra* note 147, at 222, quoting the trial court opinion of *Gonzales*.

¹⁵³ There was no objective indication for the operation. As with so many other of Dr. Nork's patients, the myelogram was absolutely normal. *Id.*

¹⁵⁴ *Id.*

¹⁵⁵ If the reader finds this surprising, it should be noted that because of the social and ethical dynamic of medicine, hospital society had developed complex rules of behavior which render this kind of response from the pathologist not at all unlikely. There is, as medical sociologists have pointed out, profound reluctance of physicians to criticize one another openly. This may be due in part to the realization that every physician has committed serious, perhaps fatal, errors. Consequently, any sort of "review" session, whether tissue committee or department rounds, becomes an exercise in diplomacy, not fact finding. The argument to justify this conduct seems two-fold. On the one hand, staff members may seek to keep an incompetent physician so that he does not admit cases elsewhere, where others may not be able to cover his mistakes. On the other hand, there is really no need to have "review" meetings because if the competent physician makes an error, he will modify his behavior; if the incompetent physician errs, no amount of criticism will change his actions. M. MILLMAN, *THE UNKINDEST CUT* 99-100, 130-33 (1977).

¹⁵⁶ Ludlam, *The Impact of the Darling Decision Upon the Practice of Medicine and Hospitals*, 11 *FORUM* 756 (1976).

¹⁵⁷ *Id.* at 759. Mercy Hospital did not appeal the trial judge's decision, and as a result of which it was to pay \$2 million in compensatory and punitive damages. Dr. Nork appealed on the question of whether his waiver of a jury trial had been knowledgeable, and won a reversal and a new trial. 60 Cal. App. 2d 829, 131 Cal. Rptr. 717 (1976). An appeal was taken by plaintiff to the California Supreme Court, which reversed on the waiver issue, and remanded to the appellate court

It is important to note that corporate responsibility does *not* mean that the hospital is a guarantor of good results for all medical acts. What it does mean is that the governing body must ultimately bear the responsibility for the shortcomings of its medical staff. The governing body should prevent incompetent or marginally competent physicians from obtaining or retaining privileges.¹⁵⁸

The Joint Commission on the Accreditation of Hospitals was stunned by the *Nork* case, and set about revamping its programs thereafter. The pre-*Nork* Professional Education Program was replaced in 1974 with the Performance Evaluation Procedure for Auditing and Improving Patient Care (PEP).¹⁵⁹ A subsequent reorganization in 1976 yielded the Quality Resource Center (QRC), which consolidated auditing and training activities.¹⁶⁰ The impetus for new regulations culminated in a major reorganization of the *Accreditation Manual for Hospitals*, the source document for Joint Commission compliance guidelines.¹⁶¹ Included in the regulations effective in April, 1976, were requirements that all physicians in any department be members of the medical staff;¹⁶² that the clinical activity of all physicians be subject to continuous review;¹⁶³ and that such review extend to all departments, including emergency, outpatient, and home care services.¹⁶⁴ A significant regulation provides that

with directions to consider *Nork's* appeal only as to substantive merit. 20 Cal. 3d 500, 573 P.2d 458, 143 Cal. Rptr. 240 (1978).

The failure of *Mercy* to appeal is apparently a calculated technique to see that the findings of the trial court do not rise to the level of appellate court law. Note, *Piercing the Doctrine of Corporate Hospital Liability*, 17 SAN DIEGO L. REV. 383, 386 n.16 (1980). Nonetheless, the actions of the hospital have proven costly. In addition to a \$500,000 payment to settle the *Gonzales* action, they have paid \$875,000 in settlement of six additional cases involving Dr. *Nork*, and made guarantees of \$3.65 million in eighteen others, in the event Dr. *Nork's* insurance company does not pay. *Id.*

¹⁵⁸ The reader may wonder what the State of California was doing while Dr. *Nork* was in practice at *Mercy Hospital*. The State of California did nothing. Dr. *Nork*, in fact, was still in the active practice of surgery in Martinez, California, in 1976, even though the California Board of Medical Examiners had full knowledge of all Dr. *Nork's* malpractice suits and the amount of damages which were awarded after January, 1971. PAIN AND PROFIT, *supra* note 147, at 238.

A citizen of Ohio has, at this writing, virtually no statutory protection from outrageous practitioners. The omnibus medical licensing bill which was supposed to correct serious deficiencies in the Ohio Medical Board was defeated in a rush to adjourn the 1980 legislative session. The Plain Dealer, Jan. 18, 1981, at 4-AA, col. 1. As of April 1982, no remedial action had been taken.

¹⁵⁹ JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, PERSPECTIVES ON ACCREDITATION, MAY-JUNE 1976, at 1.

¹⁶⁰ *Id.*

¹⁶¹ JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS (1976).

¹⁶² *Id.* at 103.

¹⁶³ *Id.* at 108.

¹⁶⁴ *Id.* at 79, 111.

"[e]ach member of the medical staff shall be qualified for membership, and for the exercise of the clinical privileges granted to him."¹⁶⁵ It should be apparent that such a standard, if applied, would have prevented the injuries described in *Purcell, Nork* and similar cases. The Joint Commission has taken great pains to clarify this important standard:

[T]he granting of such privileges is based on each individual's current competence. . . . Privileges should also be related to an individual's documented experience in categories of treatment areas or procedures *and to the results of treatment, as shown in patient care evaluation studies*. . . . [I]f based primarily on experience, the individual's credentials file should reflect the specific experience *and successful results* that form the basis for the granting of privileges.¹⁶⁶

The pertinent question is whether all these Joint Commission guidelines and judge-made standards have improved the quality of medical care in American hospitals. There is no simple answer. In hospitals with a weak administrator and a strong medical staff, there is probably no change from pre-*Darling* practices. Similarly, there is no reason to improve care in the hospitals too small for Joint Commission membership, which may not fall under any but the most cursory state scrutiny.¹⁶⁷ The hospitals in this latter category can still qualify for Medicare/Medicaid funding, but the main concern of that program is to shorten the length of hospital stays to decrease costs; quality is a secondary consideration.¹⁶⁸

¹⁶⁵ *Id.* at 103. The regulation, while not new to the 1976 compilation, has received increased attention.

¹⁶⁶ JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, PERSPECTIVES ON ACCREDITATION, MARCH-APRIL 1976, at 1, 6 (emphasis added).

¹⁶⁷ The conditions of participation for Medicare/Medicaid, set out in 42 C.F.R. § 405.901 (1980), provide that a hospital qualifies for benefits either by accreditation, if a member of the Joint Commission; by approval of a Medicare surveillance team; or by certification by the state's hospital licensing authority that the hospital is in substantial compliance with the Conditions of Participation. The difficulty of qualifying through the latter route is obviously not great, and not uniform from state to state.

¹⁶⁸ The effectiveness of Professional Standards Review Organizations was studied in a joint project by the American College of Physicians, the American Hospital Association, the American Society of Internal Medicine and the American Association of Foundations for Medical Care. The study was underwritten and coordinated by the Kellogg Foundation. The results of the study were sobering, but not unanticipated; as a quality assurance bureaucracy, the PSRO concept was felt to be the best model yet formulated, but found *never* run in a way to achieve even modest improvements in health care delivery. In addition, it does not reach into the consideration of non-Medicare cases, although that was a hoped-for goal. FEDERATION OF AMERICAN HOSPITALS, 12 REVIEW 51, 53 (1979).

It remains the responsibility of the courts to say what the duties of hospitals shall be where the hospitals will not do so themselves.¹⁶⁹ This is not an easy task. Some courts have declined to make public policy pronouncements about hospital duty, opting for noninvolvement.¹⁷⁰ In the *Hannola* decision, the court of appeals took the higher road, and did make a statement about what the patient should be entitled to. It is the nature of the *Hannola* court's position, and the facts which gave rise to it, which are now appropriate to consider.

V. THE *HANNOLA* CASE—RESTATEMENT OF PATIENT'S RIGHTS

The facts of *Hannola* resemble many domestic emergencies. Prior to March 19, 1976, the deceased, Paavo Hannola, enjoyed good health and had no history of serious illness.¹⁷¹ About the noon hour on March 19, he experienced a sudden onset of dizziness, headache, and a feeling of numbness in his right arm; his wife, Liisa, was so alarmed by these symptoms that she took him to the emergency department of Lakewood Hospital.¹⁷² He was seen sometime after 12:10 p.m. by Dr. Milton J. MacKay, a physician-employee of West Shore Medical Care Foundation, Inc. (West Shore), which was under contract to provide emergency room physicians to Lakewood Hospital. As a condition of his employment with West Shore, Dr. MacKay was a member of the Lakewood Hospital Medical Staff.¹⁷³

The nature of the physical examination given by Dr. MacKay is unclear; however, he apparently ordered skull and head X-rays.¹⁷⁴ Alleged-

¹⁶⁹ This position is not inconsistent with cases like *Kahn v. Suburban Community Hospitals*, 45 Ohio St. 2d 39, 340 N.E.2d 398 (1976), where the Ohio Supreme Court stated that judges should not tell physicians how to govern themselves. Indeed, so long as quality of patient care is not adversely affected, courts have a duty not to interfere, but the courts necessarily must invade the sanctity of hospital bureaucracy when the governing body permits the medical staff to ignore its general duty of care in such a way as to threaten public health and safety.

¹⁷⁰ See, e.g., *Hull v. North Valley Hospital*, 159 Mont. 375, 498 P.2d 136 (1972).

¹⁷¹ Brief of Plaintiffs-Appellees at 4, *Hannola v. City of Lakewood*, No. 80-804 (Ohio Sup. Ct., May 28, 1980) [hereinafter cited as Brief of Plaintiffs-Appellees].

¹⁷² Lakewood Hospital is not-for-profit corporation owned and operated by the City of Lakewood, Ohio. Affidavit of Duane Horning, Administrator; Brief of Defendants-Appellants at 48, *Hannola v. City of Lakewood*, No. 80-804 (Ohio Sup. Ct., May 28, 1980). At the time of this incident, it was classed by the American Hospital Association, of which it was a member, as a general-medical surgical hospital for short-stay cases of less than thirty days; it was also accredited by the Joint Commission on the Accreditation of Hospitals, and reported 11,282 admissions to its 382 beds with expenses of \$1.9 million and a payroll of \$1 million for the 1976 reporting year. AMERICAN HOSPITAL ASSOCIATION, GUIDE TO THE HEALTH CARE FIELD 170 (1977).

¹⁷³ See Brief of Plaintiffs-Appellees, *supra* note 171, at 2.

¹⁷⁴ *Id.* at 4.

ly, Dr. MacKay neither performed a neurologic examination nor requested consultation.¹⁷⁵ About 3:00 p.m. Dr. MacKay discharged Mr. Hannola with a prescription for pain medication and advised him to see his private physician.

Mr. and Mrs. Hannola returned home, but thereafter Mr. Hannola experienced what are described as "two grand mal seizures."¹⁷⁶ Mr. Hannola was taken back to the Lakewood Emergency Room, and again Dr. MacKay examined him. Dr. MacKay then asked Dr. Lehtinen, a staff neurosurgeon, to consult. The two decided to admit Mr. Hannola. Subsequently, Mr. Hannola became unresponsive and died on April 5, 1976.¹⁷⁷ The available medical data indicated death was due to a ruptured saccular aneurysm.¹⁷⁸

Mrs. Hannola, as executrix of the estate of Paavo Hannola, filed a wrongful death action against Dr. MacKay, West Shore and the City of Lakewood, Ohio, on January 26, 1977.¹⁷⁹ Her pleading alleged essentially two theories against all defendants: (1) that they were negligent in discharging her husband from the emergency department in the face of his symptoms; and (2) that they were negligent in not calling for consultation when he was first seen in the emergency department.¹⁸⁰ These acts were alleged to be below the anticipated standard of care for the community of physicians and for an institution such as Lakewood Hospital.¹⁸¹ In a supplemental affidavit of March 3, 1978,¹⁸² plaintiff related that she believed from all appearances that Dr. MacKay was an employee of Lakewood Hospital.

Three arguments were raised by the defense in seeking dismissal of the hospital. First, neither the hospital nor the City of Lakewood controlled or had a right to control Dr. MacKay or West Shore. Thus, there

¹⁷⁵ *Id.*

¹⁷⁶ *Id.*

¹⁷⁷ *Id.*

¹⁷⁸ *Id.* at 31, § 7. A saccular or "berry" aneurysm is a weakened portion of an artery in the brain which has been distorted by the pressure of blood into a sac-like configuration. If it bursts, blood is lost into the surrounding tissues and the parts of the brain served by that artery are deprived of nutrients and oxygen; hence, tissue death and brain damage follow.

The saccular aneurysm is a well-recognized medical event. Mr. Hannola's symptoms at his first appearance in the Lakewood Emergency Department are "classic" for this condition. Medical and/or surgical therapy may be employed in treatment depending upon the condition of the patient, although it cannot be assumed in retrospect that any therapy would have been effective. See *Neurological Surgery*, *supra* note 37, at 1660.

¹⁷⁹ *Hannola v. City of Lakewood*, No. 77-965635 (C.P. Cuyahoga County, Jan. 26, 1977).

¹⁸⁰ Brief of Plaintiffs-Appellees, *supra* note 171, at 31.

¹⁸¹ *Id.*

¹⁸² *Id.* at 33.

was no arguable basis for vicarious fault, as both were independent contractors.¹⁸³ Second, the mere presence of Dr. MacKay at Lakewood Hospital was not enough to make an apparent agency,¹⁸⁴ and liability could not be imputed to the hospital,¹⁸⁵ since those elements that would show an agency were not proven by plaintiff.¹⁸⁶ The third argument, contradicting an independent duty on the part of the hospital to supervise medical quality as a consequence of its state license to operate,¹⁸⁷ was not dealt with directly, but was merged into the other arguments.¹⁸⁸ The trial court granted defendant's summary judgment motion¹⁸⁹ and denied plaintiff's motion to amend its complaint,¹⁹⁰ and in this posture the case went to the court of appeals.¹⁹¹

The court first dealt with the apparent authority question.¹⁹² The court pointed out that the plaintiff relied on the presence of the

¹⁸³ This question of master, servant and independent contractors is critical to the case and will be discussed in detail below. For a general overview of the law of agency in Ohio, see 3 OHIO JUR. 3d *Agency and Independent Contractors* § 153 (1978), for Ohio law on the control test referred to here. See also *Clark v. Fry*, 8 Ohio St. 358 (1858).

¹⁸⁴ 3 OHIO JUR. 3d *Agency and Independent Contractors* § 82 (1978).

¹⁸⁵ The concept that mere presence does not connote apparent authority or an agency relationship with the situs of action is the principal argument advanced in *Cooper v. Sisters of Charity*, 27 Ohio St. 2d 242, 272 N.E.2d 97 (1971), and was relied on heavily by the *Hannola* defendants. Brief for Appellant, *Hannola v. City of Lakewood*, No. 80-804 (Ohio Sup. Ct., May 28, 1980), at 9, 10, 13. The court of appeals did not reject this principle, but did not reach it in its decision. *Hannola v. City of Lakewood*, 68 Ohio App. 2d 61, 426 N.E.2d 1187 (1980).

¹⁸⁶ Apparent authority (sometimes referred to herein as agency by estoppel) requires a showing of a holding out by a principal that an actor is the ostensible agent of that principal; that a third party relied on this holding out; and that, consequently, the third party was damaged. The acts of the principal follow from common law doctrine that an agent cannot prove his own agency. *Du Bois-Matlack Lumber Co. v. Henry D. Davis Lumber Co.*, 149 Or. 571, 42 P.2d 152 (1935).

¹⁸⁷ OHIO REV. CODE ANN. § 3701.71 (Baldwin 1976) (hospital licensure).

¹⁸⁸ The line of cases put forward by plaintiff advocate an independent duty of care owed by the hospital to its patients. This is generally construed as a duty to supervise staff physicians, and is articulated in the most famous of such cases, *Gonzales v. Nork*, No. 228856 (Sup. Ct. Sacramento County, Cal., Nov. 27, 1973), *rev'd*, 60 Cal. App. 3d 728, 131 Cal. Rptr. 717 (1976), *rev'd and transferred to Court of Appeals for decision on merits*, 20 Cal. 3d 500, 573 P.2d 458, 143 Cal. Rptr. 240 (1978).

¹⁸⁹ Memorandum order of April 3, 1978.

¹⁹⁰ Memorandum order of April 28, 1978.

¹⁹¹ If true, the trial court erred in granting summary judgment because such ruling is proper only when no issues of material fact are in doubt. OHIO R. CIV. P. 56(C); *Harless v. Willis Day Warehousing Co.*, 54 Ohio St. 2d 64, 375 N.E.2d 46 (1978).

¹⁹² In addition to the idea of detrimental reliance set out in *Johnson v. Wagner Provision Co.*, 141 Ohio St. 584, 49 N.E.2d 925 (1943), Ohio courts have held that the omission of a party to act which engenders a notion of apparent

Lakewood Hospital emergency room in her time of need, and that she was not aware of the employment arrangements between West Shore, the Hospital or Dr. MacKay prior to going to the hospital. Once there, she was not informed of the employment arrangements by either hospital personnel or Dr. MacKay.¹⁹³

The court subjected the ostensible agency allegation to the standard of *Rubbo v. Hughes Provision Co.*¹⁹⁴ Under this test, if goods or services are obtainable at one location, from one and only one individual, in the absence of proof of knowledge that the purveyor of goods is not an employee of the establishment, the establishment owner is estopped from denying agency.¹⁹⁵ This test is not strictly applicable to the facts in *Hannola*, for it neglects the fact that the *Rubbo* customer could more easily have gone elsewhere for goods than the Hannolas could have gone elsewhere for medical care.

If the *Gasbarra v. St. James Hospital*¹⁹⁶ disclosure test¹⁹⁷ is truly applicable here, the agency by estoppel contention seems without basis. That is, if there was no express disclaimer, *Gasbarra* requires that the knowledge which was not given—that Dr. MacKay was an independent contractor—must have been a material misrepresentation to the patient in order to find detrimental reliance, and consequently agency by estoppel. If disclosure would not have changed the outcome, or if it is deemed to be immaterial, there is not detrimental reliance.¹⁹⁸

Most courts, in passing on the question of apparent authority, have not taken the position of *Gasbarra*. In *Seneris v. Haas*¹⁹⁹ the facts that the defendant anesthesiologist worked at one hospital, obtained all of his drugs from that hospital and was subject to on-call duty by that hospital were enough for the plaintiff to make at least a *prima facie*

authority vested in an agent of that party in the mind of another party will suffice to make out a question of fact on agency for the jury. *Luken v. Buckeye Parking Corp.*, 77 Ohio App. 451, 68 N.E.2d 217 (1945). The acts of the agent, however, will not by themselves make out the apparent authority; there must be a representation by the principal. *Lodgsdon v. Main-Nottingham Investment Co.*, 103 Ohio App. 233, 141 N.E.2d 216 (1956). Having permitted the manifestations of apparent authority to occur, the principal is thereafter bound by them. *Miller v. Wick Bldg. Co.*, 154 Ohio St. 93, 93 N.E.2d 467 (1950).

¹⁹³ 68 Ohio App. 2d at 64, 426 N.E.2d at 1189.

¹⁹⁴ 138 Ohio St. 178, 34 N.E.2d 202 (1941).

¹⁹⁵ *Id.* ¶ 1 of the syllabus.

¹⁹⁶ 85 Ill. App. 3d, 406 N.E.2d 544 (1979).

¹⁹⁷ See notes 74, 83 *supra* and accompanying text.

¹⁹⁸ Here, too, there is another public policy argument. *Should* a hospital be permitted to disclaim an agency with its emergency room physicians, if it could? How would it be done? Verbal disclaimers, printed forms or signs would not be enough. If the object was to return freedom of choice to the patient, there would have to be advanced notice, which does not seem likely.

¹⁹⁹ 45 Cal. 2d 811, 291 P.2d 915 (1955).

showing of an agency relationship between the hospital and physician. In other cases, a physician "director" of an emergency room, who was guaranteed a minimum wage by the provider, was found to be an agent of the hospital despite a specific contract disclaimer.²⁰⁰ The Maryland Court of Appeals in *Mehlman v. Powell*²⁰¹ used logic very similar to that of the Ohio Supreme Court in *Rubbo v. Hughes Provision Co.*²⁰² to hold that a "full service" hospital which made no showing of separate legal status between emergency physicians and the hospital was estopped from denying an agency relationship.

These cases do not address the matter of disclosure—indeed, they avoid it. If the requirement of detrimental reliance is actually necessary to show an agency as in the *Hannola* case, however, it is demonstrable. The detrimental reliance—or, by another name, the material misrepresentation—was not a failure to identify Dr. MacKay as an independent contractor. It was, rather, a failure to disclose what steps, if any, the hospital had taken to grant him privileges such that he could practice there. Likewise, it was a misrepresentation to fail to disclose his history of malpractice suits, if any. Further, it was a breach of duty to represent that his presence was not influenced by pecuniary factors which may have overridden the hospital's quality of care. There was a manifold absence of information given to the patient. By the requirements of *Johnson v. Wagner Provision Co.*,²⁰³ this failure establishes an agency by estoppel, and provides the plaintiff with a theory of recovery.

The strongest reason for making out an agency in emergency room cases such as *Hannola* is, simply, public policy. The individual patient has no way to determine qualifications of emergency physicians; he is a captive consumer. He might never select a particular emergency facility if given a choice. It does not seem just to permit a hospital to haphazardly staff its emergency department and then disclaim any responsibility for the physicians who practice there, when it is only by the grace of the hospital that physicians' privileges to engage in such practice are given, and when the hospital "solicits" for the patients who come there.

The defense position on vicarious fault as a matter of the "employment" status was next considered by the court. The hospital asserted that since there was no right to "control" Dr. MacKay,²⁰⁴ there was no

²⁰⁰ *Mduba v. Benedictine Hospital*, 52 A.D.2d 450, 384 N.Y.S.2d 527 (1976).

²⁰¹ 281 Md. 269, 378 A.2d 1121 (1977).

²⁰² See note 198 *supra* and accompanying text.

²⁰³ 141 Ohio St. 584, 49 N.E.2d 925 (1943), at ¶ 4 of the syllabus.

²⁰⁴ *Councell v. Douglas*, 163 Ohio St. 292, 126 N.E.2d 597 (1953). If the court could reach employment principles under *Councell*, they would have gone further by relying on *Sears v. Cincinnati*, 31 Ohio St. 2d 157, 285 N.E.2d 732 (1972), holding that a municipal corporation, owner of a hospital, is liable to third persons for negligent hospital employees.

basis to assert vicarious liability.²⁰⁵ This type of argument has been advanced in other cases; the premise is that the hospital is merely a conduit for the physician's work, and is not accountable for his negligence.²⁰⁶ An important factor which, regrettably, the *Hannola* court did *not* consider, is that "control" has *never* been a factor of employment where physicians were concerned. In cases such as *Lundberg v. Bay View Hospital*,²⁰⁷ *Klema v. St. Elizabeth's Hospital*,²⁰⁸ *Rush v. Akron General Hospital*²⁰⁹ and *Koubeck v. Fairview Park Hospital*,²¹⁰ the negligence of physician-employees was imputed to the hospital with no allegation, suggestion or fact of control of the physician by the hospital.

The *Hannola* court, utilizing the contract between the two corporations as a vehicle, *created* control by the hospital over the physician and West Shore.²¹¹ The court noted that Article 7 of the contract provided that West Shore employees must be Lakewood Hospital medical staff members,²¹² implying that this bargaining piece ceded power to the hospital. However, since Joint Commission standards mandate such membership,²¹³ this hardly seems to be a concession. Such provisions are customary in all medical staff bylaws, and mere hospital committee membership by a physician is certainly not sufficient to establish vicarious liability.

The court's discussion of the hospital's independent duty of care has important precedential value; it found that this duty attached to the power granted to the governing body by the state, which in turn was used to grant or withhold privileges of physician members of the medical staff.²¹⁴ What was not stated, but what should be remembered by other courts, is that the hospital's independent duty of care is discharged *only* when hospitals abide by their own internal rules, including the Joint Commission and Medicare/Medicaid standards. Thus, when the conduct of a hospital is considered, attention must be given to its record of doing

²⁰⁵ 68 Ohio App. 2d at 66, 426 N.E.2d at 1191. The basis of liability under the control test is the ability of the principal to direct his agent toward or away from the negligent situation. *Clark v. Fry*, 8 Ohio St. 358 (1858).

²⁰⁶ See, e.g., *Moon v. Mercy Hospital*, 150 Colo. 430, 373 P.2d 944 (1962).

²⁰⁷ 175 Ohio St. 133, 191 N.E.2d 821 (1963).

²⁰⁸ 170 Ohio St. 519, 166 N.E.2d 765 (1960).

²⁰⁹ 84 Ohio L. Abs. 292, 171 N.E.2d 378 (1957).

²¹⁰ 84 Ohio L. Abs. 585, 172 N.E.2d 491 (C.P. Cuyahoga County 1960).

²¹¹ 68 Ohio App. 2d at 68-69, 426 N.E.2d at 1192.

²¹² *Id.*

²¹³ JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS 70 (1976). The standard predates the 1976 major accreditation revision, and came about with the increased popularity of independent contractor emergency room groups.

²¹⁴ See *Kahn v. Suburban Community Hospital*, 45 Ohio St. 2d 39, 340 N.E.2d 298 (1976).

what it said it would do. This amounts to a discarding of the "locality" rule of hospital practice²¹⁵ which courts have uniformly discarded in connection with physicians.

Perhaps the greatest impact of the *Hannola* case is in the implicit recognition that there are minimum attainable standards of *hospital-based* care which are achievable and to which a hospital should be held as a matter of public policy. It is not proper to make the hospital an absolute guarantor. Furthermore, it is incorrect to assume it should be responsible for treatment rendered by a private physician to a private patient, unless either an employee of the hospital was also negligent or it knew the physician was incompetent. When the hospital *creates* the health delivery environment—as in the emergency room—it removes the element of free choice from the patient, and also forecloses any ability of the patient to decline treatment (by virtue of the patient's own condition). Public policy demands that a hospital have a duty to provide the patient with the best medical care by all appropriate means including, notably, adherence to Joint Commission quality review standards.

The court of appeals decision in *Hannola*²¹⁶ preceded another potentially useful medico-legal doctrine in Ohio by a few months. In effect, this latter pronouncement changed corporate director and trustee statutory obligations under sections 1701.59 and 1702.30 of the Ohio Revised Code.²¹⁷

²¹⁵ See generally Southwick, *The Hospital's New Responsibility*, 17 CLEV.-MAR. L. REV. 146 (1968). A better rule of Ohio law for holding the hospital liable for the acts of emergency department physicians is set out in *Strayer v. Lindeman*, 68 Ohio St. 2d 32, 427 N.E.2d 781 (1981). Demised premises were damaged by the negligence of an independent contractor hired by the landlord to make repairs. Upon affirming an award for the tenant, the Ohio Supreme Court noted that when one assumes a duty, either pursuant to statute, by voluntary choice or as an exercise of public policy, it becomes nondelegable, and the actor cannot shield himself from liability for its negligent performance. *Id.*

²¹⁶ 68 Ohio App. 2d 61, 426 N.E.2d 1187 (8th Dist. 1980), *cert. denied*, No. 80-804 (Ohio Sup. Ct., Sept. 12, 1980). The case was subsequently settled.

²¹⁷ 1980 OHIO LAWS, S.B. 174 (amending OHIO REV. CODE ANN. §§ 1701.59, 1701.63, 1702.30 and 1702.33, and enacting § 1702.301; effective Aug. 7, 1980). The relevant sections for this discussion are the modifications to § 1701.59 (authority of directors) and § 1702.30 (authority of trustees). Both code sections are identical in the original and in the amended forms, except for the use of the word "director" in § 1701.59 and "trustee" in § 1702.30. Accordingly, only the text of § 1701.59 will be given here, with amending language in capitals:

(A) Except where the law, the articles, or the regulation require action to be authorized or taken by shareholders, all of the authority of a corporation shall be exercised by OR UNDER THE DIRECTION OF its directors. For their own government, the directors may adopt bylaws THAT ARE not inconsistent with the articles of the regulations.

(B) [Old § 1701.59(B) deleted. New Section (B) added.]

A DIRECTOR SHALL PERFORM HIS DUTIES AS A DIRECTOR, INCLUDING HIS DUTIES AS A MEMBER OF ANY COMMITTEE OF THE DIRECTORS UPON WHICH HE MAY SERVE, IN GOOD FAITH,

These new laws afford relief for breach of corporate duty to those in privity, namely, shareholders or members of nonprofit corporations. They also set forth procedures and sources of information which must be employed in "doing the corporate duty."²¹⁸ As such, they should guide hospital administrators and trustees in their dealings with the medical staff and in fulfilling their independent duty of care to hospital patients. What follows are a few remarks on how those two aims may be effected, in light of both *Hannola* and the revisions in the director/trustee liability statutes.

VI. CONCLUSION: HOSPITAL ACCOUNTABILITY IN OHIO

Guidance has been given to administrators and directors in the running of hospitals from the Joint Commission or Medicare/Medicaid stan-

IN A MANNER HE REASONABLY BELIEVES TO BE IN THE BEST INTERESTS OF THE CORPORATION, AND WITH THE CARE THAT AN ORDINARILY PRUDENT PERSON IN A LIKE POSITION WOULD USE UNDER SIMILAR CIRCUMSTANCES. IN PERFORMING HIS DUTIES, A DIRECTOR IS ENTITLED TO RELY ON INFORMATION, OPINIONS, REPORTS OR STATEMENTS, INCLUDING FINANCIAL STATEMENTS AND OTHER FINANCIAL DATA, THAT ARE PREPARED OR PRESENTED BY:

(1) ONE OR MORE DIRECTORS, OFFICERS OR EMPLOYEES OF THE CORPORATION WHOM THE DIRECTOR REASONABLY BELIEVES ARE RELIABLE AND COMPETENT IN THE MATTERS PREPARED OR PRESENTED;

(2) COUNSEL, PUBLIC ACCOUNTANTS, OR OTHER PERSONS AS TO MATTERS THAT THE DIRECTOR REASONABLY BELIEVES ARE WITHIN THE PERSON'S PROFESSIONAL OR EXPERT COMPETENCE;

(3) A COMMITTEE OF THE DIRECTORS UPON WHICH HE DOES NOT SERVE, DULY ESTABLISHED IN ACCORDANCE WITH A PROVISION OF THE ARTICLES OR REGULATIONS, AS TO MATTERS WITHIN ITS DESIGNATED AUTHORITY, WHICH COMMITTEE THE DIRECTOR REASONABLY BELIEVES TO MERIT CONFIDENCE.

(C) [New section]

FOR PURPOSES OF DIVISION (B) OF THIS SECTION, A DIRECTOR SHALL NOT BE CONSIDERED TO BE ACTING IN GOOD FAITH IF HE HAS KNOWLEDGE CONCERNING THE MATTER IN QUESTION THAT WOULD CAUSE RELIANCE ON INFORMATION, OPINIONS, REPORTS, OR STATEMENTS THAT ARE PREPARED OR PRESENTED BY THE PERSONS DESCRIBED IN DIVISIONS (B)(1) TO (3) OF THIS SECTION, TO BE UNWARRANTED. A PERSON WHO, AS A DIRECTOR OF A CORPORATION, PERFORMS HIS DUTIES IN ACCORDANCE WITH DIVISION (B) OF THIS SECTION SHALL HAVE NO LIABILITY BECAUSE HE IS OR HAS BEEN A DIRECTOR OF THE CORPORATION.

Id.

²¹⁸ *Id.*

dards,²¹⁹ not from case law or statute.²²⁰ This is a deplorable situation because expectations of care have surpassed legal requirements of care; only recently has there been a conscious attempt to unite the two.

Despite some progress, however, the governing body has never been given good policy on what to do with the medical staff. It is clear that all power flows from the governing body ("board," for simplicity), yet no one would suggest an authoritarian type of dictation to hospital physicians.²²¹ At the same time, however, it is clear that a weak, "cosmetic" board is worse than a strong one. Thus, if the institution is left to run itself, monumental mistakes will inevitably occur.²²² This type of *laissez-faire* attitude would also neglect the board's historic responsibility of assuring quality care in the hospital.²²³

²¹⁹ Many medical specialty organizations have their own set of standards, on the theory that the demands of their particular calling require a special commitment to excellence by the hospital. Notable in this regard is the American Board of Plastic and Reconstructive Surgery, Inc., which has waged a spirited campaign against incompetent practitioners and inadequate hospitals.

²²⁰ There are a few notable exceptions to this generalization. See, e.g., STATE OF OHIO, DEPARTMENT OF HEALTH, PUBLIC HEALTH COUNCIL, MATERNITY HOSPITAL RULES (1974).

²²¹ See *Andarsio v. Community Hospital*, No. 1483 (2d Dist. Ohio, Oct. 31, 1980) (OHIO REV. CODE ANN. § 3701.342 (Page 1980), provides the power to change physician privileges and thereby upgrade the quality of care available in the hospital).

²²² See generally notes 35-40, 98-101, 150-55, 171-78 *supra* and accompanying text.

²²³ Southwick, *The Hospital As an Institution—Expanding Responsibilities Change its Relationship with the Staff Physician*, 9 CAL. W.L. REV. 429, 437-38 (1972); Note, *Hospital Credentials Committee*, BULLETIN OF THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, AUGUST, 1963, at 3; Greenville Gas Co. v. Reis, 54 Ohio St. 549, 44 N.E. 271 (1914); Moore, *Medical Staff—Corporate Accountability*, 43 INSURANCE COUNSEL J. 110, 114 (1976). The hospital attorney can be one of the strongest allies of the board if he counsels an honest approach to responsibility, and an open profile, maximizing the public relations benefits of quality care planning. He must also diplomatically meet any frontal attacks on regulations by the medical staff, and avoid participating in any attempts to circuitously bypass legal responsibility.

One of the most striking examples of what *not* to do is set forth in *Lescoe, Regulation of Health Care by Medical Staff Bylaws*, 5 J. LEGAL MED. 17 (Feb., 1977). The author advocates "sanitizing" medical staff bylaws, so that future legal action could not be aided by plaintiff's recourse to those bylaws, as was the case in *Darling*. For example, if the bylaws said that consultation should be requested under certain circumstances (as most do), those words should be stricken, to prevent use of the bylaws in a case where a consultation was not obtained and damage resulted from that failure. *Lescoe* does not mention that this tactic has been tried and it had failed. The Pennsylvania Superior Court, in *Tonsic v. Wagner*, 220 Pa. Super. 468, 289 A.2d 138 (1972), considered a case where a surgeon had left an instrument inside a patient; there was a question of what pre- and post-operative instrument and sponge counts rules had been in effect. The trial court instructed the jury that they could find against the hospital if they found that the hospital negligently failed to make a prophylactic rule.

Compromise seems to have been most often advocated by commentators in discussing the board's responsibility to the staff, because it is likely that challenges will either lead to unseemly litigation²²⁴ or because physicians who see how the board operates may appreciate the complexities of routine operation of the modern hospital.²²⁵ Also, cooperative boards can more easily convince medical staffs to do their bidding,²²⁶ and they make the unpleasant task of discussing self-policing somewhat less odious²²⁷—whether or not any action is taken.

The *Hannola* decision and the new Ohio director/trustee laws threaten to change this pleasant relationship because they mandate board participation in hospital quality assurance. Outside interference in internal governance of a learned profession is certainly never welcome.²²⁸ Yet, not even the most narrow definition of "independent duty" would deny the hospital's (and hence, the board's) fundamental role.²²⁹

This Note disputes Lescoc's opinion, and believes that any hospital which attempts such obvious stonewalling is asking for trouble. A Joint Commission hospital would lose its accreditation, and no hospital could prevail on the trial of such a position.

²²⁴ Note, *A Hospital's Liability for Denying, Suspending and Granting Staff Privileges*, 32 BAYLOR L. REV. 175 (1980).

²²⁵ This may in fact be the wave of the future. Michael D. Bromber, Chairman of the Federation of American Hospitals, stated that increased physician involvement in hospital governing bodies is "a definite check against abuse by non-professionals. . . ." Letter, 304 NEW ENG. J. MED. 233 (1981). The board-staff approach also avoids the problem of what the board says to the public about the hospital, and what it actually does, as reflected by its position in litigation. Leonard, *Independent Duty of a Hospital to Prevent Physician Malpractice*, 15 ARIZ. L. REV. 953, 967 (1973).

²²⁶ Ohio law recognizes that an agent of the board is a useful and necessary adjunct, since the board cannot do all things itself. *Mason v. Moore*, 73 Ohio St. 275, 76 N.E. 932 (1927).

²²⁷ Warren, *The Discipline of Physicians*, 2 J. LEGAL MED. 43 (Sept.-Oct., 1974): The conclusion is inescapable that the published records and reports offer little to show that the house is being kept clean, and rather furnish considerable evidence that existing mechanisms are ineffective. What, then, can be proposed[?]. . . .

[If the definition of *professionalism* includes deserved independence and diligent self-policing, then the failure of existing mechanisms (to impress either the public or the members of the medical profession itself with being effective) invites some critical self-study and organizational self-improvement.

Id. at 46.

²²⁸ Perhaps lawyers would appreciate the plight of physicians more if (1) the incidence of legal malpractice suits approached the true incidence of legal malpractice; (2) the "media" ran exposes on shoddy law offices; and (3) every year, every lawyer's standing in his firm was reviewed by a committee of laymen, who could vote to oust him from the firm. How quickly would a "fortress mentality" develop under those circumstances?

²²⁹ Slawkowski, *Do the Courts Understand the Realities of Hospital Practices?*, 22 ST. LOUIS U.L.J. 452 (1978).

One way of dealing with this new responsibility, of course, is to delegate it. It has been argued that since only physicians know whether their peers are competent, the board should be only a rubber stamp.²³⁰ This leads to the theory that the medical staff should be responsible for retaining a negligent physician, or hiring an incompetent one, and that the board itself should have no liability.²³¹

Reality commands this result will not obtain. The legislature will not rewrite the laws, and power will not flow from medical staff to the board. Public policy suggests that in those areas where the hospital appears to be the primary provider of care—emergency, anesthesia and radiology—direct board action to control and direct the medical staff is long overdue.²³² Boards should utilize the new director/trustee laws as a focus for a frank discussion with the medical staff. Both groups should realize that their duties, enunciated more clearly than before, may not be disregarded and will be examined by courts. If the board takes a cooperative, active role in the process of medical staff review, the staff may be inspired to do a better job out of a sense of competition. On the other hand, if the staff seems less than enthusiastic with the board's new role, they may be reminded that a failure to upgrade standards inevitably means financial losses for both the hospital and the staff.²³³

²³⁰ Lescoe, *Regulation of Health Care by Medical Staff Bylaws*, 5 J. LEGAL MED. 17 (Feb. 1977):

Both medically and legally, the lay members of the governing board are incompetent to pass judgment on the quality of medical care. It would be best that the bylaws recognize this responsibility of the medical staff under the laws of the state. This takes nothing from the governing board. It also gives nothing to it to be used against the self-governing staff at a later date.

Id. at 18.

Lescoe, an attorney and thoracic surgeon, makes a good point when he notes that lay members are not as medically competent as physicians to judge quality of care, but he regrettably overlooks the state of the law. No legislature grants power to a medical staff, nor is it about to; all power flows from the board. Still, he is correct to question competence of board members, which is a serious problem and which deserves attention. See note 104 *supra* and accompanying text. This Note favors the use of arbitrators in the board-staff fights, and the creation of a recognized speciality of medical negligence law, just as admiralty or patent practice is so recognized. Medicolegal practitioners would serve as arbitrators and would probably do the bulk of malpractice and credentials cases. Of course, those who oppose specialization will see this as a "restraint of trade," without considering whether medicolegal specialty practice should be freely attempted by all attorneys, even against the best interest of their clients.

²³¹ Note, *Piercing the Doctrine of Corporate Hospital Liability*, 17 SAN DIEGO L. REV. 383, 399 (1980).

²³² Schagrin v. Wilmington Medical Center, Inc., 304 A.2d 61, 64 (Del. 1973).

²³³ The economic argument is perhaps the most convincing and least heard. If physicians realized that hospital losses meant equipment and facilities lost to them, they might be responsive to changes in medical staff governance.

Liasons to the medical association should be established, so that if a complaint is filed with the association concerning a member, the hospitals at which he practices would also be informed of the filing. These principles are not intended to be encompassing, nor are they in the ambit of legal advice; but they certainly will not harm the hospital's liability posture.

Changes that have occurred in medical negligence law have been made by judges who realized that hornbook law does not give justice to the injured patient.²³⁴ These advances have evoked glowing predictions about what might be done for the patient, and gloomy prophecies about the future of the hospital. The "citadel" of the hospital has not yet crumbled from the outside.²³⁵ If it falls, it will be from within, and it will come from the lack of attention to duty of the governing board and the medical staff.²³⁶ It is inevitable that courts must step in—as the court of appeals did in *Hannola*—to discard antiquated legal constructs which block an injured patient's path to a just recovery for his injuries. The courts must

²³⁴ *Adamski v. Tacoma General Hospital*, 20 Wash. App. 98, 579 P.2d 970 (1978):

The experience of the courts has been that application of hornbook rules of agency to the hospital-physician relationship usually leads to unrealistic and unsatisfactory results, at least from the standpoint of the injured patient. Consequently, we have seen a substantial body of special law emerging in this area; the result has been an expansion of hospital liability for negligent medical acts committed on its premises.

Id.

²³⁵ On the matter of the citadel crumbling, see Zomerski and Spitz, *Liability of a Hospital as an Institution: Are the Walls of Jericho Crumbling*, 16 FORUM 225 (1980). These authors assume that hospitals are headed in the direction of enterprise liability, and must accept the risk for whatever happens within their walls. The enterprise tort has some novel utility here, but this Note suggests it is best reserved for those places where the hospital has actually conducted an enterprise: radiology, anesthesia services and the emergency rooms. Note, *The Hospital-Physician Relationship: Hospital Responsibility for Malpractice of Physicians*, 50 WASH. L. REV. 385, 418 (1975).

²³⁶ This Note suggests that a governing body could have an easier time with its medical staff if it followed some basic rules: (1) "Sanitized" bylaws or rules should not be tolerated under any circumstances. (2) In review of credentials or renewal of privileges, experience should not be confused with competence. Every person experiences a diminution of skills with advancing age. It is unfortunate when a practitioner has to be forceably retired, but it is sometimes necessary. (3) The high risk areas of the surgical service, the intensive care units, and the emergency departments deserve special attention. Since the physicians staffing those services are likely to be more sensitive than others to the issue of quality care, the discussions with them must be tactful, but firm. (4) If physician members sit on credentials committees (as they should), none should be appointed who furnish services to the hospital as members of a professional corporation. The conflicts of interests are too great to be explained, *especially* at trial. (5) A result census should be implemented among the staff, so that at any moment the board may know who has been sued, for how much, the basis of the complaint and the disposition of all such cases.

put an end to parochialism in questions of medical negligence and recognize that hospitals should be held to a single, national standard of care which they have a paramount duty to achieve. The motivation need not be entirely selfless. Judges, like all the rest of us, may sometimes be hospital patients. As potential patients, we all deserve nothing less than excellence.

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* The author wishes to acknowledge the assistance of Robert E. Sweeney Co., L.P.A., and Peter Enslein, Esq., for providing materials on the *Hannola* decision.