Notes

Independent Duty Of A Hospital To Prevent Physicians' Malpractice

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The layman who enters a hospital for medical or surgical treatment would like to believe that the skills of his physician are merged with those of the rest of the hospital staff in a well-integrated medical unit. While hospitals generally cultivate such a public image, there are times when they would prefer that their relationship with physicians be as attenuated as possible. One such instance is when a medical or surgical procedure performed in the hospital results in a malpractice suit against the physician, and the hospital is joined as a defendant.

When such disputes develop, it is necessary to examine the nature of the relationships between physician and patient, between physician and hospital and between patient and hospital. This investigation is significant, since it aids in determining the extent to which hospitals may be held liable in situations involving a physician's negligence. In recent years, courts and legislatures throughout the country have come to realize that traditional legal analyses of these relationships accord with neither contemporary realities nor societal needs.[1] The re-

1. The Supreme Court of California, for example, has noted that:
A hospital today conducts a highly integrated system of activities, with many persons contributing their efforts. There may be, e.g., preparation for surgery by nurses and internes who are employees of the hospital; administering of anesthetic by a doctor who may be an employee of the hospital, an employee of the operating surgeon, or an independent contractor; performance of an operation by a surgeon and assistants who may be his employees, employees of the hospital, or independent contractors; and post surgical care by the surgeon, a hospital physician, and nurses. The number of those in whose care the patient is placed is not a good reason for denying him all reasonable opportunity to recover for negligent harm. It is rather a good reason for re-examination of the statement of legal theories which supposedly compel such a

sult has been increased recognition of a duty owed by hospitals to their patients with respect to the quality of medical care offered, even in the absence of a master-servant relationship between the physician and the hospital. This Note presents a brief review of traditional theories of hospital immunity, followed by a closer examination of the development of stricter standards of responsibility of the hospital for the well-being of hospitalized patients under the care of private physicians. Particular emphasis is placed on the imposition of an independent duty of the hospital to such patients, and the implications of such a duty for the hospital.

TRADITIONAL THEORIES OF HOSPITAL IMMUNITY

To make the hospital a proper defendant, the complaining patient must overcome two legal obstacles which historically have insulated hospitals from liability—theories of charitable tort immunity,[2] and the inapplicability of *respondeat superior* to the hospital-physician relationship.[3]

Charitable Tort Immunity

Divining the specific nature of the relationship between the hospital and the physician was not a critical issue when "charitable" institutions[4] enjoyed immunity from liability for the torts of even their admitted employees.[5] The concept of charitable tort immunity appears to have originated in mid-19th century England,[6] where it was based on the theory that funds donated to a charitable institution could not legally be diverted from the purposes intended for such funds by

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shocking result.
Ybarra v. Spangard, 25 Cal. 2d 486, 493-94, 154 P.2d 687, 691 (1944). *See also* Hanson & Stromberg, *Hospital Liability for Negligence*, 21 HASTINGS L.J. 1 (1969).

2. The primary emphasis here will be on charitable immunity, a theory which has shielded most private hospitals from suit. Sovereign immunity, which would protect government-run hospitals from liability, is no longer a problem in Arizona. *See* Hernandez v. County of Yuma, 91 Ariz. 35, 369 P.2d 271 (1962), *noted in* 4 ARIZ. L. REV. 306 (1963) (patient who pays for professional services performed by a government-operated hospital is entitled to the same redress for negligence available against a privately owned and operated hospital). However, the doctrine is still alive in many states, adding a complicating factor to the imposition of liability. *See* Hanson & Stromberg, *supra* note 1, at 4-5.

3. There are several types of hospital-physician relationships, usually designated in terms of degrees of staff membership. Certain physicians (such as residents and interns) may actually be salaried employees of a hospital. In terms of staff duties, the most attenuated type of staff membership is that of the courtesy staff member, who 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. *See* R. GOODMAN & F. TOZER, MODERN HOSPITAL LIABILITY—LAW AND TACTICS 162-64 (1967).

4. A "charitable" institution may include private, nonprofit hospitals, such as community hospitals, which are supported, at least in part, by public contributions. *See* Olander v. Johnson, 258 Ill. App. 89 (1930); *In re* Farmers' Union Hosp. Ass'n, 190 Okla. 661, 126 P.2d 244 (1942).

5. For a discussion of the doctrine of *respondeat superior* as applied to the physician-hospital relationship, see text accompanying notes 19-26 *infra*.

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

their donors.[7] In a result-oriented search for other ways to justify the insulation of hospitals and other charitable institutions from tort liability, some American courts adopted this "trust fund" theory,[8] while others developed new doctrines. Under the "implied waiver" theory, for example, it was contended that acceptance of the charitable hospital's services constituted a waiver by the patient of any right to claim damages for injuries suffered as a result of the negligence of the hospital or its employees.[9] Other courts ruled that *respondeat superior*, through which the master would otherwise be held liable for the tortious acts of his servants, simply did not apply when the master was a charitable institution, since such institutions were not operated for profit.[10] Finally, several courts considered the basis for immunity to be rooted in "public policy" considerations. They believed that donations would be discouraged by the fear that funds donated might be used to pay tort claims,[11] and that the legislative policy of the state was to "protect the assets of charitable institutions from use for any purpose other than that for which they were organized."[12]

In *Southern Methodist Hospital & Sanitorium v. Wilson*,[13] the Supreme Court of Arizona adopted the position that the doctrine of *respondeat superior* did not apply to charitable institutions. The court reasoned that the doctrine was originally founded solely on a public policy rationale[14] and accordingly could be limited for countervailing

7. *Id.*; *see* W. PROSSER, HANDBOOK OF THE LAW OF TORTS 993 (4th Ed. 1971).

8. *See, e.g.*, Cook v. John N. Norton Mem. Infirmary, 180 Ky. 331, 202 S.W. 874 (1918); Downes v. Harper Hosp., 101 Mich. 555, 60 N.W. 42 (1894); Gable v. Sisters of St. Francis, 227 Pa. 254, 75 A. 1087 (1910).

9. *See, e.g.*, Wilcox v. Idaho Falls Latter Day Saints Hosp., 59 Idaho 350, 82 P.2d 849 (1938); St. Vincent's Hosp. v. Stine, 195 Ind. 350, 144 N.E. 537 (1924); Forrest v. Red Cross Hosp., 265 S.W.2d 80 (Ky. 1954).

Of course, this theory is a pure fiction. First, it clearly could not apply to the patient who pays for services at a "charitable" hospital. He receives no "charity," and it is illogical to say that he agrees to waive the right to nonnegligent performance of the services for which he pays. Even the true charity patient cannot realistically be said to agree to accept negligent treatment. *See* Gamble v. Vanderbilt Univ., 138 Tenn. 616, 200 S.W. 510 (1918).

10. *See, e.g*, Evans v. Lawrence & Mem. Ass'n Hosps., 133 Conn. 311, 50 A.2d 443 (1946); Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 105 N.E. 92 (1914); Bachman v. Young Women's Christian Ass'n, 179 Wis. 178, 191 N.W. 751 (1922).

The theory was that *respondeat superior* was inappropriate because the hospital derived no benefit from the services rendered by the physician. Precisely why the doctrine's applicability should depend on the profit-making nature of an enterprise was never quite clear. *See* Ray v. Tucson Medical Center, 72 Ariz. 22, 230 P.2d 220 (1951).

11. *See, e.g.*, D'Amato v. Orange Mem. Hosp., 101 N.J.L. 61, 127 A. 340 (1925); Taylor v. Flower Deaconess Home & Hosp., 104 Ohio St. 61, 135 N.E. 287 (1922); Landgraver v. Emanuel Lutheran Charity Bd., 203 Ore. 489, 280 P.2d 301 (1955).

12. Landgraver v. Emanuel Lutheran Charity Bd., 203 Ore. 489, 493, 280 P.2d 301, 302 (1955).

13. 45 Ariz. 507, 46 P.2d 118 (1935).

14. "An injury done by one who is irresponsible must be answered for by his superior, when for his own convenience *and emolument* that superior has given the wrongdoer the opportunity of committing the injury." *Id.* at 519, 46 P.2d at 124 (emphasis added). A physician practicing in a nonprofit hospital is by definition not acting for the "emolument" of the institution or its trustees.

reasons of public policy.[15] In general, the court said, it would be in the public interest to encourage the establishment and growth of charitable institutions by assuring prospective donors that funds would not be diverted from their intended purposes.[16] Sixteen years later, in 1951, the same court found that the thrust of "public policy" had shifted from the protection of hospitals to the protection of individuals and repudiated the charitable immunity doctrine.[17] The Arizona decisions reflected a national trend—by 1961 complete charitable immunity remained the law in only seven states.[18]

Independent Contractor

Even where charitable immunity no longer prevents suit against the hospital, another legal barrier may block use of *respondeat superior* to impose responsibility on the institution for physicians' negligence: the per se inapplicability of that doctrine to the hospital-physician relationship.

The doctrine of *respondeat superior* holds a master liable for tortious acts committed by his servant within the scope of employment.[19] To establish the existence of a master-servant relationship, it is necessary to show that the master has the right to control the activities of the servant.[20] In an early treatment of the question,[21] the New York Court of Appeals held that physicians doing volunteer work in a charity hospital were not subject to this type of control. "The wrong was not that of the hospital;" Judge Cardozo wrote, "it was that of physicians, who were not the defendant's servants, but were pursuing an independent calling, a profession sanctioned by a solemn oath, and safeguarded by stringent penalties. If, in serving their patient, they violated her commands, the responsibility is not the [hospital's]; it is theirs."[22]

15. *Id.* at 522, 46 P.2d at 125.
16. *Id.*
17. Ray v. Tucson Medical Center, 72 Ariz. 22, 36, 230 P.2d 220, 229 (1951).
18. *See* 3 ARIZ. L. REV. 304, 304-05 nn.2-5 (1961). *See also* text accompanying notes 28-41 *infra.*

It should be noted that, as was observed by Judge Fuld in Bing v. Thunig, 2 N.Y. 2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957), the fear that "a substantial award in a single negligence action might destory the hospital" has much less of a valid foundation today than it did at one time in the past. "[T]oday's hospital is quite different from its predecessor of long ago; it receives wide community support, employs a large number of people, and necessarily operates its plant in businesslike fashion." *Id.* at 664, 143 N.E.2d at 7, 163 N.Y.S.2d at 9. *But see* Judge Conway's concurring opinion in that case, suggesting that many voluntary hospitals in small communities are not conducted as profit-making businesses at all, but rather end each year with considerable deficits. *Id.* at 667-68, 143 N.E.2d at 9, 163 N.Y.S.2d at 12.

19. W. SEAVEY, HANDBOOK OF THE LAW OF AGENCY 141-42 (1964).
20. *Id.* at 142.
21. Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 105 N.E. 92 (1914).
22. *Id.* at 131, 105 N.E. at 94.

Following New York's lead, many courts adopted the proposition that the doctrine of *respondeat superior* does not apply to the hospital-physician relationship, at least where the acts in question called for the exercise of the doctor's professional discretion.[23] Courts reasoned that the very nature of the medical profession requires a high degree of specialization in skills and an ability to exercise discretion, over which a hospital administrator is inherently incapable of exerting any large measure of control. Accordingly, they refused to impose liability through *respondeat superior* even when the personnel involved were salaried staff members of their employer-hospitals.[24] Thus, in some jurisdictions, the determination of the existence of a master-servant relationship turned from a case-by-case contractual analysis into the simple proposition that the physician was *always* an "independent contractor" simply using hospital facilities,[25] and *never* an employee.[26]

It is difficult to assess the effects of the isolation of hospitals from liability through the charitable immunity and independent contractor doctrines. While there is no reason to hold the hospital liable simply to add another accountable party or source of recovery, it is certainly possible that this isolation from liability has contributed to limiting the interest of the hospitals in improving the level of professional competence of their medical staffs, and, perhaps, some indifference to the presence of incompetent staff members.[27]

THE TREND TOWARD LIABILITY

In many areas of tort liability the modern trend is away from the mechanical application of doctrinal rules toward a more realistic appraisal of the relationship between legal theory and social reality.[28] The

23. *Cf.* Bing v. Thunig, 2 N.Y.2d 656, 660, 143 N.E.2d 3, 4, 163 N.Y.S.2d 3, 5 (1957). Such acts were thought of as "medical" as opposed to "administrative" ones; hospitals might still be held liable for a physician's negligent performance of "administrative" acts.

24. *See, e.g.*, Runyan v. Goodrum, 157 Ark. 481, 228 S.W. 397 (1921); Rosane v. Senger, 112 Colo. 363, 149 P.2d 372 (1944); Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 105 N.E. 92 (1914).

As the court in Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957), noted, of course, the mere existence of special skills in other professions "has never been the basis for denying the application of *respondeat superior* and, even more to the point, that very principle has been invoked to render a public hospital accountable for the negligence of its doctors, nurses and other skilled personnel." *Id.* at 662-63, 143 N.E.2d at 6, 163 N.Y.S.2d at 7-8.

25. *Cf.* Rosane v. Senger, 112 Colo. 363, 149 P.2d 372 (1944); Hull v. Enid Gen. Hosp. Found., 194 Okla. 446, 152 P.2d 693 (1944).

26. A hospital, a corporation as here, can not be licensed to, and can not, practice medicine and surgery. The relation between doctor and patient is personal. That a hospital employs doctors on its staff does not make it liable for the discharge of their professional duty since it is powerless . . . to command or forbid any act by them in the practice of their profession.

Rosane v. Senger, 112 Colo. 363, 366, 149 P.2d 372, 374 (1944).

27. See text & note 72 *infra*.

28. *See, e.g.*, Morris, *Hazardous Enterprise and Risk Bearing Capacity*, 61 YALE

hospital-physician-patient relationship has undergone such a reappraisal. The result has been a tendency to add hospitals as accountable parties in cases of physicians' malpractice. Hospitals have been held to be "masters" of physician "servants" in an expanding number of factual contexts.[29] Even more important has been the recent emergence of the concept of an *independent* duty of hospitals to protect patients from incompetent physicians.[30] A hospital's failure to perform this function conscientiously may provide a basis for imposing liability, regardless of the hospital's relationship with or vicarious liability through the offending physician.[31]

Respondeat Superior

Most courts still accept the limitations on the application of the doctrine of *respondeat superior* discussed above[32] and consequently find that physicians who treat their private patients in hospitals are not made agents or employees of the hospital simply because they have "staff member" status.[33] Some courts, however, have become impatient with the past practice of stereotyping virtually every physician practicing in a hospital as an "independent contractor," thereby isolating the hospital from possible liability.

One factor in this dissatisfaction has been the illusory nature of attempts to distinguish between acts requiring the exercise of medical discretion—for which the hospital is not liable—and those merely involving administrative discretion for which it is liable. The New York

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L.J. 1172 (1952) (abnormally dangerous activities); Prosser, *The Assault Upon the Citadel*, 69 YALE L.J. 1099 (1960) (products liability); Wade, *The Place of Assumption of Risk in the Law of Negligence*, 22 LA. L. REV. 5 (1961) (assumption of risk); Note, *Application of Strict Liability to the Production of Defective Realty*, 13 ARIZ. L. REV. 643 (1971) (products liability).

29. See text accompanying notes 32-41 *infra*.

30. *See, e.g.*, Purcell v. Zimbelman, 18 Ariz. App. 75, 500 P.2d 335 (1972); Darling v. Charleston Community Mem. Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965); Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957).

While some courts seem to have tacitly recognized a limited duty on the part of hospitals to protect patients from incompetent physicians, discussion of such a duty has generally been in terms of the traditional concepts of *respondeat superior*. Implicit in some of the older cases is the notion that the failure to meet such a duty might remove barriers to vicarious liability which would otherwise exist. *Cf.* Southern Methodist Hosp. & Sanitorium v. Wilson, 45 Ariz. 507, 522-23, 46 P.2d 118, 125 (1935); Rosane v. Senger, 112 Colo. 363, 366, 149 P.2d 372, 374 (1944).

31. See text accompanying notes 42-55 *infra*.

Duties to protect the patient from defective equipment and to exercise reasonable care in the maintenance of buildings and grounds have clearly existed for a number of years. *See* Hanson & Stromberg *supra* note 1, at 11-12.

32. See text accompanying notes 20-28 *supra*.

33. *See, e.g.*, Keene v. Methodist Hosp., 324 F. Supp. 233 (N.D. Ind. 1971); Mayers v. Litow, 154 Cal. App. 2d 413, 316 P.2d 351 (1957); Vanaman v. Milford Mem. Hosp., Inc., — Del. —, 262 A.2d 263 (Sup. Ct. 1970); Misfeldt v. Hospital Auth. of City of Marietta, 101 Ga. App. 579, 115 S.E.2d 244 (1960); Dickinson v. Mailliard, 175 N.W.2d 588 (Iowa 1970).

Court of Appeals, in repudiating its prior rule,[34] surveyed with some embarrassment its own past interpretations of the dichotomy:

> Placing an improperly capped hot water bottle on a patient's body is administrative . . . while keeping a hot water bottle too long on a patient's body is medical . . . . Administering blood, by means of a transfusion, to the wrong patient is administrative . . . while administering the wrong blood to the right patient is medical . . . . Employing an improperly sterilized needle for a hypodermic injection is administrative, while improperly administering a hypodermic injection is medical . . . .[35]

The court concluded that "[f]rom distinctions such as these there is to be deduced neither guiding principle nor clear delineation of policy."[36]

Beyond a reexamination of the medical act-administrative act distinction, there has been a broader reevaluation of the physician-hospital relationship itself. Several courts abandoned the notion that a physician, because of the professional discretion required in the practice of medicine, is inherently incapable of being in a master-servant relationship with a hospital.[37] They acknowledged that the realities of a particular situation may dictate the conclusion that the physician is, indeed, a "servant" of the hospital.

The Court of Appeals of Arizona has aligned itself with those courts emphasizing the realities of the relationship rather than the theoretical "independent contractor" status of the physician. In *Beeck v. Tucson General Hospital*,[38] the court held that a physician employed as a radiologist by the hospital was indeed an "employee" in the full meaning of the term; thus there was a master-servant relationship between the hospital and the physician, and the hospital was vicariously liable for his negligent acts under the doctrine of *respondeat superior*.[39] The court quoted with approval the position taken earlier by the New York Court of Appeals:

> The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact. Present-day hos-

34. Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 105 N.E. 92 (1914). Discussed at text & notes 21-22 *supra*.

35. Bing v. Thunig, 2 N.Y.2d 656, 660-61, 143 N.E.2d 3, 4-5, 163 N.Y.S.2d 3, 6 (1957) (citations omitted).

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

37. *See* Rice v. California Lutheran Hosp., 27 Cal. 2d 296, 163 P.2d 860 (1945); Moeller v. Hauser, 237 Minn. 368, 54 N.W.2d 639 (1952).

This proposition was recognized much earlier in some jurisdictions than in others. *See* Brown v. La Societe Francaise de Bienfaisance Mutuelle, 138 Cal. 475, 71 P. 516 (1903).

38. 18 Ariz. App. 165, 500 P.2d 1153, *review denied* (1972).

39. *Id.* at 170-71, 500 P.2d at 1158-59.

> pitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. They regularly employ on a salary basis a large staff of physicians, . . . and they charge patients for medical care and treatment, collecting for such services, if necessary, by legal action.[40]

Although the willingness of courts to examine the true nature of the physician's "employment" is encouraging, such willingness does little to alter the traditional result of nonliability when there is little question that the doctor is employed privately, using hospital facilities simply on a contractual or courtesy basis. There are, in such cases, few facts from which a court could find any master-servant relationship.[41] In the absence of any *independent* duty owed by the hospital to the patient, the injured patient would still have recourse only against the physician.

INDEPENDENT LIABILITY OF THE HOSPITAL

Where a master-servant relationship between the hospital and the physician cannot be established, the hospital may still be held liable for a breach of its independent duty to the patient. The duty of the hospital to protect its patients from a physician's malpractice, given passing notice from time to time in master-servant cases,[42] has recently received direct attention as an element in the establishment of hospital ability.

Imposition of a Duty

A major breakthrough was *Darling v. Charleston Community Memorial Hospital*,[43] in which the Supreme Court of Illinois held that a hospital could indeed be found negligent in its lack of supervision of a staff physician.[44] In that case, a physician on duty in the hospital emergency room treated an orthopedic condition, although he had no special skills in that field. The court determined that the jury's verdict for the plaintiff could be upheld on the theory that the hospital negli-

40. Bing v. Thunig, 2 N.Y.2d 656, 666, 143 N.E.2d 3, 8, 163 N.Y.S.2d 3, 11 (1957).

41. *See, e.g.*, Mayers v. Litow, 154 Cal. App. 2d 413, 316 P.2d 351 (1957), where the question of agency was not even presented to the jury for consideration: "[I]n this case there is nothing in the record from which it may legitimately be inferred that defendant Litow or Dr. Feinstein was an agent or employee of the hospital. The doctors merely used the hospital facilities to perform the operation." *Id.* at 418, 316 P.2d at 354.

42. In Rosane v. Senger, 112 Colo. 363, 149 P.2d 372 (1944), for example, the court indicated that the hospital cannot be held liable for the negligent acts of physicians unless it "by some special conduct or neglect makes itself responsible for their malpractice . . . ." *Id.* at 366, 149 P.2d at 374.

43. 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966), *noted in* 43 N.C.L. REV. 469 (1965).

44. 33 Ill. 2d at 333, 211 N.E.2d at 258.

gently "[f]ailed to require consultation with or examination by members of the hospital surgical staff skilled in such treatment; or to review the treatment rendered to the plaintiff and to require consultants to be called in as needed."[45]

While the emphasis in *Darling* on an independent basis of liability of the hospital represents a significant break with the past, there is some question as to the likely outcome had the offending physician clearly been an independent contractor with no staff duties. *Purcell v. Zimbelman*,[46] recently decided by the Court of Appeals of Arizona, offers a possible approach to the independent contractor cases. *Purcell* dealt with the question of the hospital's liability solely in terms of a separate duty to the patients. The court's conclusions represent a refinement and expansion of the concept of independent liability or hospitals.

Purcell, an osteopath in private practice, and Tucson General Hospital, on whose staff he held "courtesy" membership,[47] were both found liable for injuries resulting from Purcell's negligent performance of abdominal surgery.[48] Purcell had been a defendant in four previous suits, two of which related to the same type of operation; the hospital had been named as co-defendant in each of the prior suits. The appellate court upheld the jury's determination that the hospital had been negligent in its lack of supervision of, or action against, Purcell. The court found it "reasonably probable to conclude that had the hospital taken some action against Dr. Purcell . . . the surgical procedure utilized in this case would not have been undertaken by the doctor and [the plaintiff] would not have been injured."[49]

The court derived what appears to be an affirmative duty on the part of the hospital to prevent repetition of the doctor's negligent acts.[50] The court emphasized that the hospital had "assumed" such a duty:

> The hospital had assumed the duty of supervising the competence of its staff doctors. The Department of Surgery was acting for and on behalf of the hospital in fulfilling this duty and if the department was negligent in not taking any action against Purcell or recommending to the board of trustees that action be taken, then the hospital would also be negligent.[51]

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45. *Id.*
46. 18 Ariz. App. 75, 500 P.2d 335, *review denied* (1972).
47. See note 3 *supra.*
48. 18 Ariz. App. at 78, 500 P.2d at 338.
49. *Id.* at 83, 500 P.2d at 343.
50. In order to be successful against the hospital, of course, the plaintiff would have to prove two levels of negligence—first, the negligence of the physician in his treatment of the patient, and then the negligence of the hospital in the inadequacy of its supervision of the physician.
51. 18 Ariz. at 81, 500 P.2d at 341.

In finding that the hospital had assumed the duty of adequately policing the performance of its staff doctors, the court considered several facts relevant. Initially, the court noted that the hospital was accredited by the American Osteopathic Association, which required that the governing board of the hospital select its professional staff in such a way as to assure the public of competent medical care.[52] The court also pointed out that the goals set forth in the accreditation requirements were echoed in the by-laws of the hospital.[53] Finally, the court discussed the usual hospital practice of establishing review committees to regulate privileges granted staff doctors and to insure that such privileges are granted "only for those procedures for which the doctor was trained and qualified," and the seeming acceptance of such a practice by the board of trustees of the defendant hospital.[54]

While the result reached in *Purcell* is sound, it is questionable whether the court's conclusion can be supported solely by an explicit assumption by the hospital of a duty to protect its patients. The vague language of the accreditation documents and hospital by-laws hardly seem a suitable foundation for a theory of tort liability. It is unlikely that the absence of vague mention of a public obligation in the hospital by-laws would have compelled a different result in the *Purcell* case. Nor is it probable that the hospital's lack of action would have been excusable had it not created a department of surgery. It makes a great deal more sense to postulate that the real lesson of *Purcell* is that, under circumstances similar to those in the case, the court will impose a duty to act regardless of whether the hospital acts to "assume" such duty. In the *Beeck* case, which did not deal specifically with independent duties, the court of appeals observed that "[h]aving undertaken one of mankind's most critically important and delicate fields of endeavor, concomitantly therewith the hospital must assume the grave responsibility of pursuing this calling with appropriate care."[55]

Since the hospital had been named as a defendant in all four prior suits against Purcell, and since its department of surgery had reviewed at least two of those cases, the court determined that the hospital had sufficient notice of serious questions concerning Purcell's competence. It agreed with the plaintiff's position that "it was a jury question as to whether or not the hospital, acting through its department of surgery" was negligent in its failure to take any action against Purcell. *Id.*

For a discussion of the role played by the element of notice, see text accompanying notes 73-77 *infra.*

52. The pertinent section of the Basic Accreditation Requirements of the American Osteopathic Association reads as follows: "The governing authorities of the hospital have a responsibility of selecting its professional staff to assure the community that the physician [sic] to whom it extends the privilege of the use of its facilities are professionally competent and will offer optimum patient care. . . ." *Quoted in* Purcell v. Zimbelman, 18 Ariz. App. 75, 81, 500 P.2d 335, 341 (1972).

53. 18 Ariz. App. at 81, 500 P.2d at 341.

54. *Id.*

55. Beeck v. Tucson Gen. Hosp., 18 Ariz. App. 165, 169, 500 P.2d 1153, 1157

Accepting the proposition that the imposition of a duty explains the decision in *Purcell*, it is necessary, in order to understand the rationale behind such imposition, to examine the conflicting social interests involved in allocating burdens of liability and the justification for imposing some measure of the burden on the hospital.

Conflicting Social Interests

Physicians, the public and hospitals themselves all have legitimate interests in establishing a "satisfactory" level of staff supervision. These interests do not always coincide, however, and fulfillment of one set of interests may impede the realization of another.

The essential goal of both hospital and hospital-practicing physician is to deliver in an efficient manner the various types of medical services required by the public. While such "efficiency" clearly requires a degree of control by the hospital over the medical activities taking place within the hospital, it also requires that the hospital be able to induce well-qualified physicians to use its facilities. If the professional discretion required in the practice of medicine should not automatically make a physician an independent contractor, it is nonetheless true that a substantial degree of freedom of action is absolutely essential. A hospital cannot attract a staff of highly qualified doctors if every decision and action of the doctor is to be monitored by the hospital and subjected to its review and control. A compromise must be reached permitting hospitals to operate as efficient units while allowing the staff physicians to practice with sufficient freedom.

While the essential problem between hospital and physician involves finding an "equilibrium point" of administrative control and review, the basic issue for the "consuming" public is the extent to which they may rely on the assumption that admission to a hospital assures them of a certain minimum level of competent care, regardless of the attending physician. It has become apparent to some courts[56] that the role of the hospital, at least with respect to the public, has changed:

> Today, in response to demands of the public, the hospital is becoming a community health center. The purpose of the community hospital is to provide patient care of the highest possible quality. . . . The hospital's role is no longer limited to the furnishing of physical facilities and equipment where a physician

(1972); *see* Darling v. Charleston Community Mem. Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965).

56. *See* Gridley v. Johnson, 476 S.W.2d 484 (Mo. 1972); Moore v. Board of Trustees of Carson-Tahoe Hosp., — Nev. —, 495 P.2d 605, *cert. denied*, 409 U.S. 879 (1972). *See also* W. ROSENGREN & M. LEFTON, HOSPITALS AND PATIENTS 6-16 (1969).

treats his private patients and practices his profession in his own individualized manner.[57]

Obviously, the hospital and physician may find an "equilibrium point" at which they both feel that they can comfortably operate, which nonetheless represents a degree of control far below that at which the public can justifiably rely on the hospital to fulfill its role as a community health center. Indeed, considering the administrative difficulty of providing comprehensive supervision, hospitals and physicians might well agree that little or no review and control is desirable. It is apparent from *Purcell* and from new legislation[58] requiring hospitals to take a more direct role in the review of medical practices within their walls, that Arizona authorities, at least, will frown on such a shallow view of the hospital's role in the future.

BASES FOR IMPOSITION OF LIABILITY

Once hospitals are required to assume more active control over the practices of physicians using their facilities, logic demands that they be liable for damages resulting from the negligent exercise of this control.

Duty Imposed by Statute

In the period between the events of the *Purcell* case and the decision by the court of appeals,[59] the Arizona legislature imposed a statutory duty on all hospitals to establish committees to review the quality of medical practice within the hospital.[60] Such review must include "the nature, quality and necessity of the care provided" and assessment of "the preventability of complications and deaths occurring in the hospital," the ultimate aim being the reduction of "morbidity and mortality" and "the improvement of the care of patients provided in the institution."[61] While a general affirmative duty is thus imposed on hospitals, it is not yet clear precisely what that duty is, what its limitations are or what the consequences of its breach may be. The only indication of legislative intent with respect to liability for the consequences of activities of the required review committees is found in a section of the legislation which provides members, agents or employees of review committees with immunity from liability for "civil damages or any legal action" arising from any decision made by such committees

57. Moore v. Board of Trustees of Carson-Tahoe Hosp., — Nev. —, —, 495 P.2d 605, 608 (1972).
58. See text & notes 64-70 *infra*.
59. The operation on Zimbelman was performed in April 1969. The decision by the court of appeals came on July 20, 1972.
60. ARIZ. REV. STAT. ANN. § 36-445 (Supp. 1973).
61. *Id.*

"without malice and in good faith."[62] The obvious purpose of this section is to enable physicians to serve conscientiously on review committees without fear of adverse legal consequences. The statute does not, however, deal with the possible isolation of hospitals themselves from liability for the consequences of committee action (or inaction, as in *Purcell*).[63]

In the absence of some indication of legislative intent concerning liability of the hospital for failing properly to police the activities of its physicians, there remains the traditional tort concept that violation of statutory as well as common law duties may constitute negligence.[64] "Negligence," one court pointed out long ago, "is the breach of a legal duty. It is immaterial whether the duty is one imposed by the rule of common law requiring the exercise of ordinary care not to injure another, or is imposed by a statute designed for the protection of others."[65] Thus there is a sound basis for imposing liability on a hospital for the consequences of a failure to execute properly the duties required by the statute.

Superior Ability of the Hospital to Control and Insure

Whatever duties may be imposed by statute, it is a matter of practical necessity that the hospital bear a certain amount of responsibility for medical practices in the hospital simply because it is in the best position to assess the performance and control the activities of physicians.

It has been suggested, in another context, that in an age when the practice of medicine is so complex, only physicians themselves are able to determine whether sound medical judgment is exercised.[66] Most large hospitals have already established, in the form of professional departments and peer review committees, an administrative apparatus for the monitoring of medical performance. It would be relatively easy for such peer groups, functioning as agents of the hospital, to take a conscientious role in investigating and evaluating questions of adequate performance and in the overall control of the quality of medical practice in the hospital. Clearly, control of the quality of medical practice is more easily and effectively accomplished through such peer review than through uninformed attempts of laymen. The hospital, acting through

62. *Id.* § 36-445.02 (Supp. 1973). But, "[N]othing in this section relieves any person of liability arising from treatment of a patient." *Id.*

63. Neither an analysis of the purpose for granting immunity to those who serve on review committees, nor a literal reading of the statute, indicate that the legislature intended to confer immunity on the hospital itself. A similar provision in a California statute, in fact, is specifically limited so as to confer no immunity on a hospital where the hospital would otherwise be liable. CAL. CIV. CODE § 43.7 (West Supp. 1973).

64. W. PROSSER, *supra* note 7, at 190.

65. Osborne v. McMasters, 40 Minn. 103, 105, 41 N.W. 543, 543-44 (1889).

66. Hanson & Stromberg, *supra* note 1, at 27.

its professional peer group committees, has (1) access to relevant information concerning the performance of individual physicians, (2) the benefit of professional judgments on such matters and (3) the ultimate power to impose sanctions against offending physicians.[67] The opportunity of the hospital to be an effective factor in the prevention of malpractice should not be overlooked.

In addition to being in the best position to monitor the in-hospital acitivites of physicians, the hospital is in an excellent position to insure, at minimal cost, against the risk of liability for damages arising from the negligent performance of its duty to prevent malpractice. Hospitals which conscientiously exercise their control and review functions would be able to obtain such insurance at a reasonable cost. While the hospital's increased cost of doing business would ultimately be passed on to the "consumer", the net increase, when spread among all such consumers, would be relatively small.[68]

The degree to which the ability of a business enterprise to insure itself against liability has influenced trends in tort liability has been vigorously debated in the past. Although it is difficult to state with certainty that the existence of such insurance has led to a broadened concept of enterprise liability,[69] that very proposition has been forcefully argued by several legal writers.[70] Judges are certainly aware of the growing role insurance plays in the conduct of business enterprise.[71]

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67. See text following note 77 *infra*.

68. How much such insurance would cost is of course not readily calculable, and the reasonableness of the cost is doubly speculative. On one hand, it seems clear that hospitals held liable and obligated to pay substantial judgments will experience substantial increases in their liability insurance premiums. For example, the defendant hospital in both the *Beeck* and *Purcell* cases has experienced a doubling of its liability insurance premiums in the past 4 years. Letter from Michael Harris, Administrator, Tucson General Hospital, to the *Arizona Law Review*, November 5, 1973. Hospitals which, through better policing or better luck, are not subjected to such judgments, may experience little or no increase. St. Joseph's Hospital in Tucson, for example, has experienced no increase in the cost of its liability insurance in the last several years, and expects none in the near future. Letter from John Marnell, Administrator, St. Joseph's Hospital, to the *Arizona Law Review*, November 1, 1973.

It must be recognized, however, that, in general, hospital liability insurance premiums are rising. Hanson and Stromberg indicate that in the decade 1959 to 1969, the cost of liability insurance for California hospitals more than quadrupled. Hanson & Stromberg, *supra* note 1, at 22. Tucson Medical Center, while experiencing no recent premium increases, faced increases of 400 per cent in the period 1967 to 1970. Letter from Donald G. Shropshire, Administrator, Tucson Medical Center, to the *Arizona Law Review*, November 20, 1973. It is difficult to draw conclusions from these latter figures, since the factors motivating these increases are not readily apparent.

69. Dean Prosser was one of those who suggested that the role played by the existence of liability insurance was not as great as generally believed. W. PROSSER, *supra* note 7, at 547-48.

70. *See, e.g.*, Ehrenzweig, *Assurance Oblige*, 15 LAW & CONTEMP. PROB. 445 (1950); Friedman, *Social Insurance and the Principles of Tort Liability*, 63 HARV. L. REV. 241 (1949); Leflar, *Negligence in Name Only*, 27 N.Y.U.L. REV. 564 (1952).

71. For an excellent example of such judicial awareness, see Escola v. Coca Cola Bottling Co., 24 Cal. 2d 453, 150 P.2d 436 (1944) (Traynor, J., concurring). For indications that the existence of insurance may affect issues of liability, see O'Connor v. Boulder Colo. Sanitarium Ass'n, 105 Colo. 259, 96 P.2d 835 (1939); Wendt v. Servite

Public Reliance

The image of modern hospitals as centers of medical practice of the highest quality is understandably cultivated by the hospitals themselves. Nonprofit hospitals do not, of course, advertise as such. But they do maintain a high degree of "visibility" in the community through fund-raising campaigns, community relations programs, public service programs, press releases and the like, all presenting the hospital as a unified institution vital to community health, rather than as a mere physical shell in which private physicians practice their profession.

On the other hand, the institutional aspects of hospital health care are minimized by the hospital when tort liability rather than public relations is involved. For example, a standard hospital admission form states that the patient "recognizes that all doctors of medicine furnishing services to the patient . . . are independent contractors and are not employees or agents of the hospital."[72] In cases like *Beeck* and *Purcell*, the hospital attempts to convince the court that in fact it has no responsibility for reviewing or guiding the actions of such "independent contractors." Thus there is a conflict between the public posture of the hospital as a functionally integrated institution and the posture taken in the relative privacy of the courtroom and the small print of the admission form.

The public, however, has been led to accept its image of the hospital as the correct one; it relies on this image in its willingness to make use of hospital facilities. Public outrage, and possibly even an effect on admissions at a typical hospital, would surely follow a public announcement by the hospital that it regards all staff doctors as completely independent professionals, conducts no supervision of their performance and takes no interest in their competence. The public assumes, correctly or not, that the hospital exerts some measure of control over the medical activities taking place there.

Improved Medical Care

The reasons enumerated thus far for imposing some measure of liability on hospitals might not be persuasive if a greater duty of care would not have a positive effect on the quality of medical care received by hospitalized patients. In most cases, after all, there is already a suitable defendant—the physician—who, if found to be liable, will almost certainly be well-insured and able to satisfy a judgment.

Fathers, 332 Ill. App. 618, 76 N.E.2d 342 (1947); Rogers v. Butler, 170 Tenn. 125, 92 S.W.2d 414 (1936).

72. *See* Beeck v. Tucson Gen. Hosp., 18 Ariz. App. 165, 171, 500 P.2d 1153, 1159 (1972).

But the satisfaction of a judgment by the physician has little effect on the hospital. The possibility of direct, independent liability, on the other hand, may have a significant influence on the degree to which hospital administrators and directors become active in the process of supervising the quality of medical care being offered in their hospitals.[73]

EXTENT AND CONSEQUENCES OF THE DUTY

The Element of Notice

The *Purcell* court, ruling on the question of the admissibility of evidence relating to the prior claims against the doctor and the hospital, emphasized the importance of notice in assessing liability:

> Since the negligence of the hospital was predicated upon failure to perform its obligation to Zimbelman to see to it that only professionally competent persons were on its staff, it follows that its knowledge, actual or constructive, of Dr. Purcell's shortcomings, was an essential element for consideration in determining whether or not the hospital exercised reasonable care or had been guilty of negligence.[74]

This was so, explained the court, because where a hospital's misconduct consists of an omission to act, it cannot be held responsible unless it had reason to know that action was warranted under the duty it admittedly had.[75]

The language of *Purcell,* however, provides very little enlightenment as to the degree of knowledge required or the extent of the hospital's obligation to obtain such knowledge. The hospital had actual notice of earlier challenges of Dr. Purcell's professional competence. There were previous allegations that his ability to adequately diag-

73. This view is reinforced by the responses of several Tucson hospital administrators to questions on that subject. Michael Harris, of Tucson General Hospital (which was held liable in *Beeck* and *Purcell*), John Marnell, of St. Joseph's Hospital, and Donald Shropshire, of Tucson Medical Center all indicated that they feel that there is a positive correlation between the possibility of hospital liability where its supervision of physicians is deemed inadequate and an increased interest on the part of the hospital in promoting improvement in the general level of competence of its professional staff. Letter from Michael Harris, Administrator, Tucson General Hospital, to the *Arizona Law Review*, November 5, 1973; letter from John Marnell, Administrator, St. Joseph's Hospital, to the *Arizona Law Review*, November 1, 1973; letter from Donald Shropshire, Administrator, Tucson Medical Center, to the *Arizona Law Review*, November 20, 1973. Mr. Shropshire indicated that the increased possibility of liability was, in his opinion, only one of the factors leading to such increased interest. All three administrators agreed that peer review has become more rigorous as the result of court decisions, although Messrs. Marnell and Shropshire felt that *Darling v. Charleston Community Mem. Hosp.*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965), had a greater influence to that effect than *Beeck* and *Purcell*. Messrs. Marnell and Harris both attribute at least some of the increased rigorousness to *Beeck* and *Purcell*.

Changes which have taken place include revision of hospital by-laws, greater administrative monitoring of the peer review system, and a greater involvement of the hospital's Board of Directors in medical matters. Letter from Michael Harris, *supra*.

74. 18 Ariz. App. at 83, 500 P.2d at 343.

75. *Id.* at 84, 500 P.2d at 344.

nose and correct the condition in question was below an adequate professional standard. In fact, the Department of Surgery of the hospital had reviewed two of the earlier cases, without recommending that any action be taken against Purcell.[76] The court reasoned that a jury could reasonably find that the hospital, through its agent, the Department of Surgery, had been negligent in failing to recommend any action whatsoever.[77]

An important point of contention in the future will be the limit beyond which the hospital can no longer reasonably be deemed to have "notice" of a physician's incompetence.[78] In some circumstances, even hospitals with no *direct* knowledge might be charged with "notice"—for example, when the hospital board or medical staff has been made aware of questions of competence through newspaper articles, court records, personal information and the like. Courts may find it reasonable to expect hospitals to follow local events such as malpractice suits and to keep records for use in deciding whether to grant, refuse or restrict staff privileges.

Action Against the Physician

Once a duty has been clearly established, and its extent delineated, there remains the problem of deciding what sort of action should follow a review committee determination that a physician does not meet minimum standards of professional competence.

Assuming that the requisite procedural formalities[79] have been complied with, there are several sanctions a hospital might impose. The least severe might be a reprimand, not affecting the physician's right to practice in any manner. From there, and in increasing order of severity, the hospital could require supervision, whereby the physician would be observed by appropriate staff members during the performance of certain medical or surgical procedures, or it could place the doctor on restriction, during the period of which he would be prohibited from performing certain procedures. In the most serious cases, the hospital might suspend the physician from hospital practice for a specified or indefinite period of time.

Procedural Considerations

Few physicians will welcome the prospect of restrictions in the

76. *Id.* at 81, 500 P.2d at 341; *see* Findlay v. Board of Supervisors, 72 Ariz. 58, 64, 230 P.2d 526, 530 (1951).

77. 18 Ariz. App. at 81, 500 P.2d at 341.

78. The defendant hospital in *Purcell*, of course, had direct notice—it has been co-defendant with the doctor in four previous suits, two of which resulted in findings of malpractice involving the same type of surgery. *Id.* at 80, 500 P.2d at 340.

79. See text & notes 79-86 *infra.*

use of hospital facilities. A large part of a doctor's practice may depend on the availability of such facilities. In fact, the question of a physician's right to use hospital facilities, and the right of a hospital to restrict their use, raises serious legal questions.[80] A majority of jurisdictions have held that private hospitals, at least, have an absolute right to exclude physicians,[81] and even public or "quasi public"[82] hospitals have wide latitude in granting or denying staff privileges. The Supreme Court of Neveda recently ruled that medical staff privileges are not an absolute right, but are subject to "reasonable" regulation by the hospital: "Licensing, *per se*, furnishes no continuing control with respect to a physician's professional competence and therefore does not assure the public of quality patient care. The protection of the public must come from some other authority, and that in this case is the Hospital Board of Trustees."[83] The court cautioned, however, that "[t]he Board . . . may not act arbitrarily or unreasonably in such cases. [Its] action must . . . be predicated upon a reasonable standard."[84] That such a "reasonable standard" is required is important, especially if the view that the "quasi public" hospital (a category into which most "community" hospitals would fit) must meet the same standards as the public hospital, gains wider acceptance.

In rejecting a private hospital's contention that its decision to exclude a certain physician is not subject to judicial review, the Supreme Court of Hawaii has asserted that:

> We cannot agree . . . that the discretionary power of a hospital is absolute or that a decision of a private hospital board in refusing to grant a licensed doctor staff privileges is not subject to judicial review. The better rule provides that such review be available as to whether the doctor excluded was afforded procedural due process, and as to whether an abuse or discretion by

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80. *See, e.g.*, Silver v. Castle Mem. Hosp., 53 Hawaii 475, 497 P.2d 564, *cert. denied*, 409 U.S. 1048 (1972); Moore v. Board of Trustees of Carson-Tahoe Hosp., — Nev. —, 495 P.2d 605 (1972); Davidson v. Youngstown Hosp. Ass'n, 19 Ohio App. 2d 246, 250 N.E.2d 892 (1969). *But see* Shulman v. Washington Hosp. Center, 222 F. Supp. 59 (D.D.C. 1963); Edson v. Griffin Hosp., 21 Conn. Supp. 55, 144 A.2d 341 (1958).

81. *See* Silver v. Castle Mem. Hosp., 53 Hawaii 475, 477, 497 P.2d 564, 566 n.2 (1972), and cases cited therein.

82. The Supreme Court of Hawaii, in *Silver*, defines a "quasi public" hospital as one which would otherwise be private, but "was constructed with public funds, is presently receiving public benefits or has been sufficiently incorporated into a governmental plan for providing hospital facilities to the public." *Id.* at 481-82, 497 P.2d at 569.

83. Moore v. Board of Trustees of Carson-Tahoe Hosp., — Nev. —, —, 495 P.2d 605, 608 (1972).

84. *Id.* Such restrictions on the exercise of discretion by the hospital, of course, create a dilemma for the hospital. If the hospital does not react quickly enough when there is evidence of insufficient professional competence, it may be held liable to the patient, but if it reacts too quickly, it may be held liable to the physician for violating his due process rights.

the hospital board occurred, resulting in an arbitrary, capricious or unreasonable exclusion.[85]

The Hawaii court prescribed guidelines for the conduct of administrative hearings by hospital boards. These guidelines may serve as a useful indication of the steps which may be required in order to satisfy the demands of due process. The court stated that the doctor must be given notice of the hearing and sufficient time to prepare a defense; there must be a written statement of the charges against him, or of the reasons for the denial of his application for staff privileges; the physician's right to call witnesses in his behalf, and to have, within the sound discretion of the hospital, the assistance of counsel, must be preserved.[86] The Hawaii case does not suggest that there are any substantive limitations to the type of action the hospital may take, however.

CONCLUSION

American courts are increasingly willing to cut away the entangling web of traditional theories of immunity and non-liability. The current trend is to look much more closely at the realities of the relationships involved in each case. Where hospitals cannot be reasonably expected to take a more active role in assuring their patients competent medical services, courts will undoubtedly continue to limit their responsibility to do so. But it is certain that there will be continued exploration by the courts of the nature and extent of hospitals' duties to their patients and the consequences of a failure to perform them adequately.[87]

Future litigation is likely to center less around the existence of a duty to protect patients, and more around the extent of the duty, the requirements for its adequate fulfillment and the consequences of its negligent performance.

Obviously, increased hospital policing of the physicians who prac-

85. Silver v. Castle Mem. Hosp., 53 Hawaii 475, 479-80, 497 P.2d 564, 568 (1972). The court did not specifically decide whether it could review decisions of truly private hospitals, or of hospitals with minimal degrees of governmental-public involvement, but held that significant funding was sufficient government involvement in hospital operation to allow judicial review. *Id.* at 483, 497 P.2d at 570. Since the physician involved was not informed of the charges against him until the hearing on those charges, the court found that the requirements of procedural due process had not been met. *Id.* at 486-87, 497 P.2d at 572.

86. *Id.* at 485, 497 P.2d at 571.

87. At the same time that these questions are explored by courts and writers, alternative ways of compensating injured hospital patients will also receive attention. Some proposals would eliminate the concept of negligence entirely. For example, a Medical Injury Commission based on strict liability, and similar to the workman's compensation system is advocated by Hanson and Stromberg. See Hanson & Stromberg, *supra* note 1, at 21-33.

tice in these institutions will exact a cost in money and resources diverted from direct patient care.[88] If the benefit to the patient from better supervision of medical practice exceeds the increased costs,[89] then such costs are a socially acceptable price for better health care services.

88. For example, one Tucson hospital recently hired a full-time, hospital-paid physician as a medical director. Letter from Michael Harris, Administrator, Tucson General Hospital, to the *Arizona Law Review*, November 5, 1973.

89. That the long-term benefits will exceed the costs is the expectation of Michael Harris, the administrator of Tucson General Hospital, which was the defendant in both the *Beeck* and *Purcell* cases. *Id.*