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Hospital Corporate Liability -- Toward a Stricter Standard for Administrative Services

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HOSPITAL CORPORATE LIABILITY—TOWARD A STRICTER STANDARD FOR ADMINISTRATIVE SERVICES

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In the not too distant past, a patient who placed himself in the care of a hospital had no recourse against the institutional or corporate entity of the hospital for injuries received during treatment within its walls. The injured patient could look only to the attending physician to recover for the physician's malpractice or for his failure to supervise his supporting staff. The rule of *Schloendorff v. Society of New York Hospital*[1] was the law for many decades. In that case, Mr. Justice Cardozo wrote:

> Certain principles of law governing the rights and duties of hospitals, when maintained as charitable institutions have, after much discussion, become no longer doubtful. It is the settled rule that such a hospital is not liable for the negligence of its physicians and nurses in the treatment of patients. This exemption has been placed upon two grounds. The first is that of implied waiver. It is said that one who accepts the benefit of a

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1. 211 N.Y. 125, 105 N.E. 92 (1914). Charitable immunity barred suits against hospitals and medical facilities in South Carolina until the decision in Brown v. Anderson County Hospital Ass'n, 268 S.C. 479, 234 S.E.2d 873 (1977). There, a majority of the court stated that hospitals could not enjoy charitable immunity for "heedlessness and reckless disregard of the plaintiff's rights." *Id.* at 487, 234 S.E.2d at 877. Justice Ness wrote in dissent that charitable immunity should be abolished altogether. *Id.* at 488-91, 234 S.E.2d at 877-79.

The legislature responded to the *Brown* decision by abrogating the charitable immunity doctrine for all "tortious" acts of hospitals. S.C. CODE ANN. § 44-7-50 (1976). In 1981, Justice Ness' view prevailed and charitable immunity was abolished completely, for all types of organizations. Fitzer v. Greater Greenville Young Men's Christian Ass'n, 277 S.C. 1, 282 S.E.2d 230 (1981). In Moultrie v. Medical Univ. of S.C., 280 S.C. 162, 311 S.E.2d 730 (1984), the court affirmed a directed verdict against a teaching hospital for the negligence of its employees, apparently on the theory of *respondeat superior*. Thus, corporate liability for hospitals is a viable concept in South Carolina, at least within the bounds of *respondeat superior*.

> charity enters into a relation which exempts one's benefactor from liability for the negligence of his servants in administering the charity. The hospital remains exempt, though the patient makes some payment to help defray the cost of board. Such a payment is regarded as a contribution to the income of the hospital, to be devoted, like its other funds to the maintenance of the charity. The second ground of the exemption is the relation subsisting between a hospital and the physicians who serve it. It is said that this relation is not one of master and servant, but that the physician occupies the position, so to speak, of an independent contractor, following a separate calling, liable, of course, for his own wrongs to the patient whom he undertakes to serve, but involving the hospital in no liability, if due care has been taken in his selection. On one or the other, and often on both of these grounds, a hospital has been held immune from liability to patients for the malpractice of its physicians.[2]

Thus, the immunity enjoyed by hospital organizations has two bases: charitable immunity covering the entity itself, and a belief that hospitals lacked the control over the actions of physicians required for vicarious liability to be imposed.

It was not until the 1957 decision in *Bing v. Thunig*[3] that the courts recognized that the role of modern hospitals has changed dramatically since the turn of the century, when the hospital did little more than provide room and board for its unfortunate inmates. The court in *Bing* stated:

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

2. 211 N.Y. at 128-29, 105 N.E. at 93 (citations omitted).
3. 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957).

responsibility.

Hospitals should, in short, shoulder the responsibilities borne by everyone else. There is no reason to continue their exemption from the universal rule of *respondeat superior*. The test should be, for these institutions, whether charitable or profit-making, as it is for every other employer, was the person who committed the negligent injury-producing act one of its employees and, if he was, was he acting within the scope of his employment.[4]

While the court in *Bing* based its decision on the doctrine of *respondeat superior*, which holds a principal vicariously liable for the tortious conduct of his agent, a second theory of liability soon developed to hold a hospital *directly* liable for its negligence. In the past the law distinguished between the medical and administrative services performed by hospital employees. The decision in *Bing* addressed the problems inherent in this distinction:

The difficulty of differentiating between the "medical" and the "administrative" in this context, highlighted as it is by the disagreement of the judges below, is thus brought into sharp focus.

That difficulty has longed [sic] plagued the courts and, indeed, as consideration of a few illustrative cases reveals, a consistent and clearly defined distinction between the terms has proved to be highly elusive. Placing an improperly capped hot water bottle on a patient's body is administrative, while keeping a hot water bottle too long on a patient's body is medical. Administering blood, by means of a transfusion, to the wrong patient is administrative, while administering the wrong blood to the right patient is medical. Employing an improperly sterilized needle for a hypodermic injection is administrative, while improperly administering a hypodermic injection is medical. Failing to place sideboards on a bed after a nurse decided that they were necessary is administrative, while failing to decide that sideboards should be used when the need does exist is medical.[5]

The decision of the Illinois Supreme Court in *Darling v.*

4. *Id.* at 666-67, 143 N.E.2d at 8, 163 N.Y.S.2d at 11.
5. *Id.* at 660-61, 143 N.E.2d at 4-5, 163 N.Y.S.2d at 6.

Charleston Community Memorial Hospital[6] crystallized the sentiment that this distinction is artificial, unsound, and unpredictable. *Darling* established the principle of hospital corporate liability for negligence in the performance of its administrative duties. The standard of care announced in that decision requires that the hospital use due care not only in granting staff privileges to physicians but also in adequately supervising the treatment the physicians provide within its walls.[7]

Since *Darling*, courts have gone beyond its holding and have extended liability in circumstances in which the plaintiff could not have proven negligence. The decisions are scattered, and there is no unifying principle under which they fall. Some courts have decided in favor of plaintiffs under theories of hospital negligence that deviate significantly from traditional tort principles. Other courts have turned to theories of *res ipsa loquitur* or strict liability in tort. When the injury was caused by a dangerous medical product, some courts have been willing to consider patients' claims based upon strict products liability. To the extent that these cases adopt the policies underlying strict *products* liability, they reflect an orientation toward strict liability for hospital *services*.

This Article examines the trend toward strict liability against the background of traditional immunity of hospitals to liability in tort. It argues that the policy considerations behind implied warranty theory and strict products liability may also be extended to hospital administrative functions. It concludes that if these policies compel adoption of a strict standard of liability for "hospital malpractice,"[8] courts should further those objectives by clearly formulating a legal standard that encompasses

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6. 33 Ill. 2d 236, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966).

7. *See* Comment, *Piercing the Doctrine of Hospital Corporate Liability*, 17 SAN DIEGO L. REV. 383, 386-91 (1980). The general negligence standard is based upon the standard of conduct that would be expected from the ordinary prudent person exercising reasonable care and skill. The standard is an external or objective one rather than one of individual judgment. *See* W. PROSSER & W.P. KEETON, THE LAW OF TORTS § 32 at 73-74 (5th ed. 1984).

8. The stricter standards that are arising would apply only to hospital "malpractice" and not to physician negligence. Those hospital services traditionally governed by a negligence standard which might be subject to the stricter standard include the analysis of blood, the transportation of patients, the performance of other laboratory testing, and similar services. Nursing services and other professional functions should continue to be judged by a negligence standard regardless of how other services are governed.

both the service and product aspects of hospital care.

I. BACKGROUND

A. *Charitable Immunity*

As seen in *Schloendorff*, the traditional reluctance to impose direct liability on the hospital as a corporate entity stems from the doctrine of charitable immunity.[9] This concept arose in order to protect a charity's funds against diversion from charitable hospital purposes to nonmedical purposes. The medical and legal communities were concerned that without immunity from lawsuits, the very existence of the charity might be jeopardized. Although these concerns may have been legitimate in the past, the doctrine of charitable immunity has lost most of its vitality because, today, health care constitutes one of the largest industries in the nation. Thus, the financial necessity for immunity is no longer compelling.[10]

B. *Respondeat Superior*

Prior to *Darling*, an injured patient whose claim was not barred by charitable immunity could maintain a cause of action against a hospital only under the doctrine of *respondeat superior*. This doctrine holds a principal responsible for the torts of his agents, and generally requires the existence of an employment relationship. For this reason, patients were prevented from suing hospitals for the torts of staff physicians who were not hospital employees.[11]

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9. *See generally* Feoffees of Heriot's Hosp. v. Ross, 8 Eng. Rep. 1508 (1846).

10. *See* Cunningham v. MacNeal Memorial Hosp., 47 Ill. 2d 443, 266 N.E.2d 897 (1970). In response to the hospital's argument that it should be immune from suit, the court in *Cunningham* stated: "[W]e do not believe in this present day and age, when the operation of . . . hospitals constitutes one of the biggest businesses in this country, that hospital immunity can be justified on the protection-of-the-funds theory." 47 Ill. 2d at 457, 266 N.E.2d at 904.

11. Hospitals generally grant medical staff privileges to two types of "staff physicians." The first type receives no direct compensation from the hospital, but has the privilege of using hospital facilities in return for bringing in private patients from whom the hospital collects fees for its services. Additionally, these physicians are generally required to devote a nominal amount of time to the hospital in connection with clinical, administrative, or research functions. The second class is comprised of staff physicians who are employed full or part time and who devote most of their time to work in the

Even when the negligent physician is a hospital employee, some cases hold that *respondeat superior* is not available to hold the hospital liable.[12] Traditional agency theories fail when analyzing the physician-hospital relationship. At the heart of *respondeat superior* is the notion that the principal should be liable because he chooses to act through agents and controls their actions.[13] Hospital administrators, however, may not control physicians in the exercise of their professional medical judgment. Not only are they unqualified to do so, but such control would likely violate state medical practice statutes.[14]

Because the right-of-control test failed under these circumstances, courts created tests for liability which more accurately reflected the relationships among patient, physician and hospital. As early as 1903, courts held hospitals liable under a modified *respondeat superior* test. In that year, the California Supreme Court held in *Brown v. La Société Française de Bienfaisance Mutuelle*[15] that a two-pronged test should apply. The first element apparently asked whether the patient sought treatment primarily from the hospital. This factor is relevant because, unlike most tort victims, malpractice plaintiffs choose their tortfeasors.[16] Because of this factor, the courts should consider whether the patient looked primarily to the hospital or to the physician for treatment.

The second element of the test espoused in *Brown* concerned the relationship between the hospital and the physician, and considered whether the hospital paid the physician a salary.[17] This step in the analysis assures, in the interest of fairness to the hospital, that a close relationship exists between these

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hospital. Full time hospital physicians are not compensated on a fee-for-service or percentage basis, although they are usually expected to justify their salaries by providing medical services that create income for the facility.

12. *See* Kitto v. Gilbert, 570 P.2d 544 (Colo. App. 1977)(holding that a physician performing medical services in a hospital has the status of master or principal, not servant, and therefore the hospital cannot be held liable through *respondeat superior* for his negligence even though the physician is employed by the hospital).

13. *See* W. PROSSER & W.P. KEETON, *supra* note 7, § 70 at 500.

14. Comment, *The Hospital-Physician Relationship: Hospital Responsibility for Malpractice of Physicians*, 50 WASH. L. REV. 385 (1975).

15. 138 Cal. 475, 71 P. 516 (1903).

16. Comment, *supra* note 14, at 393-94.

17. 138 Cal. at 476, 71 P. at 516.

two actors.[18] When the physician is a salaried employee of the hospital and the patient sought treatment primarily from the hospital, liability is clearly established. When the physician receives compensation based only on the number of patients treated, the *Brown* holding would not extend liability to the hospital. However, some courts have held that a hospital may be liable for the tortious conduct of staff members who are clearly not salaried employees under an ostensible agency theory.[19]

C. *The* Darling *Decision As a New Basis for Liability*

Darling recognized that a hospital does not provide just room and board but is instead a multi-disciplinary unit which is independently responsible for the delivery of diverse services.[20] The facts of this landmark case were compelling. The plaintiff, a young college football player, sustained multiple leg fractures in the course of a game. Darling was taken to the Charleston Community Memorial Hospital, a small facility accredited by the Joint Commission on Accreditation of Hospitals and licensed by the state of Illinois. The plaintiff was treated by an on-call staff physician who was unskilled in orthopedics.[21] The leg was set

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18. Comment, *supra* note 14, at 396.

19. *E.g.*, Howard v. Park, 37 Mich. App. 496, 195 N.W.2d 39 (1972)(holding that while the defendant physician was actually an independent contractor, the defendant medical center remains liable because of the existence of an ostensible agency).

It has been suggested that the *Brown* test becomes strained when applied to a patient who seeks treatment primarily from the hospital but is referred to a nonsalaried staff physician. In such a case the *Brown* test alone may not support liability against the hospital, and the plaintiff may need to rely on an ostensible agency theory. Comment, *supra* note 14, at 403.

20. *See* Copeland, *Hospital Responsibility for Basic Care Provided by Medical Staff Members: "Am I My Brother's Keeper?,"* 5 N. KY. L. REV. 27, 33 (1978); Comment, *The Hospital's Responsibility for its Medical Staff: Prospects for Corporate Negligence in California*, 8 PAC. L.J. 141, 144 (1977).

21. 33 Ill. 2d at 334, 211 N.E.2d at 255. A separate cause of action for malpractice against the attending physician was settled out of court. The physician's negligence was therefore not at issue in the case against the hospital. There is considerable dispute whether this physician was actually employed by the hospital. Neither of the appellate opinions in *Darling* refers to the existence of any employment relationship. Yet, later cases give significant weight to the fact that the attending physician was a hospital employee. *See* Collins v. Westlake Community Hosp., 18 Ill. App. 3d 847, 299 N.E.2d 326 (1973); Lundahl v. Rockford Medical Hosp. Ass'n, 93 Ill. App. 2d 461, 235 N.E.2d 671 (1968). Notwithstanding the fact that the *Darling* court alternatively could have held the hospital liable under existing theories of *respondeat superior*, the case remains significant. *Darling* explicitly rejected vicarious liability for physician employee malpractice as

prematurely in a cast, causing edema and infection. For more than two weeks, Darling complained of pain. Nevertheless, the attending physician failed to seek a consultation from a specialist. While the nurses noted Darling's complaints, they failed to notify the attending physician of a foul odor emanating from the leg, failed to take blood tests which would have disclosed vascular deterioration, and failed to recognize symptoms of infection. The leg became gangrenous and was amputated after the efforts of another hospital to save the leg proved futile.

The Illinois courts permitted the plaintiff to maintain a cause of action directly against the hospital for the negligent selection and supervision of its staff employees.[22] Liability was based on the hospital's duty to use reasonable care in selecting and supervising its staff, which was independent of *respondeat superior* and flowed directly to the patient.[23] The imposition of a duty to supervise was unprecedented and was said to arise out of the hospital's "administrative" responsibilities in delivering medical services. Several courts adopting the *Darling* rationale, however, have gone beyond the negligence principles announced there, and have imposed liability under circumstances in which a negligence theory alone would not have been successful.[24] Thus, it becomes instructive to examine the decisions in order to provide guidance for hospitals in understanding their duties and the scope of their potential liability.

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the sole remedy available to an injured patient. The *Darling* rationale rests on the duty of the hospital staff to supervise the care provided in its facility. 33 Ill. 2d at 333, 211 N.E.2d at 256.

22. 33 Ill. 2d at 333, 211 N.E.2d at 256, *aff'g* 50 Ill. App. 2d 253, 200 N.E.2d 149 (1964).

23. *See also* Joiner v. Mitchell County Hosp. Auth., 125 Ga. App. 1, 186 S.E.2d 307 (1971), *aff'd*, 229 Ga. 140, 189 S.E.2d 412 (1972). In *Joiner*, a nonemployee staff physician negligently diagnosed a patient who subsequently died of a heart attack. The court held the hospital liable for failing to exercise due care in determining the doctor's competence. 125 Ga. App. at 3, 186 S.E.2d at 308.

24. *See, e.g.*, Fridena v. Evans, 127 Ariz. 516, 622 P.2d 463 (1980); Tucson Medical Center, Inc. v. Misevch, 113 Ariz. 34, 545 P.2d 958 (1976); Felice v. St. Agnes Hosp., 65 A.D.2d 388, 411 N.Y.S.2d 901 (1978); Purcell v. Zimbelman, 18 Ariz. App. 75, 500 P.2d 335 (1972). In *Fridena*, the court identified an "emerging trend" of holding a hospital liable for its failure to supervise staff members and to review medical treatment and held that the appropriate inquiry was whether the hospital had actual or constructive knowledge of the quality of treatment it provided. 127 Ariz. at 519, 622 P.2d at 466.

II. HOSPITAL CORPORATE LIABILITY BEYOND *Darling*

A. Liability for Negligent Selection of Staff Physicians

It seems clear that a hospital has an affirmative duty to all patients to use reasonable care in the selection of its medical staff.[25] This duty clearly was one of the bases for holding the hospital liable in *Darling*.[26] The decisions imposing this duty are not derived from some revolutionary doctrine but are grounded in traditional common law. For example, the New Jersey Superior Court in *Corleto v. Shore Memorial Hospital*[27] stated at the outset that a hospital is not liable for the negligence of a doctor who is not a hospital employee. The court stated, however, that in agency law, the negligent *engagement* of an independent contractor is itself an actionable tort. This act is independent of the physician's malpractice and renders the hospital directly, not vicariously, liable. While the result is hardly novel, the case is significant because the plaintiff joined as defendants not only the hospital as an independent entity but also the entire medical staff.[28]

In *Corleto*, the plaintiff urged that the hospital should be held liable because the medical staff, as an agent of the hospital, knew or should have known that the defendant physician was not competent to perform the procedure which resulted in injury. Although the court acknowledged that it was unlikely that

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25. *See* Tucson Medical Center, Inc. v. Misevch, 113 Ariz. 34, 545 P.2d 958 (1976); Purcell v. Zimbelman, 18 Ariz. App. 75, 500 P.2d 335 (1972); Gonzales v. Nork, 20 Cal. 3d 500, 573 P.2d 458, 143 Cal. Rptr. 240 (1978); Mitchell County Hosp. Auth. v. Joiner, 229 Ga. 140, 189 S.E.2d 412 (1972); Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966); Holton v. Resurrection Hosp., 88 Ill. App. 3d 655, 410 N.E.2d 969 (1980); Johnson v. St. Bernard Hosp., 79 Ill. App. 3d 709, 399 N.E.2d 198 (1979); Ferguson v. Gonyaw, 64 Mich. App. 685, 236 N.W.2d 543 (1975); Gridley v. Johnson, 476 S.W.2d 475 (Mo. 1972); Corleto v. Shore Memorial Hosp., 138 N.J. Super. 302, 350 A.2d 534 (1975); Bost v. Riley, 44 N.C. App. 638, 262 S.E.2d 391 (1980); Johnson v. Misericordia Community Hosp., 99 Wis. 2d 708, 301 N.W.2d 156 (1981).

26. 50 Ill. App. 2d at 333-34, 200 N.E.2d at 188-89.

27. 138 N.J. Super. 302, 350 A.2d 534 (1975).

28. The entire staff was implicated because no one could determine how much each member actually knew about the physician's professional competence. The *Corleto* court noted that there was precedent for designating the medical staff of a hospital as a party in civil litigation. 138 N.J. Super. at 312, 350 A.2d at 539. *See also* Greisman v. Newcomb Hosp., 40 N.J. 389, 192 A.2d 817 (1963); Joseph v. Passaic Hosp. Ass'n, 26 N.J. 557, 141 A.2d 18 (1958).

all 141 staff members knew or should have known of the specific act or of the individual physician's propensity to commit malpractice, it upheld the plaintiff's cause of action. The court cited *Darling* and expressly recognized the doctrine of hospital corporate negligence.[29] Liability here was predicated on the fact that, in fulfilling its administrative function of selecting and supervising treatment in the facility, the hospital must act through agents—the hospital staff.[30]

Although the *Corleto* case was subsequently settled, the fact that the court upheld a cause of action against an entire medical staff for an individual staff member's malpractice indicates that liability might be established even without any direct evidence of negligence. The plaintiff clearly was not prepared to prove fault on the part of each of the defendants. Nevertheless, in upholding the cause of action, the court chose to place the responsibility for medical staff functions directly on the medical staff. The decision, according to one commentator, "adds teeth to all the previous hospital corporate liability cases. It puts the onus on the medical staff . . . to police its own ranks."[31]

Hospitals may satisfy the standard of care for staff selection by inquiring into statements on a physician's application for staff membership. All colleges and hospitals which are listed on the application should be contacted. As with any employment application, gaps in time should be questioned. Hospitals should also seek out the applicant's peers in the profession to discover his reputation and qualifications. Administrators should be advised to check for board certification and to consult the county court files for past and pending malpractice actions.[32] It is important to note, however, that neither recommendation by other members of the medical staff nor reliance on the existence of a valid license to practice medicine is sufficient to meet this duty of care.[33] Ultimately, the responsibility is on the institution to

29. 138 N.J. Super. at 308, 350 A.2d at 538.

30. *Id.*

31. Couch, *Hospital Corporate Liability for Inadequate Quality Assurance Versus Physician's Actions for the Denial, Deferral or Limitation of Their Staff Privileges—Resolving the Dilemma in Pennsylvania*, 2 J. LEGAL MED. 14, 23 (1980).

32. *See generally* Note, Johnson v. Misericordia Community Hospital: *Corporate Liability of Hospitals Arrives in Wisconsin*, 1983 WIS. L. REV. 453.

33. *See, e.g.*, Mitchell County Hosp. Auth. v. Joiner, 229 Ga. 140, 189 S.E.2d 412 (1972).

monitor the competence of its staff.

B. Liability for Negligent Supervision

Darling also imposed on the hospital a duty to supervise[34] and review treatment within the facility.[35] This duty included a requirement that the hospital review physicians' compliance with established hospital procedures. In *Bost v. Riley*,[36] a North Carolina court held that a hospital must make a "reasonable effort" to monitor and oversee treatment. Since the hospital had required physicians to keep progress notes on each patient, the court reasoned that it had a further duty to see that this rule was followed.[37] The extent of the duty to supervise remains un-

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At the same time that hospitals were expected to tighten their criteria for staff admission, some courts were insisting that physicians applying for medical staff membership be afforded both procedural and substantive due process rights. *See generally* Loveridge & Kimball, *Hospital Corporate Negligence Comes to California*, 14 PAC. L.J. 803, 812 (1983). Thus, hospitals are forced to balance the physician's rights against its duty to its patients to provide a competent medical staff. *Id.*

34. Hospitals have also been held directly liable for breach of two other types of duties. The first is the duty to exercise reasonable care in providing proper medical equipment, medication, supplies, and food. *See* Note, *Corporate Negligence of Hospitals and the Duty to Monitor and Oversee Medical Treatment*, 17 WAKE FOREST L. REV. 309, 317 (1980)(citing Revenis v. Detroit Gen. Hosp., 63 Mich. App. 79, 234 N.W.2d 411 (1975)); Starnes v. Charlotte-Mecklenburg Hosp. Auth., 28 N.C. App. 418, 221 S.E.2d 733 (1976). *See also* Chandler Gen. Hosp. v. Purvis, 123 Ga. App. 334, 181 S.E.2d 77 (1971); Milner v. Huntsville Memorial Hosp., 398 S.W.2d 647 (Tex. Civ. App. 1966).

The second duty requires the hospital to use reasonable care in providing and maintaining safe premises, to repair known dangers, to warn of risks, and to inspect and discover unknown risks. *See* Note, *supra*, at 317 (citing Chandler Gen. Hosp. v. Purvis, 123 Ga. App. 334, 181 S.E.2d 77 (1971); Ackerburg v. Muskegon Osteopathic Hosp., 366 Mich. 596, 115 N.W.2d 290 (1962)). *See also* Norwood Clinic, Inc. v. Spann, 240 Ala. 427, 199 So. 840 (1941).

35. *See* Tucson Medical Center, Inc. v. Misevch, 113 Ariz. 34, 545 P.2d 958 (1976); Gonzales v. Nork, 20 Cal. 3d 500, 573 P.2d 458, 143 Cal. Rptr. 240 (1978); Holton v. Resurrection Hosp., 88 Ill. App. 3d 655, 410 N.E.2d 969 (1980); Foley v. Bishop Clarkson Memorial Hosp., 185 Neb. 89, 173 N.W.2d 881 (1970); Bost v. Riley, 44 N.C. App. 638, 262 S.E.2d 391 (1980). *Cf.* Fiorentino v. Wenger, 19 N.Y.2d 407, 227 N.E.2d 296, 280 N.Y.S.2d 373 (1967). In *Fiorentino*, the court held that a hospital is liable only if it is *grossly* negligent in failing to intervene. This would be the case, for example, if the hospital failed to intervene when it had *actual* knowledge that an act of malpractice would occur. The court was concerned that imposition of any higher duty would interfere with the physician-patient relationship. Note, *Hospital Corporate Liability: An Effective Solution to Controlling Private Physician Incompetence?*, 32 RUTGERS L. REV. 342, 363 (1979).

36. 44 N.C. App. 638, 262 S.E.2d 391 (1980).

37. *Id.* at 648, 262 S.E.2d at 396.

clear to date. At a minimum the cases require that any procedures established by the institution itself must be followed.

C. *Raising the Industry's Standard of Care*

In *Darling*, regulations, accreditation standards, and hospital bylaws were admitted into evidence as probative of industry custom. These items were held relevant to demonstrate both feasibility and constructive knowledge by the hospital administration of Darling's condition. The jury was properly instructed, however, that this evidence was not conclusive of the level of care which must be exercised.[38] This jury instruction was important because at issue in *Darling* was the existence of feasible, customary practices. Compare, for example, the California trial court decision in *Gonzales v. Nork*,[39] which purported to use *Darling* principles to impose a standard of care in hospital administration higher than that customarily practiced.[40]

In *Gonzales*, the patient suffered injuries which allegedly resulted from a staff physician's negligence. Gonzales sued the hospital directly for its failure to supervise and evaluate the competence of its medical staff.[41] The trial court held the defendant hospital liable for a physician's negligence despite its finding that the hospital had implemented a better-than-average peer review system for evaluating the quality of care rendered by the medical staff.[42] The court determined that its techniques for the evaluation of medical care were primitive, and thus, even the hospital's better-than-average performance would not absolve it of responsibility.[43] The court held that the hospital was liable notwithstanding its seemingly acceptable efforts to super-

38. 33 Ill. 2d at 332, 211 N.E.2d at 257.

39. Memorandum of decision, Civ. No. 228566 (Sup. Ct. Cal. Nov. 26, 1973).

40. As Dean Prosser stated: "[I]f the risk is an appreciable one, and the possible consequences are serious, the question is not one of mathematical probability alone . . . . As the gravity of the possible harm increases, the apparent likelihood of its occurrence need be correspondingly less to generate a duty of precaution." W. PROSSER & W.P. KEETON, *supra* note 7, § 31 at 171.

41. Memorandum of decision, Civ. No. 228566 (Sup. Ct. Cal. Nov. 26, 1973).

42. Although the hospital had no actual knowledge of the physician's propensity to commit malpractice, "it was negligent in not knowing. It was negligent in not knowing because it did not have a system for acquiring knowledge." Memorandum of decision, Civ. No. 228566 at 194 (Sup. Ct. Cal. Nov. 26, 1973).

43. *Id.*

vise the medical care provided within the facility. In light of the statement of the Illinois Court of Appeals in *Darling* that "[t]he duty of a hospital may not be fulfilled merely by utilizing the means at hand in the particular city where the hospital is located,"[44] the result in *Gonzales* should not be surprising. It must be remembered, however, that the *Darling* court was concerned with violations of *existing* regulations, standards, and bylaws, and not with conduct which met all established safety standards as in *Gonzales*. The court in *Gonzales* was forced to reach beyond the bounds of negligence law to impose liability based on a standard more stringent than that existing in the industry.

The California court in *Gonzales* thus attempted to set industry standards by judicial decree as did the widely criticized decision in *Helling v. Carey*.[45] In *Helling*, the Washington appellate court held a defendant ophthalmologist liable for malpractice in failing to administer a glaucoma test notwithstanding the low incidence of glaucoma among patients of the plaintiff's age. The physician argued that the test would not normally have been performed on such a patient and that his omission was not negligent according to prevailing medical standards. In rejecting the physician's argument that he had conformed to the common practice in the profession, the court in *Helling* declared that without regard to industry practice, "[c]ourts must in the end say what is required."[46] Just as *Helling* met with immediate criticism[47] and as a result of which was superseded by statute,[48] the *Gonzales* decision encountered similar resistance and was ultimately reversed on appeal.[49]

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44. 50 Ill. App. 2d at 313, 200 N.E.2d at 179.

45. 83 Wash. 2d 514, 519 P.2d 981 (1974).

46. *Id.* at 519, 519 P.2d at 983 (quoting The T.J. Hooper, 60 F.2d 737, 740 (2d Cir. 1932))(italics omitted). In a concurring opinion, Associate Justice Utter stated that even if reasonably prudent ophthalmologists would not have taken such a precaution, the physician should nevertheless be held liable under a theory of strict liability in tort for resulting injuries. 83 Wash. 2d at 520, 519 P.2d at 984.

47. The *Helling* decision spawned numerous spirited law review commentaries. *See generally* Wechsler & Classe, Helling v. Carey: *Caveat Medicus*, 48 J. AM. OPTOMETRISTS ASS'N 1526 (1977); Charfoos, Helling: *The Law of Medical Malpractice Rewritten*, 2 OHIO N.U.L. REV. 692 (1975).

48. The Washington legislature enacted a statute in the session immediately following the *Helling* decision which re-instituted the negligence standard. See WASH. REV. CODE § 4.24.290 (1975).

49. 60 Cal. App. 3d 728, 131 Cal. Rptr. 717 (1976), *rev'd*, 20 Cal. 3d 500, 573 P.2d 458, 143 Cal. Rptr. 240 (1978). The hospital did not appeal from the trial court's

While purporting to adopt the *Darling* rationale, the courts in *Corleto* and *Gonzales* have deviated from standards of care justified under a negligence theory. Rather, they have reached results that avoid inquiries into fault in imposing liability. When courts raise the standard of care required in hospital administration beyond mere negligence, the underpinnings of strict liability begin to take form.[50]

D. The Doctrine of Res Ipsa Loquitur

In the modern operating room, many specialized clinicians, using highly technical instruments, provide treatment. Consequently a patient encounters problems in proving responsibility for injuries occurring during the course of treatment. The problem becomes particularly compelling if the injury occurs while the patient is unconscious. To assist such an injured patient, courts sometimes invoke the doctrine of *res ipsa loquitur*.[51] This judicially created doctrine supplies an inference of negligence[52] in cases in which a plaintiff is injured by an instrumentality that was within the exclusive control of the defendant. To obtain the benefit of this inference, the plaintiff must prove that such an event generally does not occur in the absence of negligence and that the plaintiff was not contributorily negligent.[53] Once invoked, the doctrine of *res ipsa loquitur* shifts to the defendant

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decision.

50. *See* Weyna, Dubin v. Michael Reese Memorial Hospital and Medical Center: *Seeing Through the Product/Service Distinction*, 48 INS. COUNS. J. 399, 404-08 (1981).

51. *Res ipsa loquitur* means "the thing speaks for itself." *See* W. PROSSER & W.P. KEETON, *supra* note 7, § 39 at 242-44. The application of *res ipsa* is limited in medical malpractice litigation to cases in which the very nature of the injury is, even to the layperson, prima facie evidence that the treatment was improperly or negligently performed. Some courts, however, have been willing to enlist the assistance of experts to determine the applicability of the doctrine. *See* Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees, 154 Cal. App. 2d 560, 317 P.2d 170 (1957).

52. There is, in theory, a difference between a permissible inference and a rebuttable presumption. Unlike the rebuttable presumption, a permissible inference will not permit the plaintiff to request a directed verdict if the defendant does not meet his burden of rebutting the inference of negligence. The only practical difference between the two is that when the jury finds the probabilities of negligence to be fifty percent, the party without the burden of proof will prevail. *See* F. HARPER & F. JAMES, THE LAW OF TORTS 1100-03 (1956).

53. *See* Podell, *Application of Res Ipsa Loquitur in Medical Malpractice Litigation*, 44 INS. COUNS. J. 634, 642-43 (1977).

the burden of proving that his conduct was not negligent.[54]

Because the doctrine of *res ipsa loquitur* requires that the plaintiff establish that the defendant had exclusive control of the instrumentality causing the injury, it was of limited value in the hospital context where treatment is provided by a team of medical personnel. Until the landmark California decision in *Ybarra v. Spangard*,[55] courts refused to infer negligence against multiple defendants unless vicarious or joint liability could be established.[56]

In *Ybarra*, the court ventured into previously untraveled territory and permitted a patient who had suffered trauma to his shoulder while unconscious during an appendectomy to invoke *res ipsa loquitur* against all physicians and hospital personnel who "had any control over his body or the instrumentalities which might have caused the injuries."[57] According to the interpretation of the doctrine in *Ybarra*, neither the number of the defendants, nor their relationship, standing alone, would dictate the doctrine's applicability. By extending the principles of *res ipsa loquitur* to enable a plaintiff to reach an entire medical team, the court in *Ybarra* facilitated recovery by shifting the evidentiary burden to all persons possibly at fault.[58] *Ybarra*, however, was based solely upon negligence and did not abrogate traditional tort principles which require a showing of fault. *Res ipsa loquitur* provides only an inference of negligence that is clearly rebuttable; the reasonableness of each defendant's conduct thus remains at issue.[59]

More than twenty years later, a New Jersey court stretched the principles of liability articulated in *Ybarra* and announced a theory *requiring* that at least one of the multiple defendants be found negligent. In *Anderson v. Somberg*,[60] an injured patient

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54. The doctrine presupposes that the defendant has superior knowledge regarding the source of the injury. *See* W. PROSSER & W.P. KEETON, *supra* note 7, § 39 at 244.

55. 25 Cal. 2d 486, 154 P.2d 687 (1944).

56. The general rule is that when there are two or more defendants, the plaintiff cannot prove that it is "more likely than not" that either one was negligent. *See* W. PROSSER & W.P. KEETON, *supra* note 7, § 39 at 250-51. *But see* Summers v. Tice, 33 Cal. 2d 80, 199 P.2d 1 (1948).

57. 25 Cal. 2d at 494, 154 P.2d at 691. The court held that all defendants were required to come forth and meet the inference of negligence.

58. *Id.* at 492-94, 154 P.2d at 691.

59. *See* Podell, *supra* note 53, at 642-43.

60. 134 N.J. Super. 1, 338 A.2d 35 (1973), *aff'd*, 67 N.J. 291, 338 A.2d 1 (1975), *cert.*

sought to recover for injuries resulting when a metal fragment was severed from a surgical instrument during the course of an operation and became lodged in the patient's back.[61] In his complaint, the plaintiff joined four defendants: the physician for negligent use of the instrument; the hospital for furnishing a defective instrument; the distributor for breach of implied warranty; and the manufacturer for producing a defective instrument. In addition to permitting the suit against multiple defendants, the court instructed the jury that at least one of the defendants *must* be liable.[62]

The New Jersey Supreme Court stated that since there was no reasonable explanation for the occurrence except for negligence, and "[s]ince all parties had been joined who could reasonably have been connected with that negligence or defect, it was clear that one of those parties was liable, and at least one could not succeed in his proofs."[63] Yet, if the uncontradicted testimony of an expert metallurgist is to be believed, the strain on the instrument that caused the injury was probably cumulative over the course of several operations. The instrument could have contained microscopic cracks, unknown to either the surgeon or the hospital, caused by several instances of twisting or excessive force during use by *other* surgeons on the staff. The expert testified that no defect in the instrument was apparent. Arguably, the hospital had no duty to examine all surgical instruments under a microscope before each use. Under these facts, it cannot be said that *any* party was negligent, and the finding of liability commanded by the court is probably unjustified. The sole explanation for such a result is that the court was applying strict liability in tort for furnishing surgical instruments.[64] The court in

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denied, 423 U.S. 929 (1975).

61. The surgical instrument was a pituitary rongeur, a type of forceps used to remove soft tissue. The surgeon was using the instrument to remove disc material when the tip or "cup" of the angulated rongeur broke off while it was being manipulated in the plaintiff's spinal canal. From testimony at the trial, it was never established whether the break was caused by negligent use of the instrument or by a latent defect. The trial court also did not determine whether reasonable inspection of the instrument would have revealed a defect. 134 N.J. Super. at 3, 338 A.2d at 36.

62. 134 N.J. Super. at 5, 338 A.2d at 37.

63. 67 N.J. at 303, 338 A.2d at 7.

64. In the dissenting opinion, Justice Mountain pointed out that whether strict liability in tort would be recognized against hospitals, or whether an absolute duty of some other origin exists which would require the hospital to furnish nondefective instruments,

Anderson effectively held that under the circumstances the plaintiff need not meet even a minimal burden of proving negligence through *res ipsa loquitur*.

In practice, there may be little difference between assigning a nearly impossible burden of proof to rebut the inference of negligence, as in *Ybarra*, and prefacing the challenge by stating that, as a matter of law, at least one defendant will be unable to carry that burden. To the extent that the court in *Anderson* was willing to hold the hospital liable for furnishing a dangerous surgical instrument without proof of negligence, it undermined the fundamental tort principles on which *res ipsa loquitur* is founded.[65] Like *Corleto* and *Gonzales*, the *Anderson* decision suggests a willingness to impose a more stringent standard of liability when hospital services are in issue.[66]

III. STRICT LIABILITY FOR HOSPITAL PRODUCTS

At the same time that the doctrines of hospital corporate liability and *res ipsa loquitur* were being developed along one line of cases, another line of cases evolved for claims premised on strict liability in tort or breach of implied warranty against hospitals for furnishing products in the course of treatment. Both theories facilitate recovery by removing from the analysis inquiries into the defendant's conduct and by focusing primarily on the product that caused the injury. Section 402A of the *Restatement (Second) of Torts* holds the "seller" of a "defective product unreasonably dangerous to the user or consumer"

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were issues not presented for consideration. *Id.* at 308 n.3, 338 A.2d at 10 n.3 (Mountain, J., dissenting).

65. The court in *Anderson* did not actually label its analysis *res ipsa loquitur*. Nevertheless, one commentator suggested that "[p]erhaps it would be appropriate to call the *Anderson* two-part holding 'New Jersey *res ipsa*.'" Recent Developments, 51 WASH. L. REV. 981, 985 n.14 (citing Adamson, *Medical Malpractice: Misuse of Res Ipsa Loquitur*, 46 MINN. L. REV. 1043, 1053 (1962)).

66. The principle of *res ipsa loquitur* has commonly been referred to as a rule of sympathy for the unconscious patient because it puts the burden on the defendants to give an explanation for the cause of the plaintiff's injuries. The traditional justification for this doctrine is that evidence is usually inaccessible to patients. Critics have argued that this justification does not acknowledge that the evidentiary difficulties have been somewhat alleviated by the modern expansion of discovery procedures. *See* FED. R. CIV. P. 26(b)(3). Nevertheless, the liberal discovery rules may not benefit an injured plaintiff who is unable to gather sufficient information to frame his cause of action.

strictly liable, without fault, for the consumer's injuries.[67] The counterpart to section 402A in the Uniform Commercial Code is the implied warranty of merchantability.[68] The Code requires that a plaintiff injured by a product show that there was a "sale" of a product "not fit for the ordinary purposes" for which it was purchased.[69]

Although these requirements are minimal, they have proven to be difficult to apply in the health care context because the "product" is usually part of treatment and does not resemble the typical consumer-sales transaction. Moreover, because the warranty theory is based in contract law, courts have interpreted "sale" more narrowly in warranty cases than in tort actions under section 402A. Consequently, most courts that have considered the issue have refused to hold hospitals liable under breach of warranty for injuries resulting from the use of defective products.[70]

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67. Section 402A of the Restatement provides:

(1) One who sells any product in a defective condition unreasonably dangerous to the user or consumer or to his property is subject to liability for physical harm thereby caused to the ultimate user or consumer, or to his property, if
  (a) the seller is engaged in the business of selling such a product, and
  (b) it is expected to and does reach the user or consumer without substantial change in the condition in which it is sold.

(2) The rule stated in Subsection (1) applies although
  (a) the seller has exercised all possible care in the preparation and sale of his product, and
  (b) the user or consumer has not bought the product from or entered into any contractual relation with the seller.

RESTATEMENT (SECOND) OF TORTS § 402A (1965). "Unreasonably dangerous," within the meaning of § 402A, can also include "failure to warn." A product, although not contaminated or broken or otherwise different from products of its kind, can nevertheless be defective if it is not accompanied by an adequate warning of its dangers. *See* Davis v. Wyeth Laboratories, Inc., 399 F.2d 121 (9th Cir. 1968); Crane v. Sears, Roebuck & Co., 218 Cal. App. 2d 855, 32 Cal. Rptr. 754 (1963); RESTATEMENT (SECOND) OF TORTS § 402A comment j (1965). *See also* Dubin v. Michael Reese Hosp. & Medical Center, 74 Ill. App. 3d 932, 393 N.E.2d 588 (1979).

68. U.C.C. § 2-314, 1 U.L.A. 371 (1976).

69. J. WHITE & S. SUMMERS, UNIFORM COMMERCIAL CODE § 9-7 (2d ed. 1980). For a discussion of strict products liability and warranty theory in the hospital context, see Rubin, *Manufacturer and Professional User's Liability for Defective Medical Equipment*, 8 AKRON L. REV. 1 (1971).

70. *See generally* Magrine v. Krasnica, 94 N.J. Super. 228, 227 A.2d 539 (1967), *aff'd*, 53 N.J. 259, 250 A.2d 129 (1969); Perlmutter v. Beth David Hosp., 308 N.Y. 100, 123 N.E.2d 792 (1954). *Cf.* Cunningham v. MacNeal Memorial Hosp., 47 Ill. 2d 443, 266 N.E.2d 897 (1970)(hospital held liable for providing contaminated blood on the theory that blood is a product).

The New York Court of Appeals decision in *Perlmutter v. Beth David Hospital*[71] and the New Jersey decision in *Magrine v. Krasnica*[72] illustrate the judicial reluctance to impose liability upon hospitals for breach of warranty. In *Perlmutter*, the plaintiff was injured by a transfusion of contaminated blood,[73] while in *Magrine* the product was a defective dental needle.[74] The courts in both cases adopted what has been coined the "essence of the transaction" test.[75] Under this test, if the performance of a service forms the essence of the transaction, there can be no breach of implied warranty even if a product was the source of the injury. In contrast, the "essence" of a sale transaction between a retailer and consumer is the sale itself.[76] Because the courts in *Perlmutter* and *Magrine* found that the hospital and the dentist, respectively, were engaged primarily in providing services, they declined to impose liability.

In contrast to the narrow interpretation of "sale" in breach of warranty cases, courts have interpreted "sale" broadly in tort

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71. 308 N.Y. 100, 123 N.E.2d 792 (1954).

72. 94 N.J. Super. 228, 227 A.2d 539 (1967), *aff'd*, 53 N.J. 259, 250 A.2d 129 (1969).

73. 308 N.Y. at 103, 123 N.E.2d at 796.

74. 94 N.J. Super. at 230, 227 A.2d at 540. The plaintiff in *Magrine* sued only the dentist, who could not determine the manufacturer of the needle.

75. *See generally* Murray, *Under the Spreading Analogy of Article 2 of the Uniform Commercial Code*, 39 FORDHAM L. REV. 447 (1971); Farnsworth, *Implied Warranties of Quality in Non-Sales Cases*, 57 COLUM. L. REV. 653 (1957).

76. This test is not unique to the health care context. In Newmark v. Gimbels, Inc., 54 N.J. 585, 258 A.2d 697 (1969), the court, while reaffirming the *Magrine* decision, held that a beauty parlor, in applying a lotion to the plaintiff's hair, had transacted both a sale and a service. Thus, the court in *Gimbel* did not distinguish *Magrine* from the case in which the product was sold separately for the plaintiff to apply herself.

When the sales/service distinction has been applied to hospitals, the plaintiff has attempted to characterize the defendant-hospital as a supplier of the "goods" in question. In Silverhart v. Mt. Zion Hosp., 20 Cal. App. 3d 1022, 98 Cal. Rptr. 187 (1971), a surgical needle broke and lodged in the patient's lower pelvic region during a hysterectomy. The plaintiff urged that the hospital, as a "supplier" of a defective product, should be held strictly liable. The court in *Silverhart* observed that other cases had decided that the warranty provisions were applicable to retailors, bailors, and lessors. Nevertheless, the court distinguished these cases, holding that the hospital did not play the same integral role in the production and marketing of the product. The court determined that when the hospital obtained the instrument, it was merely a piece of equipment and the hospital was merely a "user." Thus, the essence of the relationship between the plaintiff and the defendant was the delivery of professional services, not the distribution of a product. The court concluded that the policy considerations justifying strict products liability for the marketing of defective products did not extend to the professional relationship between physicians and patients where the elements of a sale were not present. 20 Cal. App. 3d at 1028, 98 Cal. Rptr. at 191.

actions under section 402A.[77] Notwithstanding the more flexible interpretation, however, it remains difficult to determine whether there has been a "sale" in strict liability actions.[78] Nevertheless, patients injured by health care providers have achieved better success using a strict liability theory than using the principles of breach of warranty.

The Supreme Court of Illinois was the first to permit a patient to recover under strict products liability for injuries caused by a defective medical product. In *Cunningham v. MacNeal Memorial Hospital*,[79] the court rejected the defendant hospital's argument that furnishing blood for transfusions did not constitute the sale of a product.[80] Because the provision of blood was ancillary to medical services, the court determined that the sale was separable from the service and therefore was subject to the provisions of section 402A.[81] Consequently, the hospital was held strictly liable because contaminated blood is unreasonably dangerous.[82]

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77. Cunningham v. MacNeil Memorial Hosp., 47 Ill. 2d 443, 266 N.E.2d 897 (1970), held that the transfusion of blood was a "sale" of a product under § 402A. *Cunningham* relied primarily on the statement in RESTATEMENT (SECOND) OF TORTS § 402A comment f (1965) that, "It is not necessary that the seller be engaged solely in the business of selling such products."

78. *Cf.* Barbee v. Rogers, 425 S.W.2d 342, 346 (Tex. 1968). The *Barbee* court held that the improper fitting and prescription of contact lenses was not a sale of an unreasonably dangerous product under § 402A.

79. 47 Ill. 2d 443, 266 N.E.2d 897 (1970).

80. In rejecting the sales/service distinction, the court remarked: "It seems to us a distortion to take what is, at least arguably, a sale, twist it into the shape of a service, and then employ this transformed material in erecting the framework of a major policy decision." *Id.* at 450, 266 N.E.2d at 901 (quoting Russell v. Community Blood Bank, Inc., 185 So. 2d 749, 752 (Fla. Dist. Ct. App. 1966)).

81. 47 Ill. 2d at 447, 266 N.E.2d at 900-01. The court relied upon public policy considerations in proclaiming that the institution that has undertaken the duty to *provide* and *distribute* the defective product for human consumption should bear the legal consequences of the entire transaction. *Id.* at 457, 266 N.E.2d at 904.

82. The evolution of the "bad blood" cases is a very interesting part of products liability law. These cases often are concerned with undiscoverable or unavoidable dangers. In Brody v. Overlook Hosp., 127 N.J. Super. 331, 317 A.2d 392 (1974), *aff'd*, 66 N.J. 448, 332 A.2d 596 (1975), the plaintiff's decedent became ill and died from hepatitis after receiving a blood transfusion at the defendant hospital. The blood used for transfusion came from both the hospital and the nonprofit county blood bank. In considering the liability of the hospital, the court stated that the relationship between the hospital and blood bank in no way resembled a commercial enterprise, and thus the policies of strict liability did not apply. 127 N.J. Super. at 336, 317 A.2d at 395. The court further stated that at the time of the transfusion there were no known tests for determining whether blood contained a hepatitis virus. The presence of the virus was unavoidable, the product

Once a court makes the threshold determination that a defendant has engaged in the sale of a product, the plaintiff still must prove that the product was defective and that an injury resulted from its use. With respect to surgical instruments or impure drugs, the defect typically relates to a condition inherent in the product itself. A defect may also arise, however, out of a failure to warn of unavoidable dangers in the product. It is the failure to warn, not the danger itself, that makes the product unreasonably dangerous.[83] Generally, the warning should be part of the packaged product. However, in the case of most hospital products, such as contaminated blood or x-radiation, the patient never sees the "package," so the warning is effectively a service which, if provided at all, must come as an administrative function of the hospital.

In *Dubin v. Michael Reese Hospital and Medical Center*,[84] the Illinois Court of Appeals expanded the *Cunningham* decision and held that the hospital's failure to warn the plaintiff of the carcinogenic properties of x-radiation prior to giving treatment rendered the "product" defective and unreasonably dangerous.[85] Although ultimately reversed by the Illinois Supreme

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was highly useful and desirable, and the risk was known but reasonable. Thus, the product was not unreasonably dangerous. *Id.* at 338, 340, 317 A.2d at 396, 397.

While *Brody* concerned a charitable blood bank, statistics reveal that blood from paid donors in large cities is ten times more likely to carry a hepatitis virus than blood from volunteers. *See* Franklin, *Tort Liability for Hepatitis: An Analysis and a Proposal*, 24 STAN. L. REV. 439 (1972). Because of this increased risk, the FDA now requires that blood from paid donors must be labeled as such. 21 C.F.R. § 606.120(b)(2)(1978). This opens the way for liability when the hospital uses blood purchased from a commercial blood bank. To reduce the liability exposure of blood providers and hospitals, many states have enacted statutes which provide that implied warranties and/or strict liability in tort shall not apply to blood transactions. *Compare* S.C. CODE ANN. § 44-43-10 (1976) (literally applies only to implied warranties) *with* CAL. HEALTH & SAFETY CODE § 1606 (West 1979)(eliminates both implied warranty and strict liability for these transactions). *See generally* W. KEETON, D. OWEN & J. MONTGOMERY, CASES AND MATERIALS ON PRODUCTS LIABILITY AND SAFETY 458-60 (1980).

The Illinois legislature eviscerated much of the *Cunningham* decision, although the restrictive statute specifically eliminated only "blood, blood products and other human tissues." ILL. REV. STAT. ch. 91, §§ 181-84 (1977).

83. *See* RESTATEMENT (SECOND) OF TORTS § 402A comments j, k (1965).

84. 74 Ill. App. 3d 932, 393 N.E.2d 588 (1979), *rev'd*, 83 Ill. 2d 277, 415 N.E.2d 350 (1980).

85. The defendant hospital treated the plaintiff's tonsillitis with x-radiation. Many years later, the plaintiff developed cancer. He alleged that the hospital had been negligent in administering treatment and that it should be strictly liable in tort for supplying a defective product. 74 Ill. App. 3d at 933, 393 N.E.2d at 590.

Court, the appellate court, in permitting an action in strict products liability, concluded that "the supply of x-radiation . . . for treatment purposes by a hospital, for which a charge is made, places such hospital in the business of introducing such x-radiation in the stream of commerce."[86] Satisfied that the sale element was present, the court determined that x-radiation could be considered a product that was unreasonably dangerous if no warning was provided.[87] Although the failure to warn under some circumstances might be considered a product defect, providing an explanation or warning of dangerous side effects to treatment is, in the hospital context, an administrative service.

In most "failure to warn" cases, courts will hold the defendant liable only if he knew or should have known of his product's dangers.[88] In essence, the standard for warning defects is one of negligence and therefore could fall within the ambit of *Darling*.[89] In *Dubin*, however, the hospital claimed that the state of the art was such that it could not have known of the dangers associated with x-radiation. This standard arose from the decision in *Woodhill v. Parke, Davis & Co.*,[90] which held that it was necessary for a plaintiff in a products liability action to allege that the manufacturer knew or should have known of the prod-

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86. *Id.* at 945, 393 N.E.2d at 597.

87. *Id.* at 943, 393 N.E.2d at 595. *Dubin* remains important also for its definition of "product":

> [W]e find that a "product" with an unreasonably dangerous condition may subject those responsible for placing it in the stream of commerce to strict liability in tort . . .; may be unchanged from its natural state, viable, and not the result of a manufacturing process; must be of a fixed nature; and must be capable of being placed in the stream of commerce. Moreover, to satisfy the public policy reasons underlying the concept of strict liability in tort, we must also find that the "product" is something that may endanger human life and health; something whose intended use has been solicited and thought to be safe and suitable; and something that has reaped a profit for those placing it in the stream of commerce.

Id. at 939, 393 N.E.2d at 593.

88. *E.g.*, Borel v. Fibreboard Paper Products Corp., 493 F.2d 1076 (5th Cir. 1973), *cert. denied*, 419 U.S. 869 (1974). *See generally* Shandell, *Failure to Warn—A Drug Manufacturer's Liability*, 14 TRIAL LAW Q. 5 (1982).

89. One commentator has noted that "[t]he requirement that the defendant have had knowledge of the defect is a puzzling intrusion of negligence theory into the area of strict liability. Only a *negligent* failure to warn is regarded as a defect." Weyna, *supra* note 50, at 408 (emphasis in original).

90. 58 Ill. App. 3d 349, 374 N.E.2d 683 (1978).

uct's dangers.[91] The appellate court in *Dubin* held that since subsequent research ultimately revealed the hazards, the hospital could be held strictly liable.[92] The Illinois Supreme Court reversed, holding that there was no allegation that the x-radiation itself was unreasonably dangerous. Rather, the plaintiff's case rested on the inappropriateness of the *application* of x-radiation in treating the plaintiff's condition. Therefore, the thrust of the plaintiff's argument was that the "danger" resulted not from a product, but from the medical decision to administer x-radiation. Such errors of professional judgment were held to be governed by a negligence standard, not one of strict liability.[93]

The Illinois courts in *Dubin* and *Cunningham* overcame the obstacle of the sales/service distinction, which was premised on the existence of an identifiable product. "Product" was broadly defined in these decisions, but the cases ostensibly did not extend strict liability to reach hospital administrative services. One of the most recent decisions extending the principles of strict products liability to reach the hospital itself was that of the Texas Court of Civil Appeals in *Providence Hospital v. Truly*.[94] During the course of an eye operation, the physician injected into the plaintiff's eye a contaminated ocular fluid which resulted in severe eye damage.[95] The fluid had been supplied by the hospital pharmacy, where it had been sterilized and stored in a vial containing a solution of formaldehyde.[96] Although the allegedly contaminated vial was never recovered, the trial court found that improper handling of the vial during the sterilization process caused the contamination.[97]

The plaintiff alleged negligence, implied warranty and strict liability against both the hospital and Cooper Laboratories, the manufacturer of the drug. The jury absolved the hospital of negligence, but found for the plaintiff against the hospital on the warranty count. The court of civil appeals affirmed, rejecting the

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91. *Id.* at 351, 374 N.E.2d at 686. Because the defendant in *Dubin* did not assert this as a ground for dismissal, he was foreclosed from arguing the issue. 74 Ill. App. 3d at 945-46, 393 N.E.2d at 598.

92. 74 Ill. App. 3d at 934, 393 N.E.2d at 596.

93. 83 Ill. 2d 277, 280-81, 415 N.E.2d 350, 352 (1980).

94. 611 S.W.2d 127 (Tex. Civ. App. 1980).

95. *Id.* at 129.

96. *Id.*

97. *Id.*

hospital's contention that implied warranty and strict liability actions could not be maintained against hospitals and other health-care providers.[98]

The court noted that the Texas Business and Commerce Code specifically excluded only "blood, blood plasma or other human tissue or organs"[99] from the coverage of implied warranty, and determined that all others were to be included.[100] In making the sales/service distinction in the warranty context, the court in *Truly* implied that, regardless of the existence of a "sale" of a defective product, the hospital's administrative services in selecting and preparing the product for use would subject it to strict liability if carried out improperly.[101]

The following year, the same court in *Thomas v. St. Joseph Hospital*[102] held a hospital strictly liable for fatal burns to a patient whom it had provided with an inflammable hospital gown.[103] The appellate court characterized the hospital's furnishing of the gown as a hybrid sales/service transaction, holding that the supply of the product was an integral part of providing its service.[104] Moving away from the "essence of the transaction" analysis, the court in *Thomas* examined the intrinsic nature of

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98. *Id.* at 131.

99. The statute upon which the plaintiff's implied warranty claim was based recognized only the following exclusion:

> The implied warranties of merchantability and fitness shall not be applicable to the furnishing of human blood, blood plasma, or other human tissue or organs from a blood bank or reservoir of such other tissue or organs. Such blood, blood plasma or tissue or organs shall not for the purpose of this Title [Title 1 of the Uniform Commercial Code] be considered commodities subject to sale or barter, *but shall be considered as medical services.*

TEX. BUS. & COM. CODE ANN. § 2.316(e)(Vernon 1968), *cited in Truly*, 611 S.W.2d at 133 (emphasis supplied by the court in *Truly*).

100. 611 S.W.2d at 133.

101. *Id.* at 132.

102. 618 S.W.2d 791 (Tex. Civ. App. 1981).

103. The action was brought by the survivor of a patient who died from severe burns after he dropped a lighted match on his hospital gown. The alleged manufacturer of the gown was granted a directed verdict on the basis that the evidence was insufficient to establish that it was indeed the manufacturer. The jury found that the hospital was not negligent but returned a verdict in the amount of $46,500 for the plaintiff on the joint allegation of breach of warranty and strict liability. *Id.* at 793-94.

104. The court noted that the gown had been billed to the patient as part of the hospital's overhead. In distinguishing prior cases that had found strict liability inapplicable to health care providers, the court held that the medical services were dependent upon the supply of the product. *Id.* at 796-97.

the service to determine whether strict liability should apply.[105]

IV. STRICT LIABILITY FOR HOSPITAL SERVICES

The policy considerations that led to the adoption of strict liability for defective products may also apply to support its extension to services transactions. In *Johnson v. Sears, Roebuck & Co.*,[106] a federal district court in Wisconsin bridged the conceptual difference between "services" and "products" and held that a hospital could be strictly liable for defective services under limited circumstances. The court in *Johnson* rejected the sales/service distinction and determined that the relevant inquiry was "whether it [was] in the public interest for the consumer/patient or the supplier/hospital to bear the loss incurred by defective, though non-negligent, services."[107] As policies weighing in favor of strict liability on the facts of that case, the court considered that serious consequences can result when a patient receives defective hospital services, that laymen are unable to recognize or control defective services, and that doctors rely on the hospital for information about their patients' conditions.[108] The court stated:

> It is argued, since strict tort liability should not apply to professional medical services by doctors (if that is true, and I believe it is without deciding so at this time), that it follows that strict liability should not apply to mechanical and administrative services by hospitals. I do not think this follows. Medical sciences are not exact. A patient cannot consider a doctor's treatment to be defective simply because it does not cure his ailment. All that a doctor can be expected to provide is adequate treatment commensurate with the state of medical science. In other words, doctors do not contract with patients to provide cures but rather to provide treatment in a non-negli-

105. *Id.*

106. 355 F. Supp. 1065 (E.D. Wis. 1973).

107. *Id.* at 1066. *Johnson* may be read as standing for the principle that one of the "mechanical" services that a hospital provides is the training of physicians and personnel to use its equipment. Thus, under *Johnson* the hospital can be held strictly liable for its failure to properly discharge that responsibility. *See also* Cunningham v. MacNeal Memorial Hosp., 47 Ill. 2d 443, 266 N.E.2d 897 (1970); Hoffman v. Misericordia Hosp., 439 Pa. 501, 267 A.2d 867 (1970); Grubb v. Albert Einstein Medical Center, 255 Pa. Super. 381, 387 A.2d 480 (1978).

108. 355 F. Supp. at 1067.

> gent manner. To hold medical professionals strictly liable under these circumstances would not promote any social benefit. In fact, if that standard were applied to doctors, it might make them reluctant to assume responsibility for the treatment of patients, particularly when such treatment involves a developing area of medicine, which would work a serious social disservice.[109]

The court in *Johnson* concluded that in view of the vague distinction between professional and nonprofessional (administrative) services within the hospital, the applicability of strict liability to hospitals should be determined on an ad hoc basis[110] depending upon whether, under the circumstances, the public interest would be served.[111]

The Wisconsin Supreme Court discussed the *Johnson* decision in *Hoven v. Kelble*,[112] a malpractice action in which the plaintiff attempted to use *Johnson* to maintain a strict liability claim against his physician and the hospital. The court distinguished *Johnson* by noting that the plaintiff in *Hoven* alleged defective professional services. The court emphasized that *Johnson* would permit strict liability only for mechanical or administrative hospital functions and would not extend it to professional medical services.[113] The court noted that *Johnson* has been criticized for distinguishing between professional and administrative or mechanical services, a distinction which is at least as vague and confusing as the sales/service test abandoned in *Johnson*.[114] Furthermore, the Wisconsin court attacked the plaintiff's contention that other cases have upheld strict liability in tort or implied warranty actions where "defective services"

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109. *Id.* at 1066-67.

110. The court acknowledged that most jurisdictions, including Wisconsin, distinguished between sales and services and applied strict products liability only to sales transactions. The court in *Johnson* stated that liability should not be based upon a mechanical application of the sales/service distinction, but should be based upon the policy interests which impose liability. *Id.* at 1066.

111. *Id.* at 1067. The court in *Johnson* noted that the sales/service characterization had been abrogated in several contemporary cases. *Id.* at 1066. *See* Buckeye Union Fire Ins. Co. v. Detroit Edison Co., 38 Mich. App. 325, 196 N.W.2d 316 (1972); Newark v. Gimbel's, Inc., 54 N.J. 585, 258 A.2d 697 (1969); Hoffman v. Misericordia Hosp., 439 Pa. 501, 267 A.2d 867 (1970).

112. 79 Wis. 2d 444, 256 N.W.2d 379 (1977).

113. *Id.* at 466, 256 N.W.2d at 390.

114. *Id.* at 466 n.13, 256 N.W.2d at 390 n.13.

caused injury. Cases cited in support of that proposition concerned services of a routine or simple nature;[115] the decisions are unanimous in requiring that negligence be shown in order to recover when professional services are allegedly defective.[116]

A Pennsylvania superior court in *Grubb v. Albert Einstein Medical Center*[117] also cited *Johnson* in holding that while the professional services of physicians would continue to be governed by a negligence standard, a hospital may be strictly liable for its administrative services. The issue before the court in *Grubb* was whether the hospital should be subject to strict liability for supplying an allegedly defective surgical tool.[118] The court in *Grubb* cited with approval the court's reliance in *Johnson* upon public policy concerns as a means of establishing the proper standard of liability.[119] The opinion stated:

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115. *Id.* at 463, 256 N.W.2d at 388 (citing Broyles v. Brown Eng'g Co., 275 Ala. 35, 151 So. 2d 767 (1963); Buckeye Union Fire Ins. Co. v. Detroit Edison Co., 38 Mich. App. 325, 196 N.W.2d 316 (1972); Hill v. Polar Pantries, Inc., 219 S.C. 263, 64 S.E.2d 885 (1951)).

116. 79 Wis. 2d at 462-63, 256 N.W.2d at 388-89 (citing La Rossa v. Scientific Design Co., 402 F.2d 937 (3d Cir. 1968); Allied Properties v. John A. Blume & Assocs., 25 Cal. App. 3d 848, 102 Cal. Rptr. 259 (1972); Magner v. Beth Israel Hosp., 120 N.J. Super. 529, 295 A.2d 363 (1972); Hoover v. Montgomery Ward & Co., 270 Or. 498, 528 P.2d 76 (1974); Barbee v. Rogers & Rogers, 425 S.W.2d 342 (Tex. 1968)).

The court in *Hoven* concluded:

> There have been many studies of the delivery of health care in this country and of the problems of the malpractice concept of tort liability. Although there may be general dissatisfaction with our present tort medical injury compensation system, moving from the malpractice concept—even with its many problems—to a strict liability system at the present time appears to be a dubious move. Strict liability has been far from a panacea in products cases, and there has been reluctance to advocate the extension of the principle to medical services. Several commentators have proposed "no-fault liability" in lieu of negligence or strict-liability concepts. The ability of the judicial system to create a scheme of strict liability or no-fault liability rules for medical accidents has been questioned. Because of the unknown costs and the inability to assess the results, commentators have shied away from advocating the adoption of full programs of strict liability or no-fault liability in the medical service area and have suggested that the legislature and private groups establish experimental and elective techniques to deal with injuries occurring from medical services. *The Report of the Secretary's [Dep't. of Health, Education & Welfare] Commission on Medical Malpractice*, p. 100 (1973), concluded that it could not recommend adoption of an untested system which may cause even more severe problems than exist under medical malpractice.

79 Wis. 2d at 471-72, 256 N.W.2d at 392-93.

117. 255 Pa. Super. 381, 387 A.2d 480 (1978).

118. This issue was left open in *Anderson v. Somberg*. *See supra* note 64.

119. 255 Pa. Super. at 401, 387 A.2d at 490.

> In adopting the strict liability as set forth we are making a reasonable extrapolation from the already expanding interpretation of 402A, and clear policy considerations. The surgical patient is without control over the procedures and instruments used upon him. His health and future safety are at the mercy and skill of the treating physicians and the instruments he employs.[120]

V. ANALYSIS

The law of hospital malpractice has changed dramatically since the concepts of charitable immunity and *respondeat superior* developed, and it is now expanding in a way that even the court in *Darling* probably would not have foreseen. Since *Darling* was decided, the decisions suggest a trend toward a stricter standard of fault for hospital administrative services as well as for products supplied in the course of hospital treatment. Clearly, however, most of the commentary considering the issue of hospital corporate liability concludes that public policy militates against its use for purely professional services. Corporate liability has been asserted as a highly effective means of regulating the quality of medical practice and controlling professional incompetence. The threat of direct hospital liability for the malpractice of its physicians is said to be a stronger deterrent than are state licensing, voluntary self-regulation, or malpractice actions against the physician.[121] Furthermore, in many cases, the doctrine of *respondeat superior* has proven inadequate to deter incompetence since there often is no employment or agency relationship to which traditional tort principles may be extended.[122] Conversely, other commentators argue that existing tort principles are broad enough to adequately protect and compensate injured hospital patients. To hold hospitals liable outside the bounds of existing *respondeat superior* principles would need-

120. *Id.*

121. Note, *Hospital Corporate Liability: An Effective Solution to Controlling Private Physician Incompetence*, 32 RUTGERS L. REV. 342, 345 (1979).

122. *Id.* at 357. Another rationale that has been offered for corporate liability is that the hospital's grant of staff membership is a selective process which represents to the public that only competent physicians are chosen. *Id.* at 367. This reasoning is faulty as an argument for corporate liability since it is no more than an ostensible agency concept for which liability already exists under traditional tort principles.

lessly expose hospitals to liability and might encourage spurious litigation.[123] A large percentage of patients admitted into hospitals are admitted by physicians whom the patients have chosen to treat them. The patient places his trust in his own doctor and relies on him for treatment, so it cannot be said in such cases that the patient expects to be cured by hospital services rather than by his own doctor's professional judgment.[124] Consequently, existing negligence law holds the hospital liable under *respondeat superior* only when a sufficiently close relationship exists between the physician and the hospital.[125]

The patient's physician owes a duty of care which clearly cannot be delegated to others. Yet, this fact was effectively ignored by the New Jersey court in *Corleto*. The medical staff as a whole has no duty running directly to patients and should not be held liable for mistakes of professional judgment by individual doctors.[126] To hold the medical staff liable would deter participation in peer review committees which were organized to allow professionals to police themselves and to enhance the quality of health care.[127]

The purpose of imposing direct liability upon hospitals is to encourage the hospital to become more active in the care of patients. The converse of this argument may be that hospitals are encouraged to disrupt the doctor-patient relationship and to interfere in the professional medical judgment of staff physicians.[128] Corporate liability outside of traditional *respondeat superior* principles would also tend to discourage the granting of visiting physician privileges to nonstaff doctors, depriving the patient of quality health care primarily out of fear of liability.[129]

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123. Comment, *Extending Strict Liability to Health Care Providers: Can Consumers Afford the Protection?*, 13 TEX. TECH L. REV. 1435, 1460-61 (1982).

124. Note, Johnson v. Misericordia Community Hospital: *Corporate Liability of Hospitals Arrives in Wisconsin*, 1983 WIS. L. REV. 453, 480.

125. *See* Brown v. La Société Française de Bienfaisance Mutuelle, 138 Cal. 475, 71 P. 516 (1903). *See also supra* note 15 and accompanying text.

126. Loveridge, *Hospital Corporate Negligence Comes to California*, 14 PAC. L. J. 803, 812 (1983).

127. *Id.*

128. *See* Note, *Hospital Corporate Liability: An Effective Solution to Controlling Private Physician Incompetence*, 32 RUTGERS L. REV. 342, 363 (1979); Note, *Corporate Negligence of Hospitals and the Duty to Monitor and Oversee Medical Treatment*—Bost v. Riley, 17 WAKE FOREST L. REV. 309, 319 (1981).

129. Note, *supra* note 124, at 475.

Broader public policy concerns should not be ignored out of sympathy for a plaintiff who for some reason is forced to look solely to the hospital for redress for his physician's malpractice. Hospitals are providers of essential services and play a vital role in society. Even when insured, the hospital and ultimately the patient pay the price for corporate liability through increased premiums and hospital rates. Yet, there is another price exacted by hospital liability: the increased cost of health care brought about by the defensive practice of medicine results in unnecessary testing procedures and extended hospital stays.[130] Finally, these new theories for liability may result in the demise of the smaller hospital which lacks the funds to increase both its insurance coverage and the quality of its staff. These smaller hospitals may also lack the money and personnel to thoroughly monitor treatment by staff physicians.[131] Thus, in the long run, corporate liability beyond existing *respondeat superior* principles may actually diminish the quality of health care.

In the area of medical products liability, courts often strain to characterize events to impose strict liability, although existing principles of law already provide remedies for injuries caused by defective medical products. In contrast, courts must substantially deviate from the traditional concept of strict liability to reach services. This distinction between hospital products and services is often difficult to discern and does little to serve the needs of the injured patient. Nor does it appear to promote any other social policy that would justify its use. Nevertheless, courts have preferred to mold their decisions into existing forms of "product" or "service" transactions rather than to dispense with that illusory distinction in favor of an ad hoc policy determination of whether liability should be imposed.

Much of the difficulty in deciding whether to apply stricter standards of liability stems from the absence of an identifiable sale of a product by the hospital. Decisions such as *Cunningham*, *Truly*, and *Thomas* broadened the concept of a "sale" transaction in situations in which products were supplied to patients in the course of medical treatment. It is questionable, however, whether the existence of a sale is an adequate basis for resolving the ultimate issue of liability. To the extent that a

130. Note, *supra* note 121, at 367; Comment, *supra* note 123, at 1460-61.
131. *See* Note, *supra* note 124, at 475.

"sale" transaction identifies a party who is able to minimize injury and spread the costs, the distinction might serve a legitimate purpose. Nevertheless, the vague distinction between sales and services is not an appropriate basis for establishing liability.[132] Only a small minority of courts have extended strict liability to hospitals for defective products used in the course of medical treatment, even though a legal framework for doing so exists. This suggests that the courts will not easily expand the doctrine to include hospital administrative services.[133]

The district court in *Johnson v. Sears, Roebuck & Co.*[134] is alone in extending strict liability to reach purely service transactions. Unfortunately, the broad ad hoc policy considerations outlined by the court in *Johnson* do not establish predictable guidelines for determining when hospitals should be held strictly liable. This lack of guidance leads to uncertainty in the health care industry concerning the types of injuries occurring within hospitals that will expose them to liability. The court did suc-

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132. The liability for failure to warn that the appellate court in *Dubin* attempted to impose illustrates that the distinction between products and services is dubious. Failure to warn is generally considered to be based on negligence concepts, using a "reasonable manufacturer" standard. Borel v. Fibreboard Paper Products Corp., 493 F.2d 1076 (5th Cir. 1973), *cert. denied*, 419 U.S. 869 (1974). Prescription drugs, posing a threat of dangerous side effects to a sensitive consumer, are the most obvious example. While liability will be discharged through a proper warning, failure to give adequate warning or instruction constitutes a "product defect." Thus again, the judicial merging of negligence and strict products liability to reach the delivery of medical services is illustrated.

RESTATEMENT (SECOND) OF TORTS § 402A comment k (1965) specifically contemplates the application of strict liability to "unavoidably unsafe" prescription drugs. It provides that "such a product, properly prepared, and accompanied by proper directions and warning, is not defective. . . ." This provision has been interpreted to mean that strict liability may be imposed if the duty to warn is not fulfilled or if the warning given is inadequate. *See generally* Shandell, *supra* note 88.

133. Hospital advocates advance another policy argument: health care institutions are *consumers* of products, not distributors. Hospitals rely on the manufacturer to prevent defects as much as does the individual consumer. They do not promote the sale of products or make individual contracts to sell them. The hospital's liability for negligent *selection* of products should be adequate from a policy standpoint to compensate injured patients. See Crump, *Should Health Care Providers Be Strictly Liable for Product Related Injuries?*, 36 Sw. L.J. 831, 841 (1982). A further contention is that if no fault principles apply to products furnished in the course of hospital treatment, a doctor who surgically implants a product which is initially free of defects when placed in the patient may subject himself and the hospital to liability if the product fails at a later time. Following the typical strict liability pattern, the doctor would be considered a "seller" of a product and would be exposed to liability as any retailer. Thus, the medical profession would become virtually an insurer of results. *Id.*

134. 355 F. Supp. 1065 (D. Wis. 1973).

ceed, however, in demonstrating that the policies supporting strict products liability in general may apply with equal force in the hospital context.

The principles of strict liability in tort evolved out of judicial dissatisfaction with the limitations inherent in traditional negligence and warranty theories. The public policy considerations which influenced the courts in pioneering strict liability appear to be equally compelling in a hospital setting. The most persuasive argument for extending strict liability to hospitals is that it provides an incentive for hospitals to identify and alleviate unnecessary risks. Just as manufacturers are in a better position than are consumers to discover and prevent product defects, hospitals are better able to institute safeguards to minimize injuries caused by improper administration of services. For example, the *Anderson* decision illustrates that only the hospital staff generally has the ability to police itself.[135] Patients play no role in the selection of the hospital's staff and must rely on the hospital to maintain the quality of services and medical products supplied to them.[136]

A hospital is also in a better position than are patients to absorb and allocate the costs of injuries. Although the loss might be ruinous for the individual patient, most large hospitals can absorb such costs and redistribute them among all consumers with relatively minimal burden. This is analogous to requiring that each patient purchase, for a nominal fee (the patient's share of the marginal increase in the cost of services), an "insurance" premium which would cover medical injuries regardless of fault or origin. The hospitals would administer this fictitious policy and might minimize its own exposure to liability by impleading or seeking indemnity from the distributor or manufacturer if a product were involved. The hospital would further protect itself by purchasing liability insurance, now a common practice. Furthermore, the difficulty that plaintiffs normally encounter in proving negligence may be alleviated.[137]

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135. *See supra* notes 60-62 and accompanying text.

136. Frequently, it is the hospital institution itself that attracts the consumer because of its reputation for quality in its professional services and facilities. It should be emphasized that it is not the failure of treatment to which strict liability would attach but rather only the presence of some defect in the delivery of such services.

137. Injured patients often encounter difficulty in establishing the source of their injury and in obtaining sufficient proof of negligence. The burden may be compounded

It is not surprising that the extension of strict liability to include hospital administrative services has met with considerable resistance.[138] Hospitals claim that strict liability is functionally equivalent to requiring them to be insurers of medical services. Specific results cannot be guaranteed and it is often argued that the threat of liability forces hospitals to practice "defensive medicine."[139] Yet, no court has ever suggested that strict liability should be imposed merely because medical treatment fails.[140] Moreover, it is universally held that medical services provided by physicians continue to fall under traditional tort principles of malpractice, and a specific finding of negligence is required in order for a plaintiff to prevail. In assessing liability, the courts must be aware that a fine line exists between the practice of medicine and administration of hospital care. Cases such as *Darling* obscure this line, but the court in *Johnson*, explicitly noting this problem, held that the determination of liability should be made on a case-by-case basis.[141]

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when the harm involves a product whose manufacturer cannot be identified or is beyond the court's jurisdiction. Furthermore, the reluctance of physicians to testify against one another in malpractice litigation hampers a plaintiff in carrying his burden of proof. *See* Belli, *An Ancient Therapy Still Applied: The Silent Medical Treatment*, 1 VILL. L. REV. 250 (1956). A number of courts have recognized that medical experts are usually unwilling to testify against a colleague. *See, e.g.*, Hoffman v. Lindquist, 37 Cal. 2d 465, 484, 234 P.2d 34, 36 (1951)(Carter, J., dissenting); Salgo v. Leland Stanford Jr., Univ. Bd. of Trustees, 154 Cal. App. 2d 560, 569, 317 P.2d 170, 175 (1957).

138. *See supra* notes 70-75 and accompanying text.

139. For example, it is contended that hospitals would be forced to limit their services to performing only "safe" procedures, and to order unnecessary tests without regard to cost-efficiency.

140. It can be argued that in Helling v. Carey, 83 Wash. 514, 519 P.2d 981 (1974), the court came dangerously close to holding the physician strictly liable for his professional services. The court nevertheless articulated negligence principles for failing to perform the glaucoma test. *See supra* notes 45-48 and accompanying text. In Carmichael v. Reitz, 17 Cal. App. 3d 958, 95 Cal. Rptr. 381 (1971), the court held that strict liability was inapplicable to a physician. The court stated that because the physician's treatment involves a balancing of risks to the patient, liability should only be imposed upon a finding of negligence. *See also* Magner v. Beth Israel Hosp., 120 N.J. Super. 529, 295 A.2d 363 (1977); Hoven v. Kelble, 79 Wis. 2d 444, 256 N.W.2d 379 (1977). The *Magner* and *Hoven* courts held that although strict liability may be appropriate for defective products, it was inapplicable to physicians' services. *But see* Mallor, *Liability Without Fault for Professional Services: Toward A New Standard of Professional Accountability*, 9 SETON HALL L. REV. 474 (1978).

141. 355 F. Supp. at 1067.

VI. Conclusion

The *Darling* decision was significant in casting aside the distinction between administrative and medical hospital functions in favor of a standard which requires health care providers to use due care in granting staff privileges to physicians as well as in supervising hospital treatment. Since that time, the decisions have shifted away from these simple negligence principles and have imposed on the hospital a higher standard of care while simultaneously lowering the burden of proof required by the plaintiff, as, for example, through the use of *res ipsa loquitur*.

As courts attempt to invoke doctrines of strict liability, either in tort or warranty, they encounter serious analytical problems. While decisions such as *Johnson v. Sears, Roebuck & Co.* have rejected the distinction between sales and services as a basis for deciding whether to impose strict liability, they cannot shed the artificial distinction between administrative and medical functions which was rejected in *Bing v. Turnig* and in *Darling*. Medical services are based on an imperfect science, and results cannot be guaranteed. Therefore, treatment by physicians must continue to be governed by a negligence standard.

When, however, the hospital provides defective administrative services or furnishes a defective product in the course of treatment, no exercise of professional judgment is required. While there are strong policy arguments to the contrary, the hospital as a provider of products occupies no better position than any other link in a chain of distribution, and today courts do not hesitate to hold them liable.

Because of the wide spectrum of hospital services and products, a case-by-case approach is necessary and it may not be practicable in any one case to offer guidelines which could apply under a different set of facts. Even with its disadvantages in a hospital setting, strict liability analysis allows courts to deal openly and candidly with the issues of liability without being forced to bend traditional tort principles to accommodate injured plaintiffs whose cases do not fall within existing negligence doctrine.