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Administrator's View of Doctor-Lawyer-Hospital Relations

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IN THE SEPTEMBER 1959 ISSUE OF THE CLEVELAND-MARSHALL LAW REVIEW, Mr. Howard Oleck, Assistant Dean and Professor of Law of the School, has written an article discussing the legal relationships of physician, lawyer, and hospital administrator. While he addresses himself primarily to the legal relationships between these three groups, his article also concerns itself to some extent with the professional and administrative relationships involved. The article then goes on to discuss the case of *Morwin v. Albany Hospital* (7 A. D. (N. Y.) 2d 582 (Super. Ct., App. Div., 3rd Dept., Apr. 23, 1959); 185 N. Y. S. 2d 85), and certain conclusions are drawn from the author's interpretation of this case which he applies to the "triangle" of doctor, lawyer, and hospital administrator.

I believe that Mr. Oleck has presented a misleading viewpoint of both the legal and professional relationships which exist between physician and hospital. Furthermore, it is apparent that he has wholly misinterpreted the *Morwin* case, not only as to what was actually decided at the trial and on appeal, but also with respect to the strategy and motives of the attorneys who defended the hospital in this case.

I am grateful, therefore, to have an opportunity to reply to this article.

There are two broad categories of hospitals, public and private. Included in the former group are Federal, State, County and Municipal hospitals. Private hospitals can be divided into a large group of nonprofit, charitable hospitals called "voluntary" hospitals, and a very small handful of hospitals operated on a profit basis and called "proprietary" hospitals.

Voluntary hospitals are controlled either by Boards of Trustees made up of public spirited business and professional men in the community who serve without compensation, or by the religious or philanthropic organizations which build and operate them. Albany Hospital is a non-denominational, voluntary, nonprofit, charitable hospital, and my discussion will largely concern

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[*Editor's Note*: The "article" by Prof. Oleck, to which this article applies, was a digest of a speech by Prof. Oleck delivered to a joint meeting of a Bar Association and a Medical Society in Pennsylvania, published in 8 Clev-Mar. L. R. 416 (Sept. 1959). The main issue involved is the proper relation between hospital administrators and physicians with respect to legal liabilities of each, especially in hospital negligence or malpractice suits. The issue is pointed up by recent conflicts this year, such as that between hospital administration and medical personnel in Parma (Ohio) Community General Hospital, the physicians' strike at Cambridge-Maryland Hospital against administrative policy, and similar events recently featured in the press and in medical periodicals.]

this type of hospital, which constitutes the largest single group of hospitals in the country. Denominational hospitals are very similar in philosophy and operation, but have certain organizational differences that distinguish them from the non-denominational group.

The nonprofit charitable hospital of today presents a rather unique illustration of the fact that deliberately planned divided authority can occasionally be the method of choice in the operation of a certain type of institution, and that, with understanding and forbearance, it can be made to work. These hospitals were built in most instances as a result of the philanthropy of public spirited benefactors motivated by a desire to provide for the indigent poor a place where they could go when ill to receive medical and supportive care. Subsequent benefactors enlarged and modernized these hospitals, and they too were moved by the same desire to provide medical care and nursing care for sick patients, regardless of financial status. The voluntary hospital exists, therefore, for one purpose and one purpose only—the care of sick and injured patients. This is a dedicated responsibility, which is respected not only by the physicians who make up the Attending Staff of these hospitals, but also by the administrators of these hospitals, and the public spirited business men and civic leaders who serve without pay on their governing boards. Physicians on the Attending Staff, who represent the outstanding medical practitioners in the community, have a vital role to play in these hospitals, which will be discussed below, but it is the *patient,*—not the doctor, administrator, or trustee,—who provides the voluntary hospital with its "raison d'etre."

The governing boards in a sense own and operate the hospital. Their ownership is in the form of a trusteeship, however, and the trustees cannot in any way make a financial profit or business gain from their association with the hospital. There are no dividends to be paid, no profits to be divided. Because Boards of Trustees are made up of men actively engaged in business or the professions, they do not have time to operate the hospital themselves. They employ a director or executive officer of the hospital, therefore, who reports to them. It is his function to operate the hospital on a day to day basis, a position comparable to the president of a business corporation. The Board of Trustees, however, is responsible in an overall sense for everything that the director does, and for all the activities that go on in the hospital.

One of the most important responsibilities of the Board of Trustees is the appointment of the members of the Attending Medical Staff of the hospital. In this they are invariably guided by the recommendations of a Medical Board, composed of the Heads of the medical departments in the hospital, or in smaller hospitals by a committee of the Attending Staff which passes on the credentials of those physicians who wish the privilege of practicing in that hospital. It is the medical profession, as a prac-

tical matter, that controls appointment to the Attending Staff, not the hospital administrator or the Board of Trustees.

There is a second kind of staff, in larger hospitals, called the Resident Staff, composed of interns, assistant residents and residents, who are receiving postgraduate training for general practice or one of the specialties. They are employees of the hospital, and in this sense differ from the Attending Staff, which is composed of physicians in the private practice of medicine. The hospital is obviously responsible for the acts of the members of the Resident Staff, but not usually for the acts of members of the Attending Staff. The Board of Trustees, however, cannot evade responsibility for the professional acts of a member of the Attending Staff whose competence they had reason, or should have had reason, to question at the time of his appointment. The hospital management has a responsibility to appoint competent physicians to the Attending Staff, and competent workers throughout the other departments of the hospital.

Nowhere in business or industry does there exist quite the same relationship as we find between the physician and the hospital in which he works. It is true, as Mr. Oleck says, that the physician is "allowed" to come into the hospital and care for his patients. This is a misleading understatement, however. The physician is *welcome* in the hospital, and the entire machinery of the hospital is geared to provide for him and for his patients the best possible kind of service. He is willingly permitted to direct the activities of a large and important segment of the hospital employees,—the nurses and the Resident Medical Staff,—and when he writes an order in the patient's order book the nurses carry it out without question (except in those very rare instances where the order is obviously a mistake, or violates an established hospital policy).

The physician has the power to create a legally enforcible obligation between two other parties, the hospital and the patient, when he orders diagnostic or treatment procedures, special accommodations, drugs, dressings, blood transfusions, special nursing care, special diets, and all the host of other services provided by the modern hospital. The patient has little or nothing to say about these matters, in most cases, and often is unaware of all the tests that have been made, or other services rendered, until he gets the bill. If there is any resentment at the size of the bill, it is invariably directed against the hospital which provided the services, rather than at the doctor who ordered them. The hospital must then rely on the doctor to explain and justify the charges on the bill to the patient, which resolves the situation in most instances.

Mr. Oleck describes the hospital administrator as an "organization man," which is correct, but his assumption that it follows therefrom that he "is busy with organization politics and, too often, with self-advancement" is not supported by any evidence, and I would challenge it unequivocally. The hospital administra-

tor of today is more than likely to be a college graduate with two years of postgraduate training in a university course in hospital administration. He is a professional man, just as the doctor and lawyer. Conscientious hospital administrators fully recognize that the physicians on their hospital staff can practice good medicine only when the organization is functioning smoothly and effectively, and they devote every waking moment to this task. They know that physicians as a rule dislike administrative detail, and want no part of it. They feel a deep responsibility for providing an efficient and complete workshop in which the members of the staff can practice the best possible quality of medicine.

I completely agree with Mr. Oleck's statement that "the skilled and dedicated scientist-scholar, not the organization-manager, must be the most important man in our hospitals." No qualified hospital administrator would quarrel with this concept, I am sure. But it certainly does not follow from this that the physician should exercise control over all aspects of hospital management, as Mr. Oleck's article implies, or that he can with impunity ignore the day to day realities of staffing on the various locations and areas in the hospital where he carries on his activities and exercises authority over hospital employees. For example, the nurse's daily duties are made up largely of nursing acts which relate to the general care of the patient, but which have little or nothing to do with carrying out the specific orders which the doctor has written in the order book. In performing these nursing duties the nurse reports to the nursing department in the hospital. If the members of the Attending Staff wanted to direct the operation of the nursing department alone, employing approximately 50% of all the workers in the hospital and operating 24 hours a day 365 days a year, they would have to give up the private practice of medicine and devote their full time to this activity. As another example, the doctor has the privilege of ordering regular or special diets for his patients, and the dietary department carries out these orders meticulously. It would be wholly impractical, however, for the doctor to control the dietary department and all of its employees, who work in the main kitchen preparing food or in the floor kitchens serving it, and I am sure that no doctor would want any part of this type of responsibility.

It is quite true, as Mr. Oleck points out, that the doctor's effective activity in the hospital, aside from the direct orders which he gives for the care of his patients, is in general confined largely to service on committees or advisory boards. It is not true, however, as his article implies, that this is an unimportant function. On the contrary, it is absolutely vital to the welfare and reputation of the hospital, because the standards of medical care are established and implemented in these committees. A hospital administrator, whether or not he happens to be a physician, should never attempt to interpose his judgment *in medical matters* as against that of an advisory medical board or an individual at-

tending physician. If an attending doctor has a problem concerned with the care of his patients by hospital personnel, he goes to the hospital administrator, whose job it is to straighten it out. If his problem also affects the other members of his department, the usual custom in large hospitals is for the matter to be brought to the hospital administration by the head of the department, rather than by an individual member of the department. This ensures against a member of a department arriving at a decision in conjunction with the hospital administrator which is unacceptable to his department head. A considerable portion of the complaints which individual doctors make against their hospitals can be traced to the fact that the doctor disagrees with a policy or a decision which his departmental chief has established, rather than a hospital rule or regulation. Here the hospital administrator obviously must support the head of the department if the policy is sound.

Where matters involving patient care cut across departmental lines and involve all or many members of the staff, there is either a Medical Board composed of department heads (in larger hospitals which are departmentalized), or an Attending Staff organization, with an elected chief and other officers, which is empowered to speak for the Attending Staff as a whole. The departmental heads and the staff committees are quite accustomed to taking responsibility for studying and making recommendations concerning all professional aspects of patient care. These recommendations are considered with the greatest respect by the hospital administrator and the Board of Trustees. It is only rarely that staff recommendations are not followed. It behooves the administrator in such a case to explain his position to the staff representatives, and to convince them of the reasonableness of his approach. Only in exceptional cases is it impossible for agreement to be reached. In such instances the Board of Trustees has the final responsibility for making a decision. If such impasses occur with any frequency in a given hospital then something is radically wrong. It is usually not the system that is at fault in such cases, but the individuals involved.

It is not surprising that there are occasional frictions between physician and hospital management with this kind of an arrangement. Sometimes hospital administrators are not as competent or diplomatic as they should be. Sometimes doctors go behind the back of the administrator and attempt to influence the members of the Board of Trustees whom they know personally on a social or professional basis, and this can create frictions. However, it is gratifying that across the country, in the thousands of hospitals which are operated in this fashion, there is so little friction and so much cooperation every day of the year. This can be only because both doctor and hospital administrator recognize the inherent difficulties of their situation, and the responsibilities which each must bear for his sphere of activity.

Mr. Oleck urges personal injury lawyers to make the hos-

pital administrator a defendant in hospital injury cases. The reason he gives—that "joining the administrator personally as a party defendant is bound to make him think twice about trying to pin all liability on the doctor—and thus perhaps on himself" seems to be a complete non sequitur. In the first place we have only Mr. Oleck's unsupported statement that hospital administrators are trying to pin all liability on the doctor, a statement I categorically deny. Even if this were true, however, which it is not, I think the fact he was joined as a party defendant would make the average hospital administrator more anxious to have the blame assessed against someone else than if he were not personally involved. The truth of the matter is that neither the hospital as an institution nor the administrator can be personally guilty of malpractice, for they do not and can not practice medicine as an individual doctor does, but the hospital is responsible for the negligence of its employees in many states, whether it is simple negligence or malpractice, and it has a duty both moral and legal to employ competent people and appoint only competent physicians to its Attending Staff.

It is admitted that the doctor-hospital relationship is complex and delicate. But it represents an intelligent and workable compromise between two thoroughly undesirable alternatives,— (1) having physicians own and operate all voluntary hospitals or (2) placing the Attending Staff of these hospitals on a full time salaried basis, either under private or government ownership. Hospital administrators are certainly not seeking to put all practicing physicians on their staffs on a full time salary basis. They believe in the private practice of medicine and they want to perpetuate it. But at the same time they do not believe that doctors should control the day to day operation of the hospital in those areas where the Board of Trustees (but not the attending doctor) has the moral, legal and financial responsibility. The existing pattern of doctor-hospital relationships has its occasional strains and rare failures, but across the country *it has worked,* and it has produced better medical care for patients than any other system in the world.

Now with regard to the case of *Morwin v. Albany Hospital,* the original facts at issue in this case were properly stated by Mr. Oleck as follows:

> "Morwin was operated on in Albany Hospital for removal of a large parapharyngeal space abscess in his mouth near the upper left molar. Dr. S, the hospital's Assistant Resident Anesthetist, administered the anesthesia, using endotracheal intubation, as ordered by the surgeon who was to operate. Morwin already had had several gingivectomies, removing the gum tissue around the teeth. His gum tissues had been badly inflamed, some teeth had decayed and broken down. He had had pyorrhea alveolaris, which is a breakdown of the bone structure around the roots of the teeth. He was unable to open his mouth normally.

"Doctor S, while inserting the tube in Morwin's mouth, felt a tooth giving away. It was the upper right central incisor tooth. He decided to go on with the intubation, fearing that the abscess might break and drown the unconscious patient. Later Morwin sued the hospital for negligence of its agent, under the rule of respondeat superior, joining Dr. S. as a party defendant. A jury awarded a verdict of $2500 to the plaintiff. The hospital appealed."

These are the essential facts except that Dr. S, while named a defendant, was never served. The hospital's decision to defend this suit was predicated on the maintenance of the reputation of the hospital and its employee Dr. S, who voluntarily came forward and participated in the defense of the case.

In the Lower Court no evidence was introduced relating to the negligence of Doctor S in manipulating the endotracheal tube except an opinion by the patient's dentist (by whom he was referred to the oral surgeon who operated on the abscess) to the effect that endotracheal anesthesia could have been employed without knocking out the tooth, and that if another type of anesthesia had been employed, the tooth would not have been jeopardized. The case in this Court was decided in favor of the plaintiff essentially on the basis of the simple fact that the plaintiff's tooth was admittedly knocked out, although the doctrine of "res ipsa loquitur" was not specifically invoked.

The Appellate Division, 7 A. D. 2nd 582 (185 N. Y. S. 2nd 85), held on appeal that the question of whether or not Doctor S was negligent should not have been submitted to the jury without expert testimony supporting the allegation of negligence. It held that to prove negligence in the case of a physician performing a professional act, testimony must be presented from individuals who are qualified to judge whether or not the particular professional act was negligent, i.e. whether malpractice was involved. The Court held that the plaintiff's dentist in this case was not a competent witness to this point, because he was in no way qualified to exercise judgment wtih respect to the type of anesthetic that should have been administered or the method by which it was administered. The case was sent back for retrial.

The sole issue in this case was whether Doctor S, an employee of the hospital, had been guilty of malpractice in manipulating the endotracheal tube, resulting in the loss of the plaintiff's front incisor tooth. If malpractice was found, both Doctor S and the hospital were liable. If there was no malpractice, neither was liable. The burden of proving malpractice lies with the plaintiff, and the Appellate Division held that the plaintiff had not sustained this burden.

Mr. Oleck cites a N. Y. Statute (Gen. Mun. L. 50-d) which makes *municipal* hospitals liable specifically for malpractice of their doctors and dentists, and complains that the Appellate Court

paid no attention to this Statute. Why should it? The Statute applies to municipal hospitals, and Mr. Oleck apparently was not aware that Albany Hospital is a private, non-profit, charitable hospital and hence not subject to the provisions of this Statute.

There was never any issue in this case as to whether or not Albany Hospital was responsible for the acts of its employee, Doctor S. The fact of employment, and the doctrine of *respondeat superior,* were accepted by the hospital throughout the trial in the Lower Court and on appeal, and at no point were they challenged or made an issue in the case. A false assumption, therefore, serves as the basis of Mr. Oleck's entire article, i.e. that because the Court ruled that malpractice was involved rather than mere negligence, the hospital-employer is released from liability. There is nothing in the opinion, in the facts or in the law to justify this conclusion.

The most egregious error which Mr. Oleck makes in his article, however, and the one which can potentially cause the greatest harm to all concerned, is his conclusion that doctors and hospital administrators are natural enemies, and his attempt to pit one against the other in a struggle from which neither can possibly benefit. The exact opposite of this is the truth, and never was there a time when it was more vitally important for doctors and hospital administrators to forget their minor differences and unite in defense to a common danger that threatens them both equally.

All over the country a phenomenon is taking place that jeopardizes the very existence of hospitals, and at the same time is forcing many doctors to abandon the method of their choice in the diagnosis and treatment of certain patients, because of their fear of unjustified lawsuits. I refer to the rapidly growing practice on the part of patients to expect from their doctors and from their hospitals *a guarantee of a perfect result in every case.* This standard is utterly impossible to meet, in spite of the amazing advances made by modern medicine and chemistry in the diagnosis and treatment of disease. In fact, it is largely because of the miracles performed by today's doctors and hospitals that patients have begun to expect a miracle in every case,—and to sue, only too frequently, if it doesn't take place.

Doctors and hospitals can be guilty of negligence, and they should and do carry insurance to protect themselves. They and their insurance companies should be willing to make a fair settlement if the facts clearly indicate negligence (and I am using the word "negligence" to include "malpractice"). Prior to the last two decades, there were very few suits brought against doctors and hospitals that did not involve a bona fide factual question of alleged negligence.

But that situation has changed in recent years. Now there are two other kinds of lawsuits that are increasingly being brought against both doctors and hospitals,—(1) the so-called "nuisance" suit, where there is no valid claim supportable by

sound evidence of negligence, but the claimant brings this suit because he anticipates that the doctor or hospital will settle out of court rather than suffer the adverse publicity entailed, with the remote possibility of an unjustified jury verdict at the end. These suits are frequently instituted for many thousands, sometimes hundreds of thousands of dollars, yet an eventual settlement of a few hundred dollars or less may be accepted. In the meantime the insurance company is forced to set up substantial reserves which are charged against the hospital. In Ohio a recent study by the State Hospital Association showed that suits for as much as one and one-half million dollars were settled out of court for fifteen hundred dollars. This is nothing less than legalized blackmail, yet in the hospital field such suits have multiplied alarmingly in the past 15 years.

(2) The second type of suit is also multiplying rapidly and is far more dangerous. This is the case where the patient sues doctor and/or hospital, on the assumption that there must be some negligence because he is worse off, or no better off, than he was when he sought care. The age-old and time-proven common law defenses to negligence actions, i.e. that the alleged injury was accidental, with no fault on anyone's part, or that it resulted from an act involving the exercise of judgment on the part of the defendant, are being constantly eroded by judges and juries. Claimants do not always rely technically on the doctrine of *res ipsa loquitur,* but the presentation of the brief and the tenor of the arguments are in many cases attuned to creating this impression in the minds of judge and jury.

Why is this so dangerous? Why isn't it sound public policy to spread the risks and take care of the thousands or hundreds of thousands of patients every year who don't get well after treatment? The answer is two-fold. (1) From the point of view of hospitals, the explosive increases in premium rates for the past few years, together with settlements, costs of defending suits, and judgments rendered, are imposing heavy financial burdens which hospitals can ill afford to bear. In Ohio, for example, the costs of operating hospitals increased over $2,000,000 in 1958 for these reasons. Many hospitals are already experiencing serious difficulties in procuring liability insurance because of the rash of suits with which they are being threatened, and this is a growing problem in all sections of the country. Yet no hospital would want to stay in operation if it was not able to obtain adequate insurance coverage.

(2) Physicians too are having difficulties procuring insurance, and the premium rates are rising to astronomical proportions. Yet far more serious than the financial threat to the doctor's pocketbook is the growing reluctance of physicians to make available to their patients the latest and best diagnostic or treatment methods when they involve any substantial risk, which they do in many cases. Medicine is not an exact science, where black is obviously black and white obviously white. Aside from

a relatively small percentage of cases, every patient coming to a doctor presents a diagnostic problem, which tests the doctor's knowledge and judgment as to how best to handle it. Very seldom would two doctors handle a difficult case exactly the same way. And we are only now beginning to realize, through advances in the psychosomatic field, how strong a part mental and emotional factors play in many types of illnesses. These can be very difficult to evaluate or control, yet they can profoundly influence the course of disease and the response to treatment.

Almost every form of treatment which the field of medicine has developed involves some risk to the patient. Granted there is a far greater risk in the case of the injection of radio-opaque dye into a patient's arteries, for example, than in the prescription of aspirin 4 times a day. Yet the distinction is relative, and as medical science has progressed, complex methods of diagnosis and treatment undreamed of 30 years ago are now in common usage.

Let me give some illustrations.

There is a case now pending against a large medical center hospital in which a thoracic surgeon made a pre-operative diagnosis of cancer of the lung, basing this on the history, physical examination, and x-rays. When the chest was opened the lung appeared to have an area of cancerous growth, although frozen section pathological examinations during the operation did not confirm this clinical diagnosis. (A negative finding here is obviously not conclusive.) The patient was only 38 years old, and if this was cancer his only chance of survival for more than a brief period of time lay in the removal of the lung. If it was not cancer, the patient's life would not be jeopardized by removal of the lung, because it is perfectly possible for an individual to get along satisfactorily with one lung. The alternative diagnosis at operation was an area of heavy pneumonic infiltration of such a serious nature that in the opinion of the operating surgeon the lung should have been removed anyway. In the exercise of his best judgment, therefore, with all the possible facts at hand, the surgeon removed the lung. The lung turned out to be non-cancerous. The patient made a complete recovery, but is now suing both surgeon and hospital for the alleged error in diagnosis. Here is a case where a highly competent surgeon exercised the best judgment of which he was capable, performed the only procedure that could protect the patient against two contingencies, one of which would certainly, and the other probably, have cost him his life, yet he finds himself the defendant in a multi-hundred-thousand dollar lawsuit as a result. The publicity alone is not only disconcerting but can be very damaging. I cite this as an illustration of the medico-legal considerations that must now be paramount in the mind of every surgeon when he performs an operation. This case also illustrates the tendency of claimants to sue both doctor and hospital, even though the hospital here could not conceivably have been at fault, as the

surgeon was in private practice and was in no sense an employee of the hospital.

Another illustration involves the use of electric shock therapy in the treatment of mental disease. In this procedure a mild electric current is introduced between two electrodes on either side of the patient's head, causing temporary unconsciousness from which the patient begins to recover in a matter of minutes. This treatment, together with insulin shock therapy and metrazol shock therapy, has proven to be very effective in relieving tensions and alleviating depressions, as well as being helpful in several other types of psychiatric illnesses. There is an inherent risk in any type of shock therapy, however, which causes fractured bones in a minimal percentage of cases regardless of how carefully the procedure is carried out. Yet neither doctor nor hospital can become an insurer against fractures in the thousands of electric shock treatments that are given each day in large psychiatric centers. The patient must assume some risks when he agrees to certain types of diagnostic or treatment procedures, and he cannot expect the doctor or hospital to be financially liable when no negligence is involved.

Still another illustration involves the occurrence of post-operative wound infections, or other infections which appear after the patient has been admitted to a hospital. There have always been infections in hospitals and there always will be, and it is the daily responsiblity of physicians, nurses, and hospital administrators to take every possible precaution to hold such infections to a minimum. Almost no other aspect of hospital operations weighs more constantly on everyone's mind than this. There are literally hundreds of steps and procedures which hospitals establish to minimize the possibility of infections in their patients. Yet we can predict with certainty that infections will occur, and that in most cases no specific factor can be attributed as a cause. The possibility of infection is one of those risks which patients must be willing to accept as a concomitant to hospital admission and treatment, and they have always done so in the past. But now we read of lawsuits against hospitals based on the fact that "an infection developed," with the assumption that therefore someone must have been negligent. This does not mean that where there is a gross violation of sterile techniques the hospital or the attending physician, or both, should not be held liable. But neither of them can accept responsibility for the vast majority of infections which arise without any demonstrable negligence on anyone's part.

Another illustration is found in the field of commitment to mental institutions. If a patient is disoriented, excited, and threatening injury to himself or others, he should be admitted to proper psychiatric accommodations for the protection of himself and his neighbors. However, it not infrequently happens that when this occurs the patient subsequently sues the doctor and/or hospital for false imprisonment, and this is a difficult

kind of suit to defend because of the highly unfavorable publicity involved, which damages the reputation of both the hospital and the doctor, even though they may be entirely innocent of negligence or wrongdoing. By the same token, if this same patient was not committed, and he subsequently injured himself or others, a legitimate cause of action could arise against hospital and/or doctor for failure to commit the patient. Only too often there seems to be less risk of a lawsuit in doing nothing than in taking a positive action, and as a result physicians are becoming more and more influenced to "play it safe," rather than take the affirmative steps which are indicated in the best interests of the patient.

As another illustration, I mentioned above the injection of radio-opaque material into arteries for the diagnosis of arterial diseases and heart conditions. Such studies are essential in certain cases to make a proper diagnosis, and to guide the surgeon in performing the type of operation which is indicated for the survival or cure of the patient. These procedures involve a certain amount of risk of injury to the patient, even the risk of death in a small percentage of cases. However, without this diagnostic procedure the patient might be fore-doomed to an early death, as in the case of a child with congenital heart disease, or gradual deterioration leading to permanent disability or death, as in the case of certain types of arterial diseases. Doctors are accustomed to explaining these risks to their patients, and usually will not proceed unless the patient has given his permission, knowing the risks involved. However, in an increasing number of cases doctors are being sued for substantial amounts of money where patients were injured, or claimed they were injured, as a result of diagnostic procedures, even when the risks had been fully explained to them beforehand and permission granted.

I could continue with hundreds of similar illustrations. There is a risk of life and death involved every time an anesthetic is given, and every time an operation is performed. There are risks of infection, allergic reactions, and other untoward results in many, if not most, of the medical treatments which are in common use. The stronger the drug used in combating a disease or infection, the more apt it is to have dangerous side reactions. Patients in many cases produce or compound their own illnesses by virtue of mental strains or stresses of which they are either unaware or which they cannot control. Where negligence is involved, doctors and hospitals should be held accountable. But if doctors and hospitals are to be held financially liable for every accident, every error of judgment, and every bad result which befalls patients, even though no negligence is shown, the practice of medicine will radically change (to the detriment of the patient) and most hospitals will eventually be forced to close their doors.

Under English law hospitals, as charitable institutions, were once held to be immune from liability for the acts of their employees, and this doctrine of absolute immunity was carried over into most American jurisdictions when this country was first settled. Gradually this doctrine has been whittled away in this country, first to partial or conditional immunity, and ultimately to complete loss of immunity in many states. Courts have been sympathetic to the plight of the patient, realizing his previous helplessness to obtain redress where serious negligence was involved. They could not foresee that granting the patient the right to sue would be so soon and so materially abused by some patients that the very existence of hospitals may well be threatened if the trend continues. From the broad viewpoint of public policy, this situation needs further review, with some modified form of liability up to fixed limits suggesting itself as a possible final compromise. The state of New Jersey has already passed such a law limiting the liability of hospitals to $10,000 in negligence and malpractice suits, and a similar law was passed by both houses of the legislature in Ohio, but was vetoed by the governor at the last moment, in spite of the fact that he stated "I do not suppose that the number of well-intentioned and sincere people appearing or writing in behalf of a single piece of legislation was higher than on behalf of Sub. S.B. 241," (the bill in question). In Kansas, the experience of hospitals was so onerous after the courts removed their charitable exemption that the legislature restored this immunity five years later.

Doctors and hospitals are equally affected by the serious results accruing from this change in attitude on the part of patients, and it is essential that they put aside petty dissensions at this time in a concerted endeavor to ward off this growing danger so that the public will not ultimately suffer. Every effort should be made to resolve the relatively insignificant differences that exist between physicians and their hospitals, rather than exploiting these differences with inflammatory propaganda. The dangers to the public inherent in this situation have already been recognized by hospital associations and organized medicine by the appointment of committees at various levels for the purpose of eliminating common sources of liability. The same sort of cooperation is also taking place in many hospitals. Hospital administrators and Boards of Trustees on the one hand, and physicians on the other hand, have everything to gain by working together harmoniously to bring better medical and nursing care to the patients in the hospital. They have everything to lose by magnifying such small differences as are occasionally found, or creating new and artificial areas of disagreement which can be profitable to no one, but which will ensure that the patient in the hospital will ultimately receive a more expensive and a poorer quality of medical and nursing care.

The legal profession can render a real service to humanity by working toward the solution of this problem.