Nebraska Law Review

Volume 55 | Issue 3 Article 2

1976

The Quandary of the Hospital Administrator in Dealing with the Medical Malpractice Problem

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I. INTRODUCTION

To appreciate the hospital administrator's quandary in dealing with the medical malpractice problem, it is first essential to understand the purpose and functions of the hospital medical staff organization. It was first established in 1919 by the American College of Surgeons[1] to eliminate unnecessary surgery and fee splitting and to prevent unqualified physicians from doing surgery.[2] Its raison d'etre was to upgrade the quality of medical care in the hospital by serving as a quality control mechanism since there were no other groups able to function in this capacity. County, state and national medical organizations have no demonstrable track record in this area. And, whereas specialty associations and medical schools greatly contribute to the establishment of standards, they have little, if any, role in reviewing, analyzing, evaluating and enforcing compliance in individual institutions with those standards. Legally constituted state disciplinary bodies, whose prime objective presumably is public safety, for the large part have dismal records[3] in exercising disciplinary action. Disciplinary action per se is not necessarily a measure of *quality*, but its absence raises doubts about the degree of *quality* control being exercised since one can hardly trust a silent system. The Health Maintenance Organization ("HMO")[4] and Professional Standards Review Organ-

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1. L. DAVIS, FELLOWSHIP OF SURGEONS—A HISTORY OF THE AMERICAN COLLEGE OF SURGEONS 221 (1960).
2. *See* Williams, *Medical Staff Issues—Past and Present*, 1 HOSPITAL MEDICAL STAFF 3 (1972).
3. *See How Well Does Medicine Police Itself?*, MEDICAL WORLD NEWS, March 15, 1974, at 62.
4. HMOs were first promoted in 1970 by federal government health strategists with the intent of broadening the availability of and ac-

ization ("PSRO")[5] have not been on the scene long enough to demonstrate whether they are capable of exerting meaningful continuing quality control. Therefore, with the exception of the few closed-panel, prepayment group practice plans, such as Kaiser Permanente and The Health Insurance Plan of New York, the voluntary community hospital is virtually the only locus[6] for ongoing quality control of medical care.

The ability of the average hospital medical staff organization to fulfill its original purpose of ensuring that the safety and interest of the patients take precedence over all other concerns has been and is being seriously questioned. The organization's effectiveness in identifying less-than-ideal patterns of practice which, through corrective measures, could be prevented from developing into professional obsolescence and gross incompetence, has been thrown into serious question by the horror stories revealed in such widely publicized cases as *Darling v. Charleston Memorial Hospital*,[7] *Zimbelman v. Purcell & Tuscon General Hospital*,[8] and *Gonzales v. Nork & Mercy Hospital*.[9] These cannot be dismissed as rare and isolated

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cessibility to comprehensive health care programs for the general public. *See* The Health Maintenance Organization Act of 1973, §§ 3,4; 42 U.S.C. §§ 280c, 300e note (1973).

5. PSROs, legislated by the Social Security Amendments of 1973, were designed to ensure that health care services provided to patients by federal health care programs are medically necessary, meet professionally recognized standards of quality care and are provided in a setting consistent with professionally recognized standards of quality care. *See* 42 U.S.C. §§ 1320c to 1320c-20.
6. While medical schools, professional specialty societies and local, state, and national medical associations all contribute to the establishment of professional standards, they have no system or authority for determining the extent to which practicing physicians adhere to those standards, or for gaining compliance with those standards.
7. 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied* 383 U.S. 946 (1966).
8. 18 Ariz. App. 75, 500 P.2d 335 (1972). This case and others focus upon the fundamental question of who is responsible for the tragic results suffered by patients because of medical incompetence. From them has developed the concept that the hospital boards of trustees have a corporate responsibility for the quality of medical care rendered in the hospitals. *See* Southwick, *The Hospital As An Institution—Expanding Responsibilities Change Its Relationships With The Staff Physician*, 9 CALIF. WESTERN L. REV. 429, 450 (1973).
9. Unreported memorandum decision of a superior court, Sacramento, California, Dec. 1973. *Discussed in* MEDICAL WORLD NEWS, March 15, 1974, at 62. This case, widely publicized in both medical, hospital, and lay press, exposed a parade of patients who were crippled by one man's incompetence and unnecessary surgery. It served to reinforce the general impression that medical staffs do not sufficiently or adequately police their ranks, and to strengthen the concept that an institution's board and management do indeed have a responsibility to

cases. The President of the Association of Trial Lawyers of America, in discussing *Nork* and other cases stated: "I have over five hundred similar horror stories from our A.T.L.A. News Letter . . . ."[10] This writer concurs regarding the abundance of such stories, having had frequent contact with them in his consulting practice.

Further substantiation for the view that the hospital medical staff organizations have difficulty in ensuring patient safety is found in the reported findings of two recently released studies dealing with the quality of surgical care. A House subcommittee report[11] states that in 1974, 2,380,000 unnecessary surgical procedures were performed with approximately 11,900 deaths resulting from such surgery. The tenth segment SOSSUS[12] report, entitled "The Critical Incident Study of Surgical Deaths and Complications, 1973-1975,"[13] strikes a similarly dismal and discouraging note. It studied 95 hospitals and concluded that close to 50 per cent of the complications associated with surgery were preventable, as were 35 per cent of the 245 reported deaths.

The foregoing facts raise serious questions about the effectiveness of the typical hospital medical staff organization as a quality control mechanism. The architects of the PSRO legislation obviously concluded that the organization was neither willing to nor capable of exercising quality control. This is evidenced by their decision to shift the locus of such control from within the hospital to an agency outside of the hospital.

It should be asked if there can indeed be meaningful and effective peer review within the framework of the average medical staff organization, in view of the way it presently relates to the total hospital organization. Yet, as critical as we may be of its performance in policing its ranks, the hospital medical staff organization is presently the only major mechanism which conducts on-going review, analysis and evaluation of clinical performance against pre-

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make sure that there are effective quality control systems. A state appellate court has recently ordered a new trial in this case since Dr. Nork was deprived of his right to a jury trial. *See* The Register, Napa, Calif., at 2, Aug. 6, 1976.

10. Cartwright, *Change The Tort System?*, MEDICAL WORLD NEWS, Sept. 8, 1975, at 62.
11. SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATION OF THE HOUSE INTERSTATE AND FOREIGN COMMERCE COMMITTEE, 94TH CONG., 2D SESS., COST AND QUALITY OF HEALTH CARE: UNNECESSARY SURGERY (Jan., 1976) (*as reported in* PSRO LETTER, Feb. 1, 1976).
12. AMERICAN COLLEGE OF SURGEONS AND THE AMERICAN SURGICAL ASSOCIATION, STUDY ON SURGICAL SERVICES FOR THE UNITED STATES (SOSSUS) (1975).
13. *As reported in* MEDICAL WORLD NEWS, Jan. 25, 1976, at 24.

determined standards, and then in accordance with its findings, recommends corrective measures to assure that the safety of the patient has first attention and that he receives the appropriate quality of care.

The hospital medical staff organization is part and parcel of the total hospital organization.[14] It is not a separate entity but very much part of the legally constituted hospital corporation, having been created by the board of the corporation. In practical terms, it is an organizational extension of the board carrying out the necessary quality control functions which are supposed to be, and should be, determined by the board. The board, however, must inevitably render public accountability[15] as to whether those functions have or have not been effectively discharged. Thus it is obvious that the medical staff organization, its purposes, structure and functions, cannot be divorced from the governance and management of the institution. For this reason, the hospital administrator is confronted almost daily with some aspect of the quality control functions that a medical staff organization is supposed to discharge. However, the impact or influence he/she has on those functions is questionable.

II. THE QUANDARY

With the medical staff organization being such an integral part of the total hospital organization and with the administrator having been formally trained as a professional manager and serving as the board's representative in charge of the operation of the institution, it seems logical to assume that he would be the person responsible for seeing that the quality control functions were properly carried out by the medical staff. Certainly, one would assume that the administrator, as the institution's expert in management and organization, would have as his first and foremost concern the patient's interests and safety and the quality of patient care in the institution. Most administrators do have these concerns and usually have no problem in dealing with those aspects of patient care that do not directly involve physicians. However, the major component of patient care is medical care, and when the administrator becomes involved in this area, *i.e.*, by getting the board to promulgate policies dealing with controls and by making sure that medical staff officials carry out those policies and that predetermined professional standards are adhered to by the members of the medical staff, then they encounter a mountain of political, administrative

14. *See* Southwick, *supra* note 8, at 436-40 which succinctly sets forth the legal basis for this statement.
15. Williams, *Beyond Responsibility: Toward Accountability*, 53 HOSPITAL PROGRESS 44 (1972).

and personal problems related directly to the board's uncertainty about acting in this area and to resistance from the medical staff.

The responsibilities of the administrator, as the board's legal representative and manager of the total institution, are usually set forth in his position description as well as in the hospital's corporate by-laws. It is logical to assume from reading these documents that he is to be responsible for managing and coordinating *all* the institution's resources and for seeing to it that the functions of management are applied to *all* components of the total hospital organization. Tables of organization usually validate this assumption. Newer titles, such as executive director, executive vice president, president of the corporation, chief executive officer, which have replaced that of "administrator," reflect the responsibilities he is assumed to have. However, when the administrator seeks to discharge certain responsibilities, generally speaking, he finds that he does not have authority vis-à-vis quality control; and if he and his board think that he does have it, the medical staff does not. If he attempts to exercise this authority, he does so knowing full well that in any ensuing conflict he will probably be the loser. His own sense of survival (titles and presumed authority notwithstanding) dictates that he stay out of medical staff activities. Fuchs puts it in perspective when he states: "From the point of view of the hospital administrator, running a hospital is like trying to drive a car when the passengers have control of the wheel and the accelerator. The most the administrator can do is occasionally jam on the brakes."[16] His position is akin to that ascribed to a drama critic by the late Irish poet Brendan Behan—"he is like a eunuch in a harem; he knows what should be done, but he can't do much about it." Herein lies the quandary of the hospital administrator when he comes to deal with aspects of the malpractice crisis that affect his hospital. Some of the actions (and inactions) that result from this will now be examined.

The grossly incompetent physician does not develop overnight. While some major act of incompetence (and attendant tragedy) brings him and his work into question, usually it comes to light that there has been a pattern developing for years. There may have been a number of acts of gross incompetence, maybe without tragedy, or various staff committees may have expressed concern over the physician's refusal to abide by hospital regulations as evidenced by: perennially delinquent records; failure to seek other opinions in cases with diagnoses in doubt; writing pre-operative history and physical examinations at the last minute after the patient has been preoperatively medicated; the fact that some one

16. V.R. FUCHS, WHO SHALL LIVE? HEALTH, ECONOMICS AND SOCIAL CHOICE 58 (1974).

"a couple of years ago" from the executive committee may have "spoken" to him without there being follow-up or documentation or that in the past year it may have been mentioned that eventually his privileges would have to be cut back. In these situations there is practically always an antecedent pattern, and that pattern, while not readily acknowledged by physicians in positions of authority, is nonetheless usually known to them.

The administrator, the one person who should be acquainted with that developing pattern, is often not aware of it. Yet he should be and he should also be the one to insist upon corrective measures being instituted because he has closer contact with more sources of information than any other individual in the institution: the nursing service in the emergency department, patient care floors, and operating rooms, as well as through the nursing director; the medical records department personnel; members of administration who sit in on various meetings of quality control committees of the medical staff; physicians who will come directly to him (although on a "confidential" basis) to tell of some preventable incident concerning another member of the staff; the various key officials on the staff; and his own observations at medical meetings when such incidents may be discussed.

With respect to incidents involving patient safety and quality control, such as the physician's refusing to adhere to hospital policy or professional standards agreed to by his confrères or practising beyond his skill level, or physicians with a drinking problem, some pertinent questions arise. Can the administrator insist that medical staff officials take corrective action? The answer is that he can, but only to the extent that he does not come into confrontation with the medical staff, because when he does, he is automatically in a win-lose situation and he is the expendable party. Should the administrator report the incident to his board? He can (and should), but here too, there is a tolerance level. If the members of the board are not tuned in to the extent of their corporate responsibility, as many trustees are not, then they will not be receptive to such problems because correcting them means conflict with the whole medical staff or with those officials who are thought to have the responsibility for this kind of problem. Because of the pressures applied to the board by the staff, coupled with the customary charges levelled against the administrator of "interference with medical practice," the administrator can be cut to ribbons in no time.

Trying to cope with quality control problems is but one manifestation of the administrator's quandary. Another more frustrating aspect of the problem is his knowledge that the quality control mechanism, *i.e.*, the medical staff organization, which has been set

up to take care of quality control, is usually not structured so it can do so. The following examples substantiate this contention.

The responsibilities of key staff officials, such as the chief of staff and clinical department chairman, are usually not spelled out in any detail, and the authority necessary for the adequate discharge of the responsibility is not defined in medical staff by-laws. In fact, to have descriptions for those positions is the exception. What frequently happens is that responsibility and authority are diffused and diluted throughout committees of the medical staff rather than being pinpointed in certain officials. Accordingly, that which is everyone's business becomes no one's business for if responsibility is not carefully pinpointed, accountability cannot be exacted.

Carrying out quality control is also affected by the time honored "musical chairs" approach to medical staff leadership, wherein the chief of staff and department chairmen are in office for only one or two years. Not only does this mitigate against organizational stability, but it commonly precludes staff leaders from seeing developing patterns of medical incompetence. Another troubling aspect in medical staff leadership is the method whereby key officials arrive in office. It is usually done by election without any attempt to determine or set criteria for the management competency required for the office. It is as though there were an *a priori* assumption that all physicians have management skills and organizational ability or that having strong clinical skills somehow assures one of a monopoly on management skills. Such assumptions have been disproven time and again.

While the administrator is supposed to see that management functions (planning, organizing, staffing, directing, controlling) are implemented throughout the entire institution, he knows full well that they will not necessarily apply to the medical staff organization, the single most important component of the total hospital organization. Furthermore, if he tries to do much about the situation, he will often find himself in confrontation with the medical staff.

The very important management function of staffing presents another problem for the administrator. Neither he as the "corporation's general manager" nor the board can designate who will fill those key quality control positions. Organized medicine vehemently contends that this is the prerogative of the medical staff. They regard it as being necessary to preserve the democratic function. In so doing, they lose sight of the purpose of the hospital and the purposes of the medical staff organization, *i.e.*, to serve as a quality control mechanism and not as a model of democracy. It

is also difficult to comprehend how a trustee with a sense of his corporate responsibility could fail to insist that his representative, the administrator, be involved in the selection of the key guardian officials of the medical staff and that those officials come into office on a basis other than popularity. Failing to assure themselves that those who fill these positions (the ones to whom the board delegates authority) have been carefully selected in accordance with generally accepted and proven management procedures seems tantamount to abdicating their responsibility. With respect to this important function of staffing, the old adage that says the party who is to be held responsible must have control over that for which he is to be held responsible is lost. This particular area is a very sensitive one[17] and the administrator who attempts to effect change in it can find that it is a battleground on which his demise may occur.

The quandary of the administrator regarding medical malpractice extends beyond just having to deal with actual or possible quality control problems in the hospital. It also influences his external relationships. More than one administrator has said to me:

> I have to sit here, be pleasant and smile to the members of the staff, and actually cooperate with them, while they make arrangements to withhold their services. And I have to do this knowing they are the highest paid members on the health care team and that in the process of the walk out, some of the lowest paid members of the health care team will be penalized, and that there will be a measurable and deleterious impact on the bottom line of our operation. And on top of that, I must welcome them back with a smile!

The administrator also faces a dilemma when he talks patients into signing a binding arbitration agreement[18] upon their admission into the hospital. In essence this is getting patients to surrender their civil rights, and at the time they are being admitted to the hospital, they and their next of kin are not prepared to comprehend fully what they are signing away. This hardly seems consonant with the hospital's avowed purpose of putting patients' interests first. Bush states it well when he says: "Encouraging patients to sign the contract, therefore, comes perilously close to exploiting patient trust and dependency in an undisclosed conflict of interest."[19] But if the administrator did oppose such a move and recommended to his board that the hospital not be a party

17. Wall Street Journal, July 31, 1975, at 1, col. 5.
18. A patient agrees to submit any malpractice dispute to arbitration and to be bound by the findings, thus foregoing his rights of bringing suit against the physician or the hospital.
19. Bush, *Is Arbitration the Answer to Malpractice Disputes?*, MEDICAL WORLD NEWS, Jan. 26, 1975, at 46.

to encouraging patients to sign binding arbitration agreements, he would undoubtedly incur the wrath of his medical staff and destroy his effectiveness in the process.

Another dimension of his quandary involves what he is to do when he knows that a patient has suffered a misadventure at the hands of a member of the medical staff who sees no need to inform the patient of this. Should the administrator tell the patient or his next of kin (or insist that the physician do so)? If he does, he must be prepared to withstand the ire of the medical staff and the board if litigation ensues. Consider the case of a young man in his late teens who had no known genito-urinary disease and was "routinely" catheterized anyway. The incompetent physician (incompetent on numerous occasions apart from this incident) terribly traumatized the urethra so that the young man had to be transfused. Should that patient have been advised of the unnecessary misadventure and possible debilitating complications later in life? This consultant advised the board and that administrator that they should ascertain the exact extent of the injury from the appropriate specialists and then make sure that the patient was advised. Needless to say, this recommendation was not greeted with enthusiasm. It was regarded as akin to asking them to commit suicide. However, if the purpose of the hospital is to ensure that the patient's safety and interests have top priority, a hospital and its officials can do no less in such a situation. Admittedly, this is a somewhat new[20] and disturbing thought to the administrator; but it is a dimension of his quandary vis-à-vis the medical malpractice problem that he will have to cope with eventually.

III. REASONS FOR THE QUANDARY

This quandary actually involves much more than just territorial imperatives of the hospital's chief executive officer. It creates an organizational schizophrenia[21] in the total hospital organization. The prime reason it exists and persists is because the roles, relationships and responsibilities of board, administration and medical staff, one to the other, have not been clearly defined and accepted by the principals concerned. In general, physicians view the medical staff organization as a separate "self-governing" entity—a term[22] long

20. A few years ago, Herbert Dennenberg, while Insurance Commissioner of Pennsylvania, had this as the number one point of his proposed patient's bill of rights.
21. Williams, *supra* note 2, at 9.
22. WEBSTER'S SEVENTH NEW COLLEGIATE DICTIONARY defines "self-governing" as "autonomous: not subject to outside control." It is not difficult to understand why physicians consider this to mean that administration and board must stay out of medical affairs. The author,

used by the Joint Commission on Accreditation of Hospitals. On their part, boards of trustees do not want to get involved in medical affairs. They like to assume that physicians will accept responsibility for the professional practices of their confrères, and, therefore, that it is not necessary to challenge the members of the medical staff. These attitudes can be attributed to a number of factors: the trustees' lack of knowledge as to their expanding responsibility for the quality of medical care provided by the physicians to whom they have granted permission to practice in the hospital; the physician mystique which so often intimidates trustees and precludes them from applying clear cut accountability mechanisms to the medical staff; and the trustees' fears of becoming involved in confrontation with physicians and feeling the brunt of the raw power of the medical staff in the form of economic sanctions and boycott of the hospital.

For many years there has been a vaguely defined, loose, symbiotic, live-and-let-live relationship between board, administration and medical staff. The hospital literature has become replete with terms attempting to define these vague relationships. There has been built up a myth of implied equality, well-reflected in such terms as three-legged stool, triad, triumvirate, triarchy, trilogy, tripartite. A senior official[23] of the Joint Commission on Hospital Accreditation even went so far as to label it the trinity! As a result of these myths, the roles of the respective parties have not been understood, relationships have not been clearly defined and institutional responsibilities not clearly pinpointed. While boards, administrators and medical staffs may debate the issues of who is actually responsible for the quality of medical care, who is in charge of what, and who is to render accountability to whom the courts do not appear to share these hang ups. It seems to this writer that they have had no hesitation in pinpointing responsibility and exacting institutional accountability when the responsibility for the quality of medical care has not been properly discharged.

Why then should there be continuing difficulty in this area? Why are not roles, relationships and responsibilities clearly defined? Not all parties hear or interpret the messages of the court and the public in the same manner. However, such differences cannot be resolved at the local level until the major members of the health care establishment—the American Hospital Association,

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at the time of writing this article, saw a proposed draft of changes for the J.C.A.H. Guidelines for Model Medical Staff By-Laws which would delete the term. It remains to be seen if the proposed deletion becomes permanent.

23. Carroll, *J.C.A.H. Standards: Opportunities for Medical Staff Leadership*, 51 HOSPITAL PROGRESS 63, 64 (1970).

American Medical Association, Catholic Hospital Association, American College of Hospital Administrators and the Joint Commission on Accreditation of Hospitals—recognize the problem and arrive at a consensus on the matters referred to. Two of these organizations, the Catholic Hospital Association[24] and the American College of Hospital Administrators,[25] have come up with policy statements designed to remove misunderstanding and confusion about the role of the administrator as the institution's chief executive officer. These documents carefully pinpoint responsibility on the chief executive officer for the effective management of the entire institution, including seeing that the medical staff organization carries out the quality control functions established by the board. They clearly delineate roles, relationships, responsibilities and lines of accountability of the medical staff organization and its officials vis-à-vis the board and administration. By so doing, these statements potentially can minimize the quandary of the administrator; however, they are only policy statements and are not binding on an institution. Far more influential on an institution are the pressure and influence that its medical staff, with the support of organized medicine, can bring to bear. As one would expect, these policy statements have incurred the wrath of the American Medical Association.

IV. RESOLVING THE QUANDARY

The quandary of the hospital administrator boils down to who is going to run the hospital. This problem is not new and there is no magic formula for its resolution; however, there are some approaches which should be considered.

A. Achieving Consensus Within the Establishment

If the major members of the establishment, the American Medical Association, American Hospital Association, American College of Hospital Administrators, the Catholic Hospital Association and the Joint Commission on Accreditation of Hospitals, were able to reach consensus on defining the roles, relationships, responsibilities and authority of the administrator, then the quandary might be resolved because the members of each association would be hearing the same message from their parent organization and there could

24. CATHOLIC HOSPITAL ASSOCIATION, GUIDELINES ON ROLES AND RELATIONSHIPS OF BOARD, CHIEF EXECUTIVE OFFICER AND MEDICAL STAFF OF CATHOLIC HOSPITAL AND LONG TERM CARE FACILITIES (1974).

25. TASK FORCE OF THE AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, RECOMMENDATIONS ON STANDARDS TO THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS (May 24, 1974).

be a commonality of concepts followed at the local level on the contentious issues of controls, relationships and accountability of the medical staff vis-à-vis the administrator.

Before this can be achieved, all parties must acknowledge that a problem exists; however, the major hospital member of the establishment, the American Hospital Association, seems reluctant even to acknowledge the problem. The same is not the case with the major medical member of the establishment, the American Medical Association. Two years ago, it squarely acknowledged to its membership the existence of the problem and its worsening condition.[26] It has since mounted a unilateral course of action[27] which is coupled with its recent endorsement of collective bargaining for physicians and the use of job action (withholding of services). Negotiation and withholding services are but a prelude to the use of raw power, which involves confrontation, strike and economic boycott of the hospital, and can only serve to aggravate further the quandary of the administrator and perpetuate the road blocks to effective management of the institution and its resources.

B. Time for Reappraisal

A major step in resolving this quandary is a reappraisal of the medical staff organization as a quality control mechanism. Its effectiveness has been and continues to be assailed from many directions, yet the hospital continues to be the major site for setting standards and regulating medical practice and sophisticated, computerized medical information systems to ascertain whether conformity with those standards is available to the hospital. It is still the major center for continuing education for most physicians once they have completed their graduate education. However, there has been little change in the basic form or relationships of the medical staff organization in the fifty-seven years since 1919 when it was first devised.

A proposed reappraisal of the organization should not be undertaken by constituent members of the medical-hospital establishment. To do so would be self-serving and would no doubt ensure a perpetuation of the existing problems. A prestigious university, one of the major health care foundations, the Institute of Medicine

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26. AMERICAN MEDICAL NEWS, Feb. 4, 1974, at 9. This article dealt with who is running the hospital. The debate over this issue is intensive.
27. NEW AMA NEGOTIATIONS DEPARTMENT, WHAT YOU DON'T KNOW ABOUT THE ART OF NEGOTIATING IS HURTING YOU (Nov. 1975). This focuses quite clearly on the problems. "Friction between hospital governing boards and medical staffs. The disagreements are increasing. One major difficulty concerns the rules under which the medical staff operates in the hospital." *Id.* at 1.

of the National Academy of Sciences, a governmental agency, or a similar institution should sponsor such an undertaking.

C. The Likelihood of Outside Forces

The impact of court decisions regarding malpractice will continue to have an educative effect on hospital trustees. As they recognize the magnitude of their corporate responsibility, they will be forced to focus on and attempt to define more clearly the role of the administrator, their legal representative in charge of the hospital. As steps are taken to resolve the malpractice crisis, we can expect to see the hospital's responsibility for the quality of medical care more carefully and clearly delineated, as occurred in the recent *Ravenis* case.[28] This too will serve further to alert trustees to their awesome corporate responsibility regarding the provision of medical care at acceptable standards. However, it will also aggravate the problem over who is responsible for quality control and the boards will come into confrontation with their medical staffs.

One must also consider the likelihood of federal authorities imposing regulations that will strengthen the authority of boards and administrators and force medical staffs to be organized along certain lines to permit more effective management of hospitals. The withholding of services by physicians, the boycott of hospitals, the resistance of the profession to rendering accountability and its apparent inability or reluctance to police its own ranks have made it the logical target for federal action. The following illustrates how federal agencies are exhibiting an increasing interest in the affairs of organized medicine: the anti-trust suit over fee schedules filed by the Justice Department against the American Society of Anaesthesiologists; the Justice Department's inquiry into the American College of Radiology's relative value fee scale; the Federal Trade Commission's challenge to the American Medical Association's ethical prohibition on advertising by physicians, and its investigations to determine the extent of the control exercised by physicians over the nation's seventy-one Blue Shield Plans and to determine whether the American Medical Association has used its influence to restrain illegally the supply of physicians and to retard

28. Ravenis v. Detroit General Hospital, 234 N.W.2d 411 (Mich. Ct. App. 1975). Two recipients of transplants (from the same donor) subsequently lost sight in their transplanted eyes because the transplants were infected. Apparently the hospital lacked written checklists or guidelines to ascertain the suitability of prospective donors. The hospital was found liable for negligence in determining the donor, whereas the opthamology resident who actually removed the transplant material from the donor was found to be not negligent.

the development of alternative forms of health care delivery. In view of this, it is not at all inconceivable that federal agencies will turn their attention to hospitals.

D. A Separate Corporation? A Union?

From time to time one hears physicians suggest that the medical staff organization should be a separate corporation, in no way beholden to administration or to a "lay board of trustees who know nothing about medicine." Contrary to what physicians might think, this would not make life any easier for them. They would still need an administration for their own corporation, and with the channels of accountability flowing more directly to the consumer, the resulting regulation of their activities would likely be more stringent. Certainly, in setting up a separate corporation, there would be legal hurdles to be overcome, such as the concept of corporate responsibility for the quality of medical care which was established by *Darling*.

While at first glance, such a proposal presents problems, this approach should be studied since the fact remains that the present system is inadequate. The present trend toward forming physician unions is actually a development in the establishment of a separate medical staff corporation. While the union movement will probably continue, it is doubtful that the deep-seated feelings and antagonisms toward unions can be sufficiently overcome for the profession to subscribe to the concept of a separate corporation under union control. For this reason, if a separate corporate model for the medical staff is developed, it will likely be under other than union control.

It is of interest to examine some of the implications for board and administration which are presented by a separate corporate medical staff model, regardless of whether it be under the aegis of the physician members themselves or a union. Such a separate corporate model divorced from the rest of the institution at least has the merit of potentially being the means whereby responsibility could be imposed in an understandable manner. It could help resolve the administrator's quandary because the board and administration would be relieved of the sensitive and conflict-laden situation of having to interject themselves into disciplinary matters when the physicians would not act. The board in effect would relinquish to the medical staff corporation its responsibility for and control of the quality of medical care. The quid pro quo would have to be a guarantee to the hospital board by the medical staff corporation of a multimillion dollar insurance protection to cover

any situation in which the hospital might be found liable for the negligence of a member of the medical staff corporation.

The existence of a separate medical staff corporation could provide incentives to its members to self-govern more effectively and to police their ranks. However, with the responsibility for the quality of medical care (a responsibility physicians have long claimed is theirs) clearly resting in the medical staff corporation, it would become the logical target for suits alleging negligence on the part of a physician and might have to pay out large judgments. The medical staff corporation would have to provide malpractice insurance coverage for all of its members. Presumably the premium would be experience-rated, thus providing an incentive for the members of the corporation to do something about their confrères whose patterns of practice cost them money through increased premiums.

The medical staff corporation could be directly accountable to the public through the state licensing board (hopefully one that is consumer-oriented) and also answerable through the courts and the public media. There could be a written working agreement between the hospital and the medical staff corporation requiring that the hospital administrator report in writing to the administration of the corporation all instances in which its members do not adhere to predetermined professional standards or do not abide by hospital policies; all patterns of practice that come into question for any reason; every incident involving a physician which in any way tended to jeopardize the safety of the patient; all aberrant incidents of behavior occasioned by health or social habits; and all the other dimensions of routine quality controls. Thus the medical staff corporation could be kept fully informed so that it could carry out meaningful self-government and surveillance of the practices of all its members with a view to making sure that the safety of the patient always came first. As an added incentive to that end, the administrator should be required under the terms of the contractual agreement to forward copies of all such reports to the state licensing board and to the medical staff corporation's insurance carrier(s).

Costly? Practical? Effective? Who knows? It is mentioned here as one approach that merits further study, if only to point up the advantages and disadvantages to those who regard a separate corporation as a means of being freed up from hospital boards and administrator controls; or to show them the advantages of the present system and elicit their cooperation to make it work more effectively. A recent New Jersey appellate court decision,[29] which

29. Corleto v. Shore Memorial Hospital, 138 N.J. Super. 302, 350 A.2d 534

states that the entire medical staff of a hospital may be held liable for allowing an allegedly incompetent physician to continue to do surgery, seems to point the way to the medical staff's being considered a separate corporate entity. Group liability can be an incentive for the members of a medical staff to police their brethren more effectively and can also serve as a logical basis for physicians to contend that if they can be sued collectively, then they should be able to have their own separate corporate entity.

The quandary of the hospital administrator is a symptom of the long-standing tripartite system of hospital governance which no longer permits the management process to be applied effectively. Up until a decade ago, the relationships of the board, administration and medical staff were held together by the glue of goodwill. But today, with the ever-increasing societal pressures building up on each of those three members, the glue of goodwill alone no longer has the adhesive power to maintain the proper relationships and get the job done. They now have to be reappraised and carefully delineated. Continued reluctance and inability on the part of members of the medical hospital establishment to face up to the administrator's quandary of who is running the hospital will make it necessary for the courts to resolve the problem.

(1975). The action was brought against the hospital's board and the administrator, as well as the hospital medical staff, alleging that they permitted a member of the medical staff who was not competent to perform a particular surgical procedure to continue to treat the patient after his incompetence had become obvious. The court ruled that all 141 members of the medical staff could be sued collectively, even though they were only members of an unincorporated association.