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Malpractice Used as a Hospital Defense

Carl H. Miller*

HOSPITAL IMMUNITY IN NEGLIGENCE and other torts of agents and employees is disappearing steadily. The course of decisions in many states has been consistently in the direction of elimination of "charitable" immunity of hospitals.¹

Seeking another line of defense, hospital administrators have re-examined the parties generally involved in a medical negligence action—patient, physician and hospital. Hospital administrators realized quickly that in order to remain free from general negligence liability, the main onus of tort responsibility would have to be shifted to the physician (or even the nurse) whenever and wherever possible.

The first step necessary to this end was the disassociation of the hospital-physician relation from the broad principle that an employer is liable to a third person for any injury which proximately results from tortious conduct of an employee acting within the scope of his employment.² This disassociation took many forms and they met with varying degrees of success. The most successful revolved around the theory that the hospital-physician relation was not that of master-servant, but rather of principal and independent contractor.³ This theory had as a base the argument that inasmuch as hospitals, generally corporations, are not competent to practice medicine, they can in no way control, and

* B.S., Case Institute of Technology; Third-year student at Cleveland-Marshall Law School.

¹ For an analysis of this particular phase see Holdridge, *Tort Liability of Hospitals*, 8 *Clev.-Mar. L. Rev.* 394 (1959). See also Lipson, *Charitable Immunity: The Plague of Modern Tort Concepts*, 7 *Clev.-Mar. L. Rev.* 483 (1958). In regard to strictly charitable hospitals see 25 *ALR* 2d 29. For immunity of government hospitals see 25 *ALR* 2d 203.

² 35 *Am. Jur.*, *Master & Servant* § 552.

³ *Runyan v. Goodrum*, 147 *Ark.* 481, 228 *SW* 397 (1921); *Jeter v. Davis-Fischer Sanitarium Co.*, 28 *Ga. App.* 708, 113 *S. E.* 29 (1922); *Jenkins v. Charleston General Hospital and Training School*, 90 *W. Va.* 230, 110 *S. E.* 560 (1922); *Holland v. Eugene Hospital*, 127 *Or.* 256, 270 *P.* 784 (1928); *Stuart Circle Hospital Corp. v. Curry*, 173 *Va.* 136, 3 *S. E. 2d* 153 (1939); *Rosane v. Senger*, 112 *Colo.* 363, 149 *P.* 2d 372 (1944); *Wilson v. Martin Memorial Hospital*, 232 *N. C.* 362, 61 *S. E. 2d* 102 (1950); *Van Cleave v. Irby*, 204 *Okla.* 689, 233 *P.* 2d 963 (1951); *Privar v. Manhattan General*, 279 *App. Div.* 522, 110 *N. Y. S. 2d* 786 (1952); *Jones v. New York, ---- Sup. ----*, 134 *N. Y. S. 2d* 779 (1954), *rev. on other grnds.* 286 *App. Div.* 825, 143 *N. Y. S. 2d* 628; *Lewis v. Columbus Hospital*, 1 *App. Div.* 2d 444, 151 *N. Y. S. 2d* 391 (1956); *Huber v. Protestant Deaconess Hospital Assoc.*, 127 *Ind. App.* 565, 133 *N. E. 2d* 864 (1956); *Mayers v. Litow*, 154 *Cal. App.* 2d 413, 316 *P.* 2d 351 (1957); *Mrachek v. Sunshine Biscuit, Inc.*, 308 *N. Y.* 116, 123 *N. E. 2d* 801 (1954); *Bing v. Thunig*, 2 *N. Y. 2d* 656, 163 *N. Y. S. 2d* 3, 143 *N. E. 2d* 3 (1957), which abolished this theory in New York; *Bradshaw v. Iowa Methodist Hospital*, 101 *N. W. 2d* 167 (Iowa, 1960).

therefore cannot be responsible for, the professional medical acts of their staff members.⁴

Another theory, used primarily in regard to operating room torts⁵ and in a few post-operative situations,⁶ results from the concept that the surgeon in charge of an operation has complete control of everyone assisting him in the operating room.⁷ Hospitals, taking full advantage of agency law in this particular instance, argue that with control comes responsibility and therefore the surgeon is chargeable with the negligence of hospital employees assisting him. This theory has, in some cases,⁸ been repudiated by courts holding that certain duties are routine and so much a part of standard hospital practice that to hold the surgeon liable would place an undue burden upon the already burdened practitioner.

Where the primary physician-patient relation is with a doctor maintaining his own practice, hospitals have been quick to point out to the courts that this established the basic responsibility for any negligence on the part of the physician.⁹ This is

⁴ View largely limited to New York where it originated in *Schloendorf v. Society of New York Hospital*, 211 N. Y. 125, 105 N. E. 92 (1914). Refined further in *Phillip v. Buffalo General Hospital*, 239 N. Y. 188, 146 N. E. 199 (1924). See also *Sheehan v. North Country Community Hospital*, 273 N. Y. 163, 7 N. E. 2d 286 (1937); *Berg v. New York Society for Relief of the Ruptured and Crippled*, 1 N. Y. 2d 499, 136 N. E. 2d 523 (1956) which sheds doubt on the administrative-professional distinction, which has been abandoned in *Bing v. Thunig*, supra n. 3. Also note *Swigert v. City of Ortonville*, 246 Minn. 339, 75 N. W. 2d 217 (1956); *Benedict v. Bondi*, 384 Pa. 574, 122 A. 2d 209 (1956).

⁵ *Morey v. Thybo*, 199 F. 760, 42 L. R. A., N. S., 785 (7th Cir. 1912); *Beck v. German Klinik*, 78 Iowa 696, 43 N. W. 617, 7 L. R. A. 566 (1889); *St. Paul-Mercury Indem. Co. v. St. Joseph's Hospital*, 212 Minn. 558, 4 N. W. 2d 637 (1942); *Aderhold v. Bishop*, 94 Okla. 203, 221 Pac. 752 (1923); *Minogue v. Rutland Hospital*, 119 Vt. 336, 125 A. 2d 796 (1956); *Hillyer v. Governor of St. Bartholomew's Hospital*, 2 K. B. 820 (1909); *Johnson v. Ely*, 30 Tenn. App. 294, 205 S. W. 2d 759 (1947); *Ales v. Ryan*, 8 Cal. 2d 82, 64 P. 2d 409 (1936); *Ybarra v. Spangard*, 25 Cal. 2d 486, 154 P. 2d 687, 162 A. L. R. 1258 (1944); *Jordan v. Touro Infirmary*, 123 So. 726 (La. App., 1922); *Randolph v. Oklahoma City General Hospital*, 180 Okla. 513, 71 P. 2d 607 (1937); *Simons v. Northern Pacific Ry. Co.*, 94 Mont. 355, 22 P. 2d 609 (1933); *Emerson v. Chapman*, 138 Okla. 270, 280 P. 820 (1929); *Wallstedt v. Swedish Hospital*, 220 Minn. 274, 19 N. W. 2d 426 (1945); *Steinert v. Brunswick Home, Inc.*, 172 Misc. 787, 16 N. Y. S. 2d 83 (1939); *Yorston v. Pennell*, 153 A. 2d 255 (Pa., 1959).

⁶ *Davis v. Potter*, 51 Idaho 81, 2 P. 2d 318 (1931); *McConnell v. Williams*, 361 Pa. 355, 65 A. 2d 243 (1949).

⁷ See 60 A. L. R. 147.

⁸ *Covington v. Wyatt*, 196 N. C. 367, 145 S. E. 673 (1928); *Harris v. Fall*, 177 F. 79, 27 L. R. A., N. S. 1174 (7th Cir., 1910); *Harlan v. Bryant*, 87 F. 2d 170 (7th Cir., 1936); *Hohenthal v. Smith*, 72 App. D. C. 343, 114 F. 2d 494 (D. C. Cir., 1940); *Stewart v. Manasses*, 224 Pa. 221, 90 A. 574 (1914).

⁹ *Barfield v. South Highlands Infirmary*, 191 Ala. 553, 68 So. 30 (1915); *Hendrickson v. Hodkin*, 250 App. Div. 619, 294 N. Y. S. 932, revd. on other

(Continued on next page)

generally argued from the point that (1) hospitals only furnish the facilities,¹⁰ and (2) the physician has contractually (expressly or impliedly) assumed the liability for his patient's safety.

The newest line of defense by hospital administrators is through the use of physicians' malpractice itself. Although the idea of using the malpractice of a physician as a defense is basically not new,¹¹ the attrition of charitable immunity has brought it into prominence as an effective defensive weapon. The advantages in obtaining from the court a ruling that an injury was the result of malpractice instead of negligence can best be illustrated by several recent cases.

In *Morwin v. Albany Hospital*¹² the hospital, in view of a decision¹³ which abolished the rule that a staff doctor was to be considered an independent contractor, had been held liable for the negligence of a staff doctor under the theory of respondeat superior. The charge to the jury had been a general negligence charge and on appeal the reviewing court reversed the decision on the basis of that charge being erroneous. The court held that medical acts and the negligent performance thereof, for which the hospital was being held liable, fell into classification of negligence known as malpractice. Malpractice is defined¹⁴ generally as bad, wrong, or injudicious treatment of a patient, professionally and in respect to the particular disease or injury, resulting in injury, unnecessary suffering or death to the patient, and proceeding from ignorance, carelessness, want of proper professional skill, disregard of established rules or principles, neglect, or a malicious or criminal intent. Since malpractice does require an answer to whether an act was carried out with sufficient professional skill and knowledge, it naturally requires expert testimony to the effect that what was done was negligent, or could have been done better or in another way. The charge having been one of general negligence, and expert testimony not having

(Continued from preceding page)

grnds. 276 N. Y. 252, 11 N. E. 2d 899; *Gosnell v. Southern Ry. Co.*, 202 N. C. 234, 162 S. E. 569 (1932); *Bowditch v. French Broad Hospital*, 201 N. C. 168, 159 S. E. 350 (1931); *Penland v. French Broad Hospital*, 199 N. C. 314, 154 S. E. 406 (1930); *O'Rourke v. Halcyon Rest*, 281 App. Div. 838, 118 N. Y. S. 2d 693, aff'd 306 N. Y. 692, 117 N. E. 2d 639 (1953); *Konoff v. Fraser*, 62 Cal. App. 2d 788, 145 P. 2d 368 (1944); *Mayers v. Litow*, 154 Cal. App. 2d 413, 316 P. 2d 351 (1957); *Fowler v. Norways Sanitarium*, 112 Ind. App. 347, 42 N. E. 2d 415 (1942); *Carter v. Harlem Hospital*, 278 Ky. 87, 128 S. W. 2d 174 (1939); *Jackson v. Mountain Sanitarium & Asheville Agricultural School*, 234 N. C. 222, 67 S. E. 2d 57 (1951); *Stewart v. Crook Sanitarium*, 17 Tenn. App. 589, 69 S. W. 2d 259 (1933); *Kuglich v. Fowle*, 185 Wis. 124, 200 N. W. 648 (1924).

¹⁰ *Mayers v. Litow & Midway Hospital*, supra n. 3.

¹¹ *Harding v. Liberty Hospital Corp.*, 177 Cal. 520, 171 P. 98 (1918).

¹² 7 A. D. 2d 582, 185 N. Y. S. 2d 85, 88 (1959).

¹³ *Bing v. Thunig*, supra, n. 3.

¹⁴ *Black's Law Dictionary* (4th ed. 1957).

been introduced, the court concluded that the jury should have found the hospital not liable, and reversed the decision of the lower court.

This case illustrates well several of the reasons that make malpractice a potent defensive argument. In pleading malpractice, hospitals are advantageously served by the increased difficulty of proof that the plaintiff must overcome to win his case. A negligence action is generally within the scope of knowledge and experience of the average layman; but malpractice removes the charge from this level and by its nature necessitates the introduction of expert testimony.¹⁵ The difficulties which may arise in a situation involving expert medical testimony have been reiterated so often¹⁶ as to preclude the necessity for any further discussion. Contiguous with this problem, however, one cannot overlook the increased expense of litigation, an all too real stumbling block in the path of many a plaintiff.

In *Davis v. Eubanks*¹⁷ the negligent injection of penicillin brought an injury action by the patient's administratrix against a nurse and the hospital. The hospital in its answer maintained it was in a demurrable position inasmuch as the statute of limitations for malpractice¹⁸ provided a bar to the action. The argument was defensively successful and the court held that a nurse could be guilty of malpractice within the meaning of the statute of limitations, which provided that an action must be brought within one year of the accrual of the cause. The court went on to point out that where the statute of limitations was effective as a bar to the action against the nurse, an employee of the hospital, it was also effective as a bar to the action against the hospital. This case points out what is probably the most attractive consideration in the use of malpractice as a hospital defense. That is, generally, the statute of limitations limits the time available to bring the action to a shorter period in malpractice than in negligence.

This extension of the meaning of malpractice to include nurses¹⁹ is a breakthrough in its use as a defensive weapon. Prior to this a long line of decisions had, in general, consistently held that the negligence of nurses would fall upon either the hos-

¹⁵ Prosser, *Torts* 134 (2nd ed. 1955).

¹⁶ Oleck, *A Cure for Doctor-Lawyer Frictions*, 7 *Clev.-Mar. L. Rev.* 473 (1958); Lampert, *Medical Evidence and Testimony*, 8 *Clev.-Mar. L. Rev.* 465 (1959).

¹⁷ 167 N. E. 2d 386 (Ohio, 1960).

¹⁸ Ohio Rev. Code § 2305.11.

¹⁹ *Parowski v. Bridgeport Hospital*, ____ Conn. ____, 134 A. 2d 834 (1957); citing *McDermott v. St. Mary's Hospital Corporation*, 144 Conn. 417, 133 A. 2d 608 (1957). Non-liability of the hospital for the negligence of a practical nurse, see *Penaloza v. Baptist Memorial Hospital*, ____ Tex. ____, 304 S. W. 2d 203 (1957). See also Hayt, *Law of Hospital & Nurse* (1955).

pital,²⁰ or under the borrowed servant doctrine, upon the directing physicians.²¹ Typifying the majority position, we find *Isenstein v. Malcomson*,²² in which the hospital requested that the complaint be dismissed on the ground that the action, against a hospital for the negligence of a nurse, was not brought within the two year period required by the statute of limitations in malpractice actions. The court rejected this contention, holding that malpractice must be considered in its primary meaning; and according to such usage and acceptance, it has regularly been intended to import improper treatment or culpable neglect of a patient by a *physician or surgeon*. The court went on to state that in no instance had it been found to have possible application to a nurse.

Additional impetus for the growing use of defensive malpractice comes from the increased possibility of practical and procedural error²³ by the plaintiff; not to mention the conceivability of a confusion of issues in the minds of the jurors, which is illustrated below.

The extremes to which several courts have been persuaded to go in accepting the hospital's use of defensive malpractice are worth noting. In *Robinson v. Crotwell*²⁴ the plaintiff submitted to an operation to relieve a disease of the nerve, tic douloureux, upon the suggestion of the physician-owner of the hospital. As a result of the operation the plaintiff was left permanently disabled and with a 2½ inch by 1½ inch hole in his skull. In an appeal from a judgment for the plaintiff, the court held that the

²⁰ *Jones v. Baylor Hospital*, 9 Tex. Civ. 66, 284 S. W. 2d 929 (1956); *Baptist Memorial Hospital v. McTighe*, ---- Tex. ----, 303 S. W. 2d 446 (1951); *Avellone v. St. John's Hospital*, 165 Ohio St. 467, 135 N. E. 2d 410 (1956); *Ray v. Tucson Medical Center*, 72 Ariz. 22, 230 P. 2d 220 (1951); *Noel v. Menninger Foundation*, 175 Kan. 751, 267 P. 2d 934, affd. 180 Kan. 23, 299 P. 2d 38 (1956); *Durney v. St. Francis Hospital*, 46 Del. 350, 83 A. 2d 753 (1951); *Wheat v. Idaho Latter Day Saint's Hospital*, ---- Idaho ----, 297 P. 2d 1041 (1956); *Parrish v. Clark*, 107 Fla. 598, 145 So. 848 (1933), negligent injection; *Norwood Hospital v. Brown*, 219 Ala. 445, 122 So. 411 (1929), overheated water bottle; *Williams v. Pamona Valley Hospital Ass'n.*, 21 Cal. App. 359, 131 Pac. 888 (1913), overheated water bottle; *City of Shawnee v. Roush*, 101 Okla. 60, 223 P. 354 (1923), enema of too high a temperature; *Session v. Thomas E. Dee Memorial Hospital Ass'n.*, 94 Utah 460, 78 P. 2d 645 (1938), incorrect medication; *Malcolm v. Evangelical Lutheran Hospital Ass'n.*, 107 Neb. 101, 185 N. W. 330 (1921), incorrect medication; *Skidmore v. Oklahoma Hospital*, 137 Okla. 133, 278 P. 334 (1929), failure to catheterize; *Welsh v. Mercy Hospital*, 65 Cal. App. 2d 473, 151 P. 2d 17 (1944), failure to warn patient when lowering bed; *Flower Hospital v. Hart*, 178 Okla. 477, 62 P. 2d 1248 (1936); *Goff v. Doctor's General Hospital of San Jose*, 333 P. 2d 29 (Calif. 1958); *Pierce v. Yakima Valley Memorial Hospital*, 43 Wash. 2d 162, 260 P. 2d 765 (1956).

²¹ *Minogue v. Rutland Hospital*, supra, n. 5.

²² 227 App. Div. 66, 236 N. Y. S. 641, 643 (1929).

²³ *Salgo v. Leland Stanford Jr. Univ.*, 154 Cal. App. 2d 560, 317 P. 2d 170 (1957); *Lustig v. Beth Israel Hospital*, 195 N. Y. S. 2d 441 (1959).

²⁴ 175 Ala. 194, 57 So. 23 (1911).

physician-owner of the hospital could not be held liable for the malpractice of the operating surgeon since the only thing he did was to administer the anesthetic and advise against the completion of the operation due to the patient's ebbing vitality. The court added that the fact that the operating room was so inadequately furnished as to be partially responsible for the incompletion of the operation was the responsibility of the surgeon and not that of the physician-owner. *Black v. Fischer*²⁵ brought to the court a situation where the offending physician was also the managing stockholder of the defendant sanitarium. The sanitarium demurred on the ground that if there was any liability, it was upon the surgeon and not the hospital. In sustaining this point the court speciously declared that there was no control of the agent sufficient to hold the master liable for his torts.

In most states the use of malpractice as a defensive tool, to replace charitable immunity, is limited by the theory that, under the doctrine of respondeat superior, a hospital will be held liable for the negligence or malpractice of its physicians.²⁶ The destruction of the independent contractor idea for the non-liability of hospitals, however, still leaves the most important advantage, that of a short statute of limitations. This aspect of the problem requires some detailed consideration.

It would be contrary to the basic rules of agency for a court to hold a hospital liable for the torts of an agent, after the statute of limitations had erected a bar to an action against that particular agent. The most obvious approach then, since the limitations rule is statutory, is to seek a change through the

²⁵ 30 Ga. App. 109, 117 S. E. 103 (1923); see also *Barfield v. South Highland Infirmary*, 191 Ala. 553, 68 So. 30 (1915); *Jeter v. Davis-Fischer Sanitorium Co.*, supra n. 3; in *Runyan v. Goodrum*, supra n. 3, hospital was held not liable for negligence on the part of an x-ray technician who was not a doctor because of the special knowledge technician supposedly had.

²⁶ *Glavin v. Rhode Island Hospital*, 12 R. I. 411, 34 Am. Rep. 675 (1879); *Brown v. La Societe Francaise*, 138 Cal. 475, 71 P. 516 (1903); *Vaughan v. Memorial Hospital*, 100 W. Va. 290, 130 S. E. 481 (1925); *Gilstrap v. Osteopathic Sanitorium Co.*, 224 Mo. App. 798, 24 S. W. 2d 249 (1929); *Bellandi v. Park Sanitarium Ass'n.*, 214 Cal. 472, 6 P. 2d 508 (1931); *Edwards v. West Texas Hospital*, 89 S. W. 2d 801 (Tex. Civ. App., 1935); *Hansch v. Hackett*, 190 Wash. 97, 66 P. 2d 1129 (1937); *White v. Central Dispensary & Emergency Hospital*, 69 App. D. C. 122, 99 F. 2d 355, 119 A. L. R. 1002 (1938); *Stuart Circle Hospital Corp. v. Curry*, 173 Va. 136, 3 S. E. 2d 153 (1939); *Giusti v. C. H. Weston Co.*, 165 Or. 525, 108 P. 2d 1010 (1941); *Treptau v. Behrens Spa*, 247 Wis. 438, 20 N. W. 2d 108 (1945); *Rice v. California Lutheran Hospital*, 27 Cal. 2d 296, 163 P. 2d 860 (1945); *Grigalaukas v. United States*, 103 F. Supp. 543 (D. C. Mass., 1951); *Lexington Hospital, Inc. v. White*, 245 S. W. 2d 927 (Ky., 1952); *Moeller v. Hauser*, 237 Minn. 368, 54 N. W. 2d 639, 57 A. L. R. 2d 364 (1952); *Waynick v. Reardon*, 236 N. C. 116, 72 S. E. 2d 4 (1952); *Bowers v. Olch*, 120 Cal. App. 2d 108, 260 P. 2d 997 (1953); *Wilson v. Lee Memorial Hospital*, 65 So. 2d 40 (Fla., 1953); *Garfield Memorial Hospital v. Marshall*, 92 App. D. C. 234, 204 F. 2d 721, 37 A. L. R. 2d 1270 (D. C. Cir., 1953); *Miami v. Brooks*, 70 So. 2d 306 (Fla., 1954); *Seneri v. Haas*, 45 Cal. 2d 811, 291 P. 2d 915, 53 A. L. R. 2d 124 (1955); *Bing v. Thunig*, supra n. 3; *Brown v. Moore*, 247 F. 2d 711 (3rd Cir. 1957).

legislative process. Here another fallacy arises, well illustrated by two recent legislative enactments. In New Jersey a decision rendered in 1958 in *Collopy v. Newark Eye and Ear Infirmary*²⁷ ended the charitable immunity that hospitals in that state had enjoyed up until that time. In 1959, even before enough time had elapsed for a decent burial, the state legislature of New Jersey limited the liability of charitable hospitals to \$10,000.²⁸ Similarly, the Kansas courts voided the charitable theory of immunity in *Noel v. Menninger Foundation*.²⁹ Shortly thereafter, the state legislators saw fit to restore immunity by limiting hospital liability to the extent of the insurance carried by each particular hospital.³⁰ This leaves the determination of hospital liability solely in the hands of the hospital administrators, a perfect solution from the viewpoint of hospital administrators. To think that statutes of limitations will be lengthened by state legislatures requires a naive view of the influence of various medical lobbying groups, and extreme optimism in regard to legislative liberality.

Some of the advantages of hospitals, as to defensive malpractice, are threatened by the theory that a hospital may be liable for the professional acts of its staff. In *Seneri v. Haas*³¹ paralysis developed from the negligent injection of a spinal anesthetic. The court discarded the various immunity theories and claimed that it was for the jury to determine whether the anesthesiologist was the "ostensible agent" of the hospital. If so, the hospital would be liable for the negligent acts of the anesthesiologist. The court went on to say that the patient was not on notice and had no duty to inquire as to agency relations, but could generally look to the hospital for medical services, which included the acts of its professional staff. In *Brown v. Moore*³² a patient in a proprietary sanatorium, shortly after electro-shock treatment, was permitted to walk about. During the course of this walking about, he fell down a flight of stairs and broke his neck. The district court held that the doctrine of respondeat superior did not apply. On appeal this was reversed by the circuit court. The court held that whether the partners who operated the sanatorium held out or represented the physician to be their employee to administer treatment to the patient, so as to render them liable under respondeat superior, was for the jury to decide. Whether or not these two decisions will establish a trend still remains to be seen, but they do seem in keeping with the erosion of charitable immunity.³³

²⁷ 27 N. J. 29, 141 A. 2d 276 (1958).

²⁸ Ch. 90, Laws 1959.

²⁹ 175 Kan. 751, 267 P. 2d 934 (1954).

³⁰ S. B. 239.

³¹ *Supra* n. 26.

³² *Supra* n. 26. Originating action in 143 F. Supp. 816.

³³ For a state by state analysis of the present status of charitable immunity see Horty, *Hospital Law Manual* (Vol. 2, 1959).

Malpractice on several occasions has been found to be a double edged weapon, much to the woe of hospital administrators. In *Clary v. Christiansen*³⁴ a practitioner vigorously defended a malpractice charge, and returned the liability to the hospital. The physician maintained that the nurse, in preparing the operating room and supplies, was not his employee, and that her negligence was attributable to the hospital as he had no right to control and supervise. Similarly, a Tennessee court recently held, in *Rural Educational Ass'n. v. Bush*,³⁵ that a hospital was liable, under respondeat superior, for an improper sponge count conducted by the operating room nurse. The court reasoned illuminatingly that, although the surgeon is in complete control of the operating room, certain duties of attending nurses "do not involve professional skill or decision on the part of the surgeon."

That hospitals will continue to use malpractice defensively seems clear. In many cases the practitioner's and/or patient's attorney will be unable to cope with this, but if he is to be in the best possible position in protecting his client he must examine closely the physician-hospital administrator relation.³⁶ A reassessment of that relation should then be worked into one of the following avenues of argument: (1) Malpractice used defensively is akin to the "administrative vs. medical act" distinction, which has been rejected by the courts as impossibly confusing;³⁷ (2) It violates the public policy which declares hospital liability to be the same as that of any employer or principal; (3) It allows administrators to subordinate physicians (who have little enough actual control of hospitals) and to make scapegoats of physicians and nurses; (4) It is an unwise division of negligence into "class categories"; (5) It ignores the patient's actual reliance on the hospital to which he pays fees; (6) It is not equitable in its effect.

A "horrible example" of the results of use of malpractice as a defense is seen in a recent case: *Weinstein v. Prostkoff*.³⁸ There a nurse anesthetist's negligence in carrying out an obstetrician's orders to anesthetize a woman in childbirth apparently led to the death of the woman in the delivery room. Thereafter a chain of ugly events followed. The hospital records were altered. Hospital personnel blamed the obstetrician, who was at most only passively negligent, if that. At the trial, defense counsel misbe-

³⁴ 54 Ohio L. Abs. 254, 83 N. E. 2d 644 (1948). See also *Shull v. Schwartz*, 364 Pa. 554, 73 A. 2d 402 (1950).

³⁵ ---- Tenn. Ct. App. ----, 298 S. W. 2d 761 (1956). See also *Olander v. Johnson*, 258 Ill. App. 89 (1930); *Wilson v. Lee Memorial Hospital*, ---- Fla. Sup. Ct. ----, 65 So. 2d 40 (1953).

³⁶ *Oleck, Doctor, Lawyer, and Hospital Administrator: A New Triangle*, 8 Clev.-Mar. L. Rev. 416 (1959).

³⁷ *Bing v. Thunig*, supra, n. 3; *Berg v. New York Society for Relief of the Ruptured & Crippled*, supra, n. 4.

³⁸ *Weinstein v. Prostkoff*, 23 Misc. (N. Y.) 2d 376 (Supr. Ct., Kings County, decided Aug. 21, 1959; reported Sept. 28, 1960).

haved. There was an all around mess of lying and of passing the buck. The jury apparently was thoroughly confused by the malpractice aspects. It found the doctor liable, but not the nurse nor the hospital. The judge set aside the verdict as a miscarriage of justice, and ordered a new trial. It was a shocking illustration of the worst possibilities of the "defense" of malpractice.

In *Shutts v. Siehl*,³⁹ nurses refused to loosen a patient's cast without the doctor's approval. The doctor did not approve the patient's request, conveyed by the nurses. When harm to the patient followed, the court directed a verdict for the hospital; but a verdict for the doctor was reversed due to error in the instructions to the jury. The pattern of shifting the onus to the doctor is visible in this case.

The final effect of hospital denial of the respondeat superior principle, however, is found in *Sands v. Klein*.⁴⁰ There a hospital actually cross-claimed against the doctor, arguing that his negligence was active and its negligence was passive. The court summarily brushed aside this argument, holding that both were negligent, in that case, and that it was ineffective because they were joint tort feasons in *pari delicto*. But the boldness of the attempt is illuminating. In a very recent case⁴¹ the idea of active vs. passive negligence, and indemnification of the hospital by the doctor seems to be accepted.

The danger of the use of malpractice as a *defense* for hospitals, at the expense of the professional staff members, as predicted,⁴² has become very apparent. It depends on the idea of primary and secondary liability, where, as in New York, that concept of indemnification is accepted.

³⁹ 10 Ohio Op. 2d 363, 109 Ohio App. 145 (decided 1959, reported 1960).

⁴⁰ 8 App. Div. (N. Y.) 2d 236, 190 N. Y. S. 2d 262, *affd.* 7 N. Y. 2d 896, 197 N. Y. S. 2d 204 (1960).

⁴¹ *Hollant v. North Shore Hospital, Inc.*, 206 N. Y. S. 2d 177 (1960).

⁴² *Oleck, supra*, n. 36.