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DIRECT HOSPITAL LIABILITY AS A LEGAL PATH TO IMPROVED PATIENT SAFETY?

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Abstract

Tort liability is designed to economically incentivize safer behavior by compelling the tortfeasor to pay money to a person injured by the tortfeasor's conduct. In medical malpractice cases, this safer conduct should, in turn, improve patient safety and reduce adverse events. Most medical errors are the result of faulty systems and processes that are outside the control of individual clinicians working within those systems. Yet, the historical approach of holding hospitals only vicariously liable focuses solely on the individual clinicians' actions and does not hold hospitals accountable for their failure to fix the defective system and processes. Hospitals have a nondelegable duty to develop, adopt, and enforce adequate and appropriate processes, procedures, rules, and policies to ensure the delivery of quality care to their patients. Would holding hospitals directly liable for system failures motivate them financially and reputationally to improve their systems, thereby having the greatest effect on reducing patient harm?

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INTRODUCTION

Most medical errors that occur in the hospital setting are the result of faulty systems and processes.[1] The traditional approach to hospital liability—holding hospitals vicariously liable for the actions of their employees—is ineffective at improving patient safety, because the core issues are system-level and outside the control of individual clinicians working within that system. Furthermore, vicarious liability does not economically or reputationally motivate hospitals to change their systems to improve patient safety. Would direct institutional liability provide more incentive than vicarious liability for hospitals to improve these systems and make them safer for patients?[2]

I. THE HEALTH CARE SYSTEM: MEDICAL ERRORS, SYSTEM DEFECTS, AND SYSTEM IMPROVEMENTS

To understand the rationale for exploring direct hospital liability in medical malpractice claims, it is necessary to understand the incidence and causes of patient harm. A discussion of the frequency and seriousness of medical errors provides context and purpose,[3] and an exploration of the role of health care system defects in these medical errors provides a basis for examination of direct institutional liability.[4]

A. Medical Errors

Medical errors are defined as acts or omissions in either planning or implementing that could or do contribute to an unintended result.[5] Because medical errors are defined in terms of processes, not outcomes, they incorporate both adverse events and near misses/close calls.[6] Adverse events are incidents in which an undesirable outcome results from care, not from the patient's underlying disease processes.[7] Near misses or close calls are errors in the

1. Statement *from IHI and LLI About the Risks to Patient Safety when Medical Errors Are Criminalized*, INST. FOR HEALTHCARE IMPROVEMENT (Mar. 30, 2023), https://www.ihi.org/about/news/statement-ihi-and-lli-about-risks-patient-safety-when-medical-errors-are-criminalized. *See also infra* Part II.

2. *See infra* Part III; Part IV.

3. *See infra* Section I.A.

4. *See infra* Section I.B; I.C.

5. Ethan D. Grober & John M.A. Bohnen, *Defining Medical Error*, 48 CAN. J. SURGERY 39, 42 (2005).

6. Niki Carver et al., *Medical Errors*, STATPEARLS (May 7, 2023), https://www.ncbi.nlm.nih.gov/books/NBK430763/.

7. *Adverse Events*, OFF. OF INSPECTOR GEN., U.S. DEP'T OF HEALTH & HUM. SERVS. (Sept. 7, 2023), https://oig.hhs.gov/reports-and-publications/featured-topics/adverse-events/.

provision of care that are identified and remedied before patient harm occurs.[8] Medical errors include medication errors, diagnostic errors, iatrogenic injuries (e.g., preventable pressure ulcers, falls, health care associated infections, and technical complications), communication errors, treatment errors, and procedural or surgical errors.[9]

The high incidence of medical errors is concerning. The World Health Organization approximates that each year there are 421 million hospitalizations globally, during which 42.7 million adverse events occur.[10] The fourteenth leading cause of morbidity and mortality worldwide is patient harm.[11] One in ten patients receiving hospital care in high income countries like the United States face the chance of harm, with nearly half of the harm considered preventable.[12] Adverse events from unsafe care are estimated as a top ten cause of death and disability worldwide.[13] Approximately 100,000 deaths occur every year due to medical errors in hospitals and clinics.[14]

B. Defective Systems

Medical errors resulting in patient harm rarely stem from incompetent or poor care, or from a single error by a single health care worker.[15] Incompetent care only causes approximately 5% of medical harm.[16] Therefore, human errors in health care should be viewed not as the cause of patient harm, but as the

8. Steven Crane et al., *Implementing Near-Miss Reporting and Improvement Tracking in Primary Care Practices: Lessons Learned*, *in* ADVANCES IN PATIENT SAFETY AND MEDICAL LIABILITY 87, 87 (James Battles et al. eds., 2017), https://www.ncbi.nlm.nih.gov/books/NBK508085/.

9. Carver et al., *supra* note 6.

10. *Patient Safety*, WHO (Mar. 9, 2019), https://www.who.int/news-room/facts-in-pictures/detail/patient-safety.

11. *Id.*

12. *Id.* The rate of potentially preventable mortalities in acute care hospitals can vary by medical specialty. One study found that 22.6% of patients admitted under general surgery had possibly preventable deaths. This is compared to 19.4% of general medicine patients, 16.1% of cardiology patients, 12.9% of orthopedic patients, 9.7% of intensive care patients, and 3.2% of medical oncology patients. Hematology, neurology, radiation oncology, and family medicine patients had no possibly preventable deaths identified. *See* Daniel M. Kobewka et al., *The Prevalence of Potentially Preventable Deaths in an Acute Care Hospital: A Retrospective Cohort*, 96 MED. (BALT.) 1, 4 (2017); *see also* Kathy Katella, *Maternal Mortality Is on the Rise: 8 Things To Know,* YALE MED. (May 22, 2023), https://www.yalemedicine.org/news/maternal-mortality-on-the-rise ("[A]bout 84% of pregnancy-related deaths are thought to be preventable," due partially to inequities in health care.).

13. *10 Facts on Patient Safety*, WHO (Aug. 26, 2019), https://www.who.int/news-room/photo-story/photo-story-detail/10-facts-on-patient-safety.

14. Thomas L. Rodziewicz et al., *Medical Error Reduction and Prevention*, STATPEARLS (May 2, 2023), https://www.ncbi.nlm.nih.gov/books/NBK499956/.

15. *Patient Safety 101: Fundamentals of Patient Safety*, INST. FOR HEALTHCARE IMPROVEMENT, https://staff.ihi.org/education/IHIOpenSchool/Courses/Documents/SummaryDocuments/PS%20101%20SummaryFINAL.pdf (last visited Apr. 3, 2024) [hereinafter *Patient Safety 101*].

16. *Id.*

consequence of upstream system defects.[17] Even before the Institute of Medicine published the groundbreaking "To Err is Human" report in 2000, research suggested that errors are still inevitable when highly trained, competent, well-intentioned humans interact within complex systems.[18] Furthermore, "[v]irtually all [human errors] have a causal history that extends back in time and up through the levels of the system."[19]

For example, consider a pharmacist who dispensed a chemotherapy solution prepared with the wrong concentration of sodium chloride, resulting in a patient's death.[20] System failures induced this human error, through:

- Routine computer maintenance delaying the printing of medication labels, which created a backlog of orders, causing staff to feel rushed;
- An interdepartmental miscommunication that amplified time pressure on staff;
- Reduced staffing;
- No rest breaks; and
- A small, cluttered work area containing materials used to compound multiple medications for multiple patients, leading to an incorrect assumption about the materials used for the solution in question.[21]

Another example is a nurse who administered an epidural anesthetic intravenously instead of the intended penicillin—a lethal medication error.[22] System factors that contributed to the fatal error include the nurse's work schedule, which resulted in fatigue.[23] She worked a 16-hour shift the day before and doubled back to work the following morning after sleeping at the hospital.[24] A lack of training on the hospital's new barcode medication system with the resultant failure to use that system also contributed to the error.[25] In another case, three nurses intravenously administered penicillin, instead of in the intended

17. James Reason, *Human Error: Models and Management*, 320 BRIT. MED. J. 768, 768 (2000).

18. Brent C. James et al., *Patient Safety Performance: Reversing Recent Declines Through Shared Profession-Wide System-Level Solutions*, NEJM CATALYST, Dec. 12, 2022, at 5, https://catalyst.nejm.org/doi/full/10.1056/CAT.22.0318.

19. Reason, *supra* note 17, at 769; *see also* David M. Studdert & Michelle M. Mello, *In from the Cold? Law's Evolving Role in Patient Safety*, 68 DEPAUL L. REV. 421, 431 (2019).

20. *Eric Cropp Weighs in on the Error that Sent Him to Prison*, INST. FOR SAFE MEDICATION PRACS. (Dec. 3, 2009), https://www.ismp.org/resources/eric-cropp-weighs-error-sent-him-prison.

21. *Id.*

22. Stephen P. Hurley & Marcus J. Berghahn, *Medication Errors and Criminal Negligence: Lessons from Two Cases*, 1 J. NURSING REGUL. 39, 39 (2010).

23. *Id.*

24. *Id.*

25. *Id.*

intramuscular route, due to human error.[26] This resulted in a significant overdose. Fifty different system failures allowed the error to reach the newborn patient.[27]

These examples illustrate James Reason's Swiss Cheese model of system accidents.[28] In this model, each slice of cheese represents a different defense, barrier, or safeguard intended to protect patients.[29] Examples of such defensive layers include: adequate staffing levels, sufficient rest breaks and time off between shifts, barcode medication administration systems, electronic warnings and alerts, etc.[30] However, these defenses can have weaknesses or holes like Swiss cheese.[31] For example, managers may schedule adequate staffing, but if any staff call out sick, the patient-to-staff ratio is higher than intended. Also, the barcode medication administration system a hospital uses could temporarily crash. Any one of these holes, in isolation, is typically not enough to harm a patient, but when multiple holes align, an adverse event can result.[32] To illustrate: if a nurse is assigned more patients than expected due to staffing shortages, the barcode medication administration system can help prevent a medication error by this overburdened, hurried nurse. However, if the barcode system crashes or is unavailable due to routine maintenance, a medication error is more likely to reach the patient because both intended defenses are compromised.

Nearly all adverse events involve these system defects (latent conditions) and active human errors.[33] In this series of latent and active errors, the health care worker is often the final actor before patient harm. Thus, they experience disproportionate scrutiny for the error, when instead, the underlying system defects are the substantial cause of the harm.[34] Hence, the processes and systems require analysis and correction and must adjust for inevitable human error.[35] Most advances in patient safety result from health care system redesigns that focus on care delivery processes.[36]

26. *Id.* at 40.

27. *Id.* at 42; *see also Lesson from Denver: Look Beyond Blaming Individuals for Errors*, INST. FOR SAFE MEDICATION PRACS. (Feb. 11, 1998), https://www.ismp.org/resources/lesson-denver-look-beyond-blaming-individuals-errors.

28. Reason, *supra* note 17, at 769.

29. *Id.*

30. *Id.*

31. *Id.*

32. *Id.*

33. *Id.*

34. *Id.*; ATUL GAWANDE, *When Doctors Make Mistakes*, *in* COMPLICATIONS: A SURGEON'S NOTES ON AN IMPERFECT SCIENCE (2002), *as reprinted in* MARK A. HALL ET AL., MEDICAL LIABILITY AND TREATMENT RELATIONSHIPS 295, 299–300 (4th ed. 2018).

35. INST. FOR HEALTHCARE IMPROVEMENT, *supra* note 1.

36. Reason, *supra* note 17, at 769.

C. *Improving Defective Systems*

Given the significant patient harm posed by system defects, hospitals need to take responsibility to continually improve their systems and processes through patient safety, quality, system redesign, risk management programs, and leadership support.[37] These programs help identify medical errors, use tools such as root cause analysis to help detect the latent conditions and safety bypasses, and find opportunities to improve the system, eliminate the process defects, adjust for human error, build redundancies into the system (multiple layers of safety barriers), and minimize the risk of patient harm.[38] Hospital leadership must prioritize these programs, create a culture in which clinicians feel safe reporting medical errors, and invest the requisite time and resources into investigating the errors and making the recommended improvements to help prevent patient harm.[39] Leadership commitment also means embracing a just culture with individual accountability for failing to comply with safety precautions.[40]

Not only do individual health care workers need to be held accountable for frontline safety processes, but managers and directors must be held accountable by senior leadership for reviewing medical errors that occur in their units and identifying and implementing measures to mitigate the risk of a similar error recurring. One study found that while the number of reported incidents steadily increased over five years, the percentage of those with remedial recommendations by managers declined.[41] Specifically, of the 16,019 incidents reported over five years, only 2.7% resulted in the manager writing an action plan.[42] That percentage represents an astonishing number of squandered opportunities to correct system defects and mitigate the risk of future patient harm.

Because hospital boards of directors and trustees typically lack health care expertise and thus, may not understand the nuances of how hospital systems operate or how to change them, a hospital's senior clinical leadership is best equipped to oversee and enforce system changes.[43] The senior clinical

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37. Julie Dickinson, *The Criminalization of Human Errors in Healthcare*, ABA: HEALTH ESOURCE (July 27, 2022), https://www.americanbar.org/groups/health_law/publications/aba_health_esource/2021-2022/july-2022/criminalization-of-human-errors-in-healthcare/.

38. *Id.*

39. *Id.*

40. Robert M. Wachter & Peter J. Pronovost, *Balancing "No Blame" with Accountability in Patient Safety*, 361 NEW ENG. J. MED. 1401, 1401–02 (2009); *see also* Mark P. Jarrett, *Patient Safety and Leadership: Do You Walk the Walk?*, 62 J. HEALTHCARE MGMT. 88, 91 (2017).

41. Mari Liukka et al., *Problems with Incident Reporting: Reports Lead Rarely to Recommendations*, 28 J. CLINICAL NURSING 1607, 1609–10 (2019).

42. *Id.* at 1609–10.

43. John S. Toussaint & Kenneth T. Segel, *Actions to Reduce Medical Errors in U.S. Hospitals*, HARV. BUS. REV. (Apr. 20, 2022), https://hbr.org/2022/04/4-actions-to-reduce-medical-errors-in-u-s-hospitals.

leadership's level of commitment to quality and patient safety determines quality performance and improvement.[44] However, under the current legal system, neither hospital leadership, nor the hospitals they operate, are routinely held liable for system defects that contribute to patient harm.

II. THE LEGAL SYSTEM: VICARIOUS AND DIRECT LIABILITY

The legal system in the United States offers a mechanism for injured parties to seek compensation from the person or entity that harmed them.[45] Under this branch of law, known as tort law, hospitals are potentially responsible both vicariously and directly following adverse events.[46]

A. Vicarious Liability

One of the regulatory functions of tort law is to deter a tortfeasor's conduct by compelling the tortfeasor to pay money to a person injured by said conduct.[47] Typically, only tortfeasors are legally liable for their conduct, but the law recognizes several special relationships in which one person's negligence is imputed to another.[48] For instance, in the principal-agent relationship,[49] the principal authorizes its agents to act and perform on the principal's behalf.[50] Under the doctrine of vicarious liability, the principal is liable for the tortious actions of the agent that the agent committed while executing official duties.[51] In the employment setting, this vicarious liability is called *respondeat superior* (Latin for "let the master answer").[52] *Respondeat superior* doctrine allows the legal system to hold an employer liable for the acts of their employee, so long as the employee acted within the scope of employment when they committed the tort.[53] Thus, in medical malpractice cases, hospitals (principals) are held liable for the actions of their employees (actual agents). If an independent contractor

44. *Id.*

45. Tonia Aiken et al., *Legal Fundamentals*, *in* LEGAL NURSE CONSULTING PRINCIPLES AND PRACTICES 59, 64 (Julie Dickinson & Anne Meyer eds., 2020).

46. *Id.* at 79–80.

47. Michelle M. Mello et al., *Fostering Rational Regulation of Patient Safety*, 30 J. HEALTH POL. POL'Y & L. 375, 386 (2005).

48. Aiken et al., *supra* note 45, at 79.

49. *Id.*

50. *Agency*, LEGAL INFO. INST., https://www.law.cornell.edu/wex/agency (last visited Apr. 3, 2024).

51. *Id. See generally* Sword v. NKC Hosps., Inc., 714 N.E. 142 (Ind. 1999) (holding a party responsible for the negligence of another through vicarious liability "solely due to their relationship").

52. Aiken et al., *supra* note 45, at 79.

53. *Id.*; *Sword*, 714 N.E. at 147–50. Of note, this is how courts distinguish vicarious liability from the corporate practice of medicine. The latter is a legal doctrine that renders it illegal for lay management to control the actions of physicians, as this is the unlicensed practice of medicine. Vicarious liability, by contrast, does not require "control" over agents' actions, but rather, that the agents simply acted within the course and scope of their employment at the time of the negligent conduct. *See* GAWANDE, *supra* note 34, at 488.

provided the care in question, the theory of ostensible (apparent) agency may apply instead.[54] Under this doctrine, the courts may find the hospital (principal) liable for the actions of its nonemployee contractors (apparent agents), based on the patient's belief that their health care providers are hospital employees and are acting under the hospital's authority.[55]

The issue with this traditional approach of holding hospitals vicariously liable is that it focuses on the individual clinician's conduct, whereas most medical errors derive from system breakdowns that are outside the individual clinician's control.[56] In other words, this approach concentrates solely on the active error made by a single individual and does not address the latent conditions that allowed the active error to reach the patient and result in harm. If tort liability is supposed to "create[] an economic incentive for safer behavior,"[57] and the vast majority of patient harm derives from defective systems, focusing on individual clinician action is misplaced and ineffective in improving patient safety. Rather than holding hospitals vicariously liable under doctrines of *respondeat superior* or apparent agency with their misplaced focus on an individual clinician's actions, consider direct liability. For instance, would holding hospitals directly liable for system failures economically or reputationally incentivize them to improve flaws in their health care delivery systems, thereby preventing future patient harm?[58]

B. Hospital Liability

Two approaches are currently used to hold hospitals directly accountable: enterprise liability and direct/corporate liability.[59] Enterprise liability holds hospitals exclusively and vicariously liable for the actions of their clinicians (both employees and contractors); the clinicians are entirely insulated from liability.[60] There are two concerns with this approach. First, by operating under

54. Aiken et al., *supra* note 45, at 79. *See generally* Burless v. W. Va. Univ. Hosps., Inc., 601 S.E. 2d 85 (W. Va. 2004) (finding hospital "liable for a physician's negligence under an apparent agency theory" where plaintiff "establish[ed] that: (1) the hospital either committed an act that would cause a reasonable person to believe that the physician in question was an agent of the hospital, or, by failing to take an action, created a circumstance that would allow a reasonable person to hold such a belief, and (2) the plaintiff relied on the apparent agency relationship.").

55. Aiken et al., *supra* note 45, at 79; *Sword*, 714 N.E. at 148–49.

56. *See supra* Part I.

57. Mello et al., *supra* note 47, at 386.

58. *See supra* Part III.

59. GAWANDE, *supra* note 34, at 496–97; *see also* Darling v. Charleston Community Mem. Hosp., 211 N.E.2d 253 (Ill. 1965) (establishing direct liability for hospitals, based on a common law duty of hospitals to patients for adequate personnel & medical care performance). *See generally* Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381 (1994) (outlining how theory of enterprise liability developed in medical context).

60. GAWANDE, *supra* note 34, at 497.

the theory of vicarious liability, the focus remains on an individual health care worker's conduct.[61] This theory does not address any direct role the hospital played in the adverse event. Second, enterprise liability lacks shared accountability between the health care worker and the hospital by holding only the hospital financially responsible.[62] In the event that a health care provider truly gave negligent care, this model does not directly provide a deterrent effect to that clinician.

Direct or corporate liability, as currently applied, holds hospital management directly responsible for negligence related to clinician competence and patient care.[63] This theory of liability "imposes on hospitals a duty of care owed directly to patients with respect to medical judgment."[64] Direct liability claims against hospitals date back to a 1965 Illinois Supreme Court case: *Darling v. Charleston Community Memorial Hospital*.[65] In *Darling*, the 18-year-old plaintiff with a leg fracture suffered circulatory compromise caused by leg swelling or hemorrhaging, coupled with the constriction of the cast, ultimately resulting in a below-the-knee amputation.[66] He sued the hospital for negligent hospital treatment, specifically alleging that the hospital: (1) failed to employ a sufficient staff of trained bedside nurses who could recognize the progression of gangrene and bring this to the physician's attention and (2) failed to require a surgical consultation or review the physician's treatment of the plaintiff.[67] The Illinois Supreme Court affirmed the appellate court's decision to uphold the jury verdict for the plaintiff.[68] In rejecting the hospital's argument that hospitals do not practice medicine, the court held that:

> [c]ertainly, the person who avails himself of 'hospital facilities' expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility. … The Standards for Hospital Accreditation, the state licensing regulations and the defendant's bylaws demonstrate that the medical profession and other responsible authorities regard it as both desirable and feasible that a hospital assume certain responsibilities for the care of the patient.[69]

61. *Id.*
62. *Id.*
63. *Id.* at 480.
64. *Id.* at 496.
65. 211 N.E.2d 253 (Ill. 1965); *see also* Erika L. Amarante, *Corporate Liability for Hospitals*, FOR DEFENSE, Feb. 2016, at 9, https://g2bswiggins.wpenginepowered.com/wp-content/uploads/2019/09/34467_ftd-1602-amarante.pdf; Thompson v. Nason Hosp., 591 A.2d 703, 707 (Pa. 1991).
66. *Darling*, 211 N.E.2d at 255–56.
67. *Id.* at 258.
68. *Id.* at 261.
69. *Id.* at 257 (citations omitted).

Darling is touted as a "landmark decision in the field of hospital liability," because the case recognized a hospital's direct duty to maintain an acceptable standard of patient care.[70] The decision expanded traditional direct negligence claims from administrative duties (e.g., maintaining safe premises and equipment and proffering appropriate rules and regulations) to medical judgments made by individual clinicians.[71] The *Darling* decision is also significant in that it recognizes the most common sources of a hospital's direct duties to patients: regulations and statutes, the Joint Commission standards, and the hospital's bylaws and policies.[72]

1. Categories of Direct Liability Claims Against Hospitals

Direct liability or corporate negligence causes of action against hospitals generally fall into four categories (although not every state recognizes each category): (1) negligent credentialing; (2) negligent supervision; (3) failure to maintain equipment and supplies; and (4) failure to keep high-quality standards.[73] As currently used, however, all but one of these causes of action misses the mark for improving health care delivery systems,[74] thereby mitigating the largest risk to patient safety.

i. Negligent Credentialing

Negligent credentialing claims require hospitals to fulfill their duty to hire and retain only competent physicians.[75] Hospitals carry out this duty when they review physicians' clinical competency and performance history, before admitting a provider to the medical staff, and conduct periodic reviews thereafter (often every two years).[76] Adopted in over thirty states, negligent credentialing claims are the most widely accepted category of direct hospital liability claims.[77]

Under the theory of negligent credentialing, a hospital's duty to its patients starts with the physician credentialing and hiring process. These pre-employment investigation and verification steps should ensure the hospital recruits competent physicians to care for its patients. Retaining skilled physicians on staff helps to ensure that patients will receive quality care. Patients are put at risk when a hospital's credentialing and re-credentialing processes fail to properly vet and exclude, or subsequently identify and discharge, physicians who

70. GAWANDE, *supra* note 34, at 496.

71. *Id.*

72. Amarante, *supra* note 65, at 9–10 (citing Thompson v. Nason Hosp., 591 A.2d 703, 707 (Pa. 1991)).

73. *Id.* at 10 (citing *Thompson*, 591 A.2d at 707).

74. *See supra* Section I.C.

75. *Id.*

76. GAWANDE, *supra* note 34, at 498.

77. Amarante, *supra* note 65, at 11.

do not meet the desired qualifications. However, as discussed above, only a small percentage of medical harm is caused by incompetent care,[78] making negligent credentialing causes of action only applicable in a limited number of cases. This cause of action is irrelevant for 95% of medical harm involving competent clinicians working in defective systems.[79]

ii. Negligent Supervision

Negligent supervision claims place a duty on hospitals to oversee all frontline clinicians who provide direct patient care within their facilities.[80] This is the theory underpinning the *Darling* decision discussed above,[81] which imposed a direct duty on hospitals for the medical judgments made by the hospital's individual clinicians.[82]

Such case law places a direct duty on hospitals to ensure their clinicians' decisions and treatments meet the medical standard of care. Negligent supervision claims essentially impose on a hospital the duty to contemporaneously supervise daily treatment decisions as they are made.[83] This duty is highly controversial,[84] because holding hospitals liable for ensuring the standard of care is upheld in every single clinical patient encounter levies an onerous, unrealistic, and impractical burden on hospitals. Furthermore, the hospital's credentialing duty should already effectively encompass this requirement. If hospitals credential only physicians with satisfactory competency and performance, those physicians should independently meet the standard of care they owe to patients.

Courts rarely impose this supervision liability on hospitals, outside of cases involving gross negligence.[85] Gross negligence cases arise when the plaintiff alleges the hospital had constructive knowledge of a clinician's blatant deviation from the standard of care.[86] This theory is premised on the hospital's vicarious liability for the failure of its other employees, like nurses, to report the egregious behavior.[87] Nonetheless, this category of direct hospital liability concentrates on the individual clinicians' decision-making, not the system. It hones in on a clinician's active error at the point of care and not on the preceding

78. *Patient Safety 101*, *supra* note 15.
79. *Id.*
80. Amarante, *supra* note 65, at 10.
81. *See supra* text accompanying notes 65–72.
82. GAWANDE, *supra* note 34, at 496.
83. *Id.* at 498; Amarante, *supra* note 65, at 10.
84. GAWANDE, *supra* note 34, at 514.
85. *Id.* at 498.
86. *Id.*
87. *Id.*

processes where latent conditions existed that led to patient harm. Failing to look at the broader system failures does not prevent future patient harm.

iii. Failure to Maintain Equipment and Supplies

Failure to maintain equipment and supplies claims require hospitals to meet their duty to use reasonable care to maintain safe and adequate equipment, supplies, and facilities.[88] A hospital's direct duty is not limited to specific medical treatment, but rather encompasses the assurance of safe and adequate facilities. While the duty to maintain adequate equipment, supplies, and facilities helps keep patients safe, it is not specific to patients since this duty extends to business invitees.[89] As such, some of the cases in this category are merely general or premises liability cases.[90] Because this category extends beyond patient care and because latent conditions affecting patient safety are not limited to equipment, supplies, and the physical place, this cause of action is ineffective at reducing patient harm that results from a myriad of contributing factors.

iv. Failure to Keep High-Quality Standards

Failure to keep high-quality standards claims impose a duty on hospitals to develop, adopt, and enforce adequate and appropriate processes, procedures, rules, and policies to ensure the delivery of quality care to their patients.[91] As demonstrated in *Barkes v. River Park Hospital*,[92] this category of direct liability claims most closely aligns with a hospital's responsibility to continuously improve its system and processes.[93]

In *Barkes*, the patient presented to the hospital after experiencing left arm pain and nausea while performing yard work.[94] A nurse practitioner evaluated the patient and diagnosed him with a sprain from overuse.[95] The nurse practitioner discussed the patient's symptoms with the emergency department physician, who concurred with the diagnosis, without examining the patient.[96] The hospital then discharged the patient.[97] Several hours later, he died from a myocardial infarction and sudden cardiac death.[98]

88. Amarante, *supra* note 65, at 10.
89. Candler Gen. Hosp., Inc. v. Purvis, 181 S.E.2d 77, 79 (Ga. App. 1971).
90. *Id.* at 78.
91. Amarante, *supra* note 65, at 10.
92. 328 S.W.3d 829 (Tenn. 2010).
93. *Id.* at 830.
94. *Id.* at 830.
95. *Id.* at 830–31.
96. *Id.* at 831.
97. *Id.*
98. *Id.*

The patient's wife sued on his behalf, as the plaintiff, alleging that the care and treatment provided to her deceased husband (decedent) in the emergency department by the hospital fell below the acceptable standard of care.[99] Specifically, the plaintiff claimed: (a) that a registered nurse, not a paramedic, should have triaged her husband, and (b) that a physician, not a nurse practitioner, should have completed the examination.[100] The plaintiff presented expert testimony, including from a hospital administrator, that the hospital failed to follow its own written policy requiring that physicians examine every emergency department patient, asserting that this failure evidenced the hospital's breach of its duty to provide reasonable care.[101] By the end of the trial, only one claim of direct liability against the hospital remained: whether the hospital was directly liable for not enforcing the written policy.[102] The jury found the hospital 100% liable and attributed no fault to the individual clinicians, despite the hospital's claims of comparative responsibility.[103] The trial court approved and entered the verdict.[104] On appeal, the appellate court reversed the trial court's judgment, holding that state law did "not recognize a theory of corporate liability under which the hospital could be found responsible to a patient absent a finding of vicarious liability for negligence by a treating health care professional."[105] The plaintiff appealed. On appeal, the Tennessee Supreme Court determined the state law recognizes that hospitals owe a duty of reasonable care to their patients and may be directly liable to patients, even in the absence of any employee or agent negligence.[106] The court also determined that in this case, the material evidence sufficiently supported the jury's verdict.[107]

The *Barkes* case addressed patient harm from a managerial and administrative institutional failure.[108] Hospitals, through their leadership, are responsible for developing effective and safe processes for delivering patient care, educating staff and agents about these processes, and enforcing adherence.[109] A hospital also must regularly reevaluate those procedures to identify and implement any needed improvements resulting from near misses, adverse events, evidence-based practice, etc.[110] These duties will have the

99. *Id.*
100. *Id.*
101. *Id.* at 831–32.
102. *Id.* at 832.
103. *Id.*
104. *Id.* at 832.
105. *Id.* (citation omitted).
106. *Id.* at 834.
107. *Id.* at 834.
108. Amarante, *supra* note 65, at 10 (quoting *Barkes*, 328 S.W.3d at 835).
109. *Id.* at 9.
110. *See* Crane et al., *supra* note 8, at 87 (describing how reporting near-miss errors provides greater opportunity for improving hospital care); *see also* Rodziewicz et al., *supra* note 14.

greatest effect on reducing patient harm, because they address defective systems, lurking latent conditions, and safety bypasses.[111]

The bottom line: while the crux of patient safety issues is hospital-level system breakdowns, the current tort system focuses on individual actions.[112] To improve patient safety and reduce the risk of future patient harm, should all states adopt a corporate negligence cause of action against hospitals for a failure to keep high-quality standards? This approach would recognize every hospital's nondelegable duty to develop, adopt, and enforce adequate and appropriate processes, procedures, rules, and policies to ensure the delivery of quality care to their patients.[113]

III. POTENTIAL ADVANTAGES OF ADOPTING A CORPORATE NEGLIGENCE CAUSE OF ACTION AGAINST HOSPITALS

Recognizing this duty and holding hospital leadership accountable to fulfill this duty may positively affect patient safety by providing financial and reputational incentives for hospitals to improve their systems.[114] There are also public policy rationales for holding hospitals accountable for improving their health care delivery systems.[115]

A. Financial Incentives

Minimal, ineffective financial incentives currently exist for hospitals to undertake the expense of making system improvements.[116] Hospitals are financially responsible for only a small portion of medical error costs, as these expenses are largely externalized to patients, health insurers, employers, and state disability and income support programs.[117] In contrast, the cost of system

111. *See* Dickinson, *supra* note 37 (identifying safety bypasses and latent errors as two causes of "[m]ost medical errors").

112. Mello et al., *supra* note 47, at 398.

113. Edward S. Shensky, *Corporate Negligence in Medical Malpractice*, NAT'L L. REV. (Dec. 10, 2015), https://www.natlawreview.com/article/corporate-negligence-medical-malpractice.

114. ARIANNE N. CALLENDER ET AL., OFF. OF THE INSPECTOR GEN., U.S. DEP'T OF HEALTH & HUM. SERVS., CORPORATE RESPONSIBILITY AND HEALTH CARE QUALITY: A RESOURCE FOR HEALTH CARE BOARDS OF DIRECTORS 8–11 (2007).

115. Michelle M. Mello et al., *Who Pays for Medical Errors? An Analysis of Adverse Event Costs, the Medical Liability System, and Incentives for Patient Safety Improvement*, 4 J. EMPIRICAL LEGAL STUD. 835, 853–54 (2007) [hereinafter *Who Pays for Medical Errors?*].

116. *See* Julia James, *Health Policy Brief: Pay-for-Performance*, HEALTH AFFS. (Oct. 11, 2012), https://www.healthaffairs.org/do/10.1377/hpb20121011.90233/ (stating there is "limited evidence of effectiveness" for "provid[ing] financial incentives to hospitals, physicians, and other health care providers to carry out . . . improvements and achieve optimal outcomes for patients").

117. GAWANDE, *supra* note 34, at 497–98; *see also Who Pays for Medical Errors?*, *supra* note 115, at 835 (finding that hospitals bore only 22% of adverse events costs).

improvements falls solely on hospitals.[118] Thus, there is currently limited economic motivation for hospitals to better their systems since they do not pay for the outcomes generated by system defects.[119] In other words, there is minimal return on investment; hospitals will not recoup the cost of making system improvements because they spend so little on medical errors.[120]

In addition, pay-for-performance or value-based payment systems do not provide a reliable financial penalty to hospitals either.[121] Some health insurers use a pay-for-performance or value-based payment system to link reimbursement for health care services provided to metric-driven outcomes, thereby (in theory) offering financial incentives when hospitals meet certain process, quality, and efficiency measures.[122] However, metrics such as patient safety indicators are controversial, because they are based on claims, not clinical data.[123] As such, their accuracy and validity are questionable; they may lack specificity and sensitivity to actual adverse events.[124] One study found that only one of twenty-one patient safety indicators and hospital-acquired conditions provided enough data for meta-analysis and met the proposed validity threshold.[125] Unvalidated metrics result in unsubstantiated reimbursement penalties, mislead consumers about patient safety investments, and most importantly, create minimal to no effect on improved patient safety.[126] Ultimately, patient safety efforts are just undermined.[127]

A modest but limited financial incentive may result from the effect of litigation on a hospital's expenses for liability insurance.[128] A hospital's liability insurer typically undertakes the expense of the hospital's defense and

118. *See Who Pays for Medical Errors?*, *supra* note 115, at 843, 857 (distinguishing "the costs of injury prevention" from other "organizational costs of injuries," which hospitals can externalize).

119. Shefali Luthra, *When Something Goes Wrong at the Hospital, Who Pays?*, KFF HEALTH NEWS (Nov. 11, 2015), https://kffhealthnews.org/news/when-something-goes-wrong-at-the-hospital-who-pays/.

120. *Who Pays for Medical Errors?*, *supra* note 115, at 847, 852.

121. *See generally* Kyung Mi Kim et al., *Do Penalty-Based Pay-for-Performance Programs Improve Surgical Care More Effectively than Other Payment Strategies? A Systematic Review*, 60 ANNALS MED. & SURGERY 623 (2020) (finding mixed evidence whether pay-for-performance designs improve quality across hospitals and concluding that, in some cases, these designs may negatively impact vulnerable hospitals and populations).

122. *What Is Pay for Performance in Healthcare?*, NEJM CATALYST (Mar. 1, 2018), https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0245; *see also What Are the Value-Based Programs?*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs (last modified Sept. 6, 2023).

123. Bradford D. Winters et al., *Validity of the Agency for Health Care Research and Quality Patient Safety Indicators and the Centers for Medicare and Medicaid Services Hospital-Acquired Conditions*, 54 MED. CARE 1106, 1107 (2016).

124. *Id.*

125. *Id.* at 1105.

126. Barry R. Furrow, *The Confused and Bewildered Hospital: Adverse Event Discovery, Pay-for-Performance, and Big Data Tools as Halfway Technologies*, 46 AM. J.L. MED. 219, 230–31 (2020).

127. *Id.*

128. *Who Pays for Medical Errors?*, *supra* note 115, at 852.

indemnification related to negligence claims.[129] While the hospital's insurance premium and deductible may increase in response to an increased claim volume and total costs (defense expenses plus indemnity payments), this may not prove enough to offset the significant costs the hospital would incur to make system changes.[130] These defense and indemnification costs may offer more motivation to self-insured hospitals to embrace system improvements to reduce adverse events. Nonetheless, these financial risks offer some incentive for hospitals to invest in making system changes to reduce the risk of future patient harm.[131] However, the financial consequences of a marred reputation in the court of public opinion may create the most significant driving force for hospitals to embrace the expense of making system changes.[132]

B. Reputational Incentives

The reputational risk associated with direct negligence in medical malpractice cases for failing to correct known system defects may provide the strongest impetus for hospitals to make such improvements.[133] The publicity generated by such an adverse judgment could cause patients to lose trust[134] in the hospital's quality of care and lose respect for hospital leadership's ability to discharge their fiduciary obligation. Without this trust and respect, patients may take their business elsewhere.[135] Hospitals cannot afford to lose patients from bad publicity and negative word-of-mouth given the financial crises many hospitals are currently facing.[136]

This reputational risk extends to the hospital's leadership, as well.[137] A hospital's senior clinical leaders are the individuals responsible for upholding the hospital's direct, nondelegable duty to its patients.[138] Adverse verdicts against a

129. *Id.*

130. *Id.* at 857; s*ee also* Mello et al., *supra* note 47, at 396.

131. *Who Pays for Medical Errors?*, *supra* note 115, at 852.

132. Deb Woods, *The Profound Impact of Patient Experience on Healthcare's Bottom Line*, PHYSICIANS PRAC. (July 7, 2023), https://www.physicianspractice.com/view/the-profound-impact-of-patient-experience-on-healthcare-s-bottom-line.

133. *Id.*

134. This is the same trust that gives rise to the hospital's duty to its patients. *See, e.g.*, Johnson v. Misericordia Cmty. Hosp., 301 N.W.2d 156, 166 (Wis. 1981); *see also* Leslie Read et al., *Rebuilding Trust in Health Care*, DELOITTE INSIGHTS (Aug. 5, 2021), https://www2.deloitte.com/us/en/insights/industry/health-care/trust-in-health-care-system.html.

135. Read et al., *supra* note 134.

136. AM. HOSP. ASS'N., THE FINANCIAL STABILITY OF AMERICA'S HOSPITALS AND HEALTH SYSTEMS IS AT RISK AS THE COSTS OF CARING CONTINUE TO RISE 1 (2023).

137. *See* Toussaint & Segel, *supra* note 43 ("[H]ospital safety rests with the professional managers of the executive leadership team; their level of commitment determines performance.").

138. *Id.* Whether a hospital's senior clinical leaders who are required to hold a professional license (e.g., Chief Medical Officer, Chief Nursing Officer, etc.) embody the hospital's direct duty to its patients and therefore, could or should be individually named defendants in tort claim for failing to execute that

hospital for known system defects may call into question the hospital leadership's ability to uphold their fiduciary obligations and duty to their patients. This, in turn, could result in personnel changes. Thus, there is a reputational incentive for hospital administrators to faithfully discharge their fiduciary responsibilities and dedicate the requisite resources for system improvements.

C. Public Policy

The public policy behind hospitals' direct, nondelegable duty to their patients stems from the evolution of hospitals over time.[139] Hospitals started as little more than physical structures, often part of the village parish, that offered primitive therapies to the indigent.[140] To avoid crippling what little help these hospitals could offer,[141] courts exempted them from liability under the doctrine of charitable immunity.[142] Over time, however, with the advances in medicine and medical technology, hospitals became more valued in society. They began competing for customers and their money turning hospitals into businesses that advertised directly to consumers (no longer patients).[143] This led to the current public perception of hospitals as "the provider of medical services"[144] and "interwoven organizations providing comprehensive care."[145] Resultingly, the public—the consumers—expect a level of quality in the care rendered to them.[146]

The expectation that hospitals are obligated directly to the public in the provision of medical care explains the growth of hospitals' direct, nondelegable duty.[147] As a result, laws prohibit hospitals from avoiding this responsibility by deflecting it to their apparent agents; instead, laws force hospitals to take fault.[148]

The desired outcome of direct hospital liability—changing flawed health care systems and thereby improving patient safety—connects to ethical

duty is beyond the scope of this manuscript. This is distinguished from a claim against the hospital's non-clinical board of directors under a directors and officers liability claim.

139. Michael v. Hahnemann Med. Coll. & Hosp., 172 A.2d 769, 785–87 (Pa. 1961) (Musmanno, J., dissenting).

140. *Id.* at 786.

141. *Id.*

142. Dana Ohman, *Apparent Authority: Minnesota Finally Rejects Categorical Exemption for Independent Contractors in Hospital Emergency Rooms and Signifies Potential for Nondelegable Duty Doctrine*—Popovich v. Allina Health Sys., 48 MITCHELL HAMLINE L. REV. 467, 472 (2022).

143. Simmons v. Tuomey Reg'l Med. Ctr., 533 S.E.2d 312, 316–17 (S.C. 2000).

144. *Id.* at 317 (quoting Simmons v. Tuomey Reg'l Med. Ctr., 498 S.E.2d 408, 411 (S.C. Ct. App. 1998) (quoting Martin C. McWilliams, Jr. & Hamilton E. Russell, III, *Hospital Liability for Torts of Independent Contractor Physicians,* 47 S.C. L. REV. 431, 473 (1996))).

145. Ohman, *supra* note 142, at 472.

146. Ohman, *supra* note 142, at 471–72.

147. GAWANDE, *supra* note 34, at 490.

148. *Id.*

rationales, too.[149] The Code of Ethics of the American College of Healthcare Executives states that health care leaders shall "[w]ork to ensure the existence of a process to evaluate the safety, value, quality and equity of care or service rendered," "[l]ead the organization in prioritizing patient care above other considerations," and "[c]reate an organizational environment in which both clinical and leadership mistakes are minimized and, when they do occur, are disclosed and addressed effectively."[150] These ethical duties oblige hospital leaders to support continuous process improvement and promote a culture of safety via both their leadership and resources.[151] Direct hospital liability is simply a motivating means to that end.[152]

Public health policy is also implicated in the rationale behind direct hospital liability.[153] It offers transparency by publicizing when hospitals fail to fulfill their duty to provide safe processes and systems for the delivery of health care.[154] External regulation through the legal system provides additional accountability, avoids the conflicts and biases inherent in self-regulation,[155] and can provide some financial incentive to make the needed process and infrastructure changes to improve patient safety.[156]

Importantly, holding hospitals directly liable for the latent system issues—the primary cause of patient harm—appropriately focuses on the entity and its leadership, who can actually make effective system improvements, rather than the individual clinicians who cannot.[157] This addresses the perceived unfairness of holding individual clinicians liable for system issues that are outside of their control.[158] Direct liability also places the intended deterrent effect of tort law on the right receiver: the leaders who are responsible for the system.[159]

As currently practiced, the medical malpractice tort system should be viewed as a patient safety regulator of last resort, because its ability to enforce compliance with the standard of care is both retroactive and limited to the disproportionately small number of harmed patients who bring suit.[160] Holding hospitals directly liable for their system defects, however, can broaden the reach

149. *Who Pays for Medical Errors?*, *supra* note 115, at 853.

150. *Code of Ethics*, AM. COLL. OF HEALTHCARE EXECS. (Dec. 5, 2023), https://www.ache.org/about-ache/our-story/our-commitments/ethics/ache-code-of-ethics.

151. *Id.*

152. *Who Pays for Medical Errors?*, *supra* note 115, at 836.

153. *Id.*

154. Allen Kachalia et al., *Legal and Policy Interventions to Improve Patient Safety*, 133 CIRCULATION 661, 661 (2016).

155. *Id.* at 662, 665–66.

156. *Id.* at 668.

157. *Id.* at 667.

158. MICHELLE M. MELLO & ALLEN KACHALIA, EVALUATION OF OPTIONS FOR MEDICAL MALPRACTICE SYSTEM REFORM 53 (2010).

159. *Id.*

160. Mello et al., *supra* note 47, at 418.

of the medical malpractice tort system by applying the patient safety benefit prospectively to future patients receiving care in a health care system modified to improve safety.[161] To ultimately improve patient safety, public policy supports holding hospitals directly liable for their role in patient harm.[162] However, this approach is not without potential limitations.[163]

IV. POTENTIAL LIMITATIONS OF ADOPTING A CORPORATE NEGLIGENCE CAUSE OF ACTION AGAINST HOSPITALS

Despite the potential benefits to patient safety, there are hurdles and concerns with adopting a corporate negligence cause of action against hospitals. These include the underreporting of medical errors, determining when liability attaches, the discoverability of evidence needed to evaluate liability, access to senior clinical leaders for depositions, causation questions, financial concerns, and resistance from the medical community.

Medical errors are underreported in hospitals and are difficult to detect by those not directly involved in the event.[164] This raises two concerns with imposing direct liability on hospitals. First, a significant aspect of the patient safety movement is the push toward voluntary, nonpunitive error reporting by bedside clinicians (frontline workers), so these latent conditions are exposed and fixed.[165] If hospital management suppressed error reporting to avoid direct liability and its financial and reputational sequela, the effect would be significantly detrimental to patient safety advancements.[166] Such an approach leads to poor safety outcomes[167] and acts contrary to the intended goal of direct hospital liability.

Second, hospital leaders (and the quality management department) can only analyze, and make system adjustments to correct, medical errors they know about. If the hospital remains unaware of the defective processes, it is unfair to hold the entity liable.[168] Thus, hospitals should only be directly liable for system defects of which they had knowledge.[169] Furthermore, given the time and resources required to correct these issues, hospitals should only face liability if the evidence shows negligence in not taking timely and appropriate steps toward

161. MELLO & KACHALIA, *supra* note 158, at 53.

162. *Id.*

163. *See infra* Part IV.

164. Furrow, *supra* note 126, at 221–22.

165. *Reporting Patient Safety Events*, AGENCY FOR HEALTHCARE RSCH. & QUALITY (Sept. 7, 2019), https://psnet.ahrq.gov/primer/reporting-patient-safety-events.

166. Toussaint & Segel, *supra* note 43.

167. *Id.*

168. Mark E. Milsop, Comment, *Corporate Negligence: Defining the Duty Owned by Hospitals to Their Patients*, 30 DUQ. L. REV. 639, 643 (1992).

169. *Id.*

correcting those system defects.[170] This same concern arises if the first time a hospital detects a system issue resulted in patient harm and litigation. Hospitals should not be held liable for system faults previously unknown to them.[171]

Holding a hospital liable for system defects raises the legal question of when that liability attaches: does the liability arise after actual or constructive notice?[172] Under a theory of actual notice, hospitals are liable for failing to fix known system defects.[173] Following a theory of constructive notice, hospitals are liable for failing to correct system flaws they *should* have known about.[174] This latter theory essentially holds hospitals vicariously liable for their employees' and contractors' failure to report a system issue.

The next potential limitation in holding hospitals directly liable is the difficulty in discovering the evidence needed to evaluate whether a hospital knew about the system defect and what actions they took as a result.[175] Most medical errors are identified through passive incident reporting systems (in which frontline staff voluntarily report patient safety events) or active surveillance (such as staff in the quality management department conducting chart reviews based on certain triggers).[176] The quality staff and hospital leadership then utilize various tools, such as root cause analysis ("RCA"), to better understand an event, identify system causes, and correct those defects.[177] This sequence of reporting, analyzing, identifying, and correcting is part of a hospital's medical quality-assurance program, and as such, is typically confidential, privileged, and may not be disclosed (with few exceptions).[178] This may vary by jurisdiction.[179] Some plaintiffs' attorneys are retaining a patient safety or RCA expert to conduct an RCA-like analysis using the information obtained through discovery to identify system issues that potentially contributed to the event in question.[180]

Related to the two preceding limitations—a hospital's knowledge of the system issue and the discoverability of relevant evidence—is the potential

170. *See id.* (noting that some courts will not impose corporate liability unless "the hospital's negligence" was "a substantial factor in bringing about the harm to the injured party" (quoting Thompson v. Nason Hosp., 591 A.2d 703, 708 (1991))).

171. Milsop, *supra* note 168, at 643.

172. *Id.*

173. *Id.* at 649.

174. *See Notice*, BLACK'S L. DICTIONARY (11th ed. 2019) (defining constructive notice as "notice arising by presumption of law from the existence of facts and circumstances").

175. *Protecting Voluntary Reporting Systems from Legal Discovery*, *in* TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 109, 113–15 (Linda T. Kohn et al. eds., 2000).

176. AGENCY FOR HEALTHCARE RSCH. & QUALITY, *supra* note 165.

177. *Id.*

178. 38 U.S.C. § 5705(a).

179. Peter I. Bergé, *Initiating Litigation, Discovery, and Disclosure*, *in* LEGAL NURSE CONSULTING: PRINCIPLES AND PRACTICES 101, 113 (Julie Dickinson & Anne Meyer eds., 4th ed. 2020).

180. Telephone Interview with Katherine Haney, Manager of Enter. Risk & Legal, Hoag Hosp. (Sept. 18, 2020).

difficulty of deposing a hospital's senior clinical leaders. Whether through common law or codes of civil procedure, some states adopted an "apex doctrine" or "apex deposition rule," which shields high level corporate officers from abusive discovery and harassing depositions.[181] However, senior clinical leadership typically makes up part of a hospital's quality committees or reporting hierarchy and is integral to various quality initiatives such as root cause analysis reporting, peer review, and adverse event disclosures. As such, senior clinical leadership may not receive protection from deposition, because they likely can contribute some personal knowledge of the issues in question.

Causation is another potential limitation to direct hospital liability. As discussed earlier, patient harm results when a series of latent system conditions and a final, active human error align. Typically, the frontline clinician is the proximal actor in that sequence and thus, is the closest to the error.[182] Causation for the hospital's role in the preceding latent conditions would therefore not meet the typical "but for" test, which requires evidence that the harm likely would not have occurred "but for" the defendant's negligent conduct.[183] However, for cases in which

> the defendant's act or omission failed in a duty to protect against harm from another source … [i.e., that such an act or omission] increased the risk of harm to another, such evidence furnishes a basis for the jury to make a determination as to whether such increased risk was in turn a substantial factor in bringing about the resultant harm.[184]

The substantial factor test is an appropriate causation test for direct hospital liability, as failing to correct the latent conditions and to design the system to protect against foreseeable, predictable human error increases the risk of patient harm. Proximate cause is another appropriate test to use in deciding causation in direct hospital liability cases. In *Barkes*, for instance, the state supreme court held that the hospital's failure to inform providers of its policies and to oversee and enforce those policies may constitute negligence, as both policies arose from a cause in fact and a proximate cause of the patient's death.[185]

The direct hospital liability approach also raises multifactorial financial concerns. Considering the financial crisis faced by hospitals today,[186] the costs

181. Mark A. Behrens & Christopher E. Appel, *Florida Supreme Court Leads on Apex Doctrine*, ABA: THE BRIEF (Mar. 9, 2022), https://www.americanbar.org/groups/tort_trial_insurance_practice/publications/the_brief/2021-22/winter/florida-supreme-court-leads-apex-doctrine/.

182. *See* Reason, *supra* note 17, at 769 (describing active failures, which involve "unsafe acts committed by people who are in direct contact with the patient or system," which may include a frontline clinician).

183. Herskovits v. Grp. Health Coop. of Puget Sound, 664 P.2d 474, 477 (Wash. 1983).

184. *Id.* (emphasis omitted) (citing Hamil v. Bashline, 392 A.2d 1280, 1286, 1288 (Pa. 1978)).

185. Barkes v. River Park Hosp., Inc., 328 S.W.3d 829, 834 (Tenn. 2010).

186. AM. HOSP. ASS'N., *supra* note 136, at 1.

of the medical liability system,[187] and the previous "malpractice crisis" that these costs caused,[188] lawmakers, policymakers, lobbyists, and courts should consider the downstream financial effects of direct hospital liability. This deliberation should also include whether courts or lawmakers should couple direct hospital liability with damage limits to mitigate the financial effect.[189] This is particularly relevant if courts are allowed to levy punitive damages on hospitals, as these damages are typically not covered by liability insurance for public policy reasons.[190] Such downstream financial effects may induce hospitals to raise prices and thereby, reduce access to health care services for patients with limited financial means.[191]

Another potentially significant limitation is that direct hospital liability does not preclude a plaintiff from naming an individual clinician as a defendant in a medical malpractice lawsuit (in addition to the hospital). However, as noted above, incompetent care only causes approximately 5% of medical harm; the remaining 95% is related to system issues.[192] Can lawyers and plaintiffs successfully identify this, pre-litigation, to avoid clinicians unfairly bearing the burden of litigation? Such identification may prove challenging without going through discovery. In some cases, then, the jury will bear the responsibility of determining the apportionment of liability between the corporate and individual defendants. This may allow the court or jury to determine the hospital is up to 100% liable for cases involving system issues. In cases involving incompetent care, the factfinder likely may find the individual clinician liable, and the tort system's deterrent effect would affect the clinician, not the hospital.

Lastly, if history predicts the future, the medical profession may present a hurdle to the acceptance of direct hospital liability as a viable cause of action. After the aforementioned *Darling* case, which launched direct hospital liability to patients, physicians "vehemently attacked" the decision and the American Medical Association issued an "immediate and negative" reaction.[193] Similarly, when the Clinton administration proposed exclusive enterprise liability—which would hold hospitals instead of physicians solely liable for all negligent acts of its actual and apparent agents—the American Medical Association staunchly

187. Michelle M. Mello et al., *National Costs of the Medical Liability System*, 29 HEALTH AFFS. 1569, 1569 (2010) (estimating annual medical liability system costs, including defensive medicine, to be $55.6 billion in 2008 dollars).

188. *Who Pays for Medical Errors?*, *supra* note 115, at 855.

189. *Id.*

190. GAWANDE, *supra* note 34, at 336–37.

191. AM. HOSP. ASS'N., *supra* note 136, at 1.

192. *Patient Safety 101*, *supra* note 15.

193. GAWANDE, *supra* note 34, at 497. The American Medical Association "convenes 190+ state and specialty medical societies and other critical stakeholders." *About*, AM. MED. ASS'N, https://www.ama-assn.org/about (last visited Apr. 8, 2024). As a professional association for physicians, its mission is to promote medicine and public health improvement. *Id.*

opposed the policy.[194] In both instances, the medical profession expressed concern about an imbalance of power between physicians and hospitals.[195] This concern appears focused on the purported duty of hospitals to supervise the day-to-day medical care rendered. To unite the medical and legal community in a common goal of improved patient safety, education to the medical community is likely needed to explain and emphasize that this cause of action is focused on hospitals' obligations to identify and correct system issues, so as to reduce patient harm. It is not intended to micromanage the day to day clinical decision making in individual patient care encounters.

V. CONCLUSION

Adverse events from unsafe care are a leading cause of death and disability.[196] They generally result from defective systems when a series of process failures align to allow an inevitable human error to reach a patient and cause harm.[197] These flawed systems are not under the control of individual clinicians; they are controlled by the hospital. Therefore, to mitigate the risk of patient harm, hospitals—through leadership support and their quality programs—must regularly assess these processes and systems to promptly correct and address the identified flaws and opportunities for improvement.[198] Such leadership support is essential to ensure the necessary resources are invested to make these system improvements and hold employees accountable for adhering to safety processes.

Tort liability is designed to economically incentivize safer behavior.[199] Historically, hospitals are only held vicariously liable for the actions of their employees, even though this does not comport with the central issue causing patient harm.[200] If the focus of tort claims is the behavior of the individual clinicians, then tort liability is not meeting its regulatory, deterrent function. Financial and reputational motives may inspire hospitals to implement system improvements if they are held directly liable through a corporate negligence cause of action for their nondelegable duty to develop, adopt, and enforce adequate and appropriate processes, procedures, rules, and policies to ensure the delivery of quality care to their patients (i.e., to identify and correct flaws in their health care delivery systems).[201] Such a cause of action aligns with public health policies by effecting safer hospital systems that will reduce future patient harm.

194. GAWANDE, *supra* note 34, at 497.
195. *Id.*
196. *See supra* Part I.
197. *See supra* Part I.
198. *See supra* Section I.C.
199. *See supra* Part II; Part III.
200. *See supra* Section II.A.
201. *See supra* Part III.

This legal pathway, however, is not without potential limitations in implementation, execution, and effect.[202] Lawmakers, policymakers, and courts need to weigh the risks and benefits of adopting a corporate negligence cause of action against hospitals to determine its feasibility as a legal path to improved patient safety.

202. *See supra* Part IV.