Torts: Corporate Negligence: Wisconsin Hospital Held to Owe a Duty to Its Patients to Select Qualified Physicians. Johnson v. Misericordia Community Hospital, 99 Wis. 2d 708, 301 N.W.2d 156 (1981).

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NOTES

TORTS—Corporate Negligence — Wisconsin Hospital Held to Owe a Duty to Its Patients to Select Qualified Physicians. Johnson v. Misericordia Community Hospital, 99 Wis. 2d 708, 301 N.W.2d 156 (1981).

I. INTRODUCTION

In Johnson v. Misericordia Community Hospital¹ the Wisconsin Supreme Court held that a hospital owes a duty to its patients to use due care in the selection of its medical staff.² Relying on the theory of “corporate negligence,” the court found that a hospital has a direct obligation to its patients to select and maintain qualified members of its medical staff to insure quality care, diagnosis and treatment of its patients.

The adoption of corporate negligence significantly expands the independent legal duty of hospitals.³ Historically, Wisconsin hospitals were exempt from tort liability under the judicial doctrine of charitable immunity until the 1961 decision of Kojis v. Doctors Hospital⁴ abrogated this rule. Even then a hospital was liable for the negligence of a physician only under the doctrine of respondeat superior.⁵ No independent

1. 99 Wis. 2d 708, 301 N.W.2d 156 (1981).
2. In common parlance, the medical staff can include both salaried physicians and private physicians who bill their patients directly.
3. The application of the Misericordia decision is limited to private hospitals. Sovereign immunity might still shield state or municipal hospitals from tort liability.
4. 12 Wis. 2d 367, 107 N.W.2d 131 (1961). The doctrine of charitable immunity for hospitals derives from Feoffees of Heriot’s Hosp. v. Ross, 12 C. & F. 507, 8 Eng. Rep. 1508 (1846). The rule was rejected in most United States jurisdictions following President and Directors of Georgetown College v. Hughes, 130 F.2d 810 (D.C. Cir. 1942). This latter view is adopted in the RESTATEMENT (SECOND) OF TORTS § 895E (1965): “One engaged in a charitable, educational, religious or benevolent enterprise or activity is not for that reason immune from tort liability.” Even so, for many years courts refused to impose any liability for the acts of salaried hospital employees, particularly doctors. See Schloendorff v. Society of N.Y. Hospitals, 211 N.Y. 125, 105 N.E. 92 (1914), overruled by Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3 (1957). See also Copeland, Hospital Responsibility for Basic Care Provided by Medical Staff Members: “Am I My Brother’s Keeper?” 5 N. Ky. L. Rev. 27, 28-29 (1978) [hereinafter cited as Copeland].
5. Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957), recognized respondeat superior in overturning Schloendorff, supra note 4. Subsequent cases em-
duty of care regarding the acts of an independent contractor physician was imposed upon the hospital.

In addition to recognizing a hospital's independent duty to its patients the Misericordia court also set forth guidelines for a standard of care to be observed by Wisconsin hospitals. This note will review the historical development of the theory of corporate negligence. The future use of the theory will then be reviewed in light of the standard of care set forth by the court.

Misericordia was a negligence action brought by a patient of the defendant hospital for harm sustained during a surgical procedure performed by a private staff physician. The plaintiff's complaint named both the physician and the hospital as defendants in the subsequent malpractice suit. After a trial, the jury apportioned twenty percent of the causal negligence to the doctor and eighty percent to the hospital. Damages were awarded in the sum of $315,000 for personal injuries, past and future, and $90,000 for impairment of earning capacity, past and future.

The Wisconsin Court of Appeals upheld this decision on the theory of corporate negligence, finding that Misericordia had breached an independent legal duty owed to the plaintiff-patient. This duty was to exercise "that degree of care and skill usually exercised or maintained by other reputable hospitals in similar situations." On May 12, 1981, the Wisconsin Supreme Court affirmed.

II. HISTORICAL BACKGROUND OF CORPORATE NEGLIGENCE

As rapidly as the services of the modern hospital have ex-


6. 97 Wis. 2d 521, 530, 294 N.W.2d 501, 506 (1980), aff'd, 99 Wis. 2d 708, 301 N.W.2d 156 (1981). The court of appeals used the term "corporate negligence" in the body of its opinion, while the supreme court included it in a footnote. 99 Wis. 2d at 722 n.14, 301 N.W.2d at 163 n.14.

7. 97 Wis. 2d at 544, 294 N.W.2d at 513.

8. 99 Wis. 2d 708, 301 N.W.2d 156 (1981).
panded, so too have its legal duties. In 1965, the hospital's world changed drastically when the Illinois Supreme Court decided *Darling v. Charleston Community Memorial Hospital* and the United States Congress enacted Medicare. *Darling* extended the duty of a private hospital to include supervision of a staff physician, while the Medicare legislation imposed federal standards on those hospitals which wished to qualify to care for medicare patients. In *Darling*, the patient brought an action for damages against the hospital for injuries stemming from emergency room treatment of his broken leg. The general practitioner on call at the hospital had applied a plaster cast which impaired circulation. Within fourteen days so much dead tissue had accumulated in the leg that it had to be amputated below the knee. At trial the plaintiff contended that the physician had done nothing in the thirty-three years since he had graduated from medical school to update his skills to perform such a procedure, so that the hospital was negligent for hiring him for such a position. Mr. Darling also alleged that the hospital was negligent in failing to exercise adequate supervision over the case and in failing to require a consultation after complications developed.

The Illinois Appellate Court found that the hospital had breached three duties it owed the patient directly, including (1) using reasonable care to see that only board eligible or board certified surgeons were allowed to perform orthopedic surgery; (2) requiring consultations with members of the hospital staff skilled in the techniques involved; and (3) maintaining a sufficient staff of nurses to watch and report on the patient's condition. The Illinois Supreme Court in affirming this decision made no holding on the first ground of judging a physician's competence, but it did not overrule it either, and subsequent decisions have more readily found a

12. In order to be board eligible in a specialty, a physician must have completed a required residency. A board certified specialist is one who has both completed the training and passed a standard examination.
13. 50 Ill. App. 2d at ___, 200 N.E.2d at 257-61.
duty of the hospital to screen staff appointments than to supervise the medical acts of physicians. In delineating this duty of the hospital the court said that community standards in other hospitals were not solely determinative, but that the defendant hospital's own bylaws should be considered along with the standards and practices of agencies and organizations to which the hospital belongs.

The holding of *Darling* is actually rather limited. Hospital management has the responsibility in consultation with the organized medical staff to make reasonably certain that physicians working in their institution are not likely to commit malpractice.\(15\) Thus the theory of corporate negligence is quite distinguishable from that of respondeat superior. The former involves an independent, nondelegable duty while the latter makes the hospital vicariously responsible for any breach of duty committed by its professional servants.\(16\)

The Connecticut Supreme Court aptly described corporate negligence as follows: "Corporate negligence is the failure of those entrusted with the task of providing the accommodations and facilities necessary to carry out the charitable purpose of the corporation, to follow in a given situation the established standard of conduct to which the corporation should conform."\(17\) The seminal article on the subject of hospital corporate negligence was written by Arthur Southwick three years after the *Darling* decision. In his article he defined the limits of the theory in the following way:

In corporate negligence, although human error is involved, the hospital itself as an entity or as an institution, is negligent and liability attaches directly to the hospital. In other words, the hospital owes a duty directly to the patient and these duties are non-delegable to the medical staff or to other professional personnel.\(18\)

Southwick and other commentators\(19\) list four general du-

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19. See generally Copeland, *supra* note 4; Horty & Mulholland, *The Legal Status*
ties which attach to a hospital under this doctrine: (1) the duty owed to all invitees to exercise reasonable care with respect to the maintenance of buildings and grounds; (2) the duty to exercise reasonable care with respect to the selection and maintenance of equipment; (3) the duty to exercise reasonable care with regard to the selection and retention of personnel; and (4) the duty to supervise the personnel within the scope of their employment. The Misericordia decision clearly adopts the third category and, in dicta, also appears to adopt the fourth. This is consistent with the trend in other states. To date over one-quarter of the states have adopted the concept of corporate negligence for selection or supervision of staff.20

While the Darling opinion was limited to the hospital’s duty to supervise, the court in Misericordia held the hospital...
responsible for failure to take reasonable care in the selection
and retention of a staff physician. Relying on Darling, the
Georgia Supreme Court extended the hospital's duty to the
Misericordia situation in Mitchell County Hospital Authority
v. Joiner. There a staff physician treated the plaintiff's hus-
band in the emergency room for chest pains. The doctor gave
the husband a prescription and sent him home only to have
the patient die on his way back to the hospital that same day.
The plaintiff contended that the hospital had been negligent
in hiring the physician without investigating his background
and the court agreed that the mere fact that a physician is
licensed or recommended by someone on the staff does not
mean that he has been properly screened. Furthermore, the
staff members to whom the selection process was delegated
were agents of the hospital, so the hospital was not relieved of
responsibility for their actions if it knew or should have
known of the physician's incompetence. This duty does not
end when the physician is hired; it is a continuing process of
reviewing and monitoring. In arriving at its decision the court
explained:

[Plaintiff] does not seek to hold the hospital liable under the
doctrine of respondeat superior or principal and agent, but
upon the doctrine of independent negligence in permitting
the alleged negligent physician to practice his profession in
the hospital when his incompetency is known. Such negli-
gence is comparable to that of the owner of a motor vehicle
permitting an incompetent, inexperienced, or reckless driver
to operate such motor vehicle.

A similar result was reached by the Arizona Court of Ap-
peals in Purcell v. Zimbelman. A patient's administratrix
sued a surgeon and Tucson General Hospital for harm caused
by a negligent operation for cancer of the colon. Dr. Purcell,
who held courtesy membership on the staff, did not obtain a
frozen section pathology report to indicate that cancer was ac-

(1972).
22. 229 Ga. at 141-42, 189 S.E.2d at 414.
24. In general, a member of the courtesy staff is not involved at all in the operation
of the hospital but is simply entitled to admit his patients to the hospital for
treatment by him.
tually present, but performed surgery anyway. Other physicians testified at the trial that a procedure other than the one employed by Dr. Purcell would have produced less injurious results. The patient suffered loss of sexual function, loss of a kidney, a permanent colostomy and urinary problems before his death. Testimony also revealed that Dr. Purcell had been sued four times previously (twice for performing the same operation attempted on Mr. Zimbelman) and that the hospital was named as a defendant in all four prior suits. The court concluded that the hospital had actual knowledge of Dr. Purcell's incompetence and should have acted to protect other patients from his ministrations. In reaching their decision the court stated:

We believe it reasonably probable to conclude that had the hospital taken some action against Dr. Purcell, whether in the form of suspension, remonstration, restriction or other means, the surgical procedure utilized in this case would not have been undertaken by the doctor and Mr. Zimbelman would not have been injured.25

The trend of these cases is clear. Hospitals — institutions which once enjoyed total tort immunity26 — could now potentially be liable for the negligence of a physician who had negligently been given staff privileges.

III. ANALYSIS OF THE MISERICORDIA DECISION

A. Recognition of a Hospital's Duty of Care

In arriving at its decision in Misericordia the Wisconsin Supreme Court ruled for the first time that Wisconsin hospitals have a duty "of reasonable care to permit only competent physicians to use their facilities . . . ."27 Such a duty arises when the negligent party acts when some harm to someone is foreseeable.28 As applied to this case the court reasoned that:

[T]he issue of whether Misericordia should be held to a duty of due care in the granting of medical staff privileges de-

25. 18 Ariz. App. at ___, 500 P.2d at 343.
26. See note 4 supra.
27. 99 Wis. 2d at 737, 301 N.W.2d at 171, quoting the trial court's instructions to the jury.
pends upon whether it is foreseeable that a hospital’s failure to properly investigate and verify the accuracy of an applicant’s statements dealing with his training, experience and qualifications as well as to weigh and pass judgment on the applicant would prevent an unreasonable risk of harm to its patients. The failure of a hospital to scrutinize the credentials of its medical staff applicants could foreseeably result in the appointment of unqualified physicians and surgeons to its staff. Thus, the granting of staff privileges to these doctors would undoubtedly create an unreasonable risk of harm or injury to their patients. Therefore, the failure to investigate a medical staff applicant’s qualifications for the privileges requested gives rise to a foreseeable risk of unreasonable harm and we hold that a hospital had a duty to exercise due care in the selection of its medical staff.29

B. The Standard of Care

The supreme court in Misericordia also established guidelines for the standard of care a hospital must maintain. In general, the standard of ordinary care under the circumstances applies to hospitals.30 There is no language in the opinion to indicate that Wisconsin hospitals should be held to a higher standard of care, as are common carriers or innkeepers. The supreme court stated that “for Misericordia to be liable for negligence in this case, it must have failed to exercise that degree of care and skill required of a hospital under like or similar circumstances.”31

The Wisconsin court had previously rejected the locality rule in medical malpractice actions in Shier v. Freeman32 where an orthopedic surgeon from Green Bay was held subject to the standard of the “average practitioner in the class to which he belongs,”33 rather than to the standard of other orthopedic surgeons in Green Bay. Geographic area and its attendant lack of facilities are now merely circumstances that can be considered if appropriate.34 In Misericordia, therefore, the court could apply a similar national standard to hospitals.

29. 99 Wis. 2d at 723, 301 N.W.2d at 164.
30. Id. at 738, 301 N.W.2d at 171.
31. Id.
32. 58 Wis. 2d 269, 206 N.W.2d 166 (1973).
33. Id. at 283, 206 N.W.2d at 174.
34. Id. at 284, 206 N.W.2d at 174.
In arriving at this standard, both the court of appeals and the supreme court used the phrase "average hospital."\textsuperscript{35} However, the Restatement (Second) of Torts uses the word "reasonable" instead of "average" because to base a standard on a true average would mean that half of the members of a class would automatically fall below the standard.\textsuperscript{36} In view of the rejection of the locality doctrine the use of an average at least avoids the problem of the plaintiff introducing the standards of the strictest hospital to be found or of the defendant producing the standards of the most lax institution. After studying diverse cases, one law review writer concluded that the word "average" as applied to medical skills is usually used synonymously with "ordinary" learning and skill. He notes that "a true 'average' would involve an uneasy aggregation of the best and the worst, the experienced and the inexperienced, the quack and the specializing medical doctor. It has never been suggested that the law strikes the average from so diverse a grouping."\textsuperscript{37} Elsewhere, the Misericordia decision speaks of the standard of a "reputable hospital"\textsuperscript{38} — a more subjective term, perhaps, but one less fraught with problems.
than "average."

Aside from the semantic problems, the Wisconsin courts laid down specific criteria for determining the standard of care in regard to staff selection. In *Misericordia* these factors were intertwined with the type of proof needed to establish the independent negligence of the hospital. Since the procedures ordinarily employed by hospitals in evaluating applications for staff privileges are not within the realm of the ordinary experience of mankind, expert testimony was required to establish Misericordia's negligence. At trial, two Milwaukee experts on hospital administration related the procedure for screening applications for staff privileges. Both said that this process involves checking the doctor's past associations with colleagues and hospitals to test the veracity of his representations. A local board-certified orthopedist also described the information concerning medical school, internship, residency and certification which he had been required to produce for the four hospitals that granted him privileges. In contrast, the medical staff coordinator for Misericordia Hospital admitted that no one at that hospital had made any investigation of Dr. Salinsky's credentials, although that was the hospital's avowed procedure. In the minutes of the Misericordia medical staff meeting of June 21, 1973 (just one day after the administrator approved Dr. Salinsky's appointment to the staff), the medical director noted that with regard to "the physician's applications and approval of such, [it] was the responsibility of the executive committee in lieu of a non-functioning credentials committee." Thus, Misericordia's own bylaws were used to establish the standard of care for the hospital. Usually, rules adopted by private organizations are irrelevant because the standard of care upon which recovery must be based is set by law. In this case, however, the bylaws were a re-

39. 99 Wis. 2d at 739, 301 N.W.2d at 172. The court also quoted Payne v. Milwaukee Sanitarium Found., Inc., 81 Wis. 2d 264, 275-76, 260 N.W.2d 386, 392 (1977): In establishing the negligence of a hospital the necessity for expert testimony depends upon the type of negligent acts involved. Expert testimony should be adduced concerning those matters involving special knowledge or skill or experience on subjects which are not within the realm of the ordinary experience of mankind and which require special learning, study or experience.

40. 97 Wis. 2d at 537 n.6, 294 N.W.2d at 510 n.6.

quirement of licensing under the Wisconsin Administrative Code and embody much of the code language. Misericordia's bylaws incorporated the Wisconsin Administrative Code's standards which apply uniformly to all licensed general hospitals. These bylaws, therefore, did not represent isolated safety rules solely for Misericordia's internal use.

Besides the bylaws of the hospital and of other "reputable" hospitals, the Wisconsin court also allowed state statutes and the Wisconsin Administrative Code itself to be introduced as evidence of a reasonable standard of conduct. The supreme court rejected Misericordia's contention that these rules merely impose a moral, not a legal, obligation on the hospital. It was clear to the court that the legislature intended to make the hospital's governing body legally responsible for the selection of the medical staff in order to promote the welfare of the patients. Therefore, it is necessary to consider the statewide regulations along with the individual hospital's own bylaws to insure that a negligent hospital would not be protected by adopting lax standards or that a nonnegligent hospital will not be harmed by a failure to attain its own unrealistically high standards.

In other cases, such as Darling, the rules of the Joint Commission on Accreditation of Hospitals were also relied upon to establish the standard of care. These nationwide regulations place particular emphasis upon the appointment/reappointment procedure and a continuing process of evaluation of each staff member. In this case, however, Misericordia had not applied for JCAH approval. While the court notes Misericordia's failure to do so, the evidence produced at the trial came only from state and local sources. This does not exclude the possibility that JCAH regulations could be intro-

43. The Joint Commission on Accreditation of Hospitals [hereinafter cited as JCAH] was organized in 1952 by the American Hospital Association, American Medical Association, American College of Physicians, American College of Surgeons, and Canadian Hospital Association. It is a voluntary organization which sets minimum standards for patient care. Federal programs participation as well as residency and internship programs are often contingent upon JCAH approval. 99 Wis. 2d at 712 n.8, 301 N.W.2d at 159 n.8.
45. 99 Wis. 2d at 712, 301 N.W.2d at 159.
duced as evidence in an appropriate Wisconsin case. It is not clear, however, whether Wisconsin would go as far as the Darling decision, which admitted sources other than expert professional and administrative testimony to establish a hospital's standard of care. These sources constitute a whole new field of evidence with which to determine the heretofore elusive hospital standard of care. Ideally, the comprehensiveness of this material should provide a definitive guideline for nearly every situation that might arise.

Miscericordia fails to address whether a violation of a rule from any of these sources would constitute negligence per se on the part of the hospital. Legal commentators agree that such a breach would not be conclusive on the question of liability. The breach must also have been a proximate or legal cause of the injury to the patient. Nevertheless, as one writer points out:

[I]n light of subsequent cases, it is evidence of negligence which obviously weighs heavily upon the minds of the fact-finder. Where the action is based upon a breach by a staff physician, knowledge of the impending breach and a failure to prevent it, or, in the absence of knowledge, circumstances under which the hospital should have known, must be demonstrated. When this is sufficiently demonstrated, liability appears almost certain.

Another writer attributes the scarcity of case law on the subject of hospital corporate liability post-Darling to the probability that when a hospital commits a clear-cut violation of a state or federal regulation, an out of court settlement is likely.


47. 33 Ill. 2d at 332, 211 N.E.2d at 257.

48. See Expanding Duty, supra note 19, at 257.

49. See, e.g., Dornette, The Legal Impact on Voluntary Standards in Civil Actions Against the Health Care Provider, 22 N.Y.L. Sch. L. Rev. 925, 934-39 (1977). See also Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 331-32, 211 N.E.2d 258, 257 (1965), cert. denied, 383 U.S. 946 (1966). But see Pederson v. Dumouchel, 72 Wash. 2d 73, 80, 431 P.2d 973, 978 (1967), in which breach of a hospital rule concerning the mandatory attendance of a physician in the operating room during oral surgery was held to be negligence per se.

50. Expanding Duty, supra note 19, at 257.

Had Misericordia followed any of the customary procedures in processing the application of Dr. Salinsky, it would have found, contrary to his representations, that his surgical privileges had been restricted at two hospitals and that he did not have consultant privileges at two other hospitals he listed as references. Furthermore, he was neither board certified nor board eligible in the field of orthopedic surgery and he was not considered competent by many of his peers. Moreover, Dr. Salinsky failed to answer any of the questions pertaining to his malpractice insurance and Misericordia failed to check the Milwaukee County Circuit Court files where seven malpractice actions had been filed against him prior to his appointment to the Misericordia staff.

While Dr. Salinsky's incompetence at the time of his application of Misericordia was clear, the supreme court did not limit its decision to situations where the court knew or should have known of such incompetence:

[W]e do not adopt the legal theory that knowledge of incompetency is the standard for determining whether a hospital exercised due care in selecting its staff.


....

Thus, the defendant's claim that the plaintiff had the burden of showing that Salinsky was actually incompetent and that the hospital knew or should have known of his incompetence before granting him surgical privileges before the July 11, 1975, operation is in error, as we hold that Johnson was only obliged to prove that Misericordia did not make a reasonable effort to determine whether Salinsky was qualified to perform orthopedic surgery.\(^5\)

In Misericordia there was no evidence that the hospital had actual knowledge of the surgeon's incompetence as in Purcell;\(^5\) but in view of the availability and multiplicity of such information, Misericordia was charged with constructive knowledge.\(^5\) The court concluded that a reasonable hospital with knowledge of these facts would have excluded Dr. Salinsky from its staff. Thus, the supreme court affirmed that Mis-

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52. 99 Wis. 2d at 737-39, 301 N.W.2d at 171-72 (emphasis in original).
54. See Attoe v. State Farm Mut. Auto. Ins. Co., 36 Wis. 2d 539, 546, 153 N.W.2d 575, 579 (1967): "Constructive knowledge is that knowledge which one who has the opportunity, by the exercise of ordinary care, to possess."
ericordia breached the standard of care it owed to its patients and that this breach had been a substantial factor in causing the physical harm to the plaintiff. The jury verdict and apportionment of negligence was upheld and the theory of the corporate negligence of hospitals was adopted by the Wisconsin courts.

IV. CONSEQUENCES OF THE DECISION

In the wake of Misericordia, Wisconsin health care providers are naturally concerned as to whether courts will strictly or liberally construe the case's holding. Just how egregious the facts must be before a breach of duty is found remains to be seen. Misericordia was a flagrant case of hospital misfeasance which the plaintiff's attorney characterized as "the type of conduct which used to be called 'gross negligence,' and constitutes a blatant disregard for the plaintiff’s rights."55 All of the cases which followed Darling also arose out of factual situations indicative of gross negligence. While Wisconsin no longer recognizes gross negligence as a distinct kind of negligence,56 the concept can still be employed when it indicates a difference in degree but not in kind.57

Another extraordinary feature of this case which might distinguish it from others on its facts is the close connection of the negligent physician with the governing board of the hospital. Dr. Salinsky was not merely a staff physician. Shortly after his appointment to the medical staff was approved by the hospital administrator, he was elevated to the position of chief of staff; thus he endorsed his own appointment which was marked approved about two months later. Indeed, he was listed as a member of the executive committee before his appointment was approved.58 The closeness of the governing body and the medical staff was further underscored by the fact that the hospital itself was owned by three staff physicians.59

56. See Bielski v. Schulze, 16 Wis. 2d 1, 14-19, 114 N.W.2d 105, 111-14 (1962).
58. 99 Wis. 2d at 713-14, 301 N.W.2d at 159-60.
59. Id. at 711, 301 N.W.2d at 158.
There is no language in *Misericordia* to indicate that the hospital's liability should not be based on at least some degree of fault. In this case it was the salient fault of the hospital which led the jury to apportion eighty percent of the negligence to *Misericordia*. Yet the court said that hospitals are not "insurers of the competence of their medical staff, for a hospital will not be negligent if it exercises the noted standard of care in selecting its staff." Courts in the future, however, could decide to hold a hospital strictly liable for the acts of any practitioner within its walls. Some commentators see this as a more efficient way to handle costly and complicated hospital-based malpractice actions.

A more immediate probable impact of the *Misericordia* decision will be an increase in lawsuits which name the hospital as a defendant. The hospital is another deep pocket from which the plaintiff may be able to recover. This additional source of revenue could be especially important where the physician has limited or exhausted malpractice coverage or where the damages exceed his maximum coverage. Under Wisconsin's system of comparative negligence, the hospital as a joint tortfeasor would be jointly and severally liable for all damages or would be liable for the proportion not settled by a release of the doctor. Under the Wisconsin system of contribution, if the doctor had settled for more than his apportioned share of negligence with a *Pierringer*-type release (which settles for whatever percentage is later attributed to the tortfeasor by the jury), the physician's insurer could claim contribution from the hospital. Similarly, if the hospital settled before trial for more than its share of the damages, it could obtain contribution from the physician's insurer.

60. *Id.* at 745, 301 N.W.2d at 175.
61. See Greenberg v. Michael Reese Hosp., 83 Ill. 2d 282, 415 N.E.2d 390 (1980), where the hospital was held strictly liable for a patient developing cancer after a hospital physician had administered x-ray treatments to correct a thyroid condition. See also *Expanding Duty*, supra note 19, at 255 n.33, 261; *Needed Legal Sutures*, supra note 19, at 855 n.94.
62. See, e.g., *Effective Solution*, supra note 5, at 353-54.
63. In Wisconsin all physicians must be insured or be self-insured or furnish a surety bond and must participate in a patient compensation fund which covers all claims which exceed the individual's insurance. Wis. Stat. §§ 655.23, 655.27(1), (5)(a), (5)(d) (1979).
Hospitals might also encounter difficulty when their duty to scrutinize staff appointments comes into conflict with the physician's right to practice. As a witness for Misericordia Hospital pointed out at the trial, the opinions of other doctors and administrators may be colored by personal and professional jealousies, animosity or medical politics. There is also a danger that a hospital could use a decision such as Misericordia to justify excluding a physician from the staff when the underlying motive is based on the applicant's race, sex or religion. Individuals, of course, can invoke their due process rights under the fourteenth amendment; so it is a risk hospitals and doctors alike will have to endure to insure the non-negligent care of patients.

The minimum standards set forth in Misericordia are sufficiently specific to give definite guidance to concerned hospitals and yet are not so rigid that each case could not be considered on its merits. For example, a rule automatically excluding a physician from the staff after being named in a certain number of malpractice suits would not be appropriate, because all suits do not necessarily result in judgments and others are settled out of court. Sometimes it is less costly for an insurance company to settle such a claim regardless of whether the physician was negligent, so even a settlement is not necessarily indicative of the doctor's competence.

In the future, hospitals should have a more qualified pool of specialists to fill their staff openings, since the Bureau of Labor Statistics reports that the number of physicians certified in most specialties is increasing at a faster rate than the general population. Also, many states, such as Wisconsin, now require continuing education as a prerequisite to license renewal. At the same time, governmental agencies are at-

66. 99 Wis. 2d at 720-21, 301 N.W.2d at 163.
67. See Rapp, supra note 19, at 890. See generally Comment, Hospital Medical Staff Privileges: Recent Developments in Procedural Due Process Requirements, 12 WILAMETTE L.J. 137 (1975).
68. See Effective Solution, supra note 5, at 350-53.
69. CENTER FOR HEALTH SERVICES RESEARCH AND DEVELOPMENT, AMERICAN MEDICAL ASSOCIATION, PHYSICIAN DISTRIBUTION AND MEDICAL LICENSURE IN THE UNITED STATES 388 (1979).
70. Wis. STAT. § 448.13 (1979). But see Effective Solution, supra note 19, at 350.
tempting to phase out marginal hospitals.\textsuperscript{71} The problem of the flagrantly negligent physician or hospital will never be totally eradicated, however, since it is not always the substandard practitioner or institution which will fail in its duties to its patients.\textsuperscript{72}

V. Conclusion

\textit{Misericordia} should at a minimum serve as both a warning and a guide to Wisconsin health care providers who wish to avoid future liability.\textsuperscript{73} The days of total immunity have long

\footnotesize{\textsuperscript{71} Misericordia itself closed in 1977 due to bankruptcy. 
\textsuperscript{72} See \textit{Time}, July 20, 1981, at 72, reporting on the recent filing of 20 lawsuits against the University of California Davis Medical Center which the article says "was increasingly cited for excellent patient care and impressive research." The complaints contend that the hospital was negligent in allowing a "grossly incompetent" kidney transplant surgeon to operate at the center.
\textsuperscript{73} 99 Wis. 2d at 744-45, 301 N.W.2d at 174-75, which recapitulates the standard thus:

In summary, we hold that a hospital owes a duty to its patients to exercise reasonable care in the selection of its medical staff and in granting specialized privileges. The final appointing authority resides in the hospital's governing body, although it must rely on the medical staff and in particular the credentials committee (or committee of the whole) to investigate and evaluate an applicant's qualifications for the requested privileges. However, this delegation of the responsibility to investigate and evaluate the professional competence of applicants for clinical privileges does not relieve the governing body of its duty to appoint only qualified physicians and surgeons to its medical staff and periodically monitor and review their competency. The credentials committee (or committee of the whole) must investigate the qualifications of applicants. The facts of this case demonstrate that a hospital should, at a minimum, require completion of the application and verify the accuracy of the applicant's statements, training and experience. Additionally, it should: (1) solicit information from the applicant's peers, including those not referenced in his application, who are knowledgeable about his education, training, experience, health, competence and ethical character; (2) determine if the applicant is currently licensed to practice in this state and if his licensure or registration has been or is currently being challenged; and (3) inquire whether the applicant has been involved in any adverse malpractice action and whether he has experienced a loss of medical organization membership or medical privileges or membership at any other hospital. The investigating committee must also evaluate the information gained through its inquiries and make a reasonable judgment as to the approval of denial of each application for staff privileges. The hospital will be charged with gaining and evaluating the knowledge that would have been acquired had it exercised ordinary care in investigating its medical staff applicants and the hospital's failure to exercise that degree of care, skill and judgment that is exercised by the average hospital in approving an applicant's request for privileges is negligence.

(footnotes omitted)
since passed, but the burden of corporate responsibility is neither new nor oppressive. The court in *Misericordia* relied on fifteen years of prior decisions and legal scholarship in shaping its opinion. Its conclusion was a logical outgrowth of the public's perception of the hospital as the primary dispenser of all but the most routine medical services. People have come to expect a degree of protection from the providers they patronize. This decision does not place a greater burden upon hospitals than they themselves should have assumed in their own bylaws and under state regulations and the rules of voluntary associations. In making this determination the court did not abrogate an existing principle of tort or agency law, but simply found another path to what it perceived to be a just result. This result places the burden of risk management upon the hospital, the party which is now best able to protect the patient from harm.

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MENTAL HEALTH LAW — 42 U.S.C. § 6010 Held Not to Create Substantive Rights in Favor of Mentally Retarded. *Pennhurst State School v. Halderman*, 101 S. Ct. 1531 (1981). Although in the last decade courts across the country have endorsed a right to treatment and to community services under a variety of statutory and constitutional theories, none of these holdings has been affirmed by the United States Supreme Court. Therefore, the Supreme Court's decision in *Pennhurst State School v. Halderman* was awaited by mental health advocates with great interest and some anxiety. The Court, however, limited its holding to a statutory interpretation, namely that section 6010 of the Developmentally Disabled Assistance and Bill of Rights Act did not create in favor of the mentally retarded any substantive rights to "appropriate treatment" in the "least restrictive" environment, and effectively sidestepped the constitutional issues. Such a narrow decision may well leave existing, favorable constitutional precedent intact.