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THE CHEMICALLY-DEPENDENT PHYSICIAN: LIABILITY FOR COLLEAGUES AND HOSPITALS IN CALIFORNIA

The chemically-dependent physician threatens the quality of medical care provided to the public. Identification of chemically-dependent physicians is a major obstacle to this problem's solution. This Comment examines the strengths and weaknesses of mandatory reporting statutes, corporate hospital liability, and individual physician liability as means to promote the identification of chemically-dependent physicians. This Comment concludes that the doctrine of corporate hospital liability along with the imposition of a common law duty upon physicians to report impaired colleagues are the most effective means of identifying such physicians. Implementation of these concepts would also act to encourage utilization of California's voluntary rehabilitation programs.

INTRODUCTION

In the last decade, the medical profession has declared drug and alcohol addiction "[t]he prime occupational hazard in the practice of medicine." The proliferation of articles contained in medical periodicals about physicians' problems with drug and alcohol addiction is demonstrative evidence of this ongoing and pressing concern. The

1. Talbott, Some Dynamics of Addiction Among Physicians, 65 J. MED. A. GA. 77, 77 (1976). Some reasons for drug and alcohol addiction in the medical profession are the stress of professional responsibility, the limited time many physicians have for relaxation, the "invincibility ethos" that makes physicians feel they are not subject to addiction, and the availability of a wide variety of mood-changing drugs. Id. See also Garb, Drug Addiction in Physicians, 48 ANESTHESIA AND ANALGESIA 129, 132 (1969). One former physician-patient confided in his therapist, "a little personal drug abuse is necessary to fulfill the demands of medical practice." Little, Hazards of Drug Dependency Among Physicians, 218 J. A.M.A. 1533, 1534 (1971).


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American Medical Society has identified a class of physicians referred to as “impaired physicians,” which includes those physicians who are excessive users of drugs and alcohol. The impaired physician is “one who is unable to practice medicine with reasonable skill and safety to patients because of physical or mental illness, including deterioration through the aging process or lack of motor skill, or excessive use or abuse of drugs including alcohol.” This Comment considers the physician who is impaired because of chemical dependence on alcohol or other drugs.

The scope of the problem created by the chemically-dependent physician is difficult to assess. The difficulties in assessment are caused by the reluctance of some medical boards and societies to disclose any information they have about impaired physicians. Available statistical information measuring the prevalence of drug abuse and alcoholism is based on narrowly focused case series and on information from those state medical boards that do respond to questionnaires about impaired physicians from groups researching the problem. Administrators at the Georgia Disabled Doctors Program predict from their experience that “one of eight physicians in Georgia has been, is, or will be afflicted with the disease of chemical dependence.” An estimate which incorporates the American Medical Association's definition of the impaired physician indicates that nationally, one of every ten practicing physicians is impaired.

Overall, the scant information available leads to the conclusion that physicians are more vulnerable than the general population when it comes to alcoholism and drug abuse.

The effect the chemically-dependent physician has on the quality


4. When dealing with the impaired physician, state medical society reports are described as being "shrouded with mystery." Hall, supra note 1, at 787.

5. Stoudemire, supra note 2, at 654.

6. Talbott, Identification, supra note 2, at 56. From 1975 to 1980, 297 of Georgia's 6,500 physicians were contacted as candidates for entrance into the Disabled Doctors Program for Physicians Impaired by Alcohol and Drug Abuse. Of the 297 contacted, 240 entered the program. Id.

7. This estimate includes physicians impaired because of a lack of continuing education and those physicians who for poorly understood reasons have a disproportionate number of malpractice judgments against them. Arana, supra note 2, at 147-48.

8. Stoudemire, supra note 2, at 654. Information leading to Dr. Stoudemire's conclusion was: the number of physician suicides reported each year exceeded the size of the average medical school class; 40% of the suicides were associated with alcoholism and 20% with drug abuse; a British study finding physicians more than twice as likely to die of liver disease (an end result of chronic alcoholism) than the general population; and a study showing the frequency of narcotic addiction to be 30 to 100 times greater in physicians than in the general population. Id.
of medical care delivered is also difficult to assess. The Blue Cross
and Blue Shield Association estimates that impaired physicians, in-
cluding those affected by chemical dependence, are involved in pro-
viding a compromised quality of care in greater than 100 million pa-
tient visits per year.\(^9\) The chemically-dependent physician may suffer
from disordered perception causing him to respond slowly, to do less
or more than he should, or to have distorted notions of clinical
data.\(^10\) A physician under the influence of alcohol or other drugs
may not be aware of the effects of the chemicals on his general rea-
soning process.\(^11\) Furthermore, attempting to financially support his
addiction, the chemically-dependent physician may perform unneces-
sary diagnostic tests and surgery, thereby affecting the quality of
medical care he provides.\(^12\)

Although the problem of the chemically-dependent physician was
recognized more than twenty years ago,\(^13\) it remains unsolved today.
The solution is evasive because of the difficulty in identifying the
chemically-dependent physician\(^14\) and because of the fears and
doubts that colleagues and families of the chemically-dependent phy-
sician have about programs and legislation that deal with the
problem.\(^15\)

11. The judgment of a physician-addict may be incredibly lacking.
[In delivering a baby, one addict in performing an episiotomy nonchalantly cut
through into the rectum, and with no sense of remorse whatever and no serious
attempt to repair the damage, merely remarked that he must have been a little
heavy with the knife. In other words, as far as he was concerned, he was a
normal individual at that moment.
Quinn, *Narcotic Addiction: Medical and Legal Problems with Physicians*, 94 CAL. MED.
12. See, e.g., Stroedel, *The Impaired Physician-Hospital Corporate Liability*, 24
TRIAL LAW. GUIDE 488, 490 (1981) (a surgeon performed unnecessary surgery to obtain
money to purchase drugs for personal use).
13. Since the mid-1950's, the medical literature presented reports on studies of
drug problems among physicians. *Sick Physician, supra* note 2, at 684. See generally,
Fox, *Narcotic Addiction Among Physicians*, 56 J. MICH. MED. SOC'Y 217 (1957); Mod-
lin & Montes, *Narcotic Addiction in Physicians*, 121 AM. J. PSYCHIATRY 358 (1964);
The reluctance of colleagues and even medical societies to interfere in the life-
style and practice of colleagues is rationalized out of fear of bringing economic
ruin upon the physician and his family. Furthermore, professional and lay per-
sons alike doubt the effectiveness of treatment for alcohol and drug abuse. Fi-
ally, the reporting process already established by law in some thirty-one states
is poorly understood or feared.
This Comment examines the current California approach to the problem of the chemically-dependent physician. The Impaired Physician Program is the legislature’s effort to promote the identification and rehabilitation of physicians who are impaired due to the abuse of dangerous drugs and alcohol, and simultaneously protect the public health and safety. The Impaired Physician Program is under the auspices of the Board of Medical Quality Assurance, but is administered by a separate diversion committee that has no punitive powers. The diversion committee consists of members knowledgeable in the evaluation or management of persons impaired due to alcohol or drug abuse or due to physical or mental illness.

Participation in the California Impaired Physician Program is voluntary. Only those physicians who request treatment and supervision by the diversion committee are considered for the program. The diversion committee formulates an individual treatment plan for each participating physician. The physician is allowed to continue his medical practice under the supervision and surveillance of the committee if the committee determines the physician will not jeopardize the safety of his patients. When the diversion committee determines that a physician is rehabilitated, he resumes his medical practice without supervision. All records pertaining to the physician’s participation in the program are then destroyed.

The California Impaired Physician Program has been criticized because it does not require colleagues who know of an impaired physician to report the impaired physician to the Board of Medical Quality Assurance. The results of mandatory reporting requirements in other states will be examined to determine whether the addition of a mandatory reporting requirement would strengthen or weaken the effectiveness of the California program.

A California appellate court in Elam v. College Park Hospital has recognized the independent duty of a hospital to exercise reasonable care in selecting, reviewing, and evaluating its staff physicians. In Elam, the hospital had potential corporate liability for its failure to restrict a podiatrist's practice when the hospital administration knew or should have known of the podiatrist’s incompetence. This Comment suggests that if the doctrine of corporate hospital liability in Elam is extended to include recognition of the chemically-dependent physician and restriction of his practice, the risk of harm to the public will be lessened.

Id.

19. Id. at 341, 183 Cal. Rptr. at 161.
Another area explored is the influence of legislative policy on the recognition of a common law duty for colleagues of the chemically-dependent physician. The Medical Injury Compensation Reform Act of 1975\textsuperscript{20} provided the California physician with protection from the limitless expansion of malpractice damages. In exchange for this protection, the legislature forced the medical profession to become more accountable.\textsuperscript{21} This Comment proposes that the California judiciary consider this legislative policy of accountability in conjunction with the foreseeable risk of harm to the public and recognize the existence of a special relationship among physicians. This special relationship would support the application of a duty to exercise reasonable care for the protection of third parties, as recognized in \textit{Tarasoff v. Regents of the University of California}.\textsuperscript{22} to the colleagues of the chemically-dependent physician.

**IMPAIRED PHYSICIAN PROGRAMS**

**California Procedure**

Prior to the enactment of the Impaired Physician Program the Board of Medical Quality Assurance would investigate after receiving notice of possible physician impairment.\textsuperscript{23} If the investigation disclosed a physician who appeared to be impaired, a formal hearing was held before a regional Medical Quality Review Committee. A review committee's finding of impairment resulted in revocation or suspension of the physician's license.\textsuperscript{24} A stay was placed on the revocation or suspension until a hearing was held.

\textsuperscript{20} 1975 Cal. Stat. 2d Ex. Sess. Ch. 1, § 24.6 (codified at CAL. CIV. CODE § 3333.2 (Deering Supp. 1983)).

\textsuperscript{21} Measures taken to promote accountability included the formation of the Board of Medical Quality Assurance which is composed of public representatives as well as representatives of the medical profession, CAL. BUS. & PROF. CODE § 2001 (Deering Supp. 1983), the enactment of legislation requiring mandatory reporting by insurers of malpractice awards over three thousand dollars, CAL. BUS. & PROF. CODE § 801 (Deering Supp. 1983), and mandatory reporting by hospitals of privilege restrictions and disciplinary actions taken against staff physicians, CAL. BUS. & PROF. CODE § 805 (Deering Supp. 1983).

\textsuperscript{22} 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

\textsuperscript{23} Investigations of physician impairment were instituted by the Board of Medical Quality Assurance most frequently because of complaints made by patients or other members of the public. Carlova, \textit{California: A Little Kindness and a Lot of Clout}, 56 MED. ECON. 132 (1979).

\textsuperscript{24} The self-administration of drugs or alcohol to the extent that it would impair the licensee's ability to practice medicine constitutes unprofessional conduct. CAL. BUS. & PROF. CODE § 2239 (Deering Supp. 1983). The Board of Medical Quality Assurance has a legal duty to take action against any licensee charged with unprofessional conduct. CAL. BUS. & PROF. CODE § 2234 (Deering Supp. 1983).
ocation or suspension if the physician agreed to terms and conditions of probation as prescribed by the review committee and if the review committee found that allowing the physician to practice would not jeopardize public health and safety.25

A physician who voluntarily submitted to the Board of Medical Quality Assurance for rehabilitation faced identical administrative sanctions as the physician whose impairment was revealed through investigation. The punitive nature of this process created a disincentive for an impaired physician to voluntarily report for rehabilitation or for colleagues to urge an impaired physician to submit to the board for rehabilitation.26 The Impaired Physician Program was developed to remedy this problem.27

The Impaired Physician Program goals are to rehabilitate impaired physicians and to protect public health and safety.28 The diversion committee in charge of the program has no punitive powers and will only report the impaired physician to the Board of Medical Quality Assurance for disciplinary action if the impaired physician fails in the treatment program.29 The Impaired Physician Program is characterized as preventative in nature rather than remedial.30 Demonstrative of this preventative nature is that an impaired physician's colleagues and family will more often confront him with his problem and urge him to seek rehabilitation before any impairment of his clinical ability occurs if the committee he reports to is rehabilitative rather than punitive.31

Types of Impaired Physician Statutes

Impaired physician statutes can be distinguished by the presence or absence of a mandatory reporting requirement. In those statutes which have a mandatory reporting requirement, a physician who knows of a colleague's impairment must report the impaired colleague to the regulatory board for physician practice. The statutes which have a mandatory reporting requirement are subcategorized into those which require a physician who is treating an impaired physician to report, and those which protect the physician-patient

26. Id. at 142.
29. CAL. ADMIN. CODE tit. 16, R. 33 (1983). In California, the diversion committee is required to report any physician who terminates the voluntary program for any reason other than successful completion to the Division of Medical Quality of the Board of Medical Quality Assurance. Id.
30. The American Medical Association indicates that an advantage of the impaired physician programs is that action to restrict the physician's practice can be taken before patient injury occurs. Sick Physician, supra note 2, at 686.
relationship and do not require a treating physician to report the impaired physician-patient. Under the statutes which protect the physician-patient relationship, non-treating physicians are still required to report their impaired colleagues.32

Advocates of mandatory reporting argue the only effective means of prompting physicians to identify their impaired colleagues is to impose a statutory duty to report.33 The failure of a physician to report an impaired colleague is unprofessional conduct and grounds for discipline against the non-reporting physician by the regulatory board.34 If a known impaired physician injured a patient because of his impairment, a physician who failed to make the mandatory report would be personally liable for the injury.35 To avoid potential personal liability or discipline, physicians must report their impaired colleagues.

Although advocates of mandatory reporting view the statutory duty as the best method to facilitate the identification of the impaired physician, proponents of voluntary reporting criticize mandatory reporting requirements as conflicting with the rehabilitative purpose of impaired physician programs. These proponents assert if impaired physicians think a program administrator is required to report them to a regulatory board having punitive powers, few will voluntarily submit themselves for treatment.36 Moreover, physicians will be fearful that they may cost a colleague his license and will be dissuaded from urging an impaired colleague whose quality of practice has not significantly suffered to seek rehabilitation.37 Proponents of voluntary reporting define the role of medical practitioners in identifying and rehabilitating their impaired colleagues and in protecting the public from injury by the impaired physician as an ethical responsibility rather than a legal duty.38

32. Comment, supra note 17, at 730.
33. See id. at 749.
34. See id. at 746.
35. See id. at 747-49.
36. See Rosenberg, supra note 31, at 128.
38. The observations and recommendations of the American Medical Association Council on Mental Health include, “It is a physician's ethical responsibility to take cognizance of a colleague's inability to practice medicine adequately by reason of physical or mental illness, including alcoholism or drug dependence.” Sick Physician, supra note 2, at 684. See also Comment, supra note 17, at 731 (Executive Director of California's Board of Medical Quality Assurance states that the responsibility to deal with impaired physicians is an ethical rather than legal issue). The consensus of medical societies, licensing boards, and state committees is that noncoercive confrontation by a colleague is
Effects of Mandatory Reporting

Initial reports from two states which enacted mandatory reporting requirements, after previously functioning with a voluntary reporting program, did not reveal an increased rate of reporting. Additionally, in New York, the physician-administrators of the Voluntary Physician's Committee charged that the mandatory reporting requirement undermined their efforts. With the implementation of mandatory reporting, the voluntary committee stopped receiving reports of impaired physicians. The fear that members of the voluntary committee, under a statutory duty to report, would inform the regulatory board of the impaired physician stopped family and colleagues from seeking the voluntary committee's assistance. The New York Legislature recognized this problem and amended their mandatory reporting requirement to exempt those physicians who are members of a state medical society's voluntary committee for the rehabilitation of impaired physicians from general reporting requirements. Since this exemption was created, cooperation has existed between the New York Legislature, the state medical society, and the state department of health.

This information indicates that a mandatory reporting statute that does not exempt members of rehabilitation committees from general reporting requirements conflicts with the stated purposes of impaired physician programs: to persuade impaired physicians to voluntarily seek rehabilitation and to protect public health and safety. Without such an exemption, physicians are not encouraged to deal with the problem of chemical dependence at an early stage, that is, before a physician's clinical ability is impaired; instead, physicians are discouraged from identifying an impaired colleague until the chance of harm to patients is imminent.

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39. After Arizona implemented mandatory reporting requirements, complaints received from physicians about impaired colleagues rose from one complaint every two months to two complaints a month. New York showed no change in the number of reports received after mandatory reporting was enacted. Rosenberg, supra note 31, at 127-28.

40. Some medical societies formed committees which network identified impaired physicians into a rehabilitation program not under the auspices of the state board. One advantage of these programs was their purely rehabilitative, non-punitive approach. See id. at 128.

41. See id.


43. Id. at 115-16.

44. A study done by Talbott with the Georgia Disabled Doctors Program reveals that usually the last sign of physician impairment is an objective change in a physician's clinical ability. Talbott, Identification, supra note 2, at 58.
Further evidence of the ineffectiveness of mandatory reporting is illustrated in those statutes which provide for disciplinary action against the non-reporting physician. Whether the threat of disciplinary action against a non-reporting physician is an effective method of promoting the identification of impaired physicians is questionable. A survey of states having mandatory reporting requirements reveals no instance where a physician received discipline for failure to report an impaired colleague.

Empty threats of disciplinary action for non-reporting do not strengthen mandatory reporting and tend to decrease the credibility of a mandatory reporting statute.

**California's Impaired Physician Program**

California enacted an Impaired Physician Program in 1980 which did not include a mandatory reporting requirement. This program was developed to encourage impaired physicians to voluntarily seek treatment and rehabilitation before their clinical abilities were impaired causing a threat to public health and safety. Voluntary enrollment in the program would result in a type of immunity. The enrolled impaired physician would be immune to any disciplinary measures by the Board. In comparison, those impaired physicians discovered through investigations resulting from complaints received by the Board of Medical Quality Assurance would be subject to the disciplinary measures of the Board and would not be afforded the protection and benefits of the Impaired Physician Program.

Because the premise of the Impaired Physician Program was voluntary rehabilitation, the Board of Medical Quality Assurance found the inclusion of a mandatory reporting requirement unnecessary. The Board viewed the role of physicians in persuading their impaired colleagues to seek treatment as an ethical responsibility rather than

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45. The fear of being drawn into a chemically-dependent physician's malpractice action has proven to be a strong force in motivating physicians to report their impaired colleagues. Rosenberg, *supra* note 31, at 125-26.


48. "Only those physicians and surgeons who have voluntarily requested diversion treatment and supervision by a committee shall participate in a program." **CAL. BUS. & PROF. CODE** § 2350(a) (Deering Supp. 1983).

49. The legislative intent of the Impaired Physicians Program was to provide a means of identifying and rehabilitating impaired physicians and to return them to the practice of medicine in a manner which would not endanger the public health and safety. **CAL. BUS. & PROF. CODE** § 2340 (Deering Supp. 1983).
a legal duty to be imposed by a mandatory reporting statute. The mandatory reporting of the restriction of staff physician privileges by hospitals for any medical disciplinary cause or reason and of malpractice awards over three thousand dollars by insurers combined with the participation of the public were reasoned adequate measures to reveal the impaired physician whose quality of practice had suffered because of his impairment.

The disincentives and questionable effectiveness of mandatory reporting, and the voluntary foundation of the Impaired Physician Program indicate that the California Impaired Physician Program would not be strengthened by the addition of a mandatory reporting requirement. The gap left by the absence of a mandatory reporting requirement would be closed by existing common law doctrines. These doctrines would place liability on the individual physician for failing to report a colleague he knows is impaired and is not undergoing treatment, or on the hospital for failing to restrict the practice of a physician that the hospital administration knew or should have known was impaired.

CORPORATE HOSPITAL LIABILITY

Foundation of the Doctrine

Prior to the creation of the doctrine of corporate hospital liability in Darling v. Charleston Community Memorial Hospital, a hospital was liable for injuries caused by a physician if an employer-employee or agency relationship existed between the incompetent physician and the hospital. In Darling, the court recognized the changing role of the hospital and placed a duty of care on the hospital.

50. Comment, supra note 17, at 731.
53. See supra note 23.
54. Carlova, supra note 23, at 138-42.
55. In the past the California courts have expanded common law doctrines in order to achieve their goals of loss distribution and accident reduction. See Levy & Ursin, Tort Law in California: At the Crossroads, 67 CALIF. L. REV. 497 (1979).
56. 33 Ill. 2d 326, 211 N.E.2d 253 (1965).
57. See, e.g., Rice v. California Lutheran Hospital, 27 Cal. 2d 296, 163 P.2d 860 (1945) (a hospital may be liable for the physician-employee's acts even though the acts are professional in nature).
58. See, e.g., Seneris v. Haas, 45 Cal. 2d 811, 291 P.2d 915 (1955) (a hospital may be liable for physician's acts when the hospital intentionally or by want of ordinary care causes a patient to reasonably believe a physician is its agent when the physician is not actually employed by it).
59. 33 Ill. 2d at 330, 211 N.E.2d at 257. "Present-day hospitals . . . do far more than furnish facilities for treatment . . . . [T]he person who avails himself of 'hospital facilities' expects that the hospital will attempt to cure him, not that its nurses or other
hospital to maintain a qualified medical staff. An increasing number of states have recognized the doctrine of corporate hospital liability. The general duties placed on the hospital include a duty to review the medical care given to patients by staff physicians, a duty to suspend or restrict privileges of physicians found incompetent, and a duty to use reasonable care in the initial selection of physicians for the medical staff.


60. 33 Ill. 2d at 330, 211 N.E.2d at 257. The "medical staff" is the organization of physicians who have been granted staff privileges at a hospital. See CAL. BUS. & PROF. CODE § 2282 (Deering Supp. 1983); CAL. HEALTH & SAFETY CODE § 32128 (Deering Supp. 1983).


63. Comment, Piercing the Doctrine of Corporate Hospital Liability, supra note 62, at 390.

64. Standards drafted by voluntary authorities such as the Joint Commission on Accreditation of Hospitals have no force of law unless some affirmative action is taken by the legislature or the judiciary. Dornette, The Legal Impact on Voluntary Standards in Civil Actions Against the Health Care Provider, 22 N.Y.L. SCH. L. REV. 925, 931 (1977). The Joint Commission on Accreditation of Hospitals (JCAH), the foremost voluntary standards-making organization, is concerned with upgrading the quality of hospital care. The American College of Surgeons, the American College of Physicians, the American Medical Association, and the American Hospital Association financially contribute to and provide representatives for the JCAH. Id. at 925.
for the operation of a hospital, or in a hospital voluntarily assuming such standards in order to achieve accreditation. Once a breach of the voluntary standard occurs, courts may adopt the voluntary standard as a measurement of the standard of care owed by the hospital to its patients.

The doctrine of corporate hospital liability does not make the hospital vicariously liable for all acts of its staff physicians. To successfully bring an action against the hospital, the plaintiff must show that the hospital, through its administration, breached an independent duty owed to its patients. This duty of care is breached if a hospital fails to restrict the privileges of a physician after notice of the physician's technical incompetence.

The degree of notice a hospital must have regarding a physician's incompetence before liability will be imposed for failing to restrict the physician's privileges varies among jurisdictions. At one end of the spectrum, any information held by the medical staff would be imputed to the hospital administration. This approach would make the hospital liable even if the medical staff intentionally or negligently failed to inform the administration of suspected incompetence. At the other extreme, the hospital would not be liable unless the administration had actual notice of a physician's incompetence. The requirement of actual notice has been criticized for rewarding intentional efforts by the hospital to stay uninformed.

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65. In California, public hospitals are required to appoint, reappoint, and organize the medical staff according to the Joint Commission on Accreditation of Hospitals' (JCAH) standards. CAL. HEALTH & SAFETY CODE § 32128 (Deering Supp. 1983); see supra note 64 for an explanation of the JCAH.

66. Many incentives exist for private hospitals to seek accreditation by the Joint Commission on Accreditation of Hospitals (JCAH). See supra note 64. Those accredited by the JCAH are in compliance with a substantial number of conditions for participation in Medicare and receive substantially lower premiums from insurance carriers. Dornette, supra note 64, at 927-28.


68. Comment, Hospital's Responsibility, supra note 62, at 142. [T]he hospital is viewed as owing certain duties directly to the patients treated within its facilities—duties that transcend the line between hospital administration and medical treatment. If it is established that the hospital has failed to fulfill this duty of care in a particular case, the hospital may face direct tort liability for any injuries resulting therefrom.

Id.

69. Technical incompetence refers to a physician lacking skill because he does not have the education or training required to provide medical care for a specific problem. See Purcell v. Zimbelman, 18 Ariz. App. 75, 500 P.2d 335 (1972).


72. See Southwick, The Hospital as an Institution, supra note 62, at 448.
Application of Corporate Hospital Liability in California

California's adoption of the doctrine occurred in *Elam v. College Park Hospital.* In *Elam,* the court used the concept of foreseeability to create a duty of care owed by the hospital to its patients. The court concluded that a foreseeable risk of harm to patients arose if a hospital failed to maintain a competent medical staff through the careful review, selection, and evaluation of that staff. The court used the legislature's adoption of the standards of the Joint Commission on Accreditation of Hospitals to substantiate their conclusion that a hospital "owes generally a duty to insure the competency of its medical staff and to evaluate the quality of medical treatment rendered on its premises." In *Elam,* the court noted the medical staff, not the hospital administration, would be responsible for reviewing physician competency; but the court indicated the hospital would be held liable for the review since "the governing body of the hospital is responsible for establishing the review procedures." The California court viewed the imposition of a duty of care owed to patients by hospitals as creating an incentive for the hospital to become more aware of its medical staff's competence. The imposition of a duty on the hospital was reasoned to be an effective means to reduce unreasonable harm to patients because the hospital, through its medical staff, would be in the best position to evaluate the physicians practicing within its facilities. In addition to creating an incentive for the prevention of harm to patients, the court viewed the doctrine of corporate hospital liability as providing victims another avenue for relief. The court concluded that the doctrine of corporate hospital liability was consistent with legislative policy concerned with the furtherance and protection of the health care interest of the patient.

73. 132 Cal. App. 3d 332, 183 Cal. Rptr. 156 (1982).
74. Id. at 340, 183 Cal. Rptr. at 160-61.
75. Id. at 341, 183 Cal. Rptr. at 161.
76. Id. at 341-42, 183 Cal. Rptr. at 161-62.
77. See supra note 64.
78. 132 Cal. App. at 347, 183 Cal. Rptr. at 165.
79. Id. at 342, 183 Cal. Rptr. at 162.
80. Id. at 345, 183 Cal. Rptr. at 164.
81. Id. at 346-47, 183 Cal. Rptr. at 165.
Application of Corporate Hospital Liability to the Chemically-Dependent Physician

The threat to the patient’s health care from chemically-dependent physicians is equivalent to the threat created by technically incompetent physicians. Although the hospital is recognized as being in the best position to detect a physician’s incompetence, the hospital’s ability to detect the chemically-dependent physician may be more limited. The problem arises because no definitive signs of impairment may appear with the chemically-dependent physician; instead, only tentative or spurious warnings may emanate from his behavior.

Cases in which the hospital has actual notice of a physician’s chemical dependence are handled without difficulty. For example, liability was imposed on the hospital in *Penn Tanker Co. v. United States* when a patient lost his sight after being incorrectly diagnosed and treated by an ophthalmologist who was a known alcoholic. In *Penn Tanker Co.*, the rehabilitation program administrator recommended to the hospital that the ophthalmologist be allowed to resume a limited practice but that he should not perform surgery. The hospital allowed the ophthalmologist to resume an unrestricted practice and to perform surgery. The court found the hospital negligent for not enforcing the restrictions placed upon the ophthalmologist and this failure to restrict the ophthalmologist’s practice was judged a proximate cause of the patient’s injury.

The hospital, however, will not always have actual notice of a physician’s chemical dependence. In those cases demonstrating an objective deterioration in the quality of care provided by the chemically-dependent physician, the hospital’s liability will be determined similarly to other areas of incompetency. The considerations are: (1) was the hospital negligent in its review of the physician?; and (2) if the hospital had been diligent in its review and evaluation of the physician, would information have been revealed that would have led to the hospital restricting or limiting the physician’s privileges? If both these questions are answered affirmatively, the hospital’s failure to restrict and enforce limitations on the physician’s hospital privileges would be deemed a proximate cause of any injury caused by

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82. Colleagues and nurses are usually in a position to observe behavior daily. Note, *Hospital Corporate Liability, supra* note 62, at 376. The hospital administrator has closer contact with more sources of information than any other person in the hospital. These sources may reveal changing behavior patterns indicating impairment. Williams, *The Quandary of the Hospital Administrator in Dealing with the Medical Malpractice Problem, 55 Neb. L. Rev. 401, 406 (1976).*


84. Id. at 618.

the chemically-dependent physician. A more difficult situation arises when the physician's chemical dependence has not affected the quality of patient care. Chemical dependence is a gradual and growing affliction. Characteristically, an antecedent behavior pattern indicates the possibility of chemical dependence. Included in this behavior are changes in employment patterns such as numerous job changes, frequent geographic relocations for unexplained reasons, unexplained intervals between jobs, indefinite or inappropriate references, and reluctance to undergo immediate pre-employment physical examination. A hospital's failure to investigate any staff physician who demonstrates some of the characteristics of the chemical dependence antecedent behavior pattern, and to restrict or suspend the physician's privilege if chemical dependence is found, should be considered negligence and a proximate cause of any injury inflicted because of the physician's chemical dependence.

A recognized problem with the doctrine of corporate hospital liability is the hospital must rely primarily on the medical staff for initial and continuing evaluation of staff physicians. If the medical staff is not diligent in discharging this evaluation process, then the hospital may be liable for information that has been negligently or intentionally withheld. Therefore, the medical staff must be accountable

86. In Purcell v. Zimbelman, 18 Ariz. App. 75, 500 P.2d 335 (1972), the Department of Surgery was aware of malpractice claims for performing unnecessary radical surgery against the defendant surgeon. Since the department in supervising and reviewing its members was acting on behalf of the hospital, its failure to take action was considered to be the hospital's negligence. Failure of the hospital to restrict the physician's privileges was the threshold negligent event and a proximate cause of the patient's injury. Id. at 80-83, 500 P.2d at 340-43.

87. See supra note 44.

88. The Talbott study shows that signs of physician impairment usually appear in a recognizable order. Behavior areas affected are community involvement, family life, employment patterns, physical status, office conduct, and hospital duties. Signs of impairment may be apparent on initial application to the hospital for staff privileges. Talbott, Identification, supra note 2, at 58.

89. In Elam v. College Park Hospital, 132 Cal. App. 3d 332, 183 Cal. Rptr. 156 (1982), the hospital administration was aware of a malpractice action against a staff podiatrist. This malpractice claim was sufficient to give the hospital constructive notice of the podiatrist's incompetence. The Elam court held that if a diligent investigation would have revealed the podiatrist's technical incompetence, then the hospital's failure to investigate and to restrict the podiatrist's hospital privileges created a foreseeable risk of harm to patients and would be a proximate cause of an injury due to the incompetence. Id. at 346, 183 Cal. Rptr. at 165. Constructive notice of a physician's chemical dependence should create the same duty to investigate and restrict as technical incompetence. See Tucson Med. Center Inc. v. Misevch, 133 Ariz. 34, 545 P.2d 958 (1976).

90. See Comment, Piercing the Doctrine of Corporate Hospital Liability, supra
if corporate hospital liability is to be effective as a means of identifying the chemically-dependent physician. One method to ensure the medical staff's accountability is to allow a patient injured by an impaired physician to bring suit against the medical staff as an unincorporated association. A second method is to allow the hospital to dismiss a silent staff member.

LIABILITY OF THE MEDICAL STAFF

The Medical Staff as an Unincorporated Association

A procedural decision made by a New Jersey appellate court in *Corleto v. Shore Memorial Hospital*\(^9\) recognized the role of the medical staff in evaluating and reviewing staff physicians. The New Jersey court decided that a medical staff could be sued as an unincorporated association\(^9\) for its failure to effectively screen its members for competence. One reason behind this decision was that the individual members of the medical staff could be sued independently, but an action against them collectively would provide for judicial efficiency.\(^9\) In a different situation, the South Dakota Supreme Court allowed a medical staff to bring an action as an unincorporated association against a hospital.\(^9\)

These cases are important because the medical staff was recognized as a legal entity for judicial proceedings. In California, courts have treated medical staffs and societies as unincorporated associations;\(^9\) therefore, a successful action could be maintained against a medical staff as an unincorporated association when it has failed to reasonably evaluate a staff member who demonstrates the antecedent behavior pattern of chemical dependence.

The effectiveness of such actions in promoting accountability is questionable. The medical staff is organized under the auspices of the hospital,\(^9\) and is without assets as an unincorporated association.

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2. In *Corleto* the question of the medical staff’s liability was never reached. The negligent physician’s insurance company settled prior to trial. Horty & Mulholland, *The Legal Status of the Hospital Medical Staff,* 22 St. Louis U.L.J. 485, 487 (1978).
5. In an action by a physician against a hospital for wrongful exclusion from the medical staff, the court treated the medical staff as an unincorporated association. Westlake Community Hosp. v. Superior Court, 17 Cal. 3d 465, 551 P.2d 410, 131 Cal. Rptr. 90 (1976); accord Ascherman v. San Francisco Medical Soc., 39 Cal. App. 3d 623, 114 Cal. Rptr. 681 (1974). But see Horty & Mulholland, *supra* note 92, at 497-99 (the characteristics of a medical staff do not meet the criteria for an unincorporated association; the medical staff as a body has no separate life or legal rights from the hospital, to sue or be sued).
6. The governing body of a hospital must have provisions for the formal organi-
A money judgment against the medical staff as an unincorporated association could only be enforced against the association's assets. Therefore, in most instances, the medical staff would be immune from enforcement of a judgment. The practical effect of a suit against the medical staff as an unincorporated association for its failure to act upon notice of possible chemical dependence in one of its members would be reduced to a nullity.

The Silent Staff Member

A more effective means to promote accountability of medical staff members is recognition of the right of the hospital to dismiss physicians who withhold information about impaired colleagues. The American Medical Association's standard for ethical conduct states physicians are ethically responsible to take cognizance of their impaired colleagues. This standard for ethical conduct is violated by the medical staff member who knows of a colleague's chemical dependence and does not take action that would protect the public from the foreseeable risk of harm created by his chemically-dependent colleague. Hospitals are legally required to restrict medical staff membership to those physicians competent in their respective fields and who meet standards of professional ethics. The silence and inaction of a medical staff member could be construed as a violation of this ethical standard and serve as grounds for dismissal from the medical staff. Because much of a physician's practice is associated with the hospital, this potential loss of hospital privileges would...
effectively function to promote medical staff accountability.

LIABILITY OF INDIVIDUAL PHYSICIANS

Corleto suggests the existence of a duty owed to patients by the individual medical staff members who work closely with the alleged impaired physician.\textsuperscript{103} If such a duty exists, then a physician\textsuperscript{104} who fails to take action when aware of a chemically-dependent colleague who is not voluntarily undergoing treatment would be liable for the damage caused by his impaired colleague. The physician's knowledge and subsequent inaction would be viewed as a proximate cause of the patient's injuries. Before liability can be placed on the individual physician, a duty must exist requiring him to take the necessary action that would protect the public from the risk created by the chemically-dependent physician.\textsuperscript{105}

The California Supreme Court takes an expansive position on the question of duty.\textsuperscript{106} Duty is "an expression of the sum total of those considerations of policy which lead the law to say that the particular plaintiff is entitled to protection."\textsuperscript{107} The court's position on duty expanded further when it found the primary consideration in determining duty was the foreseeability of harm to the plaintiff. Although the existence of a duty is a question of law, foreseeability is a question of fact for the jury.\textsuperscript{108} The court used this concept to create liability where none previously existed. In Landeros v. Flood,\textsuperscript{109} the court found a physician to have a duty to correctly diagnose his patient's battered-child syndrome and to report this abuse to authorities.\textsuperscript{110}

Another example of the court's expansive holdings on the question of duty is Tarasoff v. Regents of the University of California.\textsuperscript{111} The Tarasoff court found a psychologist liable for the death of his pa-
tient's victim when he failed to warn the victim of the harm threatened by his patient during a therapy session. The Tarasoff rationale should be extended to impose liability on the physician who knows of a colleague's untreated chemical dependence and who fails to report the colleague to the Board of Medical Quality Assurance. This liability would be based on a duty to exercise reasonable care for the protection of a third party.

The Tarasoff court recognized the common law rules that generally one person owes no duty to control the conduct of another in order to protect a third party nor to warn those endangered by such conduct. However, exceptions to these rules exist when the defendant stands in some special relationship to either the person whose conduct needs to be controlled or to the foreseeable victim of the person whose conduct needs controlling. Relationships which support such an affirmative duty have been expanded to further the policy of accident reduction and that of spreading accident losses through insurance.

The medical profession receives special treatment from the judiciary and the legislature. The physician’s standard of care is one of “good medical practice” or what is “customary and usual in the profession.” To protect physicians from expanding malpractice awards, a statutory limit is placed on damage awards for non-economic loss. This special treatment creates and supports the public’s expectations that physicians will police their own ranks and

112. Id. at 442, 551 P.2d at 347-48, 131 Cal. Rptr. at 27-8.
113. Id. at 435, 551 P.2d at 343, 131 Cal. Rptr. at 23.
114. Id. at 435 n.5, 551 P.2d at 343 n.5, 131 Cal. Rptr. at 23 n.5.
116. W. PROSSER, HANDBOOK OF THE LAW OF TORTS § 32, at 162-65 (4th ed. 1971). Generally custom is not conclusive on deciding whether an act is negligent or non-negligent. Id. at 167-68. Traditionally the physician’s standard of care was the practice of the medical profession in the same locality. Huffman v. Lindquist, 37 Cal. 2d 465, 473, 234 P.2d 34, 39 (1951). The recent approach is to expand the physician's standard of care to the practice of the medical profession under similar circumstances. See Cobbs v. Grant, 8 Cal. 3d 229, 244-45, 502 P.2d 1, 11, 104 Cal. Rptr. 505, 515 (1972) (a physician must provide information that a skilled practitioner would provide under similar circumstances).
118. It is recognized that for years physicians have been responsible for self-policing. For the most part physicians are in charge of disciplinary agencies. Rosenberg, supra note 31, at 108. In California the Board of Medical Quality Assurance (BMQA) is composed of seven members, four of whom are physicians. CAL. BUS. & PROF. CODE § 2001 (Deering Supp. 1983). The BMQA's Division of Medical Quality which is the disciplinary branch is composed of seven members, four of whom are physicians.
insure that only quality health care be delivered. It also supports the legislative policy that physicians be accountable for the quality of health care provided. Public expectations and legislative policy create a special relationship among physicians. This relationship supports the imposition of a common law duty to report upon those colleagues who have knowledge of a chemically-dependent physician who refuses to voluntarily undergo rehabilitation.

Policy considerations noted in Tarasoff also support the imposition of a duty on the colleague to report the chemically-dependent physician. The California Supreme Court has articulated several policy considerations to be balanced when determining whether a duty exists as a matter of law. These policy considerations are:

- the foreseeability of harm to the plaintiff,
- the degree of certainty that the plaintiff suffered injury,
- the closeness of the connection between the defendant's conduct and the injury suffered,
- the moral blame attached to the defendant's conduct,
- the policy of preventing future harm,
- the extent of the burden to the defendant and consequences to the community of imposing a duty to exercise care with the resulting liability for breach,
- and the availability, cost, and prevalence of insurance for the risk involved.

The foreseeable risk of harm created by a physician who refuses to report an untreated chemically-dependent colleague is clear. The chemical dependence may at any time cause the physician's reasoning process to deteriorate, resulting in harm to the patient. The occurrence of this deterioration is not predictable, therefore action must be taken at the first sign of chemical dependence to prevent the occurrence of future harm. Responsibility for taking action to prevent harm to the public by the chemically-dependent physician is an ethical responsibility proposed by the American Medical Association. A failure to meet this responsibility should be construed as morally blameworthy conduct. If a physician had met this responsibility and reported a chemically-dependent physician who refused to undergo voluntary rehabilitation, immediate action could restrict the suspected physician's practice. By reporting an untreated chemically-dependent colleague, the physician's duty to exercise due care would be fulfilled, and the public would be afforded greater protection from unnecessary risks of harm.

Courts rarely recognize a relationship between a physician and a

119. For a description of legislative measures used to promote the accountability of the medical profession, see supra note 21.
120. Tarasoff v. Regents of University of California, 17 Cal. 3d at 434, 551 P.2d at 342, 131 Cal. Rptr. at 22.
121. Id.
122. See supra note 38.
123. The Board of Medical Quality Assurance has the authority to request the superior court of any county to enjoin a physician from conduct which would be in violation of the Medical Practice Act. 1980 Cal. Stat. ch. 1312 § 2 (codified at CAL. BUS. & PROF. CODE § 2311 (Deering Supp. 1983)); see supra note 118.
person who is not his patient. But, by undertaking the task of self-policing for the protection of the public's health care interests, physicians assume the duty of carrying out this function with due care. The American Medical Association places the responsibility for policing on its individual members. This affirmative conduct imposes a duty for the impaired physician's colleague to exercise reasonable care for the protection of patients from the risks created by a chemically-dependent physician. Reporting an untreated, chemically-dependent physician satisfies this duty.

If a physician fails to report an untreated chemically-dependent colleague and because of chemical dependence that colleague injures a patient, then the failure to report should be a proximate cause of the patient's injury. Losses incurred by the patient because of this injury should be spread through the malpractice insurance coverage of the chemically-dependent colleague and the non-reporting physician. Legislative policy would support this increased liability for non-reporting physicians in the same manner as it supported the doctrine of corporate hospital liability. The legislature's intent was not to immunize physicians from negligence liability but to protect and further the patient's health care.

The special relationship between physicians in conjunction with the satisfaction of policy considerations and the physician's assumption of a duty to self-police, strongly support the imposition of a duty to report upon those physicians who know of an untreated chemi-


125. For a discussion of self-policing see supra note 118.

126. Undertaking an affirmative course of conduct that affects the interests of another, imposes a duty to act and creates liability for negligence or a failure to act. Schwartz v. Helms Bakery Ltd., 67 Cal. 2d 232, 238, 430 P.2d 68, 72, 60 Cal. Rptr. 510, 514 (1967).

127. See supra note 38.

128. See Restatement (Second) of Torts § 323 (1965): One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of the other's person or things, is subject to liability to the other for physical harm resulting from his failure to exercise reasonable care to perform his undertaking, if . . . the harm is suffered because of the other's reliance upon the undertaking. Id.

cally-dependent physician. The physician knowing of a chemically-dependent colleague who refuses to voluntarily undergo rehabilitation should be required to report his colleague to the Board of Medical Quality Assurance. The imposition of such a duty would also satisfy the judicial policies of accident reduction and loss distribution that have previously been used to justify expansion of the incidence of liability.

The current existence in California of a common law duty to report eliminates the need for a mandatory reporting statute since both achieve the same result. The enactment of a statutory duty to report would be counterproductive. The mandatory reporting statute of New York, considered a model legislative effort in this area, is detailed and complex. This complexity often results in a time-consuming process which can last months before any action is taken.\textsuperscript{130} Confusion about the details of a mandatory reporting statute, even one exempting reporting by rehabilitation committee members, might create reluctance on the part of the chemically-dependent physician to voluntarily seek treatment.

**CONCLUSION**

While all available measures must be used to protect the public from hazards created by a chemically-dependent physician, measures of questionable effectiveness should not be enacted if they would negate the benefits and reduce the credibility of an established program. The Impaired Physician Program in California was enacted to protect the public health and safety by creating an incentive for the chemically-dependent physician to voluntarily seek treatment before the quality of medical care he delivers deteriorates. The inclusion of a mandatory reporting requirement in this program would discourage a physician from entering a voluntary rehabilitation program and would discourage colleagues and family of a chemically-dependent physician from persuading him to seek rehabilitation. A mandatory reporting requirement should not be enacted as part of the Impaired Physician Program or as part of the Medical Practice Act in general.

The corporate liability of hospitals should be expanded to those cases when the hospital has actual or constructive knowledge of a physician's chemical dependence and fails to restrict his privileges until rehabilitation is accomplished. To ensure the full cooperation of the medical staff in identifying a chemically-dependent physician to the hospital, the right of the hospital to dismiss a silent staff member must be recognized.

Personal liability of individual physicians should be expanded by

\textsuperscript{130} Fama, *supra* note 42, at 115-16.
the recognition of a duty of care. This duty would be owed by physi-
cians to the public and would require physicians to report their col-
leagues whom they know to be chemically dependent and who refuse
to voluntarily undergo rehabilitation. The combined incentives cre-
ated by a nonpunitive voluntary rehabilitation program and by the
potential for tort liability will serve to afford the public protection
from the hazards of the chemically-dependent physician.

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