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The Doctrine of Charitable Immunity and Its Impact on Medical Malpractice Litigation in the United States

Abstract

This paper examines the powerful and long lasting influence in the United States of the doctrine of charitable immunity which exempted charitable organizations from civil litigation as the result of the negligent acts of its agents. Having exempted hospitals from liability, the courts subsequently applied *respondeat superior* to staff working under the direction of physicians. The paper further examines the targeting of physicians as "deep pockets" through the creation of a number of legal fictions which include the captain of the ship and vicarious liability. The repudiation of the doctrine of charitable immunity and ascension of the doctrine of corporate liability shifted the deep pockets target of malpractice litigation from physicians to hospitals. Disclosure of adverse events is examined and settlement of malpractice suits out of court is discussed. The paper concludes with a discussion of disclosure of adverse events and expresses hope for the future of the end of the adversarial nature of resolution with the advent of programs such as Disclosure, Apology, and Offer (DA&O).

Keywords

charitable immunity, deep pockets, captain of the ship, medical malpractice, malpractice crisis, respondeat superior, disclosure, Schloendorff rule, Justice Benjamin Cardozo, Disclosure Apology and Offer (DA&O), vicarious liability, doctrine of corporate liability.

Cover Page Footnote

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INTRODUCTION

If a physician make a large incision with the operating knife, and kill him, or open a tumor with the operating knife, and cut out the eye, his hands shall be cut off.

Code of Hammurabi, number 218¹

As illustrated by this excerpt from the Code of the Great Lawgiver Hammurabi, tension between physicians and patients has existed since the dawn of recorded history. Medical malpractice litigation has often been characterized as a result of the schism between upper and lower socioeconomic classes.^{2,3} Medical malpractice litigation in England is documented as early as 1374.⁴ The current malpractice "crisis" is not the first of its kind in this country.⁵ However, there has been a shift in the target of malpractice litigation from the physician to the hospital.⁶

Prior to the 1960s, hospitals were largely protected from malpractice litigation or "tort liability" by the doctrine of charitable immunity.⁷ That is, there was a legal prohibition from successfully bringing suit against a charitable organization for the actions of its agents even if those actions were negligent. The judicial rejection of charitable immunity has shifted the prime target of medical malpractice litigation from the physician to the hospital as the "'deepest pocket,'"⁸ a turn of events that will be the focus of this paper.

The first part of the paper will look at the origin of charitable immunity in Great Britain and then its subsequent adoption in the United States. The second part of the paper will examine the foundations of medical malpractice litigation in Britain and the state of malpractice litigation in early America. Next, the case of Charles Lowell and the

impact of that case on malpractice litigation in the nineteenth century will be discussed. The paper will then focus back on the rise and fall charitable immunity, the captain of the ship doctrine, *respondeat superior* and the "deep pockets" concept.

Finally the paper will briefly look at the current state of malpractice litigation and concludes with hope for the future in the revolutionary concept of full disclosure regarding medical errors.

THE ORIGIN OF CHARITABLE IMMUNITY

British Common Law

Our American legal system, derived, as it is, from the traditions of British common law, is nonetheless a unique creation. Despite our common language, much is altered, if not completely lost in the transition or translation. The proverb, "There's many a slip 'twixt the cup and the lip" seems particularly appropriate in the context of the subject of charitable immunity.

A dictum of Lord Cottenham in British court in the case of *Feoffees of Heriot's Hospital v. Ross* (1846) stated: "To give damages out of a trust fund would not be to apply it to those objects whom the author of the fund had in view, but would be to divert it to a completely different purpose."⁹ Lord Cottenham had previously pronounced essentially the same dictum in the case of *Duncan v. Findlater* (1839). Then, in the case of *Holliday v. St. Leonard's* (1861), the British court cited the dictum from *Duncan* as its authority.¹⁰

In 1866, however, the British Courts overruled Lord Cottenham's dictum in *Duncan*. Then, in 1871, the *Holliday* case which had cited *Duncan* was overturned.¹¹ As a consequence of these reversals, the doctrine of charitable immunity "soon disappeared from English law."¹² The irony is this: not only was charitable immunity repudiated before crossing the Atlantic Ocean, it was, as interpreted here in the United States, a "misapplication of previously established principles"¹³

Welcome to America

It is unlikely that the Massachusetts Supreme Court in 1876 deciding the case of *McDonald v. Mass. General Hospital* knew that *Holliday* had been overturned five years previously. The court cited *Holliday* nonetheless, and came to this conclusion:

[I]f there has been no neglect on the part of those who administer the trust and control its management, and if due care has been used by them in the selection of their inferior agents, even if injury has occurred by the negligence of such agents, it cannot be made responsible. The funds intrusted [sic] to it are not to be diminished by such casualties, if those immediately controlling them have done their whole duty in reference to those who have sought to obtain the benefit of them.¹⁴

With those words, the doctrine of charitable immunity, dead in its homeland, rose, phoenix like, in the US where it had a major effect on health care and malpractice litigation for over one hundred years. Yet, in the case on which the doctrine was based, "[t]he action was for damages for wrongful exclusion from the benefits of the charity, not for personal injury. . . ."¹⁵

The particulars of the doctrine or "rule" of charitable immunity varied from state to state since it first appeared in the United States in 1876. Broadly, where adopted, the

rule prohibited lawsuits against charitable organizations for the tortious or negligent conduct of their employees. The definition of what a charitable organization was was not as narrowly defined as what are commonly acknowledged to be charities, such as the Salvation Army. Also included in the definition were such not-for-profit groups such as "hospitals, churches, schools and colleges, and YMCAs."¹⁶

Nor was charitable immunity accepted universally; the 1879 case of *Glavin v. Rhode Island Hospital* rejected *McDonald v. Mass. General Hospital*, stating, in part: "[W]here there is duty, there there [sic] is, *primâ facie* at least, liability for its neglect"¹⁷ The court also noted several cases in which *Holliday* had "been qualified or impugned."¹⁸ Furthermore, "[t]he authority of *McDonald v. The Massachusetts General Hospital*, in so far as it rests upon *Holliday v. St. Leonard*, is seriously impaired by these cases. . . ."¹⁹

A BRIEF HISTORY OF MEDICAL MALPRACTICE

British foundations

The first known litigation in England regarding what would eventually become known as medical malpractice was in 1374. Suit was brought on behalf of Agnes of Stratton against London surgeon John Swanlond for breach of contract. Agnes' hand had been mangled in an accident and, after healing, remained terribly deformed. She claimed he had guaranteed, for "reasonable payment",²⁰ to effect a cure on her hand.^{21, 22}

Ruling for the Court of the King's Bench in *Stratton v. Swanlond*, Chief Justice John Cavendish found error in the writ of complaint and the surgeon "escaped liability."²³ However, in his holdings Justice Cavendish elucidated the basic tenets of medical

malpractice and they passed into common law: if, through the negligent acts of the physician a patient should suffer harm, the physician should be held liable. However, a bad outcome would not open the physician to liability if he "diligently applied himself."²⁴ Our modern day concept of the "ordinary reasonable/prudent physician"²⁵ can be traced directly from Cavendish's holdings in this case.

Although the concept had become part of the common law with *Stratton* and Justice Cavendish, the term "malpractice" did not come into being until the mid eighteenth century with William Blackstone's *Commentaries on the Laws of England* (1765-69).

4. Injuries, affecting a man's health are where, by any unwholesome practices of another, a man sustains any apparent damage in his vigor or constitution. As . . . or by the neglect or unskillful management of his physician, surgeon or apothecary. For it hath been solemnly resolved, that *mala praxis* [bad practice] is a great misdemeanor and offence at common law, whether it be for curiosity and experiment, or by neglect; because it breaks the trust which the party has placed in his physician and tends to the patient's destruction.²⁶

Early American malpractice litigation

A surgical death in Connecticut in 1794 is the first known suit for malpractice in this country.^{27,28} Three hours after having a mastectomy by a physician named Cross, Mrs. Guthrie died. Her husband sued for negligence, prevailed with the jury verdict and was awarded £40.²⁹

Despite this bump in the road, the years 1790 to 1830 were a quiet time in the history of malpractice litigation, so quiet, that it has been noted that few American lawyers would have had the knowledge to properly draft a complaint.³⁰ Even as the first

great outbreak of medical malpractice litigation loomed on the horizon, medical educators such as Nathan Smith of Yale and R.E. Griffith of the University of Pennsylvania believed that medical litigation could be a positive force, helping to ensure that deficient medical care would not go unredressed. Litigation could help improve medical care by being vigilant where state and federal authorities were lax in monitoring substandard physician performance.³¹

Unfortunately, medical malpractice litigation moved quickly from a virtually unknown phenomenon^{32,33} to an atmosphere that was perceived as being "the persecution of surgeons."³⁴ And, like the case of *Stratton v. Swanlond*, it was the treatment of orthopedic injury—and one orthopedic case in particular—that signaled the change.

The case of Charles Lowell

In September 1821, 27 year old Charles Lowell of Lubec, Maine suffered a dislocated left hip when he was thrown from a horse and the horse fell on him. Two physicians, Dr. Hawkes and Dr. Faxon worked on Lowell and, believing they had reduced the dislocation, wrapped the legs, did a phlebotomy, gave a sedative, and prescribed four weeks of bedrest. Lowell walked home one or two weeks after.

When Hawkes saw Lowell a few weeks later, the leg was still deformed, and Hawkes informed the furious Lowell nothing more could be done. In December of 1821 Lowell insisted upon treatment by Dr. Warren of Mass General Hospital despite Warren telling him nothing could be done. Out of compassion for Lowell's pleadings, Warren attempted unsuccessfully for two hours to reduce the dislocation. After discharge Lowell

saw numerous other physicians and bone setters on his way home to Maine. None were able to help.

Nine months after his initial injury, Lowell filed suit against Hawkes and Faxon, prevailed and was awarded \$1962.00, the equivalent of \$1.9 million in 2008. On appeal, the jury was hung. In June 1824 a third trial ended without an award to Lowell.³⁵

For the rest of his life, Lowell and his attorneys waged a very public war of words against the physicians who had attempted to help him, vilifying them unmercifully. In pamphlets, articles, and letters to newspapers he and his attorneys kept his animus for his physicians in the public eye. He called them "assassins and quacks", accused Dr. Warren of "ignorance of anatomy and surgery" and said the doctors were "ignorant quacks poisoning suffering humanity".³⁶

The impact of the Lowell case

The publicity generated by this case contributed significantly to the boom in malpractice litigation. In the period from 1830 to 1860, appellate malpractice decisions increased by 950%, and from 1860 to 1890 there was a 457% increase.³⁷ And by the end of the nineteenth century, orthopedic injuries accounted for 90% of all medical malpractice cases.³⁸

Unfortunately, it was the most learned, best qualified physicians who bore the brunt of this boom time for malpractice litigation.³⁹ Prior to 1830, the standard of care for compound fractures was amputation. As physicians began to attempt to save limbs, their failures or less than completely successful attempts came round to haunt them. When the standard of care was amputation, with the limb missing, how could the judgment of the

physician be refuted?⁴⁰ Amputation was standard practice. However, a poorly healed or deformed limb or hand—"crippled" in the parlance of the day—certainly would speak powerfully to a jury, easily engendering sympathy for the plaintiff.

With technological advance comes heightened expectations of vastly improved outcomes. But attendant to those improved outcomes are unanticipated consequences, an ideal environment to foster malpractice litigation.⁴¹

As medicine attempted to establish standards of care and education to weed out the uneducated and the quacks, its successes sometimes worked to its detriment. In the nineteenth century the AMA was formed and physicians were attempting to elevate the practice of medicine from a mere business transaction to a trust relationship based on the physician's specialized skills and knowledge. The ordinary contract model (alleging a breach of contract as in the *Stratton v. Swanlund* case) doesn't compliment this developing model well. Whereas the contract model is based on a promised outcome, the tort model assesses a process which does compliment the trust relationship model.⁴²

CHARITABLE IMMUNITY; OTHER LEGAL FICTIONS

The rise of charitable immunity in the U.S.

Charitable immunity generally found acceptance and was written into common law by seven high courts by 1900. Over half the states in the union had approved it by 1920, and forty states had accepted it by 1938.⁴³ The case of *Jensen v. Maine Eye and Ear Infirmary* (1910) is instructive.

The *Jensen* case involved a woman who, while an "inmate" of Maine Eye and Ear Infirmary, managed to "evade the supervision of her attendants" and fell from a window five stories to the sidewalk. She died within a few hours of her fall. Her husband sued on the grounds of negligence of the staff of the institution. The defense contended (1) that the infirmary was "not a corporation for the treatment of sick and injured persons for hire" as alleged; and, (2) the infirmary was "a corporation organized and existing solely as a public charity" in conformity with chapter 519 of the Private and Special Laws of Maine (1897). The court found that since point two was valid, point one was irrelevant.⁴⁴ In its decision, the court affirms the basic rationale for charitable immunity that would stand more than thirty years longer virtually unchallenged.

[A] purely charitable institution, supported by funds furnished by private and public charity, cannot be made liable in damages for the negligent acts of its servants. Were it not so, it is not difficult to discern that private gift and public aid would not long be contributed to feed the hungry maw of litigation, and charitable institutions of all kinds would ultimately cease or become greatly impaired in their usefulness.⁴⁵

And it was not just charitable institutions that were generally exempt from liability for the medical practice of physicians.⁴⁶ In the case of *Schloendorff v. Society of New York Hospital* (1914) Justice Cardozo discussed the relationship between the hospital and the physician and held that the physician was essentially an "independent contractor". As such, the physician was "liable, of course, for his own wrongs to the patient whom he undertakes to serve, but involving the hospital in no liability, if due care has been taken in his selection."⁴⁷ In what came to be known as "the Schloendorff rule"⁴⁸ it was decided that "the principle of respondeat superior was not to be applied to doctors

and nurses even though employed by the hospital, they were to be regarded as independent contractors rather than employees. . . ."49

Charitable immunity comes under fire

A major shift in societal and judicial attitude was signaled by the United States Court of Appeals for the District of Columbia case *Georgetown College v. Hughes* (1942). Justice Rutledge gives an articulate and extremely well reasoned examination of charitable immunity, cases, and decisions, noting that dissents are "riotous" and that "[r]easons [for the dissents] are even more varied than results." Further, Rutledge maintained, a "law in flux" like this indicates a fundamental flaw in the law or a change that is trying to, but has not yet, self-corrected.⁵⁰

Yet, in academia, there was, according to Rutledge, no dissent regarding charitable immunity. Liability for one's actions is the rule, immunity, the exception. Just as individuals are responsible for their own actions, and corporations are liable for their subordinates under *respondeat superior*, so should trustees of charities be accountable for the actions of their subordinates or agents. "Charity suffereth long and is kind, but in the common law it cannot be careless. When it is, it ceases to be kindness and becomes actionable wrongdoing."⁵¹

More challenges to the doctrine occurred in various jurisdictions, as noted by Judge Rutledge, for a variety of reasons. The case of *Noel v. Menninger* (1954) attacks and rejects charitable immunity on several levels, perhaps most importantly, on its constitutionality. The Supreme Court of the State of Kansas stated: "Section 18 of our bill of rights reads: 'All persons, for injuries suffered in person, reputation or property, shall

have remedy by due course of law, and justice administered without delay."⁵² The court further noted that there was neither a constitutional nor statute driven exemption to charities for liability of the negligent or tortious acts of their agents. The court stated that if there ever was justification for charitable immunity, it no longer existed and any prior decision affirming charitable immunity was overruled.⁵³

The captain of the ship

Although the assault on charitable immunity had essentially begun in 1942, the doctrine remained a force to be reckoned with for many years thereafter. A new legal fiction appeared in Pennsylvania in the case of *McConnell v. Williams* (1949): the captain of the ship. This doctrine assigns liability to the physician for the acts of his assistants under his control but not directly employed by him.⁵⁴ Looking at the genesis of the doctrine, the United States Court of Appeals for the Third Circuit observed that the purpose of creating the fiction of the captain of the ship was "to do away with the traditional test of control and widen a doctor's vicarious liability"⁵⁵ hence circumventing charitable immunity.

Patients injured by the negligence of low level hospital employees who had no resources to pay an adverse judgment deserved redress nonetheless. The courts turned to the operating surgeon "who not only had the deepest pocket but often the only pocket from which the injured patient could recover."⁵⁶

The Schloendorff rule is reversed

The 1957 landmark case of *Bing v. Thunig* abandoned charitable immunity. *Bing* also reversed the Schloendorff rule regarding *respondeat superior* as elucidated by

Justice Cardoza.⁵⁷ As charitable immunity was being dismantled in various jurisdictions, the *Bing* court found no reason to continue to exempt hospitals—for profit or charitable—from *respondeat superior*. "The test should be . . . as it is for every other employer, was the person who committed the negligent injury-producing act one of its employees and, if he was, was he acting within the scope of his employment."⁵⁸

The assault on charitable immunity continued. By 1969 one of the few states still clinging to charitable immunity was Massachusetts, birthplace of the doctrine in this country. However, in its refusal to grant an appeal, the Massachusetts Supreme Court sent a very clear message regarding the future of the doctrine. The court noted that, on numerous previous occasions, it had "declined to renounce the defense of charitable immunity" reasoning that the change would be best handled through the legislature. However, with "only three or four states" recognizing the doctrine and no legislative activity on the horizon, "we take this occasion to give adequate warning that the next time we are squarely confronted by a legal question respecting the charitable immunity doctrine it is our intention to abolish it."⁵⁹

Down goes the captain of the ship

By 2001, with the nearly universal repudiation of charitable immunity, the legal fiction of the captain of the ship had largely outlived its usefulness. In its decision in *Lewis v. Physicians Insurance Company of Wisconsin* (2001), the Supreme Court of the State of Wisconsin rejected a motion to accept the captain of the ship doctrine. The court stated that the purpose of captain of the ship was similar to that of *respondeat superior*, a theory that allowed a plaintiff to "invoke vicarious liability." However, it had never been

adopted in Wisconsin and was being rejected in numerous other jurisdictions.

"Because 'captain of the ship,' which enabled plaintiffs to recover in the face of a hospital's 'charitable immunity,' is an antiquated doctrine that fails to reflect the emergence of hospitals as modern health care facilities, we decline to adopt it now."⁶⁰

Deep pockets

One hundred and thirty eight years have passed since *McDonald v. Mass. General Hospital* and charitable immunity was introduced. Hospitals were much different institutions then, in many ways little more than hotels where physicians could concentrate their patients. Many depended on charitable donations and trusts for their survival. Contrast that with the modern hospital, "called upon to assume the role of a comprehensive health-care center ultimately responsible for arranging and coordinating total health care."⁶¹

In the era of charitable immunity, courts invented legal fictions such as the captain of the ship to find a "deep pocket" to recompense injured patients. As charitable immunity was eroded and hospitals were increasingly held to have any liability, liability insurance became necessary. As services expanded and hospitals became more businesses than recipients of charity, the courts moved away from holding the physician legally responsible for virtually any and every thing that went wrong.⁶²

Vestiges of charitable immunity remain in some jurisdictions, but overall, we have come fully 180 degrees from charitable immunity for hospitals with the current theory of liability, the Doctrine of Corporate Liability. This doctrine imposes the liability

for negligence on the part of the hospital's agents on the hospitals.⁶³ "The modern hospital is a viable 'deep pocket,' if not the 'deepest pocket,' for an injured patient."⁶⁴

MALPRACTICE

Why settle?

From the defendant hospital's point of view, in malpractice litigation there are two key factors to be considered: the first is the cost of mounting a defense and the second is exposure versus liability. (B. S. Johnson, RN, JD, personal communication, November 15, 2013)

In mounting a defense, the defendant hospital has to set aside a certain amount of resources. A short list of those resources might include the cost incurred by engaging outside legal counsel, obtaining depositions and the attendant costs such as reporters, reimbursement to staff for time spent prepping and making depositions, travel, and expert witnesses just to name a few. Resources must be available to cover these costs and, if the cost of defense approaches the cost of settlement, settlement may be more prudent than risking a jury verdict. This brings us to exposure versus liability. (B. S. Johnson, RN, JD, personal communication, November 15, 2013)

Recalling the case of Mr. Lowell, his anger was so great, he devoted much of his life to reviling his physicians in the press. The character of his unbridled vituperation is stunning, and resulted in Dr. Warren issuing a 142 page pamphlet in his own defense. The pamphlet was an open letter to the Chief Justice of the Supreme Court of Massachusetts and contained "a detailed case history. . .correspondence with Lowell and other physicians, physicians affidavits. . . ." and much more.⁶⁵

Although the public exchange of the magnitude of the Lowell case would not be permitted in this day and age, negative publicity has the power to destroy, even if it is based on false allegation and innuendo. A closed settlement prevents the attendant negative publicity in the media and does not call for a public admission of wrongdoing. A likeable plaintiff who has suffered a bad outcome, even absent hard evidence of error or malpractice, has the potential to be a public relations nightmare. Liability may be low, but the uncertainty of a jury trial and the attendant increase in exposure and potential for damage to the reputation of the institution may not be worth the risk, if a closed settlement can be brokered. (B. S. Johnson, RN, JD, personal communication, November 15, 2013)

Another consideration of the Hospital Risk Manager in deciding to settle sooner rather than later, or for a slightly higher sum is the effect the litigation process has on the staff involved. Defending ones' self against allegations of negligence is a painful, stress inducing process. Even to staff who are not specifically named in a suit, the process of giving depositions is anxiety provoking and arduous at best. Getting staff out of the courtroom and focused back on the business of providing quality care to the sick and injured is sometimes worth the dollar outlay of a quick settlement. (B. S. Johnson, RN, JD, personal communication, May 1, 2014)

The type of settlement described above offers a little something to each side of a dispute, but there remains an inherent problem: the adversarial nature of medical error resolution is retained and reinforced.

Who is to blame?

Studies have shown that the vast majority of patients who are harmed in some way by medical malpractice or error never bring suit.⁶⁶ It has also been observed that "physicians overestimate their risk of being sued. . . ."⁶⁷

Malpractice insurance cost for physicians is not determined by the number of claims against a physician, nor even his losses nor negative judgments. Rather, the cost is determined by the specialty of the physician and geographic location.⁶⁸

There is a bunker mentality with regard to the state of malpractice, malpractice insurance, and malpractice litigation in this country. That mentality is apparent in the verbiage used: it is never simply a problem, it is almost invariably referred to as a "crisis". The stakeholder discussions are characterized by finger pointing: physicians blaming lawyers, the tort system and frivolous lawsuits, and lawyers accusing physicians of sloppy care.⁶⁹

It is difficult to pin down the costs of medical malpractice, but the best estimate is about 2% of total healthcare dollars. The bottom line is this: stakeholders are in agreement "malpractice insurance has become less affordable and available."⁷⁰ So is the problem with the doctors or with the lawyers? Or is it both? Neither?

Consider this observation: "Now, many reflect back to view the 1990s not as a medical malpractice crisis, but rather as an insurance company accounting and investment crisis resulting in damage to the healthcare profession."⁷¹

Through all the discussion of litigation, malpractice, insurance, crises, and blaming, focus on the important issue falls by the wayside: what about the person who has been harmed?

FROM PATERNALISM TO COMMUNICATION AND RESOLUTION

Forty years ago, well within the memory of the largest generation ever born, a curious patient asking the nurse what his blood pressure was would politely, but firmly, be told that was a matter he would have to bring up with his physician. Physicians routinely withheld the "real" diagnosis from any patient the doctor believed "couldn't handle it." Cancer patients in particular were lied to or misled with assurances that they did not have cancer and that, "We got all of the tumor." Patients signed surgical consents with little or no explanation, "Because Doc says this is what I need." An unfunny bit of gallows humor from the era was "Doctors bury their mistakes."

If a medical error was made or there was an adverse event, sitting down and having a frank discussion of what went wrong was unheard of, truly a heresy. Disclosure was virtually non-existent. Nurses who were witness to or strongly suspicious of an error by a physician or any other staff member would find themselves faced with an ethical dilemma. Nurses were told it was unethical to disclose what they knew, yet morally they knew it was unethical to deliberately conceal their knowledge from a sometimes bewildered patient or grieving family. To the extent that risk management existed in hospitals, the *de facto* philosophy of the time was investigate, improve, but do not disclose.

A famous study by The Institute of Medicine concluded that 44,000 to 98,000 deaths in the year 2000 in the United States were directly attributable to medical errors.⁷² Although disclosure of medical errors has not been universally embraced by Risk Managers, increasingly disclosure is becoming the norm, not an aberration. The basic

reason is this: it is simply ethically and morally the right thing to do. B. S. Johnson, RN, JD (personal communication, May 1, 2014.)

The past ten years have seen incredible, once unheard of strides with regard to disclosure of medical errors in this country, yet the United States is lagging behind. Although the results are far from perfect, in England and Wales a model national policy was implemented titled "Being Open." The goal of the initiative is to ". . . develop and implement local initiatives to promote greater openness with patients their families when things go wrong and to provide required support."⁷³ The Canadian Patient Safety Institute established Canadian Disclosure Guidelines in 2008. The Canadian Medical Protective Association (CMPA) developed a widely used booklet for practitioners titled *Communicating With Your Patient About Harm: Disclosure of Adverse Events*.⁷⁴

In 2002 New Zealand established a legal "duty of candor" and all hospitals have written guidelines regarding "open disclosure."⁷⁵ Along with the Scandinavian countries, New Zealand, in the 1970s, moved away from tort based litigation to offer financial compensation to all victims of personal injury. Funds are administered by The Accident Compensation Corporation.

And, as noted, progress is being made in the United States with increasing acceptance of the disclosure concept, renamed from *disclosure and resolution* to *communication and resolution* by the U.S. Agency for Healthcare Research and Quality.⁷⁶ And, although there is not a lot of hard data or experience working with the model, early indications are that the Disclosure, Apology, and Offer (DA&O) model demonstrates promise in shifting the paradigm from concealment of errors, anger, blame

placing, and litigation to open and direct communication regarding error, and apology and offer of compensation to resolution.⁷⁷

There are, of course, legal complications having to do with disclosure, privacy, and liability,^{78,79} complications far beyond the scope of this paper. However, there is good news for physicians in the change from paternalism to disclosure. The legal complications alluded to above are not insurmountable, they can be worked out. Programs like DA&O have the potential to decrease errors, improve the quality of care, and, if not end, at least decrease the scapegoating of physicians that has existed since at least the reign of The Law Giver, King Hammurabi.

ENDNOTES

- ¹ Yale Law School Lillian Goldman Law Library, *The Code of Hammurabi*, <http://avalon.law.yale.edu/ancient/hamframe.asp> (accessed 20 March 2014).
- ² Allen D. Spiegel & Florence Kavaler, *America's First Medical Malpractice Crisis, 1835-1865*, 22 J. Comm. Health 283, 291-293 (1997) (hereinafter Spiegel, *America's First*).
- ³ Robert I. Field, *The Malpractice Crisis Turns 175: What Lessons Does History Hold for Reform?*, 4.1 Drexel L. Rev. 1/24, 10/24 (2011) (hereinafter Field, *Crisis Turns 175*).
- ⁴ Spiegel, *America's First*, *supra* n.2 at 285.
- ⁵ *Id.* at 287.
- ⁶ Stephen H. Price, *The Sinking of the "Captain of the Ship"*, 10 J. Leg. Med. 323, 348 (1989) (hereinafter Price, *Sinking of the Captain*).
- ⁷ Bradley C. Canon & Dean Jaros, *The Impact of Changes in Judicial Doctrine: The Abrogation of Charitable Immunity*, 13 L. & Socy. Rev. 969, 972-974 (1979) (hereinafter Canon, *Abrogation*).
- ⁸ Price, *Sinking of the Captain*, *supra* n. 6, at 348 (quoting Payne & Mayes, *Vicarious Liability and the Operating Room Surgeon*, 17 S. Tex. L.J. 367, 398 (1976)).
- ⁹ *Noel v. Menninger*, 175 Kan. 751, 756, 267 P.2d 934 (Kan. 1954).
- ¹⁰ *Pierce v. Yakima Valley Mem. Hosp. Ass'n.*, 43 Wn.2d 162,167, 260 P.2d 765 (Wash. 1953).
- ¹¹ *Id.* at 167.
- ¹² Canon, *Abrogation*, *supra* n. 7 at 971.
- ¹³ *Georgetown College v. Hughes*, 130 F.2d 810, 815, 76 U.S.App.D.C. 123 (1942).
- ¹⁴ *McDonald v. Mass. General Hospital*, 120 Mass. 432, 436 (Mass. 1876).
- ¹⁵ *Georgetown*, 130 F.2d at 815.
- ¹⁶ Canon, *Abrogation*, *supra* n. 7 at 971.
- ¹⁷ *Glavin v. Rhode Island Hospital*, 12 R.I. 411,1,14, 34 Am.Rep. 675 (R.I. 1879).

¹⁸ *Id.* at 10.

¹⁹ *Id.* at 10.

²⁰ Allen D. Spiegel & Florence Kavaler, *America's First Medical Malpractice Crisis, 1835-1865*, 22 J. Comm. Health 283, 285 (1997).

²¹ Richard C. Frese & Patrick J. Kitchen, *Perspectives on Medical Malpractice Self-insurance Financial Reporting*, Healthcare Fin. Mgt. (2012) (available at <http://www.hfma.org/Content.aspx?id=13950>).

²² Field, *Crisis Turns 175*, *supra* n.3 at 10.

²³ *Id.* at 10.

²⁴ *Id.* at 10.

²⁵ Spiegel, *America's First*, *supra* n.2 at 286 (quoting C.B. Chapman, *Doctors and Their Autonomy: Past Events and Future Prospects*, Science 1978; 200:851-856).

²⁶ William Blackstone, *Commentaries on the Laws of England (1765-1769) Book 3, Chapter 8*, <http://www.lonang.com/exlibris/blackstone/bla-308.htm> (accessed April 14, 2014).

²⁷ S. Gerald Litvin, *An Overview of Medical Malpractice Litigation and the Perceived Crisis*, Clinical Orthopaedics and Related Research 8, 10 (2005).

²⁸ Spiegel, *America's First*, *supra* n.2 at 288.

²⁹ *Id.* at 288-289.

³⁰ Field, *Crisis Turns 175*, *supra* n.3 at 11.

³¹ *Id.* at 11.

³² *Id.* at 12-21.

³³ James H. Herndon, *An Orthopaedic Case Contributed Substantially to the First Malpractice Crisis in the United States in the Nineteenth Century*, 94 J. Bone Joint Surgery e129(1), e129(7)(2012). (hereinafter Herndon, *An Orthopaedic Case Contributed*).

³⁴ Field, *Crisis Turns 175*, *supra* n.3 at 12.

³⁵ Herndon, *An Orthopaedic Case Contributed*, *supra* n.33 at e129(1-3).

³⁶ *Id.* at e129(4).

³⁷ *Id.* at e129(1).

³⁸ *Id.* at e129(6).

³⁹ Field, *Crisis Turns 175*, *supra* n.3 at 12-13.

⁴⁰ *Id.* at 12-13.

⁴¹ *Id.* at 19.

⁴² *Id.* at 22.

⁴³ Canon, *Abrogation*, *supra* n. 7 at 971.

⁴⁴ *Jensen v. Maine Eye and Ear Infirmary*, 107 Me. 408, 408-411, 78 A. 898 (Me. 1910).

⁴⁵ *Jensen*, 107 Me. at 411.

⁴⁶ Sharon M. Glenn, *Tort Liability of Integrated Health Care Delivery Systems: Beyond Enterprise Liability*, 29 Wake Forest L. Rev. 305, 313 (1994).

⁴⁷ *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92 (N.Y. 1914).

⁴⁸ *Bing v. Thunig*, 2 N.Y.2d 656, 660, 143 N.E.2d 3, 163 N.Y.S.2d 3 (N.Y. 1957).

⁴⁹ *Bing*, 2 N.Y.2d at 662.

⁵⁰ *Georgetown*, 130 F.2d at 812.

⁵¹ *Id.* at 813.

⁵² *Noel*, 175 Kan. at 762.

⁵³ *Id.* at 763-764.

⁵⁴ *McConnell v. Williams*, 361 Pa. 355, 65 A.2d 243 (Pa. 1949).

⁵⁵ *Mazer v. Lipschutz*, 327 F.2d 42, 56, 7 Fed.R.Serv.2d 956 (1963).

⁵⁶ Price, *Sinking of the Captain*, *supra* n. 6, at 332 (quoting Note, *Torts—Texas Labels Captain of the Ship Doctrine: "False Rule of Agency"*, 14 Lake Forest L. Rev. 323, 325-336 (1978)).

⁵⁷ Harold L. Hirsch, *Hospital Law: The Changing Scene*, in *Legal Medicine Annual 1978*, 325, 326 (Cyril H. Wecht ed., Appleton-Century-Crofts 1978)(hereinafter Hirsch, *Hospital Law*).

⁵⁸ *Bing*, 2 N.Y.2d at 666-667.

⁵⁹ John F. Harty, *Rulings Undermine Charitable Immunity, Uphold Rights of Employes [sic] and Minors*, 114 *Modern Hospital* 60,60 (1970).

⁶⁰ *Lewis v. Physicians Ins. Co. of Wisconsin*, 243 Wis.2d 648,662-663, 627 N.W.2d 484 (Wis. 2001).

⁶¹ Hirsch, *Hospital Law*, *supra* n.57 at 327.

⁶² Gene A Blumenreich, *The Doctrine of Corporate Liability*, 73 *AANA J.* 253, 253 (2005).

⁶³ *Id.* at 253.

⁶⁴ Price, *Sinking of the Captain*, *supra* n.6, at 348 (quoting Payne & Mayes, *Vicarious Liability and the Operating Room Surgeon*, 17 *S. Tex. L.J.* 367, 398 (1976)).

⁶⁵ Herndon, *An Orthopaedic Case Contributed*, *supra* n.33 at e129(1-3).

⁶⁶ Charles R. Ellington et al., *State Tort Reforms and Hospital Malpractice Costs*, 38 *J.L. Med. & Ethics* 127, 127(2010).

⁶⁷ Allen Kachalia, Niteesh K. Choudhry & David M. Studdert, *Physician Responses to the Malpractice Crisis: From Defense to Offense*, 33 *J.L. Med. & Ethics* 416, 417(2005).

⁶⁸ M. M. Mello, *Understanding Medical Malpractice Insurance: A Primer*, *RWJF* 1, 1(2005)(hereinafter Mello, *Understanding Insurance*).

⁶⁹ Alan G. Williams, *The Cure for What Ails: A Realistic Remedy for the Medical Malpractice "Crisis"*, 23 *Stan. L. & Policy Rev.* 477, 477-479 (2012).

⁷⁰ Mello, *Understanding Insurance*, *supra* n.68 at 4.

⁷¹ Williams, *Cure for What Ails*, *supra* n.69 at 482.

⁷² Kyle Miller, *Putting the Caps on Caps: Reconciling the Goal of Medical Malpractice Reform with the Twin Objectives of Tort Law*, 59 *Vand. L. Rev.* 1457, 1465 (2006).

⁷³ Albert W. Wu et al., *Disclosing Adverse Events to Patients: International Norms and Trends*, 00 *J. Patient Safety* 1, 2 (2014).

⁷⁴ *Id.* at 2.

⁷⁵ *Id.* at 3.

⁷⁶ *Id.* at 3.

⁷⁷ Sigall K. Bell et al., *Disclosure, Apology, and Offer Programs: Stakeholders' Views of Barriers to and Strategies for Broad Implementation*, 90 *Milbank Q.* 682 (2012).

⁷⁸ *Id.* at 693-700.

⁷⁹ Allen Kachalia, *Improving Patient Safety through Transparency*, 369 *New Eng. J. Med.* 1677, 1679(2013).