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WHEN DOCTRINES COLLIDE: CORPORATE NEGLIGENCE AND RESPONDEAT SUPERIOR WHEN HOSPITAL EMPLOYEES FAIL TO SPEAK UP*

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I. Introduction

A hospitalized patient injured by the negligence of a nurse¹ can bring suit against the hospital because the nurse is a hospital employee. A hospitalized patient injured by the negligence of a private physician cannot bring suit against the hospital because the physician is not a hospital employee. Can a patient sue the hospital when a nurse is negligent, if at all, only for not speaking up about a private physician's negligence? Courts have given this question a variety of answers over the last fifty years, few of them satisfactory, and some of them simply wrong. The question is vexing precisely because it arises at the intersection of two separate lines of cases against hospitals, both based on the theory of respondeat superior.

Simple cases of nursing negligence, without the complication of a physician's mistake, form the first line; they rarely pose problems for courts today. With a few exceptions,² all jurisdic-

* Thanks to Helen Adkins for untiring cheerfulness and accuracy in processing most of these words ten times over.

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1. I refer throughout the Article to nurses instead of other hospital employees because most of the cases I rely on have dealt with nurses. The Article's reasoning and conclusions also apply to other employees like physical therapists, respiratory therapists, and laboratory technicians.

2. Until 1957, New York was the most notable exception. In *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 105 N.E. 92 (1914), the court held that when a charitable hospital's professional employees exercised their professional discretion, the hospital was not vicariously liable for their conduct, because the employees acted independently of the hospital's control. The New York Court of Appeals overturned this rule in *Bing v. Thunig*, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957). In *Bing*, Justice Fuld observed that the rule had singled out hospitals for anomalous treatment. If applied uniformly to other enterprises, the rule, said Justice Fuld, would result in an airline having no liability for the negligence of its pilots, a railroad having no liability for the negligence

tions allow suits against hospitals based on respondeat superior in this situation, as long as governmental and charitable immunities are not in issue.³ Examples of nursing negligence for which the employing hospital can be held liable include not checking a patient's transfusion needle often enough,⁴ improperly moving a patient so that a recent incision is re-opened,⁵ and using the wrong type of hypodermic needle for an injection.⁶

For years, however, in a second line of cases courts resolutely denied the liability of hospitals on a respondeat superior theory when a private physician negligently treated a patient in

of its engineers, and a chemical company having no liability for the negligence of its chemists. *Id.* at 662, 143 N.E.2d at 6, 163 N.Y.S.2d at 8. The law in England evidently went through a similar evolution, ending with Lord Denning's observation that vicarious liability, even for professional acts of employees, "all seems so clear on principle that one wonders why there should ever have been any doubt about it." *Cassidy v. Ministry of Health*, [1951] 2 K.B. 343, 360 (C.A.).

Although *Schloendorff* dealt specifically with charitable hospitals, other states adopted a similar rule for proprietary hospitals. Georgia, for example, still appears to relieve a hospital of vicarious liability when a nurse exercises medical judgment, at least in the presence of and under the direction of a physician who is not also a hospital employee. *See Moore v. Carrington*, 155 Ga. App. 12, 270 S.E.2d 222 (1980); *Porter v. Patterson*, 107 Ga. App. 64, 129 S.E.2d 70 (1962). Courts most commonly seem to discuss the question of physicians' direction and control in the context of the operating room. *See, e.g., Beaches Hosp. v. Lee*, 384 So. 2d 234, 237 (Fla. Dist. Ct. App. 1980) (sponge count error). *But see Burroughs v. Board of Trustees of Alachua Gen. Hosp.*, 377 So. 2d 801, 804-05 (Fla. Dist. Ct. App. 1979) (nurse acted under doctor's orders in administering a drug to a mental patient and in helping the patient to be discharged); *Moore v. Carrington*, 155 Ga. App. 12, 270 S.E.2d 222 (1980) (emergency room treatment). When a surgeon directs and controls an operating room nurse, the surgeon sometimes is said to borrow the nurse under the borrowed servant doctrine, rendering the surgeon vicariously liable for the nurse's negligence. *See Kitto v. Gilbert*, 39 Colo. App. 374, 377-78, 570 P.2d 544, 549-50 (1977); *Baird v. Sickler*, 69 Ohio St. 2d 652, 654-55, 433 N.E.2d 593, 594-95 (1982) (per curiam) (chief surgeon held liable for the negligence of a nurse-anesthetist); *RESTATEMENT (SECOND) OF AGENCY* § 227 (1957). *See generally Currier v. Abbott*, 104 N.H. 299, 302, 185 A.2d 263, 266 (1962) (citing *RESTATEMENT (SECOND) OF AGENCY* § 227 (1957)). The borrowed servant doctrine is declining. *See, e.g., Sparger v. Worley Hosp.*, 547 S.W.2d 582 (Tex. 1977); *Hanson & Stromberg, Hospital Liability for Negligence*, 21 *HASTINGS L.J.* 1, 9-10 (1969). Nevertheless, as the cases noted above indicate, the doctrine still has some vitality. It seems safe to say that most jurisdictions today hold a hospital vicariously liable for the negligence of its employed nurses. *See generally* 1 D. LOUISELL & H. WILLIAMS, *MEDICAL MALPRACTICE* ¶ 16A.02 (1986).

3. Most states have abolished charitable and governmental immunity for hospitals. For a state by state listing, see 1 S. PEGALIS & H. WACHSMAN, *AMERICAN LAW OF MEDICAL MALPRACTICE* §§ 3:31, 3:32 (1980 & Supp. 1986).

4. *Sherman v. Hartman*, 137 Cal. App. 2d 589, 290 P.2d 894 (1955).

5. *McElroy v. Employers' Liab. Assurance Corp.*, 163 F. Supp. 193 (W.D. Ark. 1958).

6. *Su v. Perkins*, 133 Ga. App. 474, 211 S.E.2d 421 (1974).

the hospital. The prevailing judicial attitude was that hospitals only undertake to provide a facility for the convenience of physicians and patients. Because they do not treat or attempt to cure patients, hospitals do not directly owe a medical duty to patients. Judges frequently observed, even as late as 1967, that hospitals are merely specialized hotels that cannot provide medical care,⁷ and that a hospital can neither control nor be responsible for the acts of physicians because they are independent contractors.⁸ The reasoning in these cases almost always begged the question of hospital liability: hospitals were not liable because they owed no medical duty to patients. They owed no duty because courts were unwilling to hold that they did owe a duty.⁹

7. See *Alden v. Providence Hosp.*, 382 F.2d 163, 166 (D.C. Cir. 1967) (Burger, J., concurring in part and dissenting in part) (A hospital is "essentially a custodial institution."); *Fiorentino v. Wenger*, 19 N.Y.2d 407, 414, 227 N.E.2d 296, 299, 280 N.Y.S.2d 373, 378 (1967) (A hospital "serves the function only of a specialized facility, not a direct service healing institution."); *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 130, 105 N.E. 92, 94 (1914) ("The hospital does not undertake to act through [physicians], but merely to procure them to act upon their own responsibility."); *Steinert v. Brunswick Home, Inc.*, 172 Misc. 787, 790, 16 N.Y.S.2d 83, 85 (1939), *aff'd*, 259 A.D. 1018, 20 N.Y.S.2d 459 (1940) (A "hospital undertakes, not to heal or attempt to heal through the agency of others, but merely to supply others who will heal or attempt to heal on their own responsibility.") (quoting *Bernstein v. Beth Israel Hosp.*, 236 N.Y. 268, 270, 140 N.E. 694, 695 (1923)).

8. *E.g.*, *Moon v. Mercy Hosp.*, 150 Colo. 430, 373 P.2d 944 (1962); *Vanaman v. Milford Memorial Hosp.*, 272 A.2d 718 (Del. 1970); *Overstreet v. Doctors Hosp.*, 142 Ga. App. 895, 237 S.E.2d 213 (1977).

9. Neither the hotel analogy nor the independent contractor defense ever made a great deal of sense. First, courts never declared hotels to be free of responsibility for injuries to guests. On the contrary, hotels have long been obliged to exercise at least reasonable care for the safety of their guests. See R. ANDERSON, *THE HOTELMAN'S BASIC LAW* § 5:8(b), at 60 (1965); P. VAN ZILE, *ELEMENTS OF THE LAW OF BAILMENTS AND CARRIERS, INCLUDING PLEDGE AND PAWN AND INNKEEPERS* § 368, at 341-42 (1902). The obligation extends to the protection of guests against harm from third parties when the hotel "actually knows that its guest is being harmed but takes no steps to stop the wrongdoer." R. ANDERSON, *supra* § 5:8(c), at 61. "The innkeeper, while not an insurer of a guest against personal injury, must protect him against injury from third persons so far as it is within his power to do so." J. BEALE, *THE LAW OF INNKEEPERS AND HOTELS* § 171, at 118 (1906). The hotel analogy, in short, has always offered a sound reason for holding hospitals liable when, through an employee, they actually knew a patient was being harmed and when protecting the patient was within the hospital's power.

Second, a hospital's staff physicians (*i.e.*, nonemployee physicians with privileges to treat patients at a hospital) are not simply independent contractors whose services are paid for by the hospital in the way a property owner might contract with and pay someone to build a house. Instead, the relationship between hospital and physician is analogous to that of landowner and concessionaire, which has been sufficient to impose liability on the landowner for at least fifty years. See *RESTATEMENT (SECOND) OF TORTS* § 415 (1966); Goldberg, *The Duty of Hospitals and Hospital Medical Staffs to Regulate the Quality of Patient Care: A Legal Perspective*, 14 PAC. L.J. 55, 58 (1982). Section 415 of

Whatever the soundness of this reasoning, a long line of cases declared firmly that hospitals are not liable for the negligence of private physicians.¹⁰

These two firmly entrenched doctrines distinguishing nurses' and physicians' negligence collide in the factual situation at issue in this Article. This situation, which for convenience I call the speaking up case, presents a physician negligently treating a patient, and a nurse or other hospital employee observing the negligent treatment. The injured patient sues the hospital on the grounds that its employee should have prevented or corrected this treatment.

Several analytical approaches to this situation are possible. One is to view a case as falling under the second line of cases, those that follow a general rule that hospitals are not liable for physicians' negligence. Courts taking this approach simply conclude that the hospital is not liable, without further analysis of law or policy—and without further discussion in this Article. Other courts follow the first line of cases, positing that nurses

the *Restatement* imposes liability on a landowner when the activities of a concessionaire are "unreasonably dangerous." Providing medical treatment to a patient is not the sort of thing that a court ordinarily would consider to be unreasonably dangerous, but on occasion it might well be. *See, e.g., Fiorentino v. Wenger*, 19 N.Y.2d 407, 227 N.E.2d 296, 280 N.Y.S.2d 373 (1967) (radical spinal surgery was not used by any physician except the defendant, and resulted in the patient's death).

Further, even by 1966, the *Second Restatement* had asserted that the "independent contractor" defense to liability was subject to exceptions "so numerous, and [that] have so far eroded the 'general rule,' [of immunity] that it can now be said to be 'general' only in the sense that it is applied [when] no good reason is found for departing from it." *RESTATEMENT (SECOND) OF TORTS* § 409, comment b (1965). The characterization of physicians as independent contractors has had, in light of the defense's general erosion as a defense in other contexts, a surprising vitality. For an example of a case in which a great many factors suggested an agency relationship that might easily have overcome an independent contractor defense, but did not, see *Smith v. Duke Univ.*, 219 N.C. 628, 14 S.E.2d 643 (1941). For an interesting and readable economic explanation of the relationship between physicians and hospitals, see Harris, *The Internal Organization of Hospitals: Some Economic Implications*, 8 *BELL J. OF ECON.* 467 (1977).

10. *See, e.g., Robinson v. Crotwell*, 175 Ala. 194, 57 So. 23 (1911); *Adams v. Boyce*, 37 Cal. App. 2d 541, 99 P.2d 1044, cert. denied, 311 U.S. 694 (1940); *Vanaman v. Milford Memorial Hosp.*, 272 A.2d 718 (Del. 1970); *Black v. Fischer*, 30 Ga. App. 109, 117 S.E. 103 (1923); *Hoke v. Harrisburg Hosp.*, 281 Ill. App. 247 (1935); *Pikeville Methodist Hosp. v. Donahoo*, 221 Ky. 538, 299 S.W. 159 (1927); *Messina v. Société Française De Bienfaisance*, 170 So. 801, 806-07 (La. Ct. App. 1936) (Janvier, J., concurring); *Hamburger v. Cornell Univ.*, 204 A.D. 664, 199 N.Y.S. 369 (1923), *aff'd*, 240 N.Y. 328, 148 N.E. 539 (1925); *Van Cleave v. Irby*, 204 Okla. 689, 233 P.2d 963 (1951); *Kuglich v. Fowle*, 185 Wis. 124, 200 N.W. 648 (1924).

have a duty to speak up under certain circumstances. If a nurse fails to do so, the hospital is liable under the principles of respondeat superior. One thesis of this Article is that respondeat superior principles are appropriate to speaking up cases, but courts applying them have developed a needless and confusing array of particularized duties to impose on nurses. These duties are too ambiguous to be useful in guiding decisions about either liability or nursing behavior.

Recent judicial and academic writing, particularly since the 1965 case of *Darling v. Charleston Community Memorial Hospital*,¹¹ has suggested a third approach¹² to the analysis of speaking up cases: hospitals can be liable for physicians' errors because of corporate negligence, the violation of a direct medical, as opposed to nursing, responsibility to patients.¹³ A second thesis of this Article is that corporate negligence, however useful in other contexts, is largely inapposite to the speaking up situation: it compels an analysis requiring fault by the hospital as an entity when none is present.¹⁴ Because the corporate negligence

11. 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966); *see infra* text accompanying notes 25-45.

12. Some courts suggest what appears to be a fourth approach: a hospital can be liable for a physician's negligence only if the hospital knew or should have known that the negligence would take place. *See Hedding v. Ashford Memorial Community Hosp.*, 734 F.2d 81 (1st Cir. 1984); *Fiorentino v. Wenger*, 19 N.Y.2d 407, 414, 227 N.E.2d 296, 299, 280 N.Y.S.2d 373, 377-78 (1967); *Hendrickson v. Hodkin*, 276 N.Y. 252, 257-59, 11 N.E.2d 899, 902 (1937); *see also Alden v. Providence Hosp.*, 382 F.2d 163, 167-68 (D.C. Cir. 1967) (Burger, J., concurring in part and dissenting in part); Slawkowski, *Do the Courts Understand the Realities of Hospital Practices?*, 22 St. Louis U.L.J. 452, 468 (1978). This approach does not really apply to the speaking up context. When maltreatment by a physician can be anticipated, it usually will be because past history suggests that the physician is generally incompetent. If past history is the problem, the case is not one of liability for not speaking up, as I define it; rather, the liability is for negligently retaining a physician on the staff and continuing to allow the physician the privilege of admitting and treating patients. *See infra* text accompanying notes 16-23.

13. *See infra* text accompanying notes 15-67.

14. One justifiably may ask why, if the corporate negligence doctrine is so inappropriate in speaking up cases, courts use it at all. One answer is that "corporate negligence" has received an immense amount of attention by commentators and courts, and seems to have swept the field of hospital liability in almost the same way that strict products liability swept the field of tort litigation in the mid-1960s. *See PROSSER & KEETON ON THE LAW OF TORTS* § 97, at 690 (W. Keeton 5th ed. 1984) (The onset of strict products liability "was the most rapid and altogether spectacular overturn of an established rule in the entire history of the law of torts.") [hereinafter cited as PROSSER & KEETON]; *see also* Prosser, *The Fall of the Citadel*, 50 MINN. L. REV. 791 (1966). Courts are not immune to legal fads, like "corporate negligence," even if they are not well thought out. A second answer is that corporate negligence seems to have received at least

approach to speaking up cases seems to be both seriously flawed and growing in significance, the Article discusses it first and in some detail. The Article next discusses cases relying on the respondeat superior theory, and applies a cost-benefit analysis to speaking up cases based on the Learned Hand formula for negligence. The Article concludes that courts should use the respondeat superior theory, but should not define duties at all; instead, courts should use expert testimony to establish a standard of care. The standard would show whether in a given situation a reasonable, prudent nurse would have spoken up about a physician's negligence. Simple though this conclusion may appear, most courts have not been able to reach it.

II. CORPORATE NEGLIGENCE

Corporate negligence theory treats the hospital as an entity and focuses on some administrative or managerial failing. Negligence is predicated nominally on the breach of a duty owed directly to patients,¹⁵ typically described as a duty to monitor quality, review treatment, or supervise the care delivered by private physicians.¹⁶ The most common application of the corporate negligence theory is to a hospital that has failed to investi-

part of its impetus from the doctrine of charitable immunity. When charitable hospitals were immune from suit for the negligence of their employees, they still were "corporately liable" for the negligent hiring and retention of employees. See Southwick, *The Hospital's New Responsibility*, 17 CLEV.-MAR. L. REV. 146, 151-54 (1968). These earlier doctrines, perhaps developed to circumvent charitable immunity, have a tendency to survive even in cases in which they are no longer needed.

15. See *Fridena v. Evans*, 127 Ariz. 516, 519, 622 P.2d 463, 465-66 (1980) (en banc); *Holton v. Resurrection Hosp.*, 88 Ill. App. 3d 655, 659, 410 N.E.2d 969, 973 (1980); *Bost v. Riley*, 44 N.C. App. 638, 647, 262 S.E.2d 391, 396 (1980); *Pedroza v. Bryant*, 101 Wash. 2d 226, 231-32, 677 P.2d 166, 169-70 (1984). See generally 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 16.09, at 16-48, 16-49.

16. See *Purcell v. Zimbelman*, 18 Ariz. App. 75, 80-81, 500 P.2d 335, 340-41 (1972); *Elam v. College Park Hosp.*, 132 Cal. App. 3d 332, 345-47, 183 Cal. Rptr. 156, 164-65 (1982); *Johnson v. St. Bernard Hosp.*, 79 Ill. App. 3d 709, 716-17, 399 N.E.2d 198, 204-05 (1979); *Bost v. Riley*, 44 N.C. App. 638, 645-47, 262 S.E.2d 391, 395-96 (1980); *Pedroza v. Bryant*, 101 Wash. 2d 226, 229-32, 677 P.2d 166, 168-70 (1984); 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 16.09, at 16-50; Lisko, *Hospital Liability Under Theories of Respondeat Superior and Corporate Negligence*, 47 UMKC L. REV. 171, 181 (1978); Comment, *The Hospital's Responsibility for its Medical Staff: Prospects for Corporate Negligence in California*, 8 PAC. L.J. 141, 142 (1977); Note, *Hospital Corporate Liability: An Effective Solution to Controlling Private Physician Incompetence?*, 32 RUTGERS L. REV. 342, 360 (1979); Comment, *The Hospital-Physician Relationship: Hospital Responsibility for Malpractice of Physicians*, 50 WASH. L. REV. 385, 411-16 (1975) [hereinafter cited as Comment, *The Hospital-Physician Relationship*].

gate the credentials of physicians before granting them the privilege of admitting and treating patients. Liability in this situation is straightforward because the hospital's failing is administrative or corporate. It is, after all, the hospital's board of directors that ultimately must approve the extension of privileges to a physician.¹⁷ Commonly, courts apply the corporate negligence doctrine in egregious situations: where a patient has been harmed by a physician who was removed from the staff of one or more other hospitals for incompetence,¹⁸ or who has been sued frequently for the same sort of mistake on other patients,¹⁹ or who has lied about his credentials.²⁰ Courts understandably have had little trouble holding hospitals responsible for not undertaking reasonable inquiries before granting privileges to such physicians.

A more difficult situation for the hospital, if not the courts, occurs when the hospital's administrators are aware or should be aware of a physician's incompetence after he has become a member of the hospital staff. Here again, courts have understandably found a duty to use reasonable care in the continuing retention of physicians on the staff, however reasonable their initial appointment may have been. Some cases have involved physicians

17. JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS, 1986, standard 10.4.2.1, at 109 (1985) ("Delineated clinical privileges are granted in accordance with the governing body and the medical staff bylaws, rules and regulations, and policies and are subject to approval by the governing body.") [hereinafter cited as JOINT COMMISSION]. See also standard 10.5.8 at 114, which specifies that the "governing body is responsible for the final decision, based on medical staff recommendations, regarding" renewal of physicians' privileges. Describing ultimate authority as in the hands of the hospital's governing board is perhaps too facile. Medical staff committees, composed of independent physicians, make the important recommendations about granting privileges to the governing board. The board often simply rubber-stamps the recommendations. The picture is further complicated by the fact that staff physicians are at times also members of the governing board. See, e.g., *Fridena v. Evans*, 127 Ariz. 516, 519, 622 P.2d 463, 466 (1980) (en banc); Ludlam, *Physician-Hospital Relations: The Role of Staff Privileges*, 35 LAW & CONTEMP. PROBS. 879, 880-82 (1970); Perdue, *Direct Corporate Liability of Hospitals: A Modern Day Legal Concept of Liability for Injury Occurring in the Modern Day Hospital*, 24 S. TEX. L.J. 773, 776-83 (1983).

18. *Accord Johnson v. Misericordia Community Hosp.*, 99 Wis. 2d 708, 717-18, 301 N.W.2d 156, 161 (1981) (physician's privileges to perform his specialty were terminated at his former hospital); *Fiorentino v. Wenger*, 19 N.Y.2d 407, 414, 227 N.E.2d 296, 299, 280 N.Y.S.2d 373, 377 (1967) (same).

19. *Purcell v. Zimbelman*, 18 Ariz. App. 75, 500 P.2d 335 (1972).

20. See *Hendrickson v. Hodkin*, 276 N.Y. 252, 11 N.E.2d 899 (1937) (layperson claimed to have a cure for cancer); *Johnson v. Misericordia Community Hosp.*, 99 Wis. 2d 708, 713-20, 301 N.W.2d 156, 159-62 (1981).

with serious alcohol or drug abuse problems that become well-known to the hospital administrator.²¹ Other cases have involved physicians who have been denied permission to perform a particular procedure elsewhere, but were allowed by the defendant hospital to use the procedure, with injurious consequences.²² Similarly, a hospital may be liable for continuing to allow a staff doctor to have privileges when the hospital knows about several malpractice suits against the doctor.²³

The negligent granting and retaining of privileges for physicians are both classified appropriately as corporate failings. Imposing corporate negligence liability is, however, least appropriate in speaking up cases when the hospital administration has no reason to believe that a physician is generally incompetent. Corporate liability for not monitoring quality in this situation is either a euphemism or an ill-fitting replacement for respondeat superior liability because the hospital's administration is not really at fault: there is no actual negligence by the administration, no failure to issue or enforce rules or procedures.²⁴

The case credited²⁵ with developing the corporate negligence theory in the speaking up context is *Darling v. Charleston Community Memorial Hospital*,²⁶ decided by the Illinois Su-

21. See, e.g., *Penn Tanker Co. v. United States*, 310 F. Supp. 613 (S.D. Tex. 1970); *Tucson Medical Center, Inc. v. Misevch*, 113 Ariz. 34, 545 P.2d 958 (1976) (en banc) (complaint concerning a physician's alcoholic state at the time of an operation).

22. See, e.g., *Fiorentino v. Wenger*, 19 N.Y.2d 407, 227 N.E.2d 296, 280 N.Y.S.2d 373 (1967).

23. See *Purcell v. Zimbelman*, 18 Ariz. App. 75, 500 P.2d 335 (1972); *Elam v. College Park Hosp.*, 132 Cal. App. 3d 332, 183 Cal. Rptr. 156 (1982).

24. Commentator Arthur Southwick notes that courts frequently confuse the doctrines of corporate negligence and respondeat superior. A. SOUTHWICK, *THE LAW OF HOSPITAL AND HEALTH CARE ADMINISTRATION* 358-59, 422-23 (1978); Southwick, *Hospital Liability: Two Theories Have Been Merged*, 4 J. LEG. MED. 1, 45-46 (1983). Southwick argues that a blurring of the doctrines makes little practical difference. I argue that it does make a difference in the speaking up case because it allows courts to set arbitrary "duties" and can lead to confusion over who may testify at a trial.

25. See *Elam v. College Park Hosp.*, 132 Cal. App. 3d 332, 345, 183 Cal. Rptr. 156, 164 (1982); *Bost v. Riley*, 44 N.C. App. 638, 646, 262 S.E.2d 391, 396 (1980); *Pedroza v. Bryant*, 101 Wash. 2d 226, 229, 677 P.2d 166, 168 (1984); Lisko, *supra* note 16, at 181; Southwick, *The Hospital as an Institution—Expanding Responsibilities Change Its Relationship with the Staff Physician*, 9 CAL. W.L. REV. 429, 443 (1973); Note, *Hospital Corporate Liability*, *supra* note 16, at 360.

26. 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966). For several years, there was confusion about whether the physician in the case was or was not an employee of the hospital. Had he been an employee, of course, the case against the hospital would have been a simple one of respondeat superior for the physician's

preme Court in 1965. The court clung doggedly to the idea of an administrative failing when none needed to be found; consequently, the opinion contains a series of untenable assertions that have misled both courts and commentators. In *Darling*, a college football player broke his leg and his treating physician put it in a cast. While the boy remained in the hospital, his toes gradually swelled, grew darker in color, became cold, and lost feeling. As these symptoms worsened, the attending physician first notched the cast near the toes, then cut a portion of the cast away. Finally, on the fourth day after the cast was applied, he removed the cast from a gangrenous leg that had to be amputated below the knee. The hospital nurses had observed the boy's symptoms but alerted only the treating physician, whose response had been ineffective.

The boy's parents sued the hospital, and the jury returned a verdict in their favor. The Illinois Supreme Court decided that the jury's verdict could be upheld on either of two grounds: first, that the hospital did not employ enough nurses to monitor and report on the patient's condition; or second, that the hospital failed to review the treatment or require a consultation.²⁷ The first ground is an assertion of direct corporate liability: the hospital as an institution failed to employ enough nurses to do an adequate job of caring for patients. This is an odd rationale for upholding the verdict. Testimony showed that the nurses were

negligence and the opinion would have been wholly unremarkable. At least three courts declared that the *Darling* opinion was of no relevance to corporate liability in the speaking up situation because the physician in *Darling* was in fact an employee. See *Collins v. Westlake Community Hosp.*, 12 Ill. App. 3d 847, 299 N.E.2d 326, *rev'd on other grounds*, 57 Ill. 2d 388, 312 N.E.2d 614 (1974); *Lundahl v. Rockford Memorial Hosp. Ass'n*, 93 Ill. App. 2d 461, 235 N.E.2d 671 (1968); *Hull v. North Valley Hosp.*, 159 Mont. 375, 498 P.2d 136 (1972). One commentator asserted that the opinion was ambiguous on the point. See Comment, *The Hospital-Physician Relationship*, *supra* note 16, at 413. Another commentator stated that the opinion was "far from clear." Slawkowski, *Do the Courts Understand the Realities of Hospital Practices?*, 22 St. Louis U.L.J. 452, 455 (1978). An authoritative commentator found, however, by reading the hospital's petition for rehearing in the case, that the physician had not been an employee. See A. SOUTHWICK, *supra* note 24, at 415 n.168 (1978). A careful reading of the hospital's initial brief in the case confirms that finding:

A hospital is not liable for any negligence . . . on the part of a physician or surgeon who practices his profession as an independent agent . . . ; where a patient employs a physician or surgeon not in the employ of the hospital, the hospital is not liable for his negligence.

Annot., 14 A.L.R.3d 860, 862 (1967).

27. *Darling*, 33 Ill. 2d at 333, 211 N.E.2d at 258.

aware of the changing condition of the boy's toes and even called the treating physician for re-examination.²⁸ In short, there plainly were enough nurses on the staff to monitor and report the patient's condition because they did exactly that.

The second ground was also expressed in terms of institutional responsibility, one to "review treatment," suggesting that the hospital administration should have implemented routine reviews of all physicians' treatments while the treatments were ongoing. This would be a revolutionary rule if the court meant it literally. Although hospitals do review treatments once they are completed in order to control quality,²⁹ the *Darling* court could not have been addressing after-the-fact reviews. The failure of a hospital to conduct an after-the-fact review only can be a cause of a later injury, when the hospital knows of the physician's incompetence and can act to cancel hospital privileges. It cannot be a cause of an injury that took place before the review was to be conducted. Nor does the opinion suggest any other instances of the physician's incompetence that might have put the hospital on notice. The *Darling* court's requirement that the hospital review treatment must therefore be a requirement for a review while treatment is still underway. But a requirement for routine reviews of on-going treatments would add intolerably to medical care costs. A hospital would have to hire enough physicians to double check every private physician's decisions, nearly doubling the amount that patients would pay for physicians' services.

28. See *Darling v. Charleston Community Memorial Hosp.*, 50 Ill. App. 2d 253, 270-72, 200 N.E.2d 149, 159-60 (1964), *aff'd*, 33 Ill. 2d 326, 329, 211 N.E.2d 253, 256 (1965), *cert. denied*, 383 U.S. 946 (1966).

29. The accreditation standards for hospitals call for the medical staff to perform quality assurance checks. See JOINT COMMISSION, *supra* note 17. The standards refer to the "monitoring and evaluation of the quality and appropriateness of patient care." *Id.* standard 10.6, at 114. But it is clear that the monitoring referred to is periodic, after-the-fact monitoring. See, e.g., standard 10.6.1.1.3.1, at 114 ("routine collection of information"); standard 10.6.1.1.3.2, at 115 ("periodic assessment of this information"); standard 10.6.1.2.1, at 115 ("[s]urgical case review is performed monthly"); standard 10.6.1.4.1, at 116 ("[t]he quality of medical records is reviewed at least quarterly"); standard 10.6.1.5.1, at 117 ("The medical staff performs blood usage review at least quarterly").

The standards also contain a summary section for quality assurance procedures for the hospital overall, including those undertaken by the anesthesia services, the dietetic services, the emergency services, the nursing services, etc. See *id.* standard 17, "Quality Assurance," at 205-08. Again, these hospital-wide standards refer to after-the-fact reviews. See, e.g., standard 17.2.1.1.1, at 206 (requiring monitoring and evaluating the quality of patient care through "monthly meetings of clinical departments").

Further, if failure to effect routine reviews rendered a hospital negligent, then hospitals almost always would be liable for any malpractice committed by physicians within their walls. This conclusion follows from the fact that a review of physicians' treatments, if done properly, would catch and correct most errors. The hospital's failure to make a careful review of on-going treatments would therefore be a direct cause of a patient's harm. A requirement that hospitals provide automatic review of all cases thus would impose a kind of strict liability on hospitals,³⁰ a rule rejected by most courts, including those in *Darling's* own Illinois.³¹

The best argument that *Darling* imposed an obligation on hospitals as corporate entities is the court's reference to consultations. The plaintiff alleged that the defendant hospital should have required the physician to obtain a consultation, "particularly after complications had developed."³² This allegation was reflected in a jury instruction approved by the Illinois Supreme Court.³³ Commentators have since identified *Darling* with a requirement for hospitals to establish rules and procedures for consultation.³⁴

Establishing rules and procedures sounds like an institutionalized or corporate responsibility that is appropriate in the speaking up context. Part of speaking up is calling for consultation when it is needed. But as a branch of corporate negligence, requiring consultations adds little to the analysis of these cases.

First, if a hospital procedure directs physicians to seek con-

30. Commentators have argued for the imposition of strict liability on hospitals. See Comment, *The Hospital-Physician Relationship*, *supra* note 16; Note, *supra* note 16; Note, *Risk Administration in the Marketplace: A Reappraisal of the Independent Contractor Rule*, 40 U. CHI. L. REV. 661 (1973) (arguing that those hiring independent contractors of any type should be jointly liable with the contractor for the contractor's negligence).

31. 1 S. PEGALIS & H. WACHSMAN, *supra* note 3, § 3:27, at 93-94 (Supp. 1986); see *Pickle v. Curns*, 106 Ill. App. 3d 734, 739, 435 N.E.2d 877, 881-82 (1982); *Hull v. North Valley Hosp.*, 159 Mont. 375, 498 P.2d 136 (1972); *Fiorentino v. Wenger*, 19 N.Y.2d 407, 227 N.E.2d 296, 280 N.Y.S.2d 373 (1967); *Van Cleave v. Irby*, 204 Okla. 689, 233 P.2d 963 (1951). See generally Note, *supra* note 16.

32. *Darling*, 33 Ill. 2d at 329, 211 N.E.2d at 256.

33. *Id.* at 333, 211 N.E.2d at 258.

34. 1 S. PEGALIS & H. WACHSMAN, *supra* note 3, § 3:29, at 233 (1980); Koskoff & Nadeau, *Hospital Liability: The Emerging Standard of Care*, 48 CONN. BAR J. 305, 321-23 (1974).

sultation, it adds nothing to the existing standards of medical practice. In the exercise of reasonable care, physicians already must call in consultative assistance anytime they are uncertain how to proceed.³⁵ Whether a hospital adopts procedures directing a physician to seek consultation cannot add to a physician's liability or incentives in this regard. Second, a line of cases discussed below³⁶ has asserted for years that nurses must speak up in certain circumstances, and the cases have never relied on the presence or absence of hospital procedures that called for speaking up. As with physicians, if reasonable nurses already have a duty to request consultative help from residents or other physicians, the hospital's adoption of procedures to that effect would not change the nurses' liability.

Third, it hardly makes sense to hold a hospital liable for the failure to adopt procedures that nurses already would be expected to follow as a matter of law and good nursing practice. If a nurse breaches those professional standards, the hospital as employer is liable on a respondeat superior theory. It only distorts the analysis to take this straightforward approach and recasts it in the form of corporate negligence for not adopting procedures requiring nurses to ask for consultation. Fourth, procedures requiring nurses to speak up or to call for consultation, cannot answer the central question of these cases: *when* must a nurse speak up, and when is it acceptable not to? This question vexes even those courts that do apply a simple respondeat superior approach to speaking up cases.³⁷

The *Darling* decision is best understood as finding liability not for a new theory that the hospital failed to institute review procedures or monitor quality, but for the prosaic theory that nurses negligently failed to speak up about a physician's maltreatment. Early commentary on *Darling* seemed to accept the case as unexceptional on this point.³⁸ By the 1970s, however,

35. A. HOLDER, *MEDICAL MALPRACTICE LAW* 49-52 (2d ed. 1978); 1 S. PEGALIS & H. WACHSMAN, *supra* note 3, § 2:14 (1980).

36. *See infra* text accompanying notes 68-134.

37. *Id.*

38. One commentator in the *Illinois Bar Journal* of 1966, a year after *Darling*, concluded that *Darling* imposed duties on hospitals to be informed about medical procedures, to review physicians' treatment, and to require consultations if needed—but the article treated none of these as especially significant. *See Recent Decisions, Hospitals—Evidence—Charities—Hospital Held Liable for Negligent Discharge of Medical*

commentators began to say that the *Darling* court's focus on corporate negligence represented a significant departure from earlier law.³⁹ Oddly, some of the same commentators also have

Duties, 54 ILL. B.J. 743 (1966) [hereinafter cited as Recent Decisions, *Hospitals*]. The bulk of this article discusses the court's admission into evidence of the hospital's own procedures and bylaws to set the standard of care. Another scholarly article in 1970 very briefly mentioned the possibility that *Darling* had some import for corporate negligence. See Ludlam, *supra* note 17, at 884.

Between 1965 and 1966, at least seven student notes discussing *Darling* appeared in the literature, all but one focusing on the Illinois Supreme Court's allowance of a medical treatise as evidence. Note, *Evidence—Expert Witness—Use of Authoritative Treatises on Cross-Examination*, 15 DEPAUL L. REV. 492 (1966); Comment, *Torts—Hospital's Liability—Standard of Care*, 43 N.C.L. REV. 469 (1965); Recent Decisions, *Evidence—Learned Treatises—Admissible for Use in Cross-Examining Expert to Test Knowledge*, 41 NOTRE DAME LAW. 607 (1966); Note, *Evidence—Expert Medical Witness May be Cross-Examined On the Content of Medical Texts Not Relied Upon For His Opinion*, 17 SYRACUSE L. REV. 566 (1966); Recent Decisions, *Evidence—Authoritative Treatises Can Be Used in Cross-Examination of an Expert Witness*, 1966 U. ILL. L.R. 225; Recent Developments, *Evidence—Expert Witnesses—Medical Treatises Upon Which Expert Witness Has Not Expressly Relied May Be Used in Cross-Examining Him*, 11 VILL. L. REV. 637 (1966); Case Comments, *Evidence—Use of Learned Treatises in Cross-Examination of Expert Witnesses*, 68 W. VA. L. REV. 329 (1966).

Only the *North Carolina Law Review* comment discussed corporate liability and the standard of care for hospitals. Even this comment, however, saw *Darling* as dealing with the hospital administrator's liability for employing incompetent physicians, an already well-established rule. See Comment, *Torts—Hospital's Liability—Standard of Care*, 43 N.C.L. REV. 469, 474 (1965); cases cited *infra* note 43.

Among the few articles that did find *Darling* to be of significance to corporate liability were Hanson & Stromberg, *supra* note 2, at 11-14 (three pages out of thirty-four) and Southwick, *supra* note 14.

Most commentators at first, then, did not see *Darling* as especially noteworthy. Perhaps that was partly due to the belief that the physician in the case was actually a hospital employee. See *supra* note 25. Certainly the case seems uncontroversially decided. A simple broken bone led to the amputation of a young man's leg while nurses who could have done something did nothing over a period of days. But the court relied on the language of corporate negligence, not simply on nursing negligence. By 1972, the sharp increase in medical malpractice litigation may have led commentators to seize too quickly on that language, missing the opportunity to analyze the speaking up fact pattern separately. For a report discussing the sharp increase in medical malpractice litigation, see DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE 5 (1973).

39. See 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 16.01, at 16-5, ¶ 16.09, at 16-48 to 16-50; Goldberg, *supra* note 9; Hedgepeth, *Darling Revisited*, 46 J. A.H.A. 58 (1972); Lisko, *supra* note 16, at 181; Perdue, *supra* note 17, at 788; Rapp, *Darling and Its Progeny: A Radical Approach Toward Hospital Liability*, 60 ILL. B.J. 883 (1972); Southwick, *supra* note 25, at 443-46; Spero, *Hospital Liability: Vicarious and Direct Corporate Responsibility for Acts of Professional Negligence Committed in a Hospital*, TRIAL, July 1979, at 25; Note, *Independent Duty of a Hospital to Prevent Physicians' Malpractice*, 15 ARIZ. L. REV. 953, 960-61 (1973); Note, *supra* note 16, at 360; Comment, *Hospital Liability for the Negligence of Physicians: Some Needed Legal Sutures*, 26 U. FLA. L. REV. 844, 851 (1974).

maintained that *Darling* has had only a minor effect on hospital liability, confined to rare cases of a physician's gross negligence⁴⁰ or outrageously poor treatment.⁴¹ There seems to be confusion, then, over whether *Darling* represents a major new theory of hospital liability widely cited by other courts or simply reflects a court's reaction to very rare and shocking circumstances, to be followed only in equally rare circumstances. What has actually happened is this. The *Darling* court's approach to institutional or corporate negligence has been followed principally in cases of a hospital administration's failure to screen physicians' credentials or terminate their staff privileges.⁴² Corporate negligence in these cases, though, always has been the rule.⁴³ The *Darling* court's inarticulate holding that the hospital was liable for its nurses' negligence has also been followed—but in cases in which respondeat superior was applied or should have been applied.⁴⁴ In sum, for speaking up cases, *Darling's* language is focused inappropriately on the hospital as an entity because the issue is one of individual nursing, not corporate, negligence.⁴⁵ Its holding, however, was correct.

40. See 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 16.09, at 16-55.

41. See Lisko, *supra* note 16, at 183-84.

42. See Comment, *The Hospital-Physician Relationship*, *supra* note 16, at 415-16.

43. See, e.g., *Itermann v. Baker*, 214 Ind. 308, 318, 15 N.E.2d 365, 369-70 (1938); *Smith v. Duke Univ.*, 219 N.C. 628, 634, 14 S.E.2d 643, 647 (1941); *Glavin v. Rhode Island Hosp.*, 12 R.I. 411, 424 (1879); see also *supra* note 9 (discussion of a hotel's liability). Perhaps what *Darling* helped to change was not the rule, but courts' willingness to use it as more than just a hollow dictum.

44. See *infra* text accompanying notes 68-134. To the extent that *Darling* dealt with shocking, outrageous conduct by a physician, the case fits in neatly with the respondeat superior cases that speak of "obvious" negligence. See *infra* text accompanying notes 77-106.

45. 1 S. PEGALIS & H. WACHSMAN, *supra* note 3, § 3:29. As this Article makes clear, I disagree with most other commentators on *Darling's* significance to the corporate negligence doctrine. Arthur Southwick, for example, a frequent commentator on matters of hospital liability, first observed in 1968 that *Darling* "looks like an extension of the idea of corporate negligence." Southwick, *supra* note 14, at 161. Southwick first identified the corporate negligence doctrine as consisting of duties to use reasonable care in (1) maintaining buildings and grounds, (2) providing medical equipment and devices, and (3) selecting and retaining personnel. *Id.* at 152-54. He then concluded that *Darling* extended corporate negligence because the case was based not on respondeat superior, but on "violation of direct duties that [the hospital] owes to the patient." *Id.* at 161.

By 1973, Southwick was describing *Darling* as a "landmark case" that helped to eliminate any distinctions between respondeat superior and corporate negligence. See Southwick, *supra* note 25, at 443, 452-53. He expanded on these views in a 1978 book, A. SOUTHWICK, *supra* note 24. In *The Law of Hospital* he argued that *Darling* does not require a hospital to review on-going medical cases, but does require an institutional response: "The [hospital] administration . . . is now called upon to stimulate the medi-

If *Darling* were an isolated case in this regard, the divergence between its broad language and rather narrow holding would matter little. The case and the corporate negligence doctrine have, however, continued to receive frequent attention. When that attention comes in a speaking up case, confusion follows. For example, in *Bost v. Riley*,⁴⁶ the North Carolina Court of Appeals considered whether to adopt the doctrine of corporate negligence. The plaintiff's intestate had a bicycle accident in which he injured the left side of his body. He was admitted to the defendant hospital's emergency room and was under the care of several physicians who were not hospital employees. His treatment involved several operations over the course of a month. Following his death in the hospital, the plaintiffs sued both the physicians and the hospital, alleging that the latter was negligent in granting privileges to the physicians, in failing to monitor adequately their care, and in failing to monitor adequately the decedent's condition or require the physicians to keep better progress notes.⁴⁷

The estate charged the hospital with both corporate negligence and respondeat superior liability. The trial court directed

cal staff of the institution to organize a means of reviewing the professional qualifications and performance of each individual staff physician." *Id.* at 411; see also Hanson & Stromberg, *supra* note 2, at 13 ("a hospital administration must stimulate its medical staff to establish procedures for consultation"). I argue that *Darling* does not require an institutional response to speaking up cases at all, other than that a hospital must make clear to employees that if something is going wrong, they should not hesitate to see that matters are set aright. Far from supporting the notion of corporate negligence, this type of response is absolutely indistinguishable from the institutional response that respondeat superior would stimulate. Southwick's interpretation is one that is a correct statement of law—hospitals are obliged to relieve incompetent physicians of their privileges—but it does not stem, in my view, from the holding of *Darling*.

Interestingly, the only commentators who view *Darling* and similar cases as imposing serious obligations on hospital employees—not just on hospital administrators—are either physicians, nurses, or commentators writing for a nursing audience. See 1 S. PEGALIS & H. WACHSMAN, *supra* note 3, § 3:29 (Wachsmann has both an M.D. and a J.D. degree); Greenlaw, *Reporting Incompetent Colleagues*, 1 NURSING LAW & ETHICS 4 (1980); Katz, *Reporting and Review of Patient Care: The Nurse's Responsibility*, 11 LAW, MEDICINE, & HEALTH CARE 76 (1983); SPRINGHOUSE CORPORATION BOOK DIVISION, PRACTICES 541-47 (Nurse's Reference Library 1984); see also *Lunsford v. Board of Nurse Examiners*, 648 S.W.2d 391 (Tex. Ct. App. 1983) (a nurse's license was suspended for not speaking up).

46. 44 N.C. App. 638, 262 S.E.2d 391 (1980). *Bost* is discussed at length in Note, *Tort Law—Corporate Negligence of Hospitals and the Duty to Monitor and Oversee Medical Treatment—Bost v. Riley*, 17 WAKE FOREST L. REV. 309 (1981).

47. *Bost*, 44 N. C. App. at 640-41, 262 S.E.2d at 393.

a verdict for the hospital, which the court of appeals affirmed. The appellate court dismissed the respondeat superior theory because the *physicians* were not acting as "employees, agents, or servants"⁴⁸ of the hospital. The court failed to mention the possibility of respondeat superior liability for the nurses' or other employees' negligence, leaving only corporate negligence as a basis for liability. As a matter of simple logic, the court's omission is faulty legal reasoning. The *Bost* decision therefore is flawed for not addressing the hospital's respondeat superior liability for the nurses' negligence in failing to speak up. The court did rely, however, on the corporate negligence theory.

In an effort to find authority for its reliance, the court discussed the theory at length, citing six law review commentaries and discussing earlier North Carolina cases that "implicitly" had adopted the corporate negligence theory. The court concluded that it was appropriate for it to adopt the theory. Having adopted it, however, the court held that the plaintiff's case failed on a matter of proof. There was no evidence that the victim would not have suffered injury had the hospital enforced its procedure requiring physicians to keep adequate progress notes.⁴⁹ Therefore, a directed verdict was appropriate.

It is accurate in some respects to label the hospital's failure to enforce its record-keeping requirements as corporate negligence. Enforcing hospital rules at least sounds like an administrative or corporate responsibility. But the plaintiff had also alleged the hospital's failure to monitor quality in general, presumably referring to the failure to catch the physician's treatment errors. The court simply took no notice of this allegation at all. Although it is not clear why the court did not consider the allegation, a reasonable guess is that the plaintiff failed to point to any specific acts of nursing negligence. If corporate negligence for not monitoring quality meant anything, the court should have addressed the issue even without the plaintiff's allegation of specific incidents. That the court did not address the issue suggests that monitoring quality in a speaking up case means nothing if specific employee negligence cannot be found. If specific negligence can be found, however, the simplest way to handle the case is to hold the hospital vicariously liable under

48. *Id.* at 645, 262 S.E.2d at 395.

49. *Id.* at 648, 262 S.E.2d at 397.

respondeat superior—not to adopt the theory of corporate negligence. In all, the *Bost* court's reliance on corporate negligence only muddled its analysis and offered nothing that could not have been handled on the basis of respondeat superior.

The Washington Court of Appeals in *Alexander v. Gonser*,⁵⁰ recently exhibited a similar confusion by assuming that corporate negligence extends to speaking up cases. A patient in the late stages of pregnancy had an automobile accident that forced her abdomen against the car's steering wheel. Her obstetrician admitted her to the hospital and examined her there. He gave orders for fetal heart monitoring and went home. The nurse performing the monitoring called the obstetrician at home to report that the fetal heartbeat was "equivocal," and that the patient still complained of numbness. When he nevertheless directed the nurse to discharge the patient, the nurse "voiced her concern with the test results."⁵¹ The obstetrician stood by his decision to discharge the patient, with instructions for her to return the next day. Nothing was said to the patient about the test results.

The patient returned the next morning. Renewed monitoring showed fetal distress, and a caesarean delivery resulted in a partially asphyxiated infant with permanent brain damage. The patient sued the hospital on several theories that were not clearly articulated by the court, but one of the theories was expressly identified as corporate negligence.⁵²

The court observed at the outset that "[c]orporate negligence has been extended to include placing a duty on the hospital to 'intervene in the treatment of its patients if there is obvious negligence.'"⁵³ It then cited a number of cases from other jurisdictions⁵⁴ for the proposition that these jurisdictions found

50. 42 Wash. App. 234, 711 P.2d 347 (1985).

51. *Id.* at 236, 711 P.2d at 349.

52. *Id.* at 239-40, 711 P.2d at 349. Another theory was that she did not give her informed consent to the hospital's treatment or lack of treatment because she was not told of the test results. The court held that any duty to inform her of test results rested with her physician, not the hospital, on the grounds that a contrary conclusion would interfere with the doctor-patient relationship. *Id.* at 239, 711 P.2d at 350-51.

53. *Id.* at 240, 711 P.2d at 351 (quoting *Schoening v. Grays Harbor Community Hosp.*, 40 Wash. App. 331, 335, 698 P.2d 593, 596 (1985)).

54. *Fridena v. Evans*, 127 Ariz. 516, 622 P.2d 463 (1980) (en banc); *Poor Sisters of St. Francis v. Catron*, 435 N.E.2d 305 (Ind. Ct. App. 1982); *Toth v. Community Hosp.*, 22 N.Y.2d 255, 292 N.Y.S.2d 440, 239 N.E.2d 368 (1968); *Utter v. United Hosp. Center*, 160 W. Va. 703, 236 S.E.2d 213 (1977).

hospitals liable when employees failed to speak up. None of the cases cited by the court, however, was based on the doctrine of corporate negligence; they were all handled as simple cases of respondeat superior liability.

The patient in *Alexander* introduced an affidavit by a "Dr. Jones, who specialized in psychology rather than obstetrics"⁵⁵ in support of her corporate negligence claim. The court observed that Dr. Jones "was not knowledgeable as to the standard of care for obstetricians in Washington."⁵⁶ On the basis of this affidavit, the trial court found that the patient had shown a breach of the hospital's duty to monitor her physician, but had not shown that the breach caused the "clinical situation that occurred on" the day she was injured.⁵⁷ The court of appeals accepted those findings, but should not have because they addressed the wrong question. The issue was not whether the nurses' failure to speak up caused the fetal distress on the day the patient was admitted. The proper question was whether the infant's condition at birth the next day would have been better if the nurses had spoken up by seeking consultation on the day of admission. To be sure, the patient did not help her cause or the court by having a psychologist instead of a nurse prepare an affidavit. Although it is possible that a doctor specializing in psychology would be familiar with the nursing standard of care, the court's principal confusion was its reference to the doctor's lack of familiarity with an *obstetrician's* standard of care—a standard not directly relevant to the nurses involved, who, after all, bear the obligation to speak up.

Inexplicably, the patient also introduced two depositions in which doctors, presumably physicians, stated that the nurses conformed to the accepted standard of care in conferring with the obstetrician. This evidence conflicted with the trial court's finding that the hospital improperly monitored the physician's care. The fact that some evidence conflicts with an ultimate finding is not noteworthy in itself. What is noteworthy is that neither the trial nor the appellate court sensed the contradiction: how can a hospital fail to fulfill its obligation to monitor a physician when its employees conformed to the accepted stan-

55. *Alexander*, 42 Wash. App. at 241, 711 P.2d at 352.

56. *Id.*

57. *Id.*

dard of care? The proper resolution of the case at trial would have been to recognize that corporate negligence was inappropriate and to grant summary judgment for the hospital because the patient's own evidence showed that there was no breach of the nurses' obligation to speak up.

In affirming the summary judgment for the hospital, the court of appeals relied in part on the fact that the physician's "hospital privileges did not become reviewable until after [the patient's] treatment" had been completed.⁵⁸ The court was referring to corporate negligence in its most common form: negligence in granting or continuing a physician's privileges. In a speaking up case, however, the timing of a physician's peer review is irrelevant—the only proper question is whether the nurses should have done more than they did.

Like the court's opinion, the plaintiff's case also reflects confusion over corporate negligence. The plaintiff's expert, Dr. Jones, stated in regard to the alleged failings by the hospital that "unacceptable practice patterns might have been disclosed which would have warranted closer supervision. . . ."⁵⁹ This abstract review of the situation focuses on hospital procedures in its reference to practice patterns. Hospital procedures are properly at issue when a hospital has failed to establish correct ones, but *Alexander* is a speaking up case in which there is no indication of a failure to adopt the proper procedures. A nurse's affidavit stating that a reasonable nurse would have called in a resident when the treating physician failed to do anything would have been far more pertinent for the plaintiff than this vague reference to practice patterns.

Once again, as in the *Bost* case,⁶⁰ a focus on nursing negligence, with less attention to corporate negligence, either would have strengthened the plaintiff's case, or would have allowed the court to dispose of the case because of a lack of evidence that the nurses breached a standard of care. The corporate negligence doctrine simply confused the issues.

Curiously, only eight months before *Alexander*, the Washington Court of Appeals in *Schoening v. Grays Harbor*

58. *Id.*

59. *Id.* (quoting affidavit of plaintiff's medical expert).

60. *Bost*, 44 N.C. App. 638, 262 S.E.2d 391.

Community Hospital,⁶¹ satisfactorily handled a speaking up situation under the doctrine of corporate negligence. The plaintiff had given birth to a child at the defendant hospital and was discharged two days later. For reasons not specified in the opinion, her condition began to deteriorate and she returned to the hospital. Under the care of her private physicians, her condition continued to deteriorate for seven days. She was then transferred to another hospital where she underwent various surgical procedures.

She brought suit against the treating physicians and the first hospital for injuries during the period of deterioration. As part of her case against the hospital, she introduced an affidavit from a physician that generally asserted a failure of the hospital to meet "minimum medical standards of practice."⁶² The physician based his conclusion on

[a] standard of care for hospitals [that] required continued monitoring and observation of the patient by the hospital staff, as well as obtaining an additional or independent evaluation of the patient in those instances where the care being provided by the attending physician is questionable and where the patient's condition continues to deteriorate.⁶³

The appellate court found that this affidavit was sufficient for the plaintiff to make out a jury issue on hospital negligence, and, accordingly, it reversed a grant of summary judgment for the hospital. This decision is correct: the physician stated in his affidavit that the hospital staff should have done something; a trial was necessary to determine if that assertion was correct. Notably, the doctrine of corporate negligence was just excess baggage in the case. It was enough that the nurses who observed the plaintiff's condition failed to take the steps that reasonable nurses would have taken; the hospital would then be liable as the nurses' employer.

The court implicitly acknowledged that the corporate negligence doctrine is superfluous in the speaking up context. It first noted that the corporate negligence doctrine was not adopted by the Washington Supreme Court until 1984 in *Pedroza v.*

61. 40 Wash. App. 331, 698 P.2d 593 (1985).

62. *Id.* at 335-36, 698 P.2d at 596.

63. *Id.*

Bryant.⁶⁴ It then stated that "[a]lthough the trial court did not have the benefit of *Pedroza*, the same reasoning is present in earlier cases,"⁶⁵ holding that hospital staff members were negligent and that the hospital was liable as their employer.⁶⁶ In short, the advent of the corporate negligence doctrine in *Pedroza* had not changed the law applied to speaking up cases.⁶⁷ If adoption of a doctrine like corporate negligence changes nothing, then the doctrine, as I have argued, is meaningless.

III. THE RESPONDEAT SUPERIOR CASES

Most courts resolve speaking up cases on the basis of respondeat superior without reference to the doctrine of corporate negligence. Nevertheless, these courts take a variety of approaches to a serious dilemma: a nurse should be able to follow a physician's direct order without fear of liability; at the same

64. 101 Wash. 2d 226, 677 P.2d 166 (1984).

65. *Schoening*, 40 Wash. App. at 334, 698 P.2d at 595.

66. *Id.* The court cited *Osborn v. Public Hosp. Dist.*, 80 Wash. 2d 201, 205, 492 P.2d 1025, 1028 (1972) and *Teig v. Saint Johns Hosp.*, 63 Wash. 2d 369, 373, 387 P.2d 527, 530 (1963).

67. I argue that the doctrine of corporate negligence, in speaking up cases decided so far, has either led to confusion or been superfluous. Partly that is because courts are infatuated with sweeping language about hospital duties. It is worth asking how serious courts are about corporate negligence by positing a speaking up case in which the doctrine would make a real difference from an analysis based on respondeat superior. Suppose a physician decides that a patient needs one of two alternative but risky treatments, each of which is well accepted as customary care. The physician administers one of the treatments in conjunction with nurse A. The physician then later decides to administer the second treatment, this time in conjunction with nurse B. If giving both treatments together is negligent, will the hospital be liable? Plainly neither nurse would be negligent, so reliance on respondeat superior liability would be unavailing. The hospital "knows," however, that the overall treatment is negligent because the collective knowledge of its agents is imputed to the principal. *RESTATEMENT (SECOND) OF AGENCY* §§ 268, 272 (1958). If the corporate negligence cases really are different from the respondeat superior cases, a hospital should be liable in this situation. It remains to be seen if the case will arise.

A second case is possible, but seems unlikely ever to arise. Suppose a hospital's administration issues regulations that require employees to follow physicians' orders no matter how wrong they seem. If a nurse then follows an indisputably, obviously wrong order and harms a patient, the hospital could be liable. Liability would be based on negligent (or perhaps even intentional) issuance of ill-advised rules and procedures—a genuine form of corporate negligence. Interestingly, the nurse might be liable as well, if in fact reasonable nurses would have ignored the rules and spoken up about the physician's orders. The hospital might therefore be liable both for corporate negligence and on the basis of respondeat superior. The case seems too far-fetched to argue against the point of this Article, that hospital liability for employees' not speaking up is better handled as a matter of respondeat superior, not corporate negligence.

time, a nurse should not follow an order that is obviously wrong and will very likely cause a patient harm. A clearly stated and easily applied rule of liability that takes care of these competing goals has escaped many courts so far, primarily because of the difficulty of determining what constitutes an obviously wrong order.

Some courts avoid the issue altogether by following a firm rule that a nurse is never liable for following a physician's order. The Oklahoma Supreme Court took this approach in *Van Cleave v. Irby*,⁶⁸ in which the plaintiff sued both a physician and a hospital. The physician had directed a nurse to put a patient on an electric diathermy machine for twenty minutes. The nurse had followed these instructions and the patient was burned. The case against the hospital was tried on a respondeat superior theory. Plaintiff argued that both the treating physician and the nurse were agents of the hospital and that both were negligent. The court concluded that the physician had been negligent, but was not the hospital's agent. Conversely, the court held that the nurse was the hospital's agent, but had not been negligent. Because she had followed the physician's order to leave the heat applied for twenty minutes, "[t]here [was] no evidence tending to establish negligence" by the nurse.⁶⁹ The court did not inquire whether a reasonable nurse might have known that the heat was too great or was applied too long. Nor did the court acknowledge the possibility that a physician's orders could be so wrong that a reasonable nurse would not follow them. The court thus implied that a nurse could not be negligent for following any order, no matter how wrong it could be.

In contrast to the *Van Cleave* approach, a number of courts have identified situations in which a nurse should not follow a physician's order. For example, some courts simply state, without further explanation, that employees must speak up about physicians' obvious errors;⁷⁰ or that they must obey a physician's orders unless they are clearly contraindicated.⁷¹ Another court has required that hospital employees speak up about any depar-

68. 204 Okla. 689, 233 P.2d 963 (1951).

69. *Id.* at 690, 233 P.2d at 965.

70. *See infra* text accompanying notes 75-90.

71. *See infra* note 91 and accompanying text.

ture by a physician from medical standards,⁷² without regard, presumably, to whether the departure is obvious or clear. Still other courts have not mentioned physicians' medical standards, but have implied that an employee's training is what triggers a requirement to speak up: if the employee does not have the training to know that a particular procedure is improper, then the employee should not have an obligation to say anything; if the employee is trained, however, then the employee should speak up.⁷³

These cases all rely on curious contortions of "duty" language, contortions that can best be appreciated after reading a summary of a speaking up case that avoided them. Recall that a thesis of this Article is that a court can satisfactorily dispose of speaking up cases by focusing on the need for expert testimony for proof of employee negligence. A good example is *Mundt v. Alta Bates Hospital*,⁷⁴ a 1963 California case. A patient's treating physician had installed a catheter in the patient's leg. Over a period of about twenty-four hours, the patient's leg became increasingly swollen, firm, and reddened. The nursing staff called the physician a number of times, but the physician did not see a need for action. The patient suffered an infiltration of fluid into her leg tissue, with damage sufficient to require plastic surgery. After a jury verdict for the hospital, the trial court ordered a new trial, and the court of appeals affirmed.⁷⁵ The court found additional evidence that could support a jury finding of nursing negligence, based on testimony from both a physician and other nurses that the defendant's nurses had not given proper nursing care in the circumstances.⁷⁶

Mundt's focus on a violation of the nursing standard of care, shown by expert testimony, sounds perfectly unexceptional; unfortunately, it is an exception. Most courts try to define the type of obvious physician errors about which a nurse should speak up.

72. See *infra* note 124 and accompanying text.

73. See *infra* text accompanying notes 127-33.

74. 223 Cal. App. 2d 413, 35 Cal. Rptr. 848 (1963).

75. *Id.*

76. *Id.* at 420-21, 35 Cal. Rptr. at 853.

A. Obviousness

One of the earliest cases to mention speaking up about obvious physician errors was a 1932 North Carolina case, *Byrd v. Marion General Hospital*.⁷⁷ The patient was ordered to the hospital for heat treatment in some sort of a sweat box. The attending physician and a nurse stood by while the patient became badly burned. In reversing a jury verdict against the hospital,⁷⁸ the North Carolina Supreme Court declared that "nurses . . . must obey and diligently execute the orders of the physician . . . in charge of the patient, unless, of course, such order was so obviously negligent as to lead any reasonable person to anticipate that substantial injury would result."⁷⁹ The court concluded as a matter of law that the treatment at issue was not obviously negligent.⁸⁰ To suggest the kind of treatment that would be obviously negligent, the court noted that "if a physician or surgeon should order a nurse to stick fire to a patient, no nurse would be protected from liability" for carrying out the order.⁸¹ In finding the hospital not liable, the court stressed the fact that the physician was present at the time of the injury: "if the physician is present . . . [and approves] the treatment administered by the nurse, . . . then in such event the nurse can then assume that the treatment is proper under the circumstances, and such treatment, when the physician is present, becomes the treatment of the physician and not that of the nurse."⁸² The court suggested by this language that in more compelling circumstances, perhaps where the physician is not present, a hospital would be liable for an employee nurse's failure to speak up about the physician's negligence.

Quite a few cases have echoed the *Byrd* court's language.⁸³ For example, in *Toth v. Community Hospital* the court stated in dictum that a nurse or other employee was obligated to follow a

77. 202 N.C. 337, 162 S.E. 738 (1932).

78. *Id.* The jury's verdict was for \$30,000, shockingly high in the 1930s. *Id.* at 340, 162 S.E.2d at 739.

79. *Id.* at 341, 162 S.E. at 740.

80. *Id.* at 343, 162 S.E. at 741.

81. *Id.* at 341, 162 S.E. at 740. "Sticking fire" to the patient is just about what happened, but the court saw no irony in its example.

82. *Id.* at 343, 162 S.E. at 741.

83. One court went so far as to quote *Byrd* on this point (without citation), though the language was merely dictum. See *McElroy v. Employers' Liab. Assurance Corp.*, 163 F. Supp. 193, 198 (W.D. Ark. 1958).

physician's orders unless those orders were clearly contraindicated.⁸⁴ In *Collins v. Westlake Community Hospital*,⁸⁵ the court suggested a similar standard by confining the *Darling*⁸⁶ court's finding of liability to cases of "grossly improper medical treatment" evidenced by "a multitude of glaringly obvious signals."⁸⁷ A year before *Collins*, the Ohio Supreme Court held that the unlocking of a suicidal patient's door by an employee ordered to do so by the treating physician was not obviously negligent.⁸⁸ The Washington case discussed earlier, *Schoening v. Grays Harbor Hospital*,⁸⁹ noted that a "hospital clearly has a duty to intervene in the treatment of its patients if there is obvious negligence."⁹⁰ Finally, another case applying New York law, *Schwartz v. Boston Hospital for Women*, stated that a hospital is not liable for carrying out a physician's orders "unless the hospital has actual reason to know or believe that the doctor's orders or procedures are 'clearly contraindicated by normal practice'"⁹¹

Although these formulations seem to specify the circumstances in which an employee should recognize malpractice, they do not indicate from whose viewpoint obviousness is to be judged; thus, they tend to cloud the question of whose testimony is relevant or necessary to a finding that orders are obviously erroneous. If the concept of obviousness is to have any meaning, it must be tied to someone's point of view. If a nurse, for example, must speak up about a physician's obvious errors, the requirement could mean any of at least three things: that the errors are obvious to other physicians, obvious to nurses, or

84. *Toth v. Community Hosp.*, 22 N.Y.2d 255, 265 n.3, 239 N.E.2d 368, 374 n.3, 292 N.Y.S.2d 440, 449 n.3 (1968); see also *Killeen v. Reinhardt*, 71 A.D.2d 851, 853, 419 N.Y.S.2d 175, 177 (1979) (citing *Toth*, 22 N.Y.2d at 265 n.3, 239 N.E.2d at 374 n.3, 292 N.Y.S.2d at 449 n.3).

85. 12 Ill. App. 3d 847, 299 N.E.2d 326, rev'd, 57 Ill. 2d 388, 312 N.E.2d 614 (1974).

86. See *supra* notes 25-45 and accompanying text.

87. *Collins*, 12 Ill. App. 3d at 852, 299 N.E.2d at 329; see also *McElroy v. Employers' Liab. Assurance Corp.*, 163 F. Supp. 193 (W.D. Ark. 1958); *Czubinsky v. Doctors Hosp.*, 139 Cal. App. 3d 361, 188 Cal. Rptr. 685 (1983); *Johnson v. Grant Hosp.*, 32 Ohio St. 2d 169, 291 N.E.2d 440, rev'ing 31 Ohio App. 2d 118, 286 N.E.2d 308 (1972).

88. *Johnson v. Grant Hosp.*, 32 Ohio St. 2d 169, 178-79, 291 N.E.2d 440, 445-46, rev'ing 31 Ohio App. 2d 118, 286 N.E.2d 308 (1972). The patient had left the room and jumped out of a window.

89. *Schoening*, 40 Wash. App. 331, 698 P.2d 593; see *supra* notes 61-63 and accompanying text.

90. *Schoening*, 40 Wash. App. at 335, 698 P.2d at 596.

91. *Schwartz v. Boston Hosp. for Women*, 422 F. Supp. 53, 55 (S.D.N.Y. 1976).

obvious to lay parties.⁹² Each of these interpretations of the "obvious error" rule has some drawbacks.

1. Obvious to Physicians

If an employee must speak up about a physician's errors that would be obvious only to another physician, liability often would be unfairly imposed. A nurse, respiratory therapist, or lab technician should not be expected to know that a certain medical procedure is obviously inappropriate in the circumstances, if the nurse or technician has been trained to know no more than how to carry out the procedure when asked to do so. Undoubtedly, then, the courts referring to obvious errors do not or at least should not mean errors obvious only to a physician.

2. Obvious to Employees

Perhaps, then, obviously or clearly wrong physician's orders mean those orders that should be obvious to the employee who is charged with liability for not speaking up. Under this interpretation, a nurse would not be expected to do anything about a physician's treatment that was just possibly or arguably improper. A requirement to speak up would be triggered only if the treatment were *obviously* improper to the nurse. Liability would be based on the conduct of the employee and judged from the employee's viewpoint; this seems intuitively correct.

In *Toth v. Community Hospital*,⁹³ the court in dicta imposed such a duty on hospital employees. A physician had ordered oxygen administered to two premature infants for several days; the nursing staff administered it for a much longer time period thus blinding the infants. Although the nurses acted within the accepted standard of care at the time, prolonged administration of oxygen was beginning to be recognized as a cause

92. These differences are not over refined. A completely separate area of law, design patents, has already shown the necessity of establishing a viewpoint for tests of obviousness. Design patents can be granted for designs that are, among other things, not obvious. In 1966, the Court of Customs and Patent Appeals concluded that obviousness was to be judged from the viewpoint of the layperson, or "ordinary observer." *In re Laverne*, 356 F.2d 1003 (C.C.P.A. 1966). In 1981, the same court concluded that the more appropriate viewpoint was that of the "ordinary designer." *In re Nalbandian*, 661 F.2d 1214 (C.C.P.A. 1981). That the court saw fit to discuss the matter at all shows that the question was a significant one.

93. 22 N.Y.2d 255, 239 N.E.2d 368, 292 N.Y.S.2d 440 (1968).

of infant blindness. The court found that the plaintiffs had made out a case against the hospital for the nurses' failure to follow the physician's instructions.⁹⁴ In a footnote, the court observed that a hospital employee will be held liable for not speaking up only when a physician issues an order that is "so clearly contraindicated by normal practice that ordinary prudence requires inquiry."⁹⁵ The reference to "ordinary prudence" at first sounds like a layperson's standard, but this view is undercut by other assertions in the opinion. First, the court spoke of orders contraindicated "by normal practice," presumably meaning normal medical or hospital practice.⁹⁶ A layperson would not be familiar with a hospital's normal practice; a nurse or other employee would be. Second, and more to the point, the court noted that a nurse who follows a physician's orders, even when the orders are "contrary to sound medical practice," would be immunized from liability.⁹⁷ This statement implies that a nurse would only be liable for following an order that, from the nurse's viewpoint, was "*clearly* contrary" to sound practice, not just "merely contrary." That is, "obvious" or "clearly contraindicated" means obvious or clear as judged from the viewpoint of the employee charged with negligence for not speaking up.

This interpretation would be a comfortable one for a court. It echoes the standard of appellate review for trial court factual findings: they must be clearly erroneous, not just merely erroneous.⁹⁸ A hospital employee who observes a physician's treatment with an eye toward speaking up about errors is in many ways in the same posture as an appellate court. The physician's greater training and primary responsibility for patient welfare deserve considerable deference; an appellate court similarly defers to the trial court's first-hand appreciation of the evidence and primary responsibility for fact finding. There is much to be said, then, for interpreting the obvious error requirement to mean obvious to the reviewing hospital employee.

The drawback of this interpretation is that it seems unduly

94. *Id.* at 265, 239 N.E.2d at 374, 292 N.Y.S.2d at 449.

95. *Id.* at 265 n.3, 239 N.E.2d at 374 n.3, 292 N.Y.S.2d at 449 n.3.

96. *Id.*

97. *Id.* at 265, 239 N.E.2d at 374, 292 N.Y.S.2d at 450.

98. See *Inwood Laboratories, Inc. v. Ives Laboratories, Inc.*, 456 U.S. 844, 855 (1982); Fed. R. Civ. P. 52(a); J. FRIEDENTHAL, M. KANE & A. MILLER, *CIVIL PROCEDURE* § 13.4, at 601 (1985).

protective of the employee. Suppose a physician orders a respiratory therapist to do a blood gas analysis for a patient by drawing an arterial blood sample, one when the patient is resting, and another when the patient is under stress on a treadmill. Suppose the patient complains of chest pains, of which the physician is aware but dismisses as unrelated to heart problems. Suppose further that the therapist suspects heart trouble but gives the test anyway, resulting in the patient's death from a heart attack. Why should the therapist escape liability if he thought the ordering of the test was negligent, but not obviously negligent, or contraindicated, but not clearly contraindicated?

3. Obvious to Lay Parties

The judicial requirement for speaking up about obvious errors need not, of course, refer to obviousness from the viewpoint of either a physician or a hospital employee. The first court to use the obviously negligent formulation, *Byrd v. Marion General Hospital*,⁹⁹ indicated instead that obviousness was to be judged from the viewpoint of the untrained layperson. The court not only spoke of obvious negligence, but also asserted that a physician's orders must be obeyed by hospital employees unless "*any reasonable person* [would] anticipate that substantial injury would result to the patient" from carrying out those orders.¹⁰⁰ By referring to "any reasonable person," the court seems to have meant tort law's hypothetical reasonable person, that is, someone other than a medically trained individual. This view is borne out by the fact that the court decided as a matter of law that the physician's orders were not obviously negligent.¹⁰¹ Presumably, anything other than a layperson's standard would have necessitated expert testimony on this point and hence a remand to the trial court.

Although the *Byrd* decision is now over fifty years old, in 1972 the Ohio Supreme Court decided a similar case, *Johnson v. Grant Hospital*,¹⁰² in a similar way. In this case a suicidal patient had been admitted to a general hospital. Her physician or-

99. 202 N.C. 337, 162 S.E. 738 (1932).

100. *Id.* at 341, 162 S.E. at 740 (emphasis added).

101. *Id.* at 343, 162 S.E. at 741.

102. 32 Ohio St. 2d 169, 291 N.E.2d 440, *rev'ing* 31 Ohio App. 2d 118, 286 N.E.2d 308 (1972).

dered the hospital staff to keep the patient locked in her room at night, but at her family's urgings, he ordered the room unlocked during the day. A member of the staff unlocked the door; during the next nursing shift, the patient left her room and jumped out of a window. The patient's family sued the hospital, but lost on a directed verdict. The Ohio Court of Appeals reversed on the grounds that any reasonable person either would have kept the door locked in spite of what the physician ordered, or, having received the order, would have told the next nursing shift about the patient's history of attempted suicides.¹⁰³ The Ohio Supreme Court reversed the appellate court and reinstated the directed verdict.¹⁰⁴ The court reasoned that because the hospital was not a mental hospital, the physician's order to unlock the door was not obviously negligent.¹⁰⁵

The supreme court evidently accepted the appellate court's reliance on the standard of a reasonable layperson: it did not question the use of that standard, and it found it proper to reinstate the directed verdict without need of expert testimony. Yet, the court found it significant that the hospital was a general, not a mental, hospital. This distinction suggests that there is some relevant difference between the training or experience of psychiatric nurses and other nurses. If a difference in professional training or experience is relevant, then expert testimony about what a nurse in a general hospital ought to know should have been required.¹⁰⁶ The court's failure to recognize the need for expert testimony could have been avoided by using the approach put forth in this Article: a hospital employee's negligence for not speaking up should be determined from the testimony of other, similarly situated employees about what the reasonable employee would do.

Even if the inconsistency in the court's reasoning were eliminated, judging physicians' errors from the viewpoint of a layperson would have at least three drawbacks. First, in practice, it would practically constitute an immunity for hospitals. Very few physicians' decisions, even when wrong, would be obviously

103. *Johnson v. Grant Hosp.*, 31 Ohio App. 2d 118, 286 N.E.2d 308, *rev'd*, 32 Ohio St. 2d 169, 291 N.E.2d 440 (1972).

104. *Johnson*, 32 Ohio St. 2d 169, 291 N.E.2d 440.

105. *Id.* at 178-79, 291 N.E.2d at 455-56.

106. *Cf. Pisel v. Stamford Hosp.*, 180 Conn. 314, 336-38, 430 A.2d 1, 13-14 (1980) (several nurses testified to the proper psychiatric nursing care for a psychotic patient).

wrong to a person wholly untrained in medicine.¹⁰⁷ A court might, of course, want to provide hospitals with immunity as a matter of policy, but poorly articulated requirements about obviousness and lay parties seems an underhanded way to do it.

Second, tort law has long provided that defendants with special expertise who are engaged in tasks calling for the use of that expertise ought to rise to an expert's standard.¹⁰⁸ This rule applies to physicians,¹⁰⁹ airplane pilots,¹¹⁰ architects and engineers,¹¹¹ and nurses in nonspeaking up cases,¹¹² among others. There is little reason to treat a speaking up case differently by holding a nurse to a lower standard.

Finally, a layperson's standard implies that patients could be found contributorily or comparatively negligent for not speaking up about their own mistreatment. Contributory negligence by patients has rarely been argued in cases where the patient was hospitalized,¹¹³ but it has been in other contexts.

107. Not surprisingly, then, hospitals themselves would be expected to prefer this standard for liability. In the *Darling* case, for example, the defendant hospital's brief argued that a hospital cannot be liable for a nurse's following a physician's order "unless such order is so obviously negligent as to lead any reasonable person to anticipate substantial injury to the patient from its execution." Annot., *supra* note 26, at 863. Liability might well have been found under that test: even a layperson would be likely to suspect some problem with a physician's failure to do anything when a patient's toes, protruding from a leg cast, turn steadily darker and colder and lose feeling. It would have been an appropriate question for the jury to decide whether the physician's failure was simply wrong or obviously wrong from a layperson's viewpoint. Yet the Illinois Supreme Court implicitly rejected the proposal that obviousness was to be judged from that viewpoint. The court held that the jury was entitled to find the nurses negligent for not speaking up in a situation in which "skilled nurses recognized" the symptoms of gangrene but did nothing about them. *Darling*, 33 Ill. 2d at 333, 211 N.E.2d at 258. The court did not indicate whether the nurses recognized, or had to recognize in order to be liable, the physician's treatment as obviously wrong or just merely wrong. By focusing on the nurse's recognition, however, the court certainly rejected any notion in *Byrd* that the decision to speak up should be made from a lay viewpoint.

108. PROSSER & KEETON, *supra* note 14, § 32, at 185-86.

109. See generally McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549 (1959).

110. *Heath v. Swift Wings, Inc.*, 40 N.C. App. 158, 252 S.E.2d 526 (1979).

111. *City of Eveleth v. Ruble*, 302 Minn. 249, 225 N.W.2d 521 (1974). See generally Bell, *Professional Negligence of Architects and Engineers*, 12 VAND. L. REV. 711 (1959).

112. *Bamert v. Central Gen. Hosp.*, 77 A.D.2d 559, 430 N.Y.S.2d 336 (1980).

113. But see *Allman v. Holleman*, 233 Kan. 781, 667 P.2d 296 (1983) (finding no contributory negligence when a hospital patient tossed and turned so extensively that she dislodged an endotracheal breathing tube). Most of the nonhospital contributory negligence cases seem to fall into two categories: a patient's failure to come back to a physician for follow-up visits, see Annot., 100 A.L.R.3d 723 (1980), and a patient's failure

These arguments, in fact, have been based on something like a requirement that patients themselves speak up about obvious negligence. A 1944 Ohio case, *Champs v. Stone*, is illustrative.¹¹⁴ The patient visited a physician for a blood test for a marriage license. The physician insisted that the patient needed a series of injections, though the opinion does not say what they were for. The physician was drunk at the time. The patient knew that the physician was drunk, but submitted to an injection anyway and was injured in the process. A directed verdict for the physician, on grounds of the patient's contributory negligence, was affirmed by the appellate court.¹¹⁵ When a patient is "fully aware" of a physician's intoxication, the court held, an ordinarily careful patient would "seriously doubt the physician's ability and . . . refuse treatment."¹¹⁶

At least one other court has set a standard similar to the one in *Champs*, but used it to deny a contributory negligence defense. In this 1901 Iowa case, *Schoonover v. Holden*,¹¹⁷ a patient's dislocated knee was treated improperly. In the lawsuit that followed, the physician boldly argued that the patient was contributorily negligent in not seeking a second opinion about her knee when it did not seem to be healing properly. The Iowa Supreme Court affirmed the jury's verdict in favor of the plaintiff, stating that "she was not bound to call other physicians unless she was fully aware" of her own physician's maltreatment.¹¹⁸

The fully aware and seriously doubt language is equivalent to the obviously negligent or clearly contraindicated language of other courts. In fact, the court in a 1977 California case, *Barton*

to give a complete medical history when requested to do so by a physician. See Annot., 33 A.L.R. 4TH 790 (1984). Many of the other so-called contributory negligence cases are actually about intervening causes or aggravating negligence: a physician does something improper, then later the patient does something improper that aggravates the injury. See *Jenkins v. Charleston Gen. Hosp. & Training School*, 90 W. Va. 230, 238-39, 110 S.E. 560, 563-64 (1922); *Lawrence v. Wirth*, 226 Va. 408, 309 S.E.2d 315 (1983). These cases are correctly handled not by upholding contributory negligence as a complete defense but by reducing the patient's recovery in an amount attributable to the patient's own negligence.

114. 74 Ohio App. 344, 58 N.E.2d 803 (1944).

115. *Id.*

116. *Id.* at 349, 58 N.E.2d at 805.

117. 87 N.W. 737 (Iowa 1901) (per curiam).

118. *Id.*; see also *Halverson v. Zimmerman*, 60 N.D. 113, 125, 232 N.W. 754, 758 (1930) ("fully cognizant").

v. Owen,¹¹⁹ stated in dictum that "when a doctor's negligence is 'obvious' to anyone as a matter of common sense, i.e., the leaving in of a sponge, so might there arise similar situations on the part of the plaintiff where his negligence is similarly 'obvious.'"¹²⁰ Under any of these formulations, if the assessment is to be made from the layperson's viewpoint, a patient could be held contributorily or comparatively negligent for not speaking up about his own maltreatment.¹²¹

To be sure, a different threshold—specifically requiring obviousness to be judged from a nurse's perspective—would not eliminate the possibility of contributory negligence in those cases in which a physician's error was obvious to any reasonable person as well as to a nurse. The use of the nurse's perspective alone as a standard at least would allow speaking up cases to go forward to trial. If the standard were assessed from the layperson's perspective only, then plaintiffs who had been conscious of their treatment would be barred from suit by definition. Merely

119. 71 Cal. App. 3d 484, 139 Cal. Rptr. 494 (1977).

120. *Id.* at 506, 139 Cal. Rptr. at 506.

121. One unusual case, *Southeastern Ky. Baptist Hosp. v. Bruce*, 539 S.W.2d 286 (Ky. 1976), has actually touched on the possibility of a patient's being contributorily negligent in regard to a speaking up situation. A patient named Gladys Bruce was in the hospital for surgery, waiting in her room. From the operating room, a surgeon instructed the hospital staff to prepare their next patient, a woman named Jessie Smith, for a thyroidectomy. For reasons that could never be explained, a staff member went to Ms. Bruce's room instead of Ms. Smith's. He evidently asked if Ms. Bruce were Jessie Smith, and Ms. Bruce answered yes, she was. Ms. Bruce was accordingly wheeled into surgery, where the surgeon proceeded to operate without checking her identification bracelet until after the initial incision.

Ms. Bruce brought suit against both the surgeon and the hospital. The jury returned a verdict against both; the hospital appealed on the grounds that Ms. Bruce had been contributorily negligent as a matter of law in answering to the name Smith. The Kentucky Supreme Court concluded that Ms. Bruce, in a naturally confused condition before surgery, had not been contributorily negligent in answering as she did. *Id.* at 287-88. (Kentucky applied the contributory negligence rule until 1984. See *Hilen v. Hays*, 673 S.W.2d 713 (Ky. 1984).)

Though literally a case of too much speaking up, *Bruce* is plainly a situation in which a defendant argued contributory negligence for a patient's failure to correct an improper procedure undertaken by hospital employees. The case is not squarely on point with the situation being examined in this Article, because it dealt with hospital employees', not physicians', improper acts. Thus, *Bruce* cannot stand for the broad proposition that physicians' errors are to be judged from a lay standpoint. The error in the case was confusion over who was in which room, an error, even if made by a physician, that can readily be judged by any reasonable person. Yet the case illustrates well the point that if a hospital employee, and by analogy, a physician, can be negligent, so can a patient for not speaking up about it.

alleging that the physician's error was obvious to a layperson necessarily would entail the conclusion that it was obvious to the patient; negligence by a nurse for not speaking up would mean negligence by the patient as well. On balance, judging obviousness from the viewpoint of laypersons is therefore unsatisfactory.

B. *Substantial Departure*

Although a number of courts rely on a test of obvious error or clear contraindication, the defendant hospital in *Poor Sisters of St. Francis v. Catron*¹²² offered as a test the requirement that employees speak up about substantial departures from proper medical treatment. This formulation, not yet adopted by any court, seems to take the focus of analysis away from the observing employee and shift it to the physician whose improper conduct is observed by the employee. The departure must refer to the physician's departure from the usual standard.

Yet the same problems of interpretation complicate this standard that complicate the obvious formula. What is "substantial" is, after all, in the eye of the beholder. A substantial departure could mean a departure deviating so sharply from the norm that even a layperson would recognize it. In this version, the test is similar to the *Byrd* suggestion that maltreatment must be obvious even to a layperson.¹²³ On the other hand, if there is a difference between the *Poor Sisters* and *Byrd* standards, a substantial departure is one that would cause laypersons to observe that something was amiss, but not that it was obviously or substantially amiss. Again, substantiality could be intended to refer to the employee's perspective, not the layperson's. A court using this test might find liability for not speaking up when a nurse or other employee would regard the physician's acts as a substantial departure from the ordinary. Or perhaps the requirement means that substantial departures are those varying so extremely from the normal physicians' standard of care as to be recognizable as departures by a hospital employee, but not necessarily as substantial departures. The substantial departure rule, in short, is at least as ambiguous as the obviously negligent rule.

122. 435 N.E.2d 305, 307 (Ind. Ct. App. 1982).

123. *Byrd*, 202 N.C. at 341, 162 S.E. at 740.

C. Any Departure

In *Poor Sisters of St. Francis*, the court rejected the substantial departure rule, holding instead that a hospital employee must speak up about a physician's treatment that is simply "not in accord with standard medical practice."¹²⁴ Evidently the court used "not in accord with" to mean something like "any departure from." The defendant hospital's proposed jury instruction stated a requirement for its employees to speak up whenever a physician's treatment was "a substantial departure from accepted medical standards."¹²⁵ The court's choice of "not in accord" thus appears to be in pointed contrast to the hospital's suggested instruction.

On its facts, *Poor Sisters of St. Francis*¹²⁶ is a good case for suggesting that nurses should speak up about any departure from standards. A physician inserted an endotracheal tube into a patient who had breathing difficulty and left it in place for five days. The patient's larynx became scarred, resulting in either permanent or long-term impairment to her breathing and speaking. Testimony at the trial showed that both nurses and inhalation therapists knew that as a rule of thumb, endotracheal tubes should be left in place for three days at most.

The court, then, simply required nurses and therapists to speak up about a possible maltreatment of which testimony showed they were well aware. Unfortunately, the court's language was far broader than its holding and appears to state a general rule that would define a hospital employee's duty by referring to a physician's conduct. Indeed, the rule, though perhaps used to reach a sensible result in the case, seems patently wrong. Surely there will be cases in which a physician's departure from the norm would not be recognized by a hospital employee, like a nurse, or even by a physician trained in a different specialty. If there were no such cases, there would be no need for expert testimony by physicians in malpractice cases; any hospital employee could testify to a physician's departure from medical standards. Of course, courts have not relaxed the requirement for expert testimony to anything approaching that degree.

124. *Poor Sisters of St. Francis*, 435 N.E.2d at 308-09.

125. *Id.* at 307.

126. *Id.* at 308.

If a nonphysician employee is not qualified to testify to a physician's maltreatment, then the same employee should not be liable for not speaking up about that maltreatment. One doubts that the court would adhere to its own rule in a less compelling case.

D. Employee training

In a less compelling case, the most likely modification to an any departure rule would be to refine the requirement so that an employee must speak up about any departure *that the employee should recognize* as such. As modified, the rule makes far more sense, and conforms to the court's actual holding in *Poor Sisters of St. Francis*. Several other courts have also implicitly recognized this standard.

In *Brook v. Saint John's Hickey Memorial Hospital*,¹²⁷ for example, the Indiana Supreme Court considered an action against a hospital for the alleged negligence of an X-ray technician. A radiologist administered a necessary injection into a child's calf muscle, an unusual site for injections. X-ray technicians observed, but said nothing. Four months later the child developed a shortening of the achilles tendon that may have been due to trauma at the injection site. The child's parents sued the hospital on the theory that the technicians were obliged to report the unusual injection site to the hospital administration. The court concluded that a directed verdict in favor of the hospital had been proper: the plaintiffs had introduced no evidence that the technicians were "qualified by any training to know the propriety of injection sites."¹²⁸ The court noted that technicians were required only to graduate from a two-year training program, and had no requirement of licensure.¹²⁹

127. 269 Ind. 270, 380 N.E.2d 72 (1978).

128. *Id.* at 273, 380 N.E.2d at 74. In fact, there appears to have been evidence concerning the technicians' training. One of the plaintiff's experts testified to the proper knowledge of X-ray technicians. The expert, trained in both law and medicine, seems to have been viewed with some suspicion by the court: his testimony was dismissed as "sophistic" and "pure speculation." *Id.* at 274, 380 N.E. 2d at 75 (emphasis in original).

129. *Id.* at 274, 380 N.E.2d at 75. The court may have been additionally persuaded to its result by the fact that the radiologist did not appear to be negligent in selecting the injection site. A court hardly would be interested in ordering a new trial for a technician's failure to report something that the evidence showed was perfectly proper in the first place. Medical literature cautioned against injections in the buttocks or thighs of small children. The physician had decided to give the injection in the calf muscle as the

The absence of licensure is irrelevant only in that it suggests a low degree of training and knowledge. By implication, an employee with more training and knowledge would be required to speak up. Interpreted in this fashion, the opinion implies that an employee who could recognize a physician's departure from customary care should speak up about it or risk liability. Whether the court would actually reach this implicit holding in an appropriate case is another question.

A similar view appears in *Walker v. United States*,¹³⁰ a suit brought in 1982 under the Federal Tort Claims Act.¹³¹ The plaintiff, a retired military serviceman, entered a military hospital for kidney surgery. The operating physician, whom the court found to be an independent contractor and therefore not a government employee, stitched an internal incision with nonabsorbable filament. A kidney stone later formed around the filament and necessitated further surgery. The plaintiff's case against the government for the operating physician's acts was dismissed because the Federal Tort Claims Act immunized the government for the acts of independent contractors.¹³²

More importantly, the plaintiff's case against other operating room personnel failed as well. The court found that neither an orthopedic surgeon, who was present during the operation but did not perform the surgery, "nor any of the other Hospital personnel in the operating room knew, or by training should have known, whether the use of a nonabsorbable suture . . . might cause the formation of kidney stones Hence, none of them could have acted negligently by failing to object [to its use]."¹³³ Like the *Brook* court, however, the court in *Walker* did not state what conditions were necessary to a finding of liability. It merely decided that liability could be found when an employee is not trained to know that a physician's treatment is improper.¹³⁴

A requirement to speak up about any departure the employee is trained to recognize is more sensible than a require-

next largest muscle mass. *Id.* at 273, 380 N.E.2d at 74.

130. 549 F. Supp. 973 (W.D. Okla. 1982).

131. 28 U.S.C. § 1346(b) (1982).

132. *Walker*, 549 F. Supp. at 975-76.

133. *Id.* at 979.

134. *Id.*

ment to speak up about any departure at all. Yet, this requirement is unnecessarily limited because it focuses on training to the exclusion of experience. An X-ray technician, for example, could have observed hundreds of injections given to children and would have noticed that none of them were given in the calf muscle, despite a lack of training on the procedure. Quite apart from formal training, an employee acquires knowledge through experience about normal medical practice. Accordingly, there is no reason to confine the inquiry to the employee's training alone; a focus on what other, reasonable employees would do under the circumstances would necessarily take both training and experience into account.

IV. RESPONDEAT SUPERIOR AND "THE HOSPITAL"

In contrast to those cases that describe liability in terms of an employee's obligation to speak up, another line of cases has cast liability rules in the form of hospital duties or hospital standards of care.¹³⁵ The cases are typically based on respondeat superior, not corporate negligence. When a court uses the term "hospital" in a respondeat superior case, it ought to use it as a metaphor; it should mean the hospital as employer of an employee alleged to have been negligent. Unfortunately, in some of these cases, the repeated reference to "the hospital" prevents a focus on the nurse or other employee who should speak up and, consequently, diverts attention from the question of what testimony or evidence can be used to show the employee's negligence. Perhaps this oversight is merely a drawback of an overreliance on a convenient shorthand, but one suspects it is also a manifestation of the commentators' and courts' increasing attention to hospitals as corporate entities under the corporate negligence theory.

The court in *Bost v. Riley*¹³⁶ suggests the latter influence. This court treated the case, discussed above,¹³⁷ as one of corporate negligence. In reviewing other North Carolina cases that had "implicitly" adopted the theory, the court mentioned *Byrd*

135. *Alden v. Providence Hosp.*, 382 F.2d 163, 166 (D. C. Cir. 1967) (hospital duty); *Darling*, 33 Ill. 2d at 330-31, 211 N.E.2d at 256-57 (hospital standard of care); *Johnson v. Saint Bernard Hosp.*, 79 Ill. App. 3d 709, 716, 399 N.E.2d 198, 204-05 (1979) (discussing both).

136. *Bost*, 44 N.C. App. 638, 262 S.E.2d 391.

137. See *supra* text accompanying notes 46-49.

v. Marion County Hospital,¹³⁸ the 1932 case in which a nurse was present while a physician directed that a patient remain under a heat treatment too long.¹³⁹ The *Bost* opinion characterized *Byrd* as holding that "[t]he hospital has the duty not to obey instructions of a physician which are obviously negligent or dangerous."¹⁴⁰

The characterization of *Byrd* as implicitly adopting the approach of corporate negligence is strained. The suit was brought against the nurse personally and against the hospital's proprietor personally under respondeat superior. *Byrd* was, therefore, a simple case of nursing negligence. The characterization would not matter, except that it led the *Bost* court to overlook the possibility of nursing negligence in that case.¹⁴¹

This reference to the "hospital" as an entity arises occasionally in hospitals' defenses to speaking up cases in the form of an assertion that "a hospital cannot practice medicine."¹⁴² Evidently this statement means that corporate entities like hospitals cannot obtain a license to practice medicine. Certainly, a hospital as such cannot practice medicine, just as it cannot go to medical school or take an exam. Individuals can do all these things, however, and can be employed by a hospital, which can have respondeat superior liability for their negligence. That "a hospital cannot practice medicine" is simply incorrect if it refers to a hospital as an employer of physicians; if it refers to the hospital solely as an entity, it is correct, but irrelevant.

If assertions about hospitals as such were confined to defendants' arguments, no harm would result. But courts also frequently refer to the "hospital" in a way that steers their attention away from the direct question of employee negligence. These cases, including some speaking up situations and some situations of employee negligence alone, posit a variety of hospital duties. These duties, like the duties imposed directly on em-

138. *Byrd*, 202 N.C. 337, 162 S.E. 738.

139. *Bost*, 44 N.C. App. at 647, 262 S.E.2d at 396.

140. *Id.* at 647, 262 S.E.2d at 396 (emphasis added).

141. See *supra* text accompanying notes 46-49.

142. See *Johnson v. Saint Bernard Hosp.*, 79 Ill. App. 3d 709, 718, 399 N.E.2d 198, 205 (1979); *Fiorentino v. Wenger*, 19 N.Y.2d 407, 414-16, 227 N.E.2d 296, 299-300, 280 N.Y.S.2d 373, 378-79 (1967); see also *Slawkowski*, *supra* note 12, at 468 ("hospitals do not practice medicine").

ployees,¹⁴³ vary among different jurisdictions. For example, some courts state that a hospital has an obligation to exercise the same degree of care for its patients that other similar hospitals would exercise.¹⁴⁴ Many courts have stated that hospitals must give patients the care that their known condition requires,¹⁴⁵ or the care that their patients' condition, whether actually known or reasonably knowable, requires.¹⁴⁶ Other courts have tried to combine these standards by saying that a hospital has a duty "to give the patient such reasonable care and attention as his condition requires. 'This duty is measured by the degree of care, skill and diligence customarily exercised by hospitals generally in the community.'"¹⁴⁷ Finally, one court has recognized the conflict between the different standards and has distinguished them by finding that for medical care, the standard is what other, similar hospitals would do; but for routine, administrative care, the standard is what is reasonable in light of the patient's condition.¹⁴⁸

None of these formulations is satisfactory. Combining different standards seems reasonable on the surface: hospitals must give patients the care they require, a duty measured by what other hospitals would do. But if the duty is measured by what other hospitals do, speaking of the care that patients require is either redundant or meaningless. Neither does this formulation

143. See *supra* text accompanying notes 68-121.

144. *Johnson v. Saint Bernard Hosp.*, 79 Ill. App. 3d 709, 716, 718, 399 N.E.2d 198, 204, 205 (1979); *Johnson v. Misericordia Community Hosp.*, 99 Wis. 2d 708, 737-38, 301 N.W.2d 156, 171 (1981).

145. This formulation of the rule is so common that it is listed as "the" rule in *Corpus Juris Secundum* under "Hospital," § 8, which cites the following cases, among others, in footnote 70: *Emerick v. Raleigh Hills Hosp.*, 133 Cal. App. 3d 575, 581, 184 Cal. Rptr. 92, 95 (1982); *Hawthorne v. Blythewood Inc.*, 118 Conn. 617, 623, 174 A. 81, 84 (1934); *Piedmont Hosp. v. Anderson*, 65 Ga. App. 491, 497, 16 S.E.2d 90, 93 (1941); *Paulen v. Shinnick*, 291 Mich. 288, 290-91, 289 N.W. 162, 163 (1939); *Flower Hosp. v. Hart*, 178 Okla. 447, 449-50, 62 P.2d 1248, 1250 (1936) (quoting *Tulsa Hosp. Ass'n v. Juby*, 73 Okla. 243, 247-48, 175 P. 519, 523 (1918)). 41 C.J.S. *Hospital* § 8 (1944 & Supp. 1986).

146. *Foley v. Bishop Clarkson Memorial Hosp.*, 185 Neb. 89, 173 N.W.2d 881 (1970).

147. *Alden v. Providence Hosp.*, 382 F.2d 163, 166 (D.C. Cir. 1967) (quoting *Garfield Memorial Hosp. v. Marshall*, 204 F.2d 721, 725 (D.C. Cir. 1953)); see also *Rice v. California Lutheran Hosp.*, 27 Cal. 2d 296, 299, 163 P.2d 860, 862 (1945) (quoting *Wood v. Samaritan Inst.*, 26 Cal. 2d 847, 851, 161 P.2d 556, 558 (1945) (quoting 41 C.J.S., *Hospitals*, § 8(3), at 349 (1944))).

148. *Kastler v. Iowa Methodist Hosp.*, 193 N.W.2d 98, 101 (Iowa 1971).

specify exactly who is or is not qualified to testify to what "other hospitals" do.

The last mentioned approach, that one standard applies to medical care and another to routine care, requires courts to make the distinction between medical and routine or administrative activities. For years, courts in some states have made that distinction for another purpose: to know whether the respondeat superior doctrine should be applied against a hospital for the acts of physicians or nurses who were concededly employees of the hospital.¹⁴⁹ Until the 1960s the rule in these states was that a hospital had respondeat superior liability for the administrative or ministerial acts of its employees, including physicians and nurses, but no liability for their medical decisions.¹⁵⁰ Other states rejected such a distinction.¹⁵¹ But even New York, which made much of the distinction, finally abandoned it in 1957 in *Bing v. Thunig*.¹⁵² Part of the reason for abandoning it, according to the New York Court of Appeals, was the difficulty of making the distinction in close cases. The court in *Bing* cited other cases as examples, finding that:

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 . . . to the wrong patient is administrative . . . while administering the wrong blood to the right patient is medical.¹⁵³

These and other examples persuaded the court that the distinctions rested on "neither guiding principle nor clear delineation of policy."¹⁵⁴

If courts are now to make these same distinctions in speaking up cases, they are likely to find the distinctions just as un-

149. *Bing v. Thunig*, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957); see also *Schoonover v. Holden*, 87 N.W. 737 (Iowa 1901); *Pivar v. Manhattan Gen., Inc.*, 279 A.D. 522, 110 N.Y.S.2d 786 (1952). But see *Parrish v. Clark*, 107 Fla. 598, 145 So. 848 (1933).

150. See, e.g., *Messina v. Société Française de Bienfaissances*, 170 So. 801, 806-07 (La. Ct. App. 1936) (Janvier, J., concurring); *Pivar v. Manhattan Gen., Inc.*, 279 A.D. 522, 524-25, 110 N.Y.S.2d 786, 789 (1952); *Steinert v. Brunswick Home, Inc.*, 172 Misc. 787, 789, 16 N.Y.S.2d 83, 85 (Sup. Ct. 1939), *aff'd*, 259 A.D. 1018, 20 N.Y.S.2d 459 (1940).

151. See, e.g., *Parrish v. Clark*, 107 Fla. 598, 145 So. 848 (1933); *Moeller v. Hauser*, 237 Minn. 368, 377-78, 54 N.W.2d 639, 645-46 (1952).

152. 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957).

153. *Id.* at 660-61, 143 N.E.2d at 4, 163 N.Y.S.2d at 6 (citations omitted).

154. *Id.* at 661, 143 N.E.2d at 5, 163 N.Y.S.2d at 6.

satisfactory as the New York court did. A straightforward approach, recommended in this Article, would be for courts to avoid trying to impose duties on the "hospital" itself, but simply to ask which employee observed the physician's error, and whether similar, reasonable employees would have spoken up under the same circumstances. This focus on the employee would allow a court to get directly to the question of who must testify to the employee's exercise of due care.

V. A NEGLIGENCE FORMULA

The permutations of obvious negligence, clear contraindication, substantial departure, any departure, and any recognizable departure with the different viewpoints of physician, employee, layperson, and hospital, seem inexhaustible. One thing is clear: little analysis or thought has gone into the development of these judicially created tests of liability for failure to speak up. The tests are too ambiguous to be of meaningful help in future cases. The inevitable conclusion is that these tests are not tests at all, but court-imposed duties. As in many negligence cases decided on the basis of duty, the formulation of a specific duty is as much a statement of results as it is a basis for those results.¹⁵⁵ That the duty concept is used merely to label the end result is clear. In *Byrd*,¹⁵⁶ for example, the court dismissed the action against a nurse by concluding as a matter of law that the physician's conduct was not obviously negligent. The court found no need to consider seriously what obvious meant or from whose viewpoint it was to be judged.

A similar manipulation of the concept of duty can be found in then-circuit Judge Burger's concurring and dissenting opinion in *Alden v. Providence Hospital*.¹⁵⁷ In *Alden*, a treating physician had ordered his patient transferred to another facility. The patient was suffering from undiagnosed lung disorders and claimed that his transfer exacerbated his illness. He sued the hospital for not countermanding the physician's order. The majority found that he had made out a *prima facie* case against the

155. See *Elam v. College Park Hosp.*, 132 Cal. App. 3d 332, 338, 183 Cal. Rptr. 156, 159 (1982).

156. *Byrd*, 202 N.C. 337, 162 S.E. 738.

157. 382 F.2d 163, 166 (D.C. Cir. 1967) (Burger, J., concurring in part and dissenting in part).

hospital.¹⁵⁸ Judge Burger, however, challenged the majority to find any evidence in the record showing that the hospital had a duty to make its own diagnosis before discharging a patient.¹⁵⁹ What makes Judge Burger's statement so suspect is that duty is purely a legal requirement, to be imposed by the court.¹⁶⁰ Duties, therefore, cannot be found from any evidence in the record. Many of the cases discussed so far show a similar lack of reasoning: they offer purely legal conclusions framed in terms of particularized duties.

But to say that courts decide many of these cases almost instinctively, and then simply label the result with some sort of duty specification, is not to say that the cases are wrongly decided or that judicial instincts are flawed. Courts inevitably must balance a number of competing objectives in these cases; the formulation of duty rules is an understandable effort to effect that balance. On the one hand, a too-ready imposition of liability provides an incentive for employees to speak up about everything. Constant back seat driving like this would either become perfunctory and meaningless or would undermine physicians' authority and make every medical order the subject of scrutiny and debate. Just as an army cannot afford to have the enlisted troops question every officer's directive, a hospital cannot afford to have employees question every medical directive. On the other hand, requiring employees to speak up only when a physician's treatment would be obviously wrong to a layperson goes too far in the other direction. If a nurse is trained to recognize when a patient is steadily bleeding to death, why should the fact that this is not obvious to a layperson immunize the nurse from liability?

Another consideration enters the picture as well. It is possible for physicians to deviate from the standard of medical care by falling below it. But it is also possible for a physician to deviate above the standard of care.¹⁶¹ That is, a particular physician may use an unusual treatment that departs from customary care precisely because it is superior to customary care. The calf mus-

158. *Id.* at 165.

159. *Id.* at 168-69.

160. PROSSER & KEETON, *supra* note 14, § 53.

161. See *McClarín v. Grenzfelder*, 147 Mo. App. 478, 488-89, 126 S.W. 817, 821 (1910).

cle injection in *Brook v. Saint John's Hickey Memorial Hospital*¹⁶² is such an example. The technician might well have been able to say—had the court inquired—that the calf muscle is not the usual site for injections. Yet, from all that appears in the case, the physician's choice was a highly intelligent one, based on a thoughtful consideration of past practices. Similarly, in *Toth v. Community Hospital*¹⁶³ the physician's order for reduced oxygen administration to premature infants was a departure from normal practice. Yet it was the correct order; customary practice, as followed by the nurses, caused the injury. Requiring an employee to speak up in these cases serves no purpose but delay.

To put it another way, hospital employees are faced with two possibilities, "type 1" and "type 2" harms.¹⁶⁴ A type 1 harm is the harm to patients when an employee fails to speak up about a physician's maltreatment. A type 2 harm is the general harm to orderly hospital functioning when an employee speaks up unnecessarily about a physician's treatment that is either within the customary standard of care or better than that standard. Part of a court's determination of speaking up duties may well turn on an intuitive feeling for which of the two types of errors is the more likely. If a judge thinks that physicians rarely err and are frequently better than average, then type 2 errors are more likely than type 1 errors. A liability rule responsive to this situation would tend to minimize speaking up behavior by establishing a duty based on errors obvious to a layperson. Conversely, if a judge thinks that physicians frequently make mistakes that could be corrected by the observing employees, then the likelihood of type 1 errors is much higher. A rule responsive to this view would center on a requirement to speak up about any deviation from standard practice.

Like most tort dilemmas, the question of the relative likelihood of type 1 and type 2 errors is both an empirical question that can be answered properly only by careful studies, and an empirical question that in all likelihood will never be answered

162. 269 Ind. 270, 380 N.E.2d 72 (1978).

163. 22 N.Y.2d 255, 239 N.E.2d 368, 292 N.Y.S.2d 440 (1968).

164. The terms come from the field of statistics, where they are used to indicate the different types of errors possible when deciding whether two samples derive from the same population. See N. DOWNIE & R. HEATH, BASIC STATISTICAL METHODS 129 (1965).

by careful studies. Even if accurate numbers are forthcoming, however, we can visualize the relationship among these concepts in a graphic way that may help in understanding what courts are doing in setting a variety of duties in speaking up cases. The starting point for this analysis is the Learned Hand cost-benefit formula.¹⁶⁵

Under the traditional Learned Hand formula, a defendant is liable in negligence if the cost of preventing a harm is less than the expected loss from that harm. That is, negligence exists if

$$B < PL$$

where B is the burden or cost of preventing a harm, P is the probability of the harm's occurring, and L is the loss that will fall on the plaintiff if the harm does occur.

At first glance, the Hand formula seems to impose liability in every speaking up case. Whatever the probable loss to an improperly treated patient, the burden of speaking up—asking the treating physician to re-evaluate orders or asking a hospital resident or chief of staff to comment or consult—appears trivial. As noted before, however, this narrow view would result in requiring employees to speak up about almost everything, well past the point of diminishing returns. The burden, then, may be viewed more accurately as the burden on the hospital as a whole from too much speaking up. This makes B in the formula larger than first appears, reflecting the possibility of type 2 errors: speaking up unnecessarily.

Second, the burden on a nurse of speaking up will frequently be the burden of questioning a physician's orders. Questioning a physician is not likely to come easily to a nurse, nor is it likely to be conducive to career advancement or job security. The authoritarian relationship of physician to nurse is therefore an intangible, but real, element in the burden on a nurse of speaking up.¹⁶⁶ Once again, B is greater than it first appears.

165. *United States v. Carroll Towing Co.*, 159 F.2d 169, 173 (2d Cir. 1947).

166. V. HENDERSON & G. NITE, *PRINCIPLES AND PRACTICE OF NURSING* 953 (6th ed. 1978) ("[T]he communication and interpersonal relationships of physicians and nurses have been characterized for the most part by medical authoritarianism and nursing dependence."); see also P. ANDERSON, *NURSE* 222 (1978) ("[S]ince doctors don't often ask a nurse's opinion, I guess it's not surprising that when a nurse offers a suggestion, she sometimes gets a flip answer. A doctor may say, 'what are you trying to do, teach me my business?' "). I also base the assertion in the text on anecdotal evidence from friends who are or have been nurses.

Third, the possibility of type 1 errors needs to be figured into the analysis. Here, the situation gets a bit more complicated. In the ordinary negligence case, PL reflects a simple discounting of harm by the likelihood that the harm will come to pass. But the hospital employee observing a physician's treatment is one step removed from the product of P and L. The physician directing the treatment already will have performed a kind of cost-benefit analysis for different treatment options, weighing the benefits of the treatment against the possible harms from the treatment. The employee considering possible harm to the patient will therefore have to take into account that the physician already may have made an appropriate risk-benefit analysis.

Any physician's treatment, in short, will involve a certain risk of harm or PL. What the employee in a position to speak up must consider is not just that risk of harm, but also the likelihood that the physician's exposure of the patient to that risk of harm was improper. The employee must discount PL by the probability that the treating physician has done the wrong thing in choosing that particular PL. Therefore, the employee's Learned Hand formula looks like this:

$$B < P_2 P_1 L$$

Here, P_1 is the probability that the patient will suffer a harm of L from the physician's treatment; and P_2 is the probability that the physician erred by prescribing that treatment.

Whatever the value of P_1 and P_2 , as probabilities they will each be less than one, and their product will be smaller than either alone. Compared to a situation in which an employee merely had to assess the product of P and L, the smaller product of P_1 , P_2 , and L reduces the number of occasions in which the burden of speaking up will be less than the likely harm, and hence, the number of occasions in which the Hand formula will suggest negligence for not speaking up. Although it would be difficult to assign specific numbers to the two probabilities P_1 and P_2 in a particular case, it is possible to draw some inexact conclusions about their relationship. In particular, if a physician orders a treatment that has a very low probability of harm (low P_1), we would expect there to be little likelihood that the treatment was incorrect (low P_2). Conversely, if the physician's treat-

ment carries a very large probability of harm (high P_1), we would expect that the treatment was far more likely to be incorrect (high P_2).

In short, in the absence of data giving us a more accurate picture, we would intuitively expect that a low P_1 would be matched by a low P_2 , and a high P_1 by a high P_2 . At this level of accuracy, which is admittedly a pretty low level, we can simplify things even further and assume that the two probabilities P_1 and P_2 are directly proportional to each other; and further, because it eases the calculation slightly, that they are equal to each other. These simplifying assumptions do not alter the conclusion, as long as the two probabilities are in fact correlated such that when one is low, the other is also low, and when one is high, the other is also high. The Hand formula now becomes:

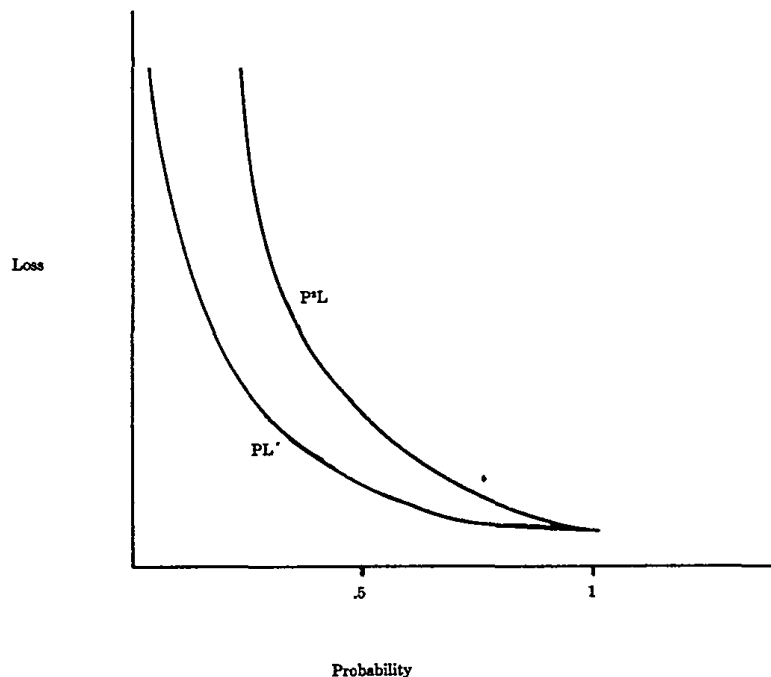
$$B < PPL$$

or

$$B < P^2L$$

For any given amount of burden in speaking up, we can now see graphically what PL would be, and what P^2L would be in comparison.

Graph of the Learned Hand formula with B set at any arbitrary value, showing the relationship of L , P , and P^2



The original Hand formula with only PL means that for any given burden, all the possible combinations of PL that fall above and to the right of the PL curve—that is, are greater than B—represent the area in which there is negligence. The speaking up situation, which is shown by the upper curve representing P²L, bounds a smaller area of negligence, to the upper right. This confirms graphically why it is incorrect for a court to require employees to speak up about any deviation from a physician's standard of care. The any deviation line is the line bounding the physician's negligence, PL. The employee's boundary is P²L, which intuitively corresponds with the judicial requirement of speaking up about obvious negligence or clearly contraindicated orders or something more than just any departure from customary care standards.

A second look at the facts of the speaking up cases confirms this cost-benefit approach. In almost all of the cases finding liability or allowing the issue to go to the jury, one theme is dominant: a patient's progressive decline over a period of hours or days. In *Darling v. Charleston Community Memorial Hospital*¹⁶⁷ and *Utter v. United Hospital Center*,¹⁶⁸ days went by while the patient's limb blackened and gangrene set in; in *Goff v. Doctors General Hospital of San Jose*,¹⁶⁹ hours went by while the patient slowly bled to death; in *Poor Sisters of St. Francis v. Catron*,¹⁷⁰ several days elapsed while an endotracheal tube injured the patient's throat; in *Alden v. Providence Hospital*,¹⁷¹ a patient with several days of breathing difficulties, yellow fluid in the lungs, and opaque lung X-rays was nevertheless transferred to another hospital without any diagnosis of lung disease; in *Ohligschlager v. Proctor Community Hospital*,¹⁷² a caustic medication administered intravenously slowly leaked into the patient's arm tissue over almost twelve hours; in *Mundt v. Alta Bates Hospital*,¹⁷³ a case similar to *Ohligschlager*, an intravenous solution slowly leaked into the patient's arm for more than twelve

167. 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966).

168. 236 S.E.2d 213 (W. Va. 1977).

169. 166 Cal. App. 2d 314, 333 P.2d 29 (1958).

170. 435 N.E.2d 305 (Ind. App. 1982).

171. 382 F.2d 163 (D.C. Cir. 1967).

172. 55 Ill. 2d 411, 303 N.E.2d 392 (1973), *rev'g*, 6 Ill. App. 3d 81, 283 N.E.2d 86 (1972).

173. 223 Cal. App. 2d 413, 35 Cal. Rptr. 848 (1963).

hours before matters were attended to; and finally, in *Schoening v. Grays Harbor Community Hospital*,¹⁷⁴ the plaintiff's condition went steadily downhill for seven days before his transfer to another hospital.

Conversely, a common thread in many cases denying hospital liability is an allegation that a physician's maltreatment occurred over a relatively short period of time, or without evidence that the patient's condition progressively deteriorated.¹⁷⁵ In *Brook v. Saint John's Hickey Memorial Hospital*,¹⁷⁶ for example, the claim was that an X-ray technician should have recognized that a child's calf muscle is an improper site for an injection. An injection is completed in a matter of seconds. In *Johnson v. Grant Hospital*,¹⁷⁷ the hospital employees followed a physician's orders in unlocking a suicidal patient's room. The patient later left the room and jumped out of a window to her death, but the hospital was found not to be liable. The patient did not experience any progressive deterioration over the several hours from the unlocking of the door to the suicide. In *Walker*,¹⁷⁸ the nonabsorbable suture would have been put into place within a matter of minutes.

These cases of progressive decline make good sense both intuitively and in terms of the Hand formula. As time passes for a deteriorating patient, all of the variables—B, P₁, P₂, and L—shift toward liability. Looking at the opposite situation of a sudden emergency helps to show why that is so. In emergencies, there is a premium on quick, decisive action. Requiring employees to speak up in that situation would mean forcing a rethink-

174. 40 Wash. App. 331, 698 P.2d 593 (1985).

175. See the discussion and notes immediately following. Not all cases, however, neatly fit this pattern. For example, in *Czubinsky v. Doctor's Hosp.*, 139 Cal. App. 3d 361, 188 Cal. Rptr. 685 (1983), a surgeon ordered a nurse to leave a postoperative patient in the operating room and attend a second surgery with him in another room. The nurse resisted because hospital regulations required her to stay and assist the anesthesiologist in reviving the patient. The surgeon yelled at her, according to her testimony, so she left with him. The patient suffered a cardiac arrest with consequent injuries that the presence of the nurse would have prevented. The court found her conduct to be in violation of the hospital's written procedures, and the hospital to be liable as her employer. This case represents a situation in which liability was imposed even though a patient was not progressively declining over an extended period of time.

176. 269 Ind. 270, 380 N.E.2d 72 (1978).

177. 32 Ohio St. 2d 169, 291 N.E.2d 440, *rev'd* 31 Ohio App. 118, 286 N.E.2d 308 (1972).

178. 549 F. Supp. 973 (W.D. Okla. 1982).

ing of the treatment or putting the patient on hold while a consultant is summoned. Plainly such a delay from speaking up would intolerably burden the administration of emergency care, raising B sharply.

The probable harm to a patient from emergency treatment ($P_1 * L$), will vary depending on the nature of the emergency and the type of treatment. The Hand formula shows a perverse result here, however. In the usual case, negligence is defined as a failure to take a precaution that would cost less than the probable harm resulting from not taking the precaution. The assumption is that taking the precaution will reduce the probable harm, either by decreasing its likelihood, or decreasing the magnitude of the harm, or both. In an emergency, taking the precaution of speaking up has the effect of *increasing* the probable harm. An emergency is a situation that by definition requires prompt action, and speaking up delays that prompt action; a delay means the patient's probable harm will be greater than if prompt action had been taken.

Thus, the burden and the probable harm are dependent on each other in a way that renders the Hand formula awkward for assessing negligence in an emergency. The formula also requires a closer look at the probability from the employee's perspective that the emergency treatment selected is the wrong one (P_2). In an emergency, the likelihood that a treatment is incorrect is higher than in a nonemergency. Under the press of time, careful laboratory tests and other diagnostic measures obviously cannot be undertaken. An increase in P_2 over nonemergencies suggests that employees should speak up in emergencies. But recall that P_2 is the probability from the employees' perspective that a treatment decision is incorrect, not the probability judged by an omniscient observer or with hindsight. In an emergency, it is just as difficult for an employee to be certain about a treatment as the treating physician. If the employee is unable to make a reasoned assessment of the probable incorrectness of the treatment, the natural presumption would be that probability is low and therefore the employee need not speak up. Emergencies, then, are the primary occasions for which speaking up should not be encouraged by a finding of employee liability.

Now let us shift the focus to a situation of gradual patient deterioration. The lack of time pressure means that the burden on orderly hospital functioning will be very low if an employee

requests that someone review the physician's treatment. There will be plenty of time for a review, which in many cases can be satisfied by having employees such as nurses simply confer with a nursing supervisor or stop and question a resident making rounds. Second, the probability that a patient is suffering harm gradually rises as time passes and deterioration continues. Naturally, the amount of loss, *L*, will increase also, because deterioration means increasing damage. Finally, with time for reflection, an employee can better assess the likelihood that the treating physician has erred. Situations of progressive deterioration, then, are the ones in which liability for not speaking up should be, and in fact seem to be, most readily found.

VI. DOES IT MATTER?

If courts instinctively are responding to the conflicting pressures on employees who commit type 1 and type 2 errors, perhaps the fact that their intuitive judgments are not well articulated or consistent should make no difference. But to describe the situation as one of poorly articulated inconsistency is to suggest that it does make a difference. Perhaps not in the clear-cut cases, for almost any rule takes care of gross departures from whatever standard is set, but certainly the choice of rule will make a difference in closer cases. Several cases have arisen in which the analysis proposed in this Article would have made a difference.

One case, for example, that raises the problem of who should testify in speaking up litigation is *Schwartz v. Boston Hospital for Women*.¹⁷⁹ In *Schwartz*, a patient's treating physician had ordered the hospital staff to perform a curettage on the patient after a Caesarean section. The patient later suffered from an infection and sterility, which she alleged was caused in part by the failure of the staff to object to the order for the curettage. The patient introduced an affidavit from a physician stating that the curettage was a departure from the medical standard of care, but evidently offered no other evidence on this point. The hospital moved for summary judgment on the issue.

The court quoted the *Toth* rule that a hospital employee is not liable for carrying out an order unless the order is "clearly

179. 422 F. Supp. 53 (S.D.N.Y. 1976).

contraindicated by normal practice.' ”¹⁸⁰ On the basis of the affidavit concerning common medical practice, the court denied the hospital’s motion.¹⁸¹ The affidavit was couched in terms of what was accepted medical practice—not what was accepted nursing practice. The expert, an obstetrician-gynecologist, said specifically that “[i]t was a deviation from customary and usual obstetrical procedures” for the treating physician to have ordered the curettage.¹⁸² Nothing mentioned in the court’s opinion justified a jury finding that *nurses* should have recognized the curettage as clearly contraindicated. On a motion for summary judgment, the affidavit was probably enough to support denial of the motion. The absence of any discussion of the affidavit or of what sort of testimony would be necessary at trial nevertheless suggests that the court did not recognize the issue.

In another New York case, *Kileen v. Reinhardt*,¹⁸³ a patient allergic to penicillin was hospitalized for asthma. While in the hospital, her private physicians ordered the administration at different times of two drugs, Cephalotin and Dilaudid, that may have been contraindicated for patients with a penicillin allergy. The patient eventually died, though apparently more from a failure of her physicians to recognize that pneumonia complicated the asthma than directly from the medication prescribed. In any event, part of the estate’s suit was against the hospital on the theory that the hospital staff should have countermanded the orders of medication.¹⁸⁴ At trial, the jury entered a general verdict for the plaintiff after the submission of this and several other theories of hospital liability.

On appeal, the court cited *Toth* for the proposition that physicians’ orders must be followed unless clearly contraindicated and observed that “[o]n this record, it cannot be concluded that the administration of both of these drugs was so clearly contraindicated as to cast liability upon the hospital.”¹⁸⁵ Significantly, the court said nothing about the trial judge’s con-

180. *Schwartz*, 422 F. Supp. at 55 (quoting *Toth v. Community Hosp.*, 22 N.Y.2d 255, 265 n.3, 239 N.E.2d 368, 374 n.3, 292 N.Y.S.2d 440, 449 n.3 (1968)) (applying New York law).

181. *Schwartz*, 422 F. Supp. at 56.

182. *Id.*

183. 71 A.D.2d 851, 419 N.Y.S.2d 175 (1979).

184. *Id.* at 853, 419 N.Y.S.2d at 177.

185. *Id.*

clusions on this point. Whether the trial judge had applied the *Toth* rule at all, whether the application of that rule had been erroneous or clearly erroneous, or whether any expert testimony existed to provide substantial evidence in support of a conclusion of liability by the jury, was not addressed. The appellate court must therefore have decided the issue itself as a matter of law. By not referring to any expert testimony, the court must have meant that the question of clear contraindication was to be determined from the viewpoint of a layperson. In sum, the court held that the administration of Cephalotin and Dilaudid to a patient allergic to penicillin is not something clearly contraindicated to laypersons.

That holding is undoubtedly correct. Most laypersons would not know whether the drugs were clearly contraindicated. But if the question of contraindication is to be judged from a nurse's perspective, as *Toth* seems to require,¹⁸⁶ the outcome of this issue should have been different. Expert testimony from nurses about the administration of specified drugs would have been necessary in a new trial. It is entirely possible that nurses would know that certain medications are contraindicated, and perhaps even clearly contraindicated, for patients who are allergic to penicillin.

Finally, the Louisiana Supreme Court in *Hunt v. Bogalusa Community Medical Center*,¹⁸⁷ held a hospital liable for the failure to override a physician's decision to put up partial bedside rails for a sedated, seventy-three-year-old patient with a history of strokes and dizziness. Partial rails extend from the head of the bed about half-way toward the foot. Full rails run the length of the bed. The patient injured herself falling from the bed and sued the hospital. At trial, there was mixed testimony about whether full rails provided any more protection from falling than partial rails. A trial court judgment for the patient was reversed by the Louisiana Court of Appeals because testimony showed that most hospitals would have used partial rails in the same circumstances, unless ordered by a physician to use full rails. The Louisiana Supreme Court, however, reinstated the judgment for the patient. The court pretermitted the question of community standards for hospitals and effectively determined

186. See *supra* text accompanying notes 95-97.

187. 303 So. 2d 745 (La. 1974).

that the hospital should have overridden the physician's orders to use partial rails.¹⁸⁸

It is nearly impossible to figure out what rule or standard the court applied to reach its conclusion. Nothing at all is mentioned in the opinion about obvious negligence or substantial departures from established standards or any similar formulation. Because other hospitals routinely used partial rails and because the physician in this case actually ordered partial rails, the hospital should not have been liable. Certainly, it would be hard to maintain that partial rails were either obviously wrong to a layperson or a substantial departure from medical custom. Nor did the evidence show that partial rails were wrong from the viewpoint of a trained physician. Yet, because the court reinstated a jury verdict that conflicted with expert testimony about hospital practice, the court must have judged the requirement for speaking up from the viewpoint of a layperson. *Hunt* is therefore an altogether unsatisfactory case.

Varying standards or duties, then, can make a difference in the outcome of a case. The existing formulations of various duties do not make clear who is to testify about employee liability. If a duty to speak up is imposed for errors perceived by a layperson, then the jury itself can reach a conclusion; if the viewpoint is that of the employee, then other employees should testify; if the viewpoint is that of a physician, then only physicians need testify. Confusion about who needed to testify was the heart of the error in *Schwartz*, as noted above, and certainly might have made a difference in both *Hunt* and *Kileen*.

VII. CONCLUSION

A review of the cases and a cost-benefit analysis show that courts are generally on the right track in finding and denying liability in the speaking up situation. The problem lies in the courts' over-reliance on intuition to set widely differing duties on employees, duties that offer only vague guidelines to employees and to future courts. In close cases, these disparate concepts of duty may well lead to the wrong results. If hospital liability is expanding as rapidly as some commentators assert,¹⁸⁹ these

188. *Id.* at 747.

189. See Southwick, *supra* note 25, at 430; Note, *supra* note 16, at 343.

questions about liability for speaking up will likely arise more and more frequently. Courts need a sturdier framework to allow for principled decision making. Rather than repeatedly referring to ambiguous duties, courts should develop an approach that relies on a broadly stated standard of care and then focuses on how a breach of that standard should be established. The standard would be that of the reasonable employee; a breach of that standard would be shown by the testimony of similarly trained employees.

A shift from a particularized duty approach to a broader standard of reasonable care approach is preferred by courts in other torts cases¹⁹⁰ and was espoused by Prosser¹⁹¹ as the more satisfactory approach to negligence questions. Aside from this general rationale, there is the added benefit to a standard of care analysis that employee liability would be placed on the same footing as physician liability in malpractice cases. Courts do not customarily assert, for example, that physicians have a duty not to sew forceps inside a patient, even though any number of cases would justify that conclusion. Rather, courts assert that physicians must comport with a standard of customary medical prudence;¹⁹² the only question in the sewn-up-forceps type of case is whether, under the circumstances, leaving the forceps was a departure from that standard.¹⁹³ There is no reason that this same approach would not work equally well in speaking up cases.

The proper approach, then, is not to set duties at all, but to rely on a general standard of care and to hold employees liable for not speaking up in circumstances in which testimony shows that other, similar, prudent employees would speak up. In the normal case, because juries cannot be expected to sense the pressures of compliance with medical directives, let alone appre-

190. See, e.g., *Pokora v. Wabash Ry. Co.*, 292 U.S. 98 (1934) (former obligation of plaintiffs to stop, look, and listen at railroad crossings replaced with an obligation to exercise reasonable care under the circumstances); *Rowland v. Christian*, 69 Cal. 2d 108, 443 P.2d 561, 70 Cal. Rptr. 97 (1968) (landowners' differing obligations to licensees, invitees, and trespassers replaced with a single obligation to exercise due care); *Darling v. Charleston Memorial Hosp.*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966).

191. PROSSER & KEETON, *supra* note 14, § 53, at 356.

192. *Hernandez v. United States*, 636 F.2d 704, 706 (D.C. Cir. 1980); *Erickson v. United States*, 504 F. Supp. 646 (D.S.D. 1980).

193. See, e.g., *Burke v. Washington Hosp. Center*, 475 F.2d 364, 365 (D.C. Cir. 1973); *City of Somerset v. Hart*, 549 S.W.2d 814, 817 (Ky. 1977).

ciate the assessment of probabilities of harm and incorrect treatment, liability should be based only on expert testimony. If a nurse is a defendant, then other nurses should testify to what reasonable nurses would do. If an X-ray technician is a defendant, then other technicians should testify, and so on. The seminal case of *Darling v. Charleston Community Memorial Hospital*,¹⁹⁴ despite its other drawbacks, came close to this approach. The court discussed the difference between a duty and a standard of care analysis, and addressed the question whether experts from other hospitals should have been required to testify for the plaintiff. The court concluded that a standard of care can be established by expert testimony or by written procedures, which includes health regulations, accreditation standards, and hospital by-laws.¹⁹⁵ In all, *Darling* satisfactorily focused on the issue of standards of care but regrettably has not been widely followed on that point.

Naturally, just as with cases of a physician's negligence, there will be situations in which the court is entitled to conclude that expert testimony is unnecessary. In *Czubinsky v. Doctor's Hospital*,¹⁹⁶ for example, a physician ordered a nurse to leave a postoperative patient to assist the physician in another surgical procedure elsewhere in the hospital. The nurse's leaving violated hospital regulations and left the patient, who died from a cardiac arrest, inadequately attended. The trial court had entered a judgment notwithstanding the verdict for the hospital because the plaintiff offered no expert testimony on nursing standards. The appeals court reversed because the nurse had displayed a "[w]ant of care . . . so obvious as to render expert testimony unnecessary."¹⁹⁷

These exceptional situations in which expert testimony is

194. 33 Ill. 2d 326, 211 N.E. 253 (1965), *cert. denied*, 383 U.S. 946 (1966).

195. *Id.* at 330-31, 211 N.E.2d at 256. See generally, Recent Decisions, *Hospitals*, *supra* note 38, at 743-49. See also *Alexander v. Gonser*, 42 Wash. App. 234, 240, 711 P.2d 347, 351 (1985), which says that the standard of care in corporate negligence cases (*i.e.*, those in which policies or procedures are involved) is generally set by the accreditation standards of the Joint Commission on Accreditation of Hospitals and by the hospital's own by-laws. Despite *Darling's* assertions, written standards will seldom eliminate the need for expert testimony because written standards cannot specify when a physician's negligence is "obvious" or "clear." *Darling* is a rare case precisely because the physician's conduct was so egregious.

196. 139 Cal. App. 3d 361, 188 Cal. Rptr. 685 (1983).

197. *Id.* at 367, 188 Cal. Rptr. at 688.

unnecessary can be assessed on a case-by-case basis, just as they are in cases of a physician's negligence. Indeed, the whole point of adopting a reasonably prudent employee standard for speaking up cases is that it would function exactly like the universally-used reasonably prudent physician standard. Courts are thoroughly familiar with the latter standard. Relying on it for employee speaking up cases would be simple, would be consistent with other medical malpractice actions and would avoid the problems of conflicting formulations of various duties that have made the existing decisions so confusing.

The prudent employee standard would automatically eliminate the need to choose among an obvious negligence standard, a substantial departure standard, and all the other standards. It would inevitably focus on the employee's viewpoint, not a physician's or a layperson's, a focus that previous discussion has shown to be preferable. And finally, it would neatly bypass the misleading and distinctly unhelpful approaches based on corporate negligence or hospital standards of care. The prudent employee test may or may not make the outcome of speaking up cases more predictable than they are presently, but at least it would be frank in its unpredictability, consistent with and no worse than the test for physicians' liability, and it would minimize the ease with which results can be manipulated. It has much to commend it.