State Licensing Regulations and Hospital Liability

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GREATER SIGNIFICANCE is given to State hospital licensure regulations by a 1965 decision of the Illinois Supreme Court (*1*). We shall present the major issues discussed in the court decision, place the decision within the context of the developing central role of the hospital in the medical care system, and discuss the implications of the decision for health departments engaged in hospital licensure and inspection activities. The impact of this case on medical staff organization in hospitals has been discussed elsewhere (*2*).

In the case of *Darling* v. *Charleston Community Memorial Hospital*, the court upheld the award of damages to a college student whose leg had to be amputated after treatment of a fracture. A cast had been applied by a general practitioner who was called to care for the young man in the emergency room of a local hospital. Sometime after the cast was applied, the patient complained of severe pain, and his toes became swollen and dark in color. After 10 days in the hospital, during which his condition deteriorated and during which no consultation was arranged by the physician or otherwise provided, the patient was moved by his family to a university hospital in another city, where amputation of the leg was performed.

A trial jury awarded the patient $150,000 in damages against the local hospital, a charitable corporation, reduced by $40,000 for which the physician settled out of court.

At the trial and on appeal, the hospital contended that it had not been negligent in the legal sense of the term. The definition of negligence for legal purposes is "the omission to do something a reasonable man, guided by those ordinary considerations which ordinarily regulate human affairs, would do or the doing of something which a reasonable and prudent man would not do" (*3*). A major line of the defense was that it was not customary practice for similar hospitals in the same or similar localities to intervene in the care provided by independent-contractor physicians to their private patients. It was argued further that the hospital, not being licensed to practice medicine, was powerless to interfere in the physician's professional acts. The defense was presented in accordance with long and apparently well-established doctrine in the field of hospital law (*4*).

As to the conclusiveness of evidence of custom in defining a reasonable man's duty, the court cited the noted Federal Justice Learned Hand (*5*):

> There are, no doubt, cases where courts seem to make the general practice of the calling the standard of proper diligence; we have indeed given some currency to the notion ourselves. . . . Indeed in most cases

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reasonable prudence is in fact common prudence; but strictly it is never its measure; a whole calling may have unduly lagged in the adoption of new and available devices. It never may set its own tests, however persuasive be its usages. Courts must in the end say what is required; there are precautions so imperative that even their universal disregard will not excuse their omission.

The State hospital licensing regulations provided another standard of conduct (*6*) for consideration of the jury:

The medical staff shall be organized in accordance with written by-laws, rules and regulations, approved by the governing board. The by-laws, rules and regulations shall specifically provide . . . (*h*) for consultation between medical staff members in complicated cases. . . .

Accordingly, the plaintiff argued that the hospital's nurses had a duty to observe the patient's difficulties and to report developments to the hospital administrator; the administrator had a duty to bring the situation to the attention of the medical staff; and the staff had a duty to take action, presumably to obtain expert consultation. Failing the discharge of these duties, the hospital must answer for the damages suffered by the patient.

Much of this is not new legal doctrine. In a 1958 California case, the court found a hospital liable when, after a private physician on a private case failed to suture an episiotomy and the patient died, the staff nurses did not, among other things, notify the hospital administrative authorities when they were "horrified" at the physician's treatment of the patient. The hospital, as employer, was held responsible for these omissions of duty by its nurses (*7*).

The Illinois court held that the jury verdict against the hospital could be supported by evidence along either of two lines: (*a*) that the hospital's nurses had failed to observe and test the patient's condition closely enough to recognize his danger and to bring the condition to the attention of the medical staff and the hospital administration; or (*b*) that the hospital had failed to obtain consultation.

In the absence of overriding action by the Federal courts—the U.S. Supreme Court refused on March 21, 1966, to accept the case for review—the hospital owes the patient $110,000, and the doctrine that failure to observe hospital licensing regulations opens a hospital to liability for damages becomes a part of our legal system, backed by the authority of the highest court of a major State.

Neither was the court persuaded by the argument that the hospital was not responsible for the professional acts or omissions of the physicians on its staff. Refusing to accept this theory, the court cited the following 1957 New York decision (*8*):

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 interns, 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 responsibility.

In effect then, the State licensing regulations, with accreditation standards and the hospital's medical staff bylaws, may be introduced into evidence and considered by the jury in determining whether a hospital has breached duties owed to the patient. These standards perform the same function as evidence of custom and may result in denying the hospital the defense that the attending physician was an independent contractor. In short, the effect of the *Darling* decision, when considered with the *Bing* case (*8*) and others, is to state that the hospital has a direct duty to the patient to provide medical services consistent with regulatory and professionally accepted standards.

In these cases the courts give legal recognition to the role of the hospital as a central organization in the provision of medical services. This role has been assumed in response to profound technological, economic, and social factors. The requirements for coordinating the diverse specialisms that have developed to master major advances in medical knowledge and technology, the needs for economical use of expensive equipment and skills, the increasing prevalence of long-term disabilities requiring coordinated and protracted care, and the problems of meet-

ing the increased demand and more recognized medical needs of a rapidly expanding population have been the principal factors that have enhanced the hospital's position (*9*).

Recognizing the need for effective organization mechanisms to discharge the hospital's functions, professional leaders in medicine and hospital administration have developed interdependent structures of governing boards and administrative and medical staffs to govern the hospital and control its operations. In these structures the responsibility of the hospital as a single organization for providing quality medical services is recognized, and parts of this responsibility are appropriately delegated within the organization. These organizational forms have been professionally sanctioned for almost half a century in the approval program of the American College of Surgeons, succeeded in 1952 by the standards of the Joint Commission on Accreditation of Hospitals, and further reinforced by the training program requirements of the Council on Medical Education and Hospitals of the American Medical Association (*10–13*).

As widespread agreement on these standards was reached by professional leaders and as they were adopted by most hospital institutions, public authorities have been giving the standards official force by incorporating them into licensing requirements, as in the Illinois regulations cited. Still further social support is provided by the courts, which have determined in the *Darling* case that the hospital, as an organization, is financially liable for damages caused by failure to provide its patients with the protection called for by the standards.

The course of social action has not been smooth and in a single direction. Aberrant tendencies still may be seen, as in the action of the Congress in separating the services of radiologists and pathologists from the hospital reimbursement mechanisms of the hospital insurance benefit program for the aged in the Social Security Act Amendments of 1965. This development toward fragmentation of the hospital structure is noticeable and surprising, precisely because it is counter to the dominant movement toward a more tightly knit hospital organization.

What are the implications of the *Darling* decision for public health departments, with their licensing authority in the hospital field? As the Illinois decision becomes diffused throughout the country, the courts will look to the licensing regulations for an authoritative definition of the standards of conduct expected of hospitals, to be applied in judging negligence suits. This will be particularly true when the regulations reflect leading professional judgments as expressed by such organizations as the Joint Commission on Accreditation of Hospitals.

Fortification of the licensing standards by the courts cannot be expected, however, if the regulations are so vague and indefinite as to not provide a clear course of conduct for reasonable persons to follow or to avoid. The requirement, for example, that "sufficient nursing staff shall be employed to care for the patients in the hospital," can hardly provide guidance for either hospital staff or courts (*14*).

With the weaving of licensing standards into the negligence liability system, public officials may receive considerable help in inspection, consultation, and enforcement from the powerful insurance industry. Large volumes of insurance have been written to cover hospital risks in liability suits, with the attrition of doctrines of governmental and charitable immunity (*15*). The Darling boy, for example, is due to receive from an insurance carrier $100,000 of the court's judgment against the Charleston Community Memorial Hospital.

Out of simple business prudence, the companies that write fire insurance policies advise insured hospitals concerning safety practices, make careful inspections of premises, and press for compliance with fire safety standards in order to reduce their losses. Similar considerations may be expected to lead insurance carriers to exercise their substantial talents in assisting hospitals to observe the licensing regulations on the organization and control of medical services in the hospital.

Summary

A 1965 decision of the Illinois Supreme Court in the case of *Darling* v. *Charleston Community Memorial Hospital* enhances the effectiveness of State hospital licensing regulations since it adds

the sanction of liability for damages brought about by actions that are not in conformity with such regulations. The case represents one development in a long trend toward strengthening the position of the hospital in the medical care system, this trend being set in motion by technological, economic, and social forces.

Professional organizations have devised organizational forms and established standards of conduct to control hospital practice. These forms and standards have been incorporated in official regulations and are now further strengthened by court application in defining the duties to be considered in negligence cases. The insurance companies that insure the risks of negligence claims against hospitals may be expected to assist in obtaining compliance with the standards embodied in hospital licensing regulations.

REFERENCES

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(4) Principles of hospital liability. *In* Hospital law manual. Sec. 2–1. University of Pittsburgh, Pa., 1959.

(5) *The T. J. Hooper*, 60 Fed 2d 737 (1932).

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(7) *Goff* v. *Doctors General Hospital of San Jose*, 333 P. 2d 29 (California, 1958).

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Evaluation of Exfoliative Oral Cytology

By June 30, 1966, more than a quarter-million persons will have been examined in 13 Public Health Service hospitals and 20 clinics as part of a study to evaluate exfoliative oral cytology as a method of determining malignancies. In the first 2 years of the study, 133,600 persons 15 years of age or older, including merchant seamen, members of the Armed Forces and their dependents, and Federal employees injured on duty or ill from causes related to their work, were examined.

During each examination, a cytological smear is taken of all lesions discovered except those of a benign nature plainly related to gum diseases. If a lesion shows abnormal cells, biopsy and microscopic examination are performed to determine if it is malignant. Some 8,000 mouth lesions have been discovered to date; complete findings of the 3-year study will be published later this year.

A pilot study, conducted in 1962 at the Public Health Service hospitals in Baltimore, San Francisco, and Staten Island, and outpatient clinics in New York City, Pittsburgh, and Washington, D.C., covered 14,449 patients. Among them, 1,120 lesions were found, of which 142 were subjected to biopsy. The biopsies revealed that 24 patients, 2.1 percent of those with mouth lesions, had cancer.