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Howard L. Oleck

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Doctor, Lawyer, and Hospital Administrator: a New Triangle

*Howard L. Oleck**

HOSPITALS ARE DEEPLY INVOLVED in the great majority of medicolegal case problems. Yet surprisingly little attention has been given to the relation of the hospital to doctor-lawyer-patient situations *as a factor in itself.* Most discussions of hospitals and law deal generally with hospital liability for negligence of hospital agents—as though the hospital were a monolithic entity in itself.

Lawyers seldom look further into the relation of the doctor to the hospital administration and vice versa; deeming this to be a matter of small concern to them. Doctors, of course, know well the importance of hospital politics and procedures to medical practice. Lawyers may be astonished at how directly medicolegal cases are affected by the complex relation of physicians to hospital administrations; at how important this relation is to the patient, and thus to the attorney who represents that patient, the physician, or the hospital.

Physician vis-a-vis Hospital

Most lawyers mistakenly over-estimate the authority of the physician in modern hospital planning and operation. (We speak here of the general, voluntary "charitable hospital," rather than of the small private clinic-hospital which may be hardly more than a large doctor's office by comparison.) True enough that the physician's own plans may affect those of the hospital, but basically today hospital administration and operation is largely a "profession" unto itself. It is no secret that hospital administrators and physicians often view each other as quite different and rather odd collaborators. In brief, the hospital as an organization in most cases today is run not by the doctors, but by administrators who mostly are not physicians. Yet the primary responsibility for care and cure of patients is on the doctors.

* Asst. Dean and Professor of Law, Cleveland-Marshall Law School; author and editor of various medicolegal, corporation, and other works; etc.

[*Editor's Note*: This frankly controversial article is a revised version of a paper prepared by the writer for delivery before the second annual joint meeting of the Bar Association and the Medical Society of Washington County, Pennsylvania, at Washington, Pa. on Sept. 12, 1959.]

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Moreover, the authority of the doctor over hospital personnel is distinctly limited. It is a mistake to view the doctor as the absolute commander of the little army of persons who look after the care and comfort of his patient in the hospital. The elaborate courtesy and respect shown by nurses, orderlies, technicians and other hospital personnel to the doctor is quite misleading in this respect. He controls and commands them only indirectly, through the chains of command of the hospital administration, and then only to a limited extent. Insofar as he gives orders directly, these "orders" are actually requests. The hospital administration commands the hospital personnel, lending their services to the physician, so-to-speak, but not giving to him anything like absolute control of them.

Finally, in physician vis-a-vis hospital relations, the physician ordinarily has little or nothing to say about the control or evaluation of hospital personnel performance. The doctor is sternly responsible for the effectiveness of the methods and procedures of cure of his patients. Yet he must delegate to hospital personnel most of the actual application of his prescribed curative procedures. He must delegate that much to people whom he cannot directly control. And if they do the job poorly he must depend on the hospital administration to educate or replace them.

It is amazing, under these conditions, that patients do not file even more hospital-negligence claims than they already do. It is no surprise at all that so many patients attribute to their doctors mistakes that may have been made by hospital employees.

In terms of hospital organization the physician is *in* the hospital and yet not *of* it. He has almost none of the executive power that normally accompanies high responsibility. Usually his only direct part in the hospital's organizational functioning is as a member of some technical advisory committee. If he spends time and effort trying to teach and advise nurses, technicians or other hospital personnel, he does so on his own initiative and not under any firm authority as part of the hierarchy of the hospital. Mostly he can only pray that they will be motivated by high moral principles to work hard at curing his patients. They certainly will not be motivated by financial gain—not under today's wage scales for hospital personnel.

The irony of all this is that it came to be because of the physicians' impatience with administrative work. Being scientists, the doctors long sought to free themselves of the drudgery of

administrative work in hospital operation. Now they find that they have succeeded all too well. Office managers, keepers of books and records, managers of supply and service, fund raisers, finance supervisors, and other purely non-scientist executives now operate the voluntary hospitals in most cases. *They* are the hospital administrators; and not often are they physicians. The doctors are not managing most of the hospitals any more, but they still are very much responsible for the patients in the hospitals. The doctors have become subordinates of the bureaucracies that they themselves fostered.

In government hospitals, curiously enough, this process has not gone as far as it has in voluntary hospitals. But even in government hospitals the same thing has happened to a somewhat lesser degree.

The tendency of some administrators to make themselves independent of (and controllers of) the scientists or scholars they are supposed to serve, is a widespread phenomenon of this century. This kind of bureaucracy is evident in some schools as well as in some hospitals, with the school supervisor or principal or other administrators telling the teachers what they can and cannot do. The same is true in many other modern types of organizations. This is the age of *the organization man,* as we all know. The true scientific or scholarly "professional man" is busy with his studies and pursuit of knowledge. The "organization man" is busy with organization politics and, too often, with self-advancement. Refusing to be quoted (for obvious reasons) many physicians are bitterly outspoken (in private) about physician-versus-administrator frictions in some hospitals. This is not true of all hospitals, but it is true of too many.

Meanwhile, the pupil in the school, or the patient in the hospital, is lost between two opposing camps in a world he never made.

But the sharpest irony of the situation, when the pupil or patient is hurt as a result, is that the lawyer for the injured person may not even suspect the existence of the invisible pressures and jealousies that may have led to the actual injury of commission or omission. To most lawyers the doctor in the hospital and the hospital with its doctors represent a simple, solid, uncomplicated concept. At most the average lawyer will draw a distinction between "medical services" and "administrative services"—lumping doctors and nurses and technicians with the first and cleaning women or window washers with the second.

Nice and simple—but a little too simple! The truth is that very often one element consists of the physician, lonely apart; while the rest, today, is "administration."

From this fundamental fact many legal consequences should flow far differently than they now do.

Malpractice vis-a-vis Hospital Negligence

By far most lawsuits for medical malpractice involve hospitals. Most such actions are based on injuries suffered in the operating room, through poor diagnostic procedures involving x-rays or other hospital equipment, improper post-operative techniques, and the like. Relatively few cases arise out of simple doctor-patient procedures in the doctor's office. Yet the whole idea of injury to a patient, anywhere, is closely associated in most people's minds with *fault on the part of the doctor.* Nor have the hospital administrators made any particular efforts to change this public opinion; quite the contrary, in some cases.

A brilliantly illuminating case decided in New York very recently, revealed much more than it expressly said, for those who have eyes to see. That was the case of *Morwin v. Albany Hospital* (7 A. D. (N. Y.) 2d 582 (Supr. Ct., App. Div., 3rd Dept., Apr. 23, 1959); 185 N. Y. S. 2d 85).

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.

Dr. S, while inserting the tube in Morwin's mouth, felt a tooth giving way. 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.

Now here the court became very subtle indeed. Not long ago New York had abolished the immunity of hospitals from liability for torts of their agents, in the celebrated case of *Bing v. Thunig* (2 N. Y. 2d 656, 163 N. Y. S. 2d 3, 143 N. E. 2d 3 (Ct. Appls., May 16, 1957)). New York had tried, before that, to distinguish between "medical" and "administrative" negligence, holding hospitals liable only for "medical" negligence. That distinction was impossibly elusive, as the cases showed. Administering a blood transfusion to the wrong patient was held to be administrative, while administering the wrong blood to the right patient was medical. Employing an improperly sterilized needle for a hypodermic injection was administrative, while improperly administering a hypodermic injection was medical; and so on. The *Bing* case said that "hospitals should, in short, shoulder the responsibilities borne by everyone else"; and as for immunity from liability, the immunity rule was abolished.

But in the *Morwin* case, the lower appellate court seized on another kind of distinction in order to free the hospital corporation from liability. That this was done at the expense of the physician did not seem to trouble the court at all. The court paid no attention to a New York Statute (Gen. Mun. L. § 50-d) which makes *municipal* hospitals liable specifically for *malpractice* of their doctors and dentists, though it strongly suggests what that State's public policy is as regards hospital liability. The distinction they employed was the technical legal difference between "negligence" and "malpractice."

Malpractice is peculiarly a term suggesting *professional* incompetence. Its essence is failure to use the degree of skill and care used by other practitioners in the particular specialty. *Anybody,* on the other hand, can be guilty of negligence—even hospital administrators. Only doctors can be guilty of medical malpractice. Obviously, said the hospital attorneys (and agreed the court) Dr. S was doing technical professional work, employing *professional judgment,* and no malpractice can exist if a choice of *judgment* is involved, at least not unless other experts condemn it, and even then probably not. So let's send the case back for new trial—*of Dr. S's professional judgment.*

The court (and hospital) passed the buck to the doctor, ordering a new trial. What matter that he definitely was a resident doctor (an agent of the hospital)! If he was guilty of malpractice the hospital would not be liable. By the time the jury understands the difference between malpractice and ordinary neg-

ligence, much can happen. Or the plaintiff, discouraged, may drop the whole thing. In any event, this leaves an out for the hospital.

A veritable *tour de force* of legal subtlety!

There is a side effect of this triumph of legalistic cleverness, however. Now the physicians really know how they stand, vis-a-vis some hospital administrators. *Outside!* The administrator runs the hospital. The doctor well knows already that *it is a privilege, not a right,* to practice in a non-governmental hospital. Now, according to the *Morwin* case, if a patient sues, the doctor is the ultimate target, not the hospital.

A pretty picture! To this have the learned physicians come—to be at the mercy of the bureaucracies that now own some of the doctors' hospitals. We must hasten to add that many hospital administrators will be just as shocked as the physicians by the concept expressed in the *Morwin* decision. But some administrators are sure to seize the opportunity it offers—perhaps only to be shocked in their turn, because there is a second joker in the joker of that "opportunity."

The hidden speciousness of the view embodied in the *Morwin* case is this: If the doctor actually *is* an incompetent, the ultimate fault is that of the administrator. If the administrator *is* the *boss,* then he must accept the responsibilities of a boss, not only the advantages. That is elementary law.

A master is personally liable for the torts of his servant done in the course and scope of his employment. And if the servant acts outside the course and scope of that employment (i.e.,—commits *malpractice*) the master is liable for hiring, or retaining in his service, a servant who he reasonably should have known to be incompetent or negligent. The negligence then may be *his*—that of the administrator, and of the hospital entity.

Lawyer vis-a-vis Hospital

In the light of the *Morwin* decision it behooves lawyers to take a long, hard look at hospital practices and procedures, and especially at the real relation of the doctor to the hospital and vice versa. The silent coolness between some doctors and some hospital administrators must be understood and properly evaluated. Then the lawyers must decide, in practical effect, which side they favor and with which side their own interests lie. They cannot ignore this situation without themselves becoming

pawns in the silent duels that rage inside some calm hospital walls.

In the crassest terms of self-interest most personal injury lawyers should recognize a new and vulnerable party in many hospital injury cases—the administrator. This is poetic justice, because in selling the doctor down the river the kind of administrator who does that may expose his own liability.

Put otherwise, 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. Then perforce he may accept the responsibility that should accompany his authority—accepting liability (where there is liability) for the hospital *as an entity,* a corporate unit of mutually helpful parts.

It does seem that here the more professional choice, for the lawyer, is the more constructive choice.

Of course not all voluntary hospital administrations are alike. Some hospitals have M.D.'s as administrators. Some have full-time medical directors. A few have full-time chiefs of medical services. But these technically-trained supervisors usually are merely added to the purely administrative organization, as separate parallel hierarchies ordinarily. This has not solved the problem of coordination of administrative and medical functions. Moreover, doctors in private practice disapprove of this system. And most physicians still do not want to become business managers.

Most doctors still view even M.D. administrators as rather businessmen than physicians, not quite as estimable as the pure scientist-physician. What they think of administrators who lack the M.D. degree is easy to imagine. Oddly enough, lawyers view hospital administrators as generally worthy of great respect. Any man who can achieve top executive authority usually is respected by most lawyers. After all, the big law retainers come from executives, not from scientists. But "the big executive" also is a choice target as a defendant, as well as as a client; more so than a poor staff resident. What's more, he is a far more vulnerable target, possibly being liable for the mistakes of anyone on the hospital staff, if he runs the show.

Ironic as it may sound, perhaps the kind of hospital administrator who sets himself above doctors may be, unwittingly and unwillingly, the means of curing some of the friction between the

legal and the medical professions. There is nothing like a common enemy to unite dissident allies.

There are some hospital administrators (fortunately, not most of them) who are prime examples of the modern organization man triumphant—in fine, the autocrat of modern bureaucracy and corporate organization, the "clever man" skilled chiefly in "political" maneuvering. As against this type, most men of the two chief learned professions, law and medicine, are among the last surviving exponents of individual study, labor and skill —the last of the rugged individualists who still believe in advancement by merit and achievement alone.

Take warning from what already has happened in so many schools, where teachers now are generally subservient to administrators; in the business world, where inventors are subservient to administrators, and in many other areas of our society where the tail now busily wags the dog.

When an "organization man" not only denies to the medical "professional man" control of his own hospital, but also makes him the *scapegoat* for "the organization," professional men must defend their rights if they are to survive. The skilled and dedicated scientist-scholar, not the organization-manager, must be the most important man in our hospitals. The hospital organization exists for the use of the physician, not the physician for the use of the organization. And it is the duty of lawyers to protect the fundamental *values* of our society.