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The Hospital’s New Responsibility

Arthur F. Southwick*

The focus for this discussion is the hospital as a corporate institution and its liability for injuries caused a patient or visitor. The fundamental question is: What legal duties does the hospital and its personnel owe the patient or the visitor?

To attempt an answer to this question one must first have an understanding of the role and nature of a hospital in modern society. It would seem that the primary purpose of every non-profit, community hospital is to provide patient care of the highest possible quality. As will be noted, significant and influential court decisions have asserted, in effect, that a hospital is directly responsible to the patient for providing competent medical care. Accordingly, failure on the part of the hospital to control adequately medical staff appointments and privileges, to “supervise” the attending physician in certain circumstances, to require the attending physician to seek consultation in problem cases, and to remove him from a case in extreme situations may result in legal liability.

A hospital does not, therefore, consist of two organizations—business and medical. Rather, it is a single organization. Legally, the medical staff is “subservient” to the Board of Trustees in that the Board is ultimately responsible for medical staff appointments and privileges, the rights and responsibilities provided for in the medical staff by-laws, and discipline of staff. In other words, ethically and legally, the Board of Trustees is responsible for the institution’s standards of patient care. From a de-facto point of view, as well as legal, both the public and medical profession view the hospital as an institution where medical care is provided and not simply as a place where an unorganized group of private physicians care individually for their patients.

Hence, professional standards become a joint problem of hospital administration and medical staff. The matter of medical standards cannot be separated from business administration. It serves no purpose for the hospital to blame the doctor or the doctor to blame the hospital and its employees when accidents occur in the course of rendering patient care. In short, the doctrine that the attending physician is an independent contractor, the borrowed servant rule and the argument that the institution has no direct corporate duty to provide medical care are defenses that are being circumvented by the courts in hospital liability cases. In any

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event, both attending physicians and the hospital are likely defendants in any suit. To blame each other in a public courtroom serves the interest of no one.

Accordingly, lay hospital administration must be aware of newly developing medical standards and encourage the medical staff to adopt the higher standards. The courts are measuring the existing standards of individual hospitals against institutions in remote areas. The "community" is now nation-wide. In effect, the courts are saying that hospitals and medical staff must adopt the "best" methods of professional standards and not average methods or local community methods. To illustrate, in Favalora v. Aetna Insurance Company, the court said that the practice of a radiologist not to check the medical history of patients was unreasonable even though it was not customary in the local community for similarly situated radiologists to make such a review. This was especially so when medical school training recognizes the community's practice as faulty. Likewise it was held in Kolesar v. United States, and Kapuschinsky v. United States, that it was no defense to argue that the accepted standard of care is measured by prevailing practices within the local community. Professor David W. Louisell and Harold Williams, M.D. have written that "... courts are becoming increasingly aware of the reality that medical standards are approaching uniformity nationwide." In Riley v. Layton, it was said that the standard for a general practitioner in a large city was comparable to that expected of a general practitioner in a small town. Hence, a San Francisco physician was permitted to testify as an expert witness in a malpractice action against a practitioner in a small Utah community. Similarly, the Washington court has said that the expert testimony of a doctor who practiced in another state in a city 50 miles from the town where the patient was treated was admissible to establish local standards.

Moreover, standards promulgated by private bodies such as the Joint Commission on the Accreditation of Hospitals and by public licensing authorities can now be considered in the courtroom as evidence of acceptable standards. Whether or not these standards have been met is a question for the jury, and juries are not sympathetic to deviation from standards established by reliable private or public authorities. The re-

1 144 So.2d 544 (La. App. 1962).
4 Louisell & Williams, Trial of Medical Malpractice Cases 211 (1960).
5 329 F.2d 53 (10th Cir. 1964).
7 Darling v. Charleston Community Hospital, 33 Ill.2d 326, 211 N.E.2d 253 (1965).
result is that hospital administration must make every conceivable effort to see that accreditation and licensing standards are being followed by both lay and professional personnel.

It is, therefore, readily apparent that the trend in the courts of pace-setting jurisdictions indicates that the historical separation of hospital administration, on one hand, and clinical medicine, on the other, is being obliterated. The trend is thoroughly consistent with the realities of modern medical practice. To be sure, this is a very difficult problem for the lay hospital administrator and the nursing staff of the institution. Joint, mutual problems must be solved by having well-trained nursing staff, an energetic chief of staff, and responsible medical staff committees acting in the interest of the hospital as an institution.

The concept advanced here that a hospital as an institution establishes, or at least is legally responsible ultimately for the standards of medical care practiced within its walls, is further illustrated in the recent New York litigation entitled Fiorentino v. Wenger. In this action against a physician and a hospital to recover damages for the wrongful death of a minor, the evidence showed that the doctor had developed a surgical procedure that was not the generally accepted treatment in the community for the patient's condition and was a procedure utilized only by the defendant physician. In at least five of thirty-five previous cases unexpected and untoward results had occurred. The attending physician, who was a private practitioner and not an employee of the hospital, failed to disclose the novelty of the procedure and the risks thereof to the parents of the patient. In affirming a trial court judgment against both the attending surgeon and the hospital, the appellate division held that the hospital as an institution had a duty to ascertain whether or not the physician had made full disclosure and obtained from the patient, or his authorized representative, an informed consent before permitting the operation to take place. A dissent as to the judgment against the hospital argued that the majority decision rendered the institution a guarantor of the conduct of all staff doctors whether employees or not. On appeal to the New York Court of Appeal, the judgment against the hospital was reversed. Clearly, the surgeon was liable for failing to obtain informed consent. The court then addressed itself to the extent of the hospital's duty. There was, on these facts, no duty to obtain a second consent, to verify the one received by the surgeon, or to go behind the signed consent form filed in the medical record. However, the court acknowledged "that a hospital may be liable in tort for permitting its facilities to be used by an unlicensed person or by a licensed person committing an act of malpractice with the knowledge of the hospital or under circumstances putting

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9 35 Law Week 2632 (1967).
it on notice of such wrongful act.”\textsuperscript{10} With respect to the instant litigation the court concluded that “liability does not attach to the hospital unless it knew or should have known that there was lack of informed consent or that the operation was not permissible under existing standards.”\textsuperscript{11} Accordingly, even though there was not liability in this case, it appears that there can be liability wherever the administration of the hospital knows, or should know, that independent staff physicians are departing from acceptable standards of care, or not obtaining an informed consent for surgical procedures. It therefore seems to be perfectly clear that the lay administration of the hospital cannot ignore or close its eyes to what is going on professionally within the walls of the institution.

**Fault as the Basis for Hospital Liability**

Traditionally and historically, most hospital liability has been based upon the concept of fault. Litigation is generally founded upon tort law—either negligence or assault and battery causes of action. The lack of informed consent cases are actually founded on assault and battery, although some courts call these actions “malpractice.” The wrong occurs whenever any treatment, or drug, is administered in the absence of an emergency without the consent of the patient or his authorized representative. In a negligence action, a plaintiff must generally allege and prove that somebody—the hospital as an institution or an employee of the hospital for whose actions the hospital is vicariously liable—was negligent. “Malpractice” is simply the negligence of a professional individual and, as shall be seen, there are many situations where the hospital will be liable for the negligence of a professional person.

In a case founded upon negligence, the plaintiff must prove that a duty was owed, that there was breach of duty which caused the plaintiff injuries, and that the plaintiff was free from contributory negligence. The fault concept is illustrated by a recent trial court decision in Cook County, Illinois. In the litigation, the hospital and the attending physicians were not liable for the side effects of tissue necrosis when the drug Levophed was injected to save the life of a patient in shock. A directed verdict for the defendants was held to be proper.\textsuperscript{12}

However, sometimes the doctrine of *Res Ipsa Loquitur* applies in negligence actions. For example, *res ipsa* has been applied in medication cases where an injection caused injury under circumstances where common knowledge indicated that no harm would normally result unless the administration was unskilfully done.

\textsuperscript{10} Ibid.

\textsuperscript{11} Id. at 2633.

\textsuperscript{12} D’Ford v. Evanston Hospital, No. 60C-8069 (Cook County Cir. Ct., 1966).
In general, res ipsa will apply against the hospital and/or the attending doctors whenever the patient was unconscious or otherwise incapacitated so that he is unable to prove what happened, where the injury is of a kind that even laymen know does not happen unless someone has been negligent, where the defendant had exclusive control of the instrumentality causing the injury, and where there has been no contributory negligence. The application of the doctrine assures the plaintiff of reaching the jury and requires the defendant to dispel the inference of negligence. To illustrate, res ipsa was applied in a recent Wisconsin case against both the physician and the hospital when the plaintiff was burned during surgery.\textsuperscript{13} The Montana court permitted the doctrine where the plaintiff suffered a broken arm during a grand mal seizure occurring when she was either unconscious or under the influence of drugs following a surgical hysterectomy.\textsuperscript{14} It was said that it was not necessary for the plaintiff to prove the precise "thing" that caused her injury and that the hospital nurses were the "instrumentalities" whose negligence could have caused or contributed to the injury.

Liability of the hospital—or that of the professional individual, the doctor, the pharmacist or the nurse—has not, therefore, generally been based on breach of contract or warranty. Existence or non-existence of a contractual relationship between the plaintiff and defendant is usually immaterial. The concepts of contractual warranty and strict liability have not as yet come to the field of hospital and professional liability. Of course, it is sometimes possible for a cause of action to sound and succeed in contract. If a physician should promise or warrant a cure or specific result, the door is open for the plaintiff to base his cause of action in contract. For example, in Noel v. Proud,\textsuperscript{15} the doctor promised that ear surgery would not worsen the plaintiff's condition. It was found that he had made a contract to this effect and accordingly, the contract statute of limitations applied to the action and not the tort statute of limitations. But, in general, as in Benson v. Mays,\textsuperscript{16} a patient's suit for damages against a hospital and/or professional individuals sounds in tort despite contract allegations in the complaint and is thus governed by the rules of negligence.

In the blood transfusion-serum hepatitis cases brought against hospitals and blood banks, the courts have traditionally held that there is no cause of action based upon warranty or promise that the blood administered was fit for the purpose intended.\textsuperscript{17} The rationale of these

\textsuperscript{13} Beaudoin v. Watertown Memorial Hospital, 32 Wis.2d 132, 145 N.W.2d 166 (1966).
\textsuperscript{14} Gormley v. Montana Deaconess Hospital, 423 P.2d 301 (Mont. 1967).
\textsuperscript{16} 227 A.2d 220 (Md. App. 1967).
decisions has been that the defendant furnishes blood as a part of its service and does not sell blood. The courts have thus proceeded on the assumption that a warranty attaches only to a sale of a product. Moreover, the courts have traditionally said that the transfusion of blood is a matter of service even if a hospital should make a specific charge for the substance. These cases are also, of course, relevant to drugs furnished to the hospital patient. However, recent Florida cases brought against blood banks signify a change of attitude, at least as to the type of defendant involved in the litigation. In Russell v. Community Blood Bank, the appellate court said the transaction was arguable as a sale and that there should be no distinction between commercial manufacturers of food and drugs and a blood bank which supplies blood. A new trial was ordered on the issue of whether the harmful substance could be scientifically removed from the blood. In Hoder v. Sayet it was said that a blood bank’s furnishing of blood to a patient for a consideration is regarded as a “sale” to which a warranty can attach but that no cause of action for breach of warranty can be stated against a hospital since as to the hospital there is no sale of blood.

It would seem that the traditional rationale of the courts to the effect that a hospital furnishes blood and drugs as a part of its service, rather than selling the substance, or drug administered to the patient, is not necessarily sound reasoning but is simply one means of achieving the desired result. The true basis for these decisions would rather seem to be that the courts have not as yet come to the point where they are willing to say that a hospital should be liable in a blood or drug case on the basis of warranty or non-fault concept of liability. The prevailing decisions would seem to be founded simply upon public policy dictating that a hospital should not be liable unless somehow there was human fault.

Corporate Negligence and Vicarious Liability

Hospital liability is based on either corporate negligence or vicarious liability. The latter, of course, is the doctrine of respondeat superior. Under respondeat superior an employer is liable for the tort of an employee committed within the scope of employment. At times courts seem to confuse these two separate bases for liability.

In only a very few states is a charitable non-profit hospital immune from all types of tort liability. In contrast, some states still adhere to

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18 185 So.2d 749 (Fla. App. 1966).
19 196 So.2d 205 (Fla. App. 1967).
20 Massachusetts, South Carolina, Missouri and Maine are examples of total charitable immunity. See, Decker v. Bishop of Charleston, 147 S.E.2d 264 (S.C. 1966); and Koprivica v. Bethesda General Hospital, 410 S.W.2d 84 (Mo. 1966). In Maine a statute permits recovery only to the extent of liability insurance coverage. See, Rhoda v. Aroostock General Hospital, 226 A.2d 530 (Me. 1967).
the doctrine of charitable immunity for liability based upon respondeat superior while holding the hospital liable for corporate negligence. In these jurisdictions, it becomes a matter of crucial importance, therefore, whether the basis for liability is vicarious or corporate. In the majority of states the charitable hospital is fully liable to both patients and visitors whether the theory of liability is respondeat superior or corporate negligence.

In corporate negligence, although human error is involved, the hospital itself as an entity or as an institution, is negligent and liability attaches directly to the hospital. In other words, the hospital owes a duty directly to the patient and these duties are non-delegable to the medical staff or to other professional personnel. The Connecticut court defined corporate negligence as follows, "Corporate negligence is the failure of those entrusted with the task of providing the accommodations and facilities necessary to carry out the charitable purpose of the corporation, to follow in a given situation the established standard of conduct to which the corporation should conform." Therefore, with respect to corporate negligence the legal question becomes what duties does the hospital owe directly to the patient?

Traditionally and historically, the situations illustrating corporate negligence are three in number. The first is the duty owed to all invitees to exercise reasonable care with respect to the maintenance of buildings and grounds. Local statutes may prescribe the standards expected and a violation of the statutory standards can be negligence per se. In the absence of a statutory standard the hospital must exercise reasonable care and, generally, the plaintiff must prove that the defendant through its employees knew or should have known of a defective or dangerous condition likely to cause injury. Frequently, these issues become jury questions as in Ackerberg v. Muskegon Osteopathic Hospital, and Wheeler v. Monadnock Hospital. In Ackerberg, the Michigan Supreme Court said that the issue of negligence was for the jury when a father, who had taken his daughter to the hospital emergency room, became dizzy and stepped outside through an unmarked door onto an unguarded platform and fell to the ground 2 1/2 -3 feet below the platform. In the New Hampshire case, a six year old child visitor to the hospital fell from an unprotected retaining wall seven to nine feet in height and the evidence at trial tended to show that the hospital knew of the danger.

21 Indiana, Texas and Connecticut.
22 Recent decisions repudiating charitable immunity are: Bell v. Presbytery of Boise, 421 P.2d 745 (Idaho 1966); Myers v. Droza, 141 N.W.2d 852 (Neb. 1966); and Rabon v. Rowan Memorial Hospital, 152 S.E.2d 485 (N.C. 1967). 
23 Bader v. United Orthodox Synagogue, 172 A.2d 192, 194 (Conn. 1961).
The second direct duty of the hospital to the patient is in regard to the furnishing of defective or inadequate equipment. There would seem to be at least two prongs to this duty. First, the hospital is said to have a duty to exercise reasonable care in the selection of equipment for the purpose intended, and secondly, the hospital must exercise reasonable care with respect to maintenance of the equipment to assure proper operation. For example, the hospital was liable in South Highlands Infirmary v. Camp, for furnishing a surgeon an instrument used for the removal of skin which had a defective spring. The hospital had not examined the instrument before it was given to the doctor and it argued that it had no duty to do so. The court rejected this argument saying that there can be liability for failure to exercise reasonable care in furnishing equipment fit for the uses and purposes intended. In Milner v. Huntsville Memorial Hospital, a heavily sedated patient was given a heating pad with three manual settings and suffered severe burns after a night of use. Nobody knew how the control was changed to “high” but the burns could have been prevented by covering the pad with a towel regardless of the setting or a particular setting could have been secured by covering the control button. Consequently, it was error for the trial court to give a summary judgment for the hospital. Rather, it was a question of fact for the jury whether or not the hospital had failed in its duty to provide reasonably safe equipment for a sedated patient. Of course, the hospital does not guarantee that all equipment will work perfectly; there was no liability when a glass thermometer broke while being shaken down by a nurse. The court observed that the hospital had carried out its duties by furnishing standard equipment, by making reasonable inspections, and by remedying any defects discoverable by such inspections. Moreover, there is no duty to furnish the newest, most modern equipment on the market.

There can be liability if a hospital does not have the equipment and facilities necessary to treat adequately the patient’s case. For example, there was liability in a California case when a patient with third degree burns was retained in the hospital for 53 days and the institution did not have facilities for the “open” method treatment of burns or for skin grafting. The court said the hospital failed to have the equipment reasonably necessary for treatment required by the patient and under these circumstances there was a duty to transfer the patient to another hospital. In Ball Memorial Hospital v. Freeman, a paying outpatient was

26 180 So.2d 904 (Ala. 1965).
31 245 Ind. 71, 196 N.E.2d 274 (1964).
injected with a fluid labeled "Novocain." The label had been affixed by a hospital employee and was inaccurate. In this case involving the administration of a wrong medication it was alleged by the plaintiff that his injuries were caused by the negligence of the institution in improperly arranging and implementing the method or the system for the preparation and dispensing of novocain. A jury verdict for the plaintiff was upheld upon appeal. The Indiana court said that the failure to employ proper instrumentalities and facilities in the preparation, bottling and dispensing of medications constituted negligence on the part of the hospital. Moreover, the doctrine of *res ipsa loquitur* applied because the hospital had complete control and dominion over the instrumentality causing the injury. The surgeon had done nothing to change the character of the solution and the crystals used in mixing the preparation were not defective in any way. The dissent held the case to be one of vicarious liability, or liability for the negligence of servants of the hospital, and maintained that charitable immunity applied. In contrast, the majority of the court seemed to extend the idea of corporate negligence and this is the clear trend in other decisions. In a Texas case a hospital maintaining a pharmacy was liable on the theory of corporate negligence when it failed to employ a licensed pharmacist in violation of standards established by the Joint Commission on Accreditation of Hospitals and the American Hospital Association.\(^{32}\)

The third type of case illustrating corporate negligence is the failure on the part of the hospital to exercise reasonable care in the selection of or the retention of personnel.\(^ {33}\) What is proper care is often a case for the jury to determine. This direct duty to the patient has relevance to the employment of pharmacists, medical technicians, nurses, and other professional personnel in the hospital. Certainly, the administration must check references, credentials, background, and the training of all people employed. Furthermore, the administration must make certain that its in-service training programs are operating and up-to-date. An employee should be discharged or transferred when he cannot do the job assigned. Moreover, professional individuals might be liable for failure to supervise properly those for whom they are responsible. For example, the director of nursing, or pharmacist, could be individually liable for the failure to exercise reasonable care in the assigning of duties to subordinates, the assessing of qualifications, and in the supervision of employees within his department or area of concern.

**The Hospital's Vicarious Liability**

Hence, historically, courts have not said that the hospital as an institution has a direct duty to exercise reasonable care in providing patient  

care since corporate negligence has been limited in scope. Traditionally, professional people care for the hospital patient. But the hospital can be liable vicariously for the negligence of a professional employee under the doctrine of respondeat superior providing there is no prevailing doctrine of hospital immunity and providing also that the individual is an actual or apparent employee presumably under the control of the hospital, acting within the scope of his employment at the time of his negligent act or omission.

For the purposes, then, of the doctrine of respondeat superior, or vicarious liability, the question becomes, who is a hospital employee? Traditionally, the test has been the right to exercise control with respect to the hospital employee’s responsibilities. In general, a staff doctor, having no more relationship to the hospital than the right to treat private patients is not an employee of the institution; rather, the cases in the past have said that he is an independent contractor. Therefore, the hospital is not liable for his professional negligence or malpractice.

However, a salaried arrangement between the hospital and the doctor might well change this conclusion. The clear trend in hospital administration is to increase the number of situations in which a doctor is on full or part-time salary. Furthermore, resident and intern physicians are generally considered as employees and the hospital is liable for their malpractice. In the case of a resident or an intern the patient has not employed the physician; often the resident or intern is on salary. The courts, in short, ignore professional status when evaluating the position of a house physician. By the weight of authority this is true even when a medical act results in injury to the patient.34

Moreover, the doctrine of apparent or ostensible agency might change the conclusion that a physician is not an employee of the hospital for whose malpractice the hospital need not answer. Where the hospital leads the patient to believe that a professional person is its employee, then the legal result will be that the hospital is liable for his negligence. Certainly the tendency is to expand the number of situations where the doctrine of apparent agency applies. In the leading California case of Seneris v. Haas,35 the hospital was liable for the negligence of an anesthesiologist. The anesthesiologist worked only at the defendant hospital and was one of six such men on call. The hospital had procured the services of the physician for the patient and although the doctor billed the patient himself it became a jury question as to whether or not the patient was led to believe that the professional individual was an employee of the institution. Similarly, an Ohio hospital was liable for the negligence of an independent pathologist. The hospital was estopped from

34 Klema v. St. Elizabeth’s Hospital, 170 Ohio St. 519, 166 N.E.2d 765 (1960).
asserting the defense of independent contractor because it had represented to the patient that the doctor was in the employ of the institution.\(^{36}\) A recent Montana case further illustrates the doctrine. In \textit{Kober v. Stewart},\(^{37}\) the hospital's X-Ray department was operated under contract with a private clinic. The clinic supplied a qualified radiologist as the department’s director and was paid 35\% of the gross receipts. The hospital hired all X-Ray technicians, owned the equipment, and made the charge to the patient. The patient had no contract with the radiologist. The hospital called the doctor to read the patient's films. It was held to be error for the trial court to give a summary judgment for the hospital on the basis that the radiologist was an independent contractor and that it became an issue of fact for the jury to determine whether or not the doctor was an agent or a servant of the hospital.

Although a few states still draw a distinction between medical and administrative acts as a means of determining the right of control and hence whether a professional person is an independent contractor or not, the clear trend since the landmark case of \textit{Bing v. Thunig},\(^{38}\) in New York in 1957, is to ignore any distinction between medical and administrative acts. In general, therefore, we can safely say that the independent contractor doctrine as a defense for the hospital is dying.

It is perfectly clear that nurses are employees of the institution when performing their routine nursing functions. They are in control of the hospital even when performing a professional act. Therefore, in most instances, the hospital is clearly liable for a nurse’s medication error and it would seem that nurses must know the fatal dosage of all drugs and be familiar with the usually acceptable rules and routes of drug administration. The nurse’s duties to the patient as an employee of the hospital include the obligation to notify hospital administration if she knows or should know in her professional judgment that the doctor is not caring for his patient properly.\(^{39}\) Therefore, nurses have a duty to challenge physicians, to inquire regarding a doctor's care, and, especially, to inquire regarding prescriptions of medications, whenever they as professional individuals know or should know that the physician's judgment is not right or that his prescription is wrong or not clear. In \textit{Norton v. Argoaut Insurance Company},\(^{40}\) an infant died from an overdose of digitalis administered by injection. In this litigation, the defendants were the hospital, the nurse, and the attending physician. A trial by jury resulted in a judgment for the plaintiff against all the defendants. The evidence

\(^{36}\) Lundberg v. Bay View Hospital, 175 Ohio St. 133, 191 N.E.2d 821 (1963).
\(^{37}\) 417 P.2d 476 (Mont. 1966).
\(^{38}\) 2 N.Y.2d 656, 143 N.E.2d 3 (1957).
\(^{40}\) 144 So.2d 249 (La. App. 1962).
showed that the patient had been receiving the drug orally. On one particular occasion, the doctor wrote a prescription as follows, “Give 3 cc. lanoxin today for one dose only.” Apparently he intended the medication to be administered in oral form. Instead it was given by the nurse by injection and proved to be a fatal overdose. The nurse had not called the attending doctor for clarification. She was not even aware that the drug came in the oral form. She was, however, aware that the prescription was a large dose; indeed, she had asked two other doctors for clarification and they told her, in effect, that if the prescribing physician ordered the medication then she should administer the prescription. Judgment was affirmed against the doctor because testimony showed that the better practice is to specify the route of administration of such a drug; judgment was affirmed against the nurse as she was negligent in attempting to administer a drug with which she was not familiar; and, finally, judgment was affirmed against the hospital on the doctrine of *respondeat superior* because the nurse was acting as an employee of the hospital at the time of her negligence. In general then, *respondeat superior* is applied to the hospital in situations involving the negligence of nurses.

Clearly, the hospital pharmacist is an employee of the institution and therefore should he be negligent, the institution would be liable for his tort. In addition, of course, the pharmacist himself would be personally responsible.

**Borrowed Servants Doctrine**

The borrowed, or loaned, servant doctrine holds that a resident physician, nurse, or some other individual usually in the employ of the hospital may temporarily become an employee under the control and supervision of another. When the doctrine applies the new employer is liable for the negligence of the employee pursuant to the doctrine of *respondeat superior*. The determining factor in the application of the borrowed servant doctrine is, in theory, the right to control and direct the means and methods of the servant’s work. It is clear, however, that the mere fact that a doctor orders or prescribes treatment or medication does not make the person carrying out the order a borrowed servant of the physician thereby making the physician an employer of the negligent individual.

In the hospital field the assumption has been made from time to time that a given individual can have only one master or employer at a time. Hence, in some cases it has been said that if the hospital employee temporarily becomes an employee of the attending physician who himself is an independent contractor, then the hospital is insulated from liability.  

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41 Minoque v. Rutland Hospital, 119 Vt. 336, 125 A.2d 796 (1956). Patient’s rib fractured by hospital nurse who was assisting doctor during obstetrical delivery. Nurse was held to be a “borrowed servant” and the doctor was liable for her negligence.
This, however, would seem to be an erroneous assumption. The Restatement of the Law of Agency, Section 226, indicates that a given employee can have two masters at once. Hence, an employee can serve both masters or at least can serve the mutual interests of two employers, and, therefore both employers can be liable for the employee’s negligence. A recent hospital case has followed this duo-master concept by holding that a hospital employee participating in a surgical operation was under the concurrent control of the hospital and an independent anesthesiologist. It was said that the patient was entitled to go to the jury on the case against the hospital for nerve injuries sustained while under anesthesia.

In any event, however, it is clear that the fact that the doctor orders or prescribes treatment or medication does not make the person carrying out the order a borrowed servant of the physician. Normally, of course, the physician is not physically present at the time of drug administration. To illustrate, in Honeywell v. Rogers, an infant patient suffered paralysis of the left leg and it was claimed that the injury was the result of a hypodermic injection given by a nurse. A physician had ordered the medication and even sketched instructions for its administration. The technique of administration was known to the nurse and practiced in the hospital. It was held that the doctor was not responsible. There was no evidence of any personal negligence on the part of the physician in writing the prescription or issuing instructions. Moreover, the nurse was not a borrowed servant of the doctor because he did not control the administration of the medication. A similar case was Bria v. St. Joseph’s Hospital, where it was said on appeal that the jury should have been instructed by the trial court that the doctor was not liable under the doctrine of respondeat superior when he ordered that a certain injection be given the patient and injury resulted when the hypodermic needle penetrated the sciatic nerve. In other words, these cases have said that the borrowed servant rule does not apply to non-surgical medication cases involving negligent administration. The hospital is liable for the nurse’s error but the attending physician is not responsible unless he is personally negligent in the preparation of the prescription or order.

The borrowed servant rule has been applied in surgical room situations where the surgeon in charge has the right to control all members of the surgical team. In this litigation a surgeon completing a caesarian section was liable for the negligent act of an intern putting silver-nitrate into the eyes of the newborn infant. In actuality, the surgeon had no

42 Dickerson v. American Sugar Refining Co., 211 F.2d 200 (3rd Cir. 1954).
45 220 A.2d 29 (Conn. 1966).
physical control over the intern's act but it was said that he had ultimate supervisory control and the right and responsibility to give orders to the intern. Sometimes it has been held that the surgeon in charge is "Captain of the Ship" and hence is responsible for all that goes on within the operating suite.

There is evidence that courts are abandoning the captain of the ship notion and this would seem to be the clear trend of the decisions as substantive law changes permitting the hospital to be held liable. For example, in *French v. Fisher*, a surgeon was not liable for a nurse's mistake in a sponge count. She was, in other words, doing the count while under the general control of the hospital. To the same effect is *Danks v. Maker*. Similarly, the hospital was liable for the negligence of personnel in permitting a weak patient to fall and faint while standing in the X-Ray department. The hospital employees were not acting under the direct supervision and control of the doctor and therefore it was the hospital that was liable and not the doctor. In *Salgo v. Stanford*, the surgeon was not liable for the negligence of an anesthesiologist, and in *Thompson v. Liliehei*, the surgeon was not liable for the act of other physicians on the surgical team. In the latter case all members of the surgical team were on salary from the hospital and all were assigned to their separate roles by the head of the department of surgery.

In *Davis v. Wilson*, a hospital technologist had mislabeled bottles of blood with the result that incompatible blood was given to the patient causing his death. The court held that the negligent technologist was not the employee of the hospital pathologists and that, therefore, they were not liable for her negligence under the doctrine of *respondeat superior*. The pathologists were paid by the hospital by check as regular employees. They had supervisory responsibility for the work of the laboratory employees but the latter had also been hired by the hospital and were therefore hospital servants and not the servants of the pathologists.

These cases all indicate that borrowed servant is a dying defense so far as the hospital is concerned. The fundamental trends in the law of hospital liability clearly show that the institutionalization of medical care results in the institutionalization of liability.

**The Institutionalization of Medical Care and Liability**

Does a hospital, therefore, have a direct duty to furnish competent medical care? The most significant case indicating that it does is *Darling*...
In this litigation a young man was brought to the emergency room of a small community hospital having suffered a fractured leg during a football game. A general practitioner, Dr. Alexander, was the physician on emergency call duty and he set the patient's leg with the help of the hospital's employees. The patient later lost his leg due to a circulatory impairment from compression by swelling and hemorrhage, constricted by the plaster cast. For several days the patient had complained bitterly of pain; the nurses had noticed that the toes of the patient were turning blue; and it was general knowledge throughout the hospital that the doctor was having difficulty with the case. Suit was brought against both the physician and the hospital. The former settled the claim against him and was dismissed as a defendant in the litigation. The case against the hospital was taken to trial and the jury found in favor of the plaintiff. Allegations against the institution included claims that the hospital had permitted an unqualified doctor to do orthopedic surgery, that the hospital failed to have reports of its medical staff tissue committee on orthopedic cases in order to determine the qualifications of medical staff, that the hospital medical staff failed to have monthly medical meetings to review surgical procedures within the hospital, and that the administration knew from the nurses' daily reports that the patient was a problem and did nothing to correct the situation. In support of the allegations the plaintiff pleaded the standards of the Joint Commission on the Accreditation of Hospitals to the effect that the Board of Trustees is ultimately responsible for the standards of patient care, the Illinois Department of Public Health regulations to the same effect, and the Medical Staff by-laws of Charleston Community Hospital which required attending physicians to have consultation in "problem cases." The hospital defended on the general basis that it could not practice medicine under the law and that it was therefore powerless to forbid or command any act of a doctor. The trial court allowed the jury to apply the private standards of hospital accreditation and the public standards of licensing as evidence of expected standards of care. The jury's verdict against the hospital was upheld by both the appellate court and the Supreme Court of Illinois. Moreover, review was denied by the United States Supreme Court. The Supreme Court of Illinois observed that the jury's verdict was supportable on either the basis that the hospital failed to have a sufficient number of nurses on duty to recognize the progressively worsening condition of the plaintiff's leg and of bringing the situation to the attention of hospital administration and medical staff so that adequate consultation could have been secured, or on the basis that the hospital had failed to require consultation or to review the treatment given to the plaintiff.

53 33 Ill.2d 326, 211 N.E.2d 253 (1965).
In the opinion of the author, the decision looks like an extension of the idea of corporate negligence. It is not a *respondeat superior* case. The negligence of the doctor was never proven in court, and therefore the hospital is not being held liable for the negligence of an actual or apparent employee. Rather, the hospital is being held liable for violation of direct duties that it owes to the patient.

It is unlikely that the *Darling* case means that lay individuals must actually control the medical practice of doctors. Rather, it would seem that the court considered the “hospital” to be both administration and medical staff. The court’s opinion has emphasized shared, joint responsibility for the standards of patient care. To implement the decision requires the administration of the hospital to stimulate its medical staff to be organized—to review the work of each staff physician—to conform to standards promulgated by the Joint Commission on Accreditation and hospital licensing authorities. There must be an established procedure for consultation among physicians and lines of communication between clinical medicine and lay administration must be open. Fragmentation within the walls of the hospital must be reduced and eliminated insofar as is humanly possible. 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. The corporate practice rule originated in the context of profit oriented business in an age of medical quackery and commercialization. It can be forcefully argued that it has no application to a non-profit hospital striving for high standards of professional excellence.

The courts are recognizing that the community hospital is becoming a community health center. For a variety of reasons the use of the hospital’s emergency room is increasing. Moreover, the hospital is no longer simply a place for housing the acutely ill. Outpatient services are relatively more important than a decade or two ago; the hospital’s role in the diagnosis of illness is more significant now than during years past. The hospital’s role in nursing home services and home care programs is constantly growing in importance and significance. All of these trends will inevitably be accelerated by the Medicare and Medicaid legislation. Furthermore, medical specialization leads to the need for consultations, team work among physicians, and practice in groups. Accordingly, on all counts, the practice of physicians is more and more hospital and colleague oriented. The result of all this is to increase the exposure of the hospital to liability when human error occurs during the course of medical care.