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September 29, 2005, will mark the fortieth anniversary of the Illinois Supreme Court's landmark decision in the case of *Darling v. Charleston Community Memorial Hospital.*[1] This paper examines the impact that *Darling* and its progeny have had and continue to have on hospital liability over the last four decades. Part I is an analysis of the holdings in the Illinois Appellate Court and Supreme Court decisions themselves. Part II demonstrates *Darling*'s impact on hospital agency liability theory. Part III identifies other changes in hospital liability jurisprudence effected and foreshadowed by *Darling*.

INTRODUCTION

In the view of the author, the *Darling* decision was the "Big Bang" event that, in an instant, gave rise to a totally new and still expanding universe of hospital liability theory.[2] The basic facts of the *Darling* case are truly unremarkable, yet its impact has been profound and transformative of hospital liability theory.

On the surface, the *Darling* decision merely affirmed a $110,000 judgment against a rural, fifty-bed hospital in downstate Illinois as compensation for a leg amputation resulting from improper casting of a broken leg and the medically mismanaged infection that ensued. Yet the *Darling* case has been cited to date in over 340 state and federal cases,

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1. 211 N.E.2d 253 (Ill. 1965).

2. The author found the eighty-four page Illinois Appellate Court decision (Darling v. Charleston Cmty. Mem'l Hosp., 200 N.E.2d 149 (Ill. App. Ct. 1964)) more illuminating than the fourteen page *Darling* Illinois Supreme Court decision (211 N.E.2d at 257) and therefore relies additionally on the Illinois Appellate Court's analysis in his discussion of the *Darling* paradigm.

including 32 Illinois Supreme Court cases, 166 Illinois Appellate Court cases, 57 other state supreme court (or equivalent court) cases and 59 other state appellate court cases encompassing the great majority of this country's state court jurisdictions.[3] To date, it has also been the subject of, or referenced in, an additional 389 law review articles, monographs, treatises, etc.[4] The reasons for such prolific citation are set forth below.

I. RADICAL CHANGES IN HOSPITAL LIABILITY THEORY EFFECTED BY THE *DARLING* DECISION: THE "NEW" POST-1965 PARADIGM

The *Darling* decision effected two radical changes in hospital liability jurisprudence. The first is the extension of direct liability theory to hospital entities in their role as providers of care. The second has to do with what can constitute competent evidence of the duties of care owed by a provider-hospital directly to its patients which, if found to have been violated, can result in direct liability for the hospital.

No court prior to *Darling* had ever enunciated either of these two radical elements, much less ever combined them. Before *Darling*, there was no equivalent in the American jurisprudence of hospital liability for either of these elements. Then the *Darling* Big Bang occurred, giving rise to a new and still expanding universe of hospital liability theory.

A. Hospital Direct Liability

At the core of the Illinois Supreme Court's decision is its holding, for the first time ever, that hospital entities themselves, acting through both their employees and independent (non-employed) medical staff members, undertake to treat patients and that in their capacity as providers of care, hospitals owe separate duties of care to their patients directly (hence, "direct liability") which, if violated, will result in liability for the hospital entity.[5] These direct duties of care owed by hospitals are in addition to the vicarious liability exposures hospitals have under the doctrine of *respondeat superior* for their agents' breaches of other independent duties of care owed by those agents to patients (typically having to do with the standards of hands-on medical or clinical care).

The methodology employed by the Illinois Supreme Court in reaching this result is interesting. The court cited *Bing v. Thunig* for the proposition that hospital entities undertake to treat patients through their doctors and

3. *See* LEXIS SHEPARD'S, http://www.lexisnexis.com (last visited Apr. 14, 2005) (enumerating the various jurisdictions that have cited the Illinois Supreme Court's decision in *Darling*).

4. SHEPARD'S, *supra* note 3.

5. *Darling*, 211 N.E.2d at 257.

nurses.[6] The *Bing* court reached this conclusion after finding that health care as delivered by hospitals in 1957 had become a big business and did not merely furnish facilities where health care professionals acted on their own responsibility.[7] However, *Bing*'s central finding became the premise for vastly expanding a New York hospital's vicarious liability exposure.[8] The Illinois Supreme Court adopted *Bing*'s rationale and found that hospitals had likewise become big businesses in Illinois by 1965. However, the court used *Bing* as the premise for its first-ever direct liability holding, not vicarious liability.[9]

B. Hospitals' Separate Direct Duties of Care

The *Darling* court next addressed the issue of what constitutes competent evidence of the separate duties of care owed directly to patients by hospitals as providers.[10] The *Darling* court responded as follows:

> In the present case the regulations, standards, and bylaws which the plaintiff introduced into evidence, performed much the same function as did evidence of custom. This evidence aided the jury in deciding what was feasible and what the defendant knew or should have known. It did not conclusively determine the standard of care and the jury was not instructed that it did . . . .
>
> The Standards for Hospital Accreditation, the state licensing regulations and the defendant's bylaws demonstrate that the medical profession and other responsible authorities regard it as both desirable and feasible that a hospital assume certain responsibilities for the care of the patient.[11]

In the author's view, it is this element of the *Darling* decision that constitutes the most radical change concerning direct liability. Before *Darling,* there was no equivalent for this element either. It has given rise to a virtually limitless evidentiary base for hospitals' (and now other providers') duties of care to patients, given the all-encompassing scope and the sheer number of accreditation standards set forth by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), as well as hospital licensing standards. There are endless variations in these state and local equivalent licensing regulations, not to mention the unique

6. *Id.*
7. *Id.* (citing Bing v. Thunig, 143 N.E.2d 3, 8 (N.Y. 1957)).
8. *Bing*, 143 N.E.2d at 11-12.
9. *Darling*, 211 N.E.2d at 257.
10. *Id.*
11. *Id.*

provisions in corporate and medical staff bylaws, as well as other documents deemed relevant by the courts over time. It is precisely this virtually infinite number of evidentiary variations, more than any other feature of the *Darling* decision, which drives the ever-expanding nature of the new hospital liability paradigm set off by *Darling*'s 1965 Big Bang.

A more recent example of this still expanding "universe" is *Jones v. Chicago HMO Ltd.*, in which *Darling*'s direct liability theory was extended to Health Maintenance Organizations (HMOs).[12] The issue decided in that case dealt with the reasonableness of HMO physician patient load limits. Among the documents admitted into evidence were HMO accreditation standards, HMO entity and plan documents, and physician provider agreements.[13]

As exemplified by the *Darling* decision, it is legally sufficient to affirm a judgment if only one of the total number of duties found by the jury to have been violated can be sustained on appeal. Of the thirty or so duty of care issues submitted to the *Darling* jury, only two were focused on and sustained by the Illinois Supreme Court: (a) nurse staffing inadequacy or incompetence; and (b) failure to review the plaintiff's medical case while hospitalized.[14] For defendant hospitals, this harsh legal reality lends a particularly lethal characteristic to the post-1965 *Darling* paradigm.

The illuminating *Darling* Illinois Appellate Court decision highlighted the following as relevant evidentiary sources from which the jury could discern the defendant hospital's duties of care: (a) Illinois Hospital Licensing Act regulations promulgated by the Illinois Department of Public Health (IDPH) addressing the hospital governing board's responsibilities for employing "competent and well qualified personnel in adequate numbers" and of requiring "that the medical staff function in conformity with reasonable standards of competency;"[15] (b) IDPH medical staff bylaws content regulations requiring clear standards for medical consultations, experience-based determinations for granting practice privileges, and regular and ongoing review of "clinical experience" based on patient medical records;[16] (c) JCAH (now JCAHO) nursing-department accreditation standards requiring that nurses "function in close relationship with other services of the hospital, both administrative and professional;"[17] (d) JCAH nursing department hospital accreditation standards requiring "an adequate number of professional nurses and ancillary personnel for bedside

12. 730 N.E.2d at 1128.
13. *Id.* at 1132-33.
14. *See Darling*, 211 N.E.2d at 163-66.
15. *Id.* at 163.
16. *Id.* at 164.
17. *Id.* at 165.

care;"[18] (e) JCAH governing body accreditation standards requiring the appointment of qualified and competent medical staff members;[19] (f) JCAH medical staff accreditation standards placing overall responsibility for the quality of medical care on the organized medical staff as a whole, requiring "constant analysis and review of the clinical work done in the hospital," as well as clear criteria for medical consultations;[20] (g) Charleston Community Memorial Hospital's medical staff bylaws provisions which "ensured the best possible care" as part of its purposes statement;[21] (h) vague defendant hospital medical staff bylaws provisions requiring medical consultations "in all major cases in which the patient is not a good risk or should the diagnosis appear to be obscure;"[22] and (i) medical staff bylaws provisions requiring emergency coverage on an organized rotation basis.[23]

II. *DARLING'S* IMPACT ON HOSPITAL AGENCY LIABILITY THEORY

Before *Darling*, the doctrine of *respondeat superior* was alive and well and was applied on occasion to impose hospital agency liability, albeit under some very narrow and highly limited circumstances.[24] The prevailing judicial view of hospitals well into the twentieth century was that as legal entities, hospitals were essentially charitable trusts and were therefore deserving of special treatment under the law in order to prevent what would otherwise be the inappropriate diversion of charitable trust assets.[25]

By the 1950s, the courts had fashioned and adopted a number of factors or circumstances, which, if proven to exist in a given case, rendered agency liability theory inapplicable to the defendant hospital. Among these factors were: (a) the view that hospitals merely provided facilities in which health care professionals (including employed nurses) acted therein on their own responsibility;[26] (b) the distinction between "medical" and "administrative" acts under which, generally speaking, hospital agency liability could result only in the case of the latter; (c) generally, hospitals were not even held liable for the "medical" acts of their employed nurses; (d) the "captain of the ship" doctrine insulated hospitals from agency liability resulting from the acts or omissions of attending physicians or surgeons as well as other

18. *Id.*
19. *Id.*
20. *Darling*, 211 N.E.2d at 164-65.
21. *Id.* at 165.
22. *Id.*
23. *See id.* at 166.
24. *Bing*, 143 N.E.2d at 3; *See also* Shloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 95 (N.Y. 1914).
25. *Bing*, 143 N.E.2d at 5-6; *See also Shloendorff*, 105 N.E. at 95.
26. *Bing*, 143 N.E.2d at 8.

health care professionals deemed to be acting under their direction; and (e) hospital agency liability for the acts or omissions of independent (non-employed) physicians was virtually unheard of.[27]

The landmark case of *Bing v. Thunig* exemplifies the sea-change in hospital agency liability theory that was then beginning to occur, some eight years prior to *Darling*.[28] As stated in Part I above, the Illinois Supreme Court cited *Bing* and adopted its finding that health care had evolved into just another form of big business, no longer deserving of special treatment by the courts.

The *Bing* court first reviewed, then abolished, a number of the pre-existing hospital agency liability insulating factors.[29] It then simply extended to hospitals the same two-part agency liability test or query as for any other employer: (a) whether the negligent actor was an employee of the hospital; and (b) if so, whether the negligent act or omission occurred in the course and scope of that employment.[30] This was a liability theory based on actual agency, or agency-in-fact, not the apparent or ostensible agency liability theory for hospitals which would come some years later.[31]

The end result reached in *Darling* was the establishment for the first time ever of the rule of direct hospital liability, not the extension to hospitals of the general principles of agency liability based on actual agency or employment.[32] How then can it be said that *Darling* also had an impact on hospital agency liability theory?

The answer is that both of these disparate end results are rooted in the same *Bing* rationale cited with approval and relied upon by the *Darling* court, namely:

> The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact. Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. They regularly employ on a salary basis a large staff of physicians, nurses and interns, as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such services, if necessary, by legal action. Certainly, the person who avails himself of 'hospital facilities' expects that the hospital will attempt to cure him, not that its nurses or other employees will act on

27. *See id.* at 4, 6 (summarizing *Schloendorff*, *supra* note 24).
28. *Id.* at 3.
29. *Id.* at 5-9.
30. *Id.* at 8.
31. *See Bing*, 143 N.E.2d at 8.
32. *See id.*

their own responsibility.[33]

In the author's view, the *Darling* court implicitly endorsed *Bing*'s abolition of the pre-existing insulating circumstances for hospital agency liability, but went beyond *Bing* to establish for the first time ever the rule of hospital direct liability. Thus, the *Darling* court endorsed two separate and distinct theories of hospital liability that are complementary and not mutually exclusive: direct hospital liability, and implicitly, hospital agency liability based on employment or actual agency.

The above excerpt from the *Bing* decision relied upon by the *Darling* court in imposing direct liability foreshadows elements of hospital apparent agency (ostensible agency) that emerged later.[34] Of particular relevance are the findings that in treating patients, hospitals act through their doctors and nurses and that patients "expect" that the *hospital* will attempt to cure them, not that nurses or physicians working there are acting on their own responsibility.[35] This shift in perspective to what the *patient* may reasonably expect in receiving hospital-based care is the very bedrock of hospital apparent or ostensible agency liability over and above hospital agency-in-fact liability.[36]

The emergence of apparent agency as a fully developed hospital liability theory occurred post-*Darling*. The exemplar Illinois case is *Gilbert v. Sycamore Municipal Hospital*,[37] which liberally referenced and relied upon *Kashishian v. Port*.[38] The *Gilbert* court identified the elements of hospital apparent agency liability as: (a) the hospital holding itself out as the provider of care; (b) the patient reasonably believing that the independent physician rendering care to him or her is the hospital's agent; and (c) justifiable reliance on such belief to the patient's detriment.[39] The first two elements, at least, perhaps in a more rudimentary form, can be found in the above excerpt from *Darling*.[40]

Gilbert and *Darling* have the following common decisional findings: 1) hospitals are deemed big businesses, not charitable institutions as in the past;[41] 2) hospitals act through their doctors in treating patients;[42] and 3) patients naturally assume that physicians unfamiliar to them are hospital

33. *See Darling*, 211 N.E.2d at 257 (quoting *Bing*, 143 N.E.2d at 8).
34. *Id.*
35. *Id.*
36. *Id.*
37. 622 N.E.2d 788, 793-94 (Ill. 1993).
38. 481 N.W.2d 277, 282 (Wis. 1992).
39. *Gilbert*, 622 N.E.2d at 795.
40. *Darling*, 211 N.E.2d at 257 (quoting *Bing*, 143 N.E.2d at 8).
41. *See Gilbert*, 622 N.E.2d at 793; *Darling*, 211 N.E.2d at 263.
42. *See Gilbert*, 622 N.E.2d at 793; *Darling*, 211 N.E.2d at 257.

employees and are not acting on their own responsibility as independent contractors.[43]

III. OTHER CHANGES EFFECTED OR FORESHADOWED BY *DARLING*

A. Abolition of Charitable Immunity for Hospitals in Illinois

The judicially-created doctrine of charitable immunity originally exempted all the assets of "charitable institutions," including hospitals, from the reach of judgment creditors as an impermissible diversion under principles of charitable trust law.[44] Before *Darling*, the Illinois Supreme Court permitted limited recovery, but only against commercial insurance coverage limits, if any.[45] The *Darling* court eliminated altogether the last vestiges of this immunity doctrine, but with prospective effect only, except for the defendant hospital.[46]

B. Abolition of the So Called "Hotel Defense" for Hospitals

Before *Darling*, the "hotel defense" was based on the premise that hospitals as entities did not undertake to treat patients. Instead, hospitals merely undertook to provide facilities and procure professionals who acted on their own responsibility for the most part. The *Darling* court, citing *Bing v. Thunig,*[47] squarely held that hospitals treated patients acting through their employed nurses and medical staff.[48]

C. Creation of Personal Liability Exposures

Hospital directors, managers, and medical staff members are among those exposed to personal liability. Personal liability arises under the various accreditation and licensing standards and regulations establishing explicit duties owed by directors, managers, and organized medical staff, which, if not complied with, will bring personal liability for these individuals in addition to the hospital's separate direct liability. While used infrequently, these personal exposures are very real.[49]

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43. *See Gilbert*, 622 N.E.2d at 794; *Darling*, 211 N.E.2d at 257.

44. *See Bing*, 143 N.E.2d at 7; *Schloendorff*, 105 N.E.2d at 95.

45. *See* Molitor v. Kaneland Cmty. Sch. Dist. No. 302, 182 N.E.2d 145, 147 (Ill. 1962).

46. *Darling*, 211 N.E.2d at 260.

47. *Bing*, 43 N.E.2d at 8.

48. *Darling*, 211 N.E.2d at 257.

49. See Part II, *supra*, for how these standards and regulations may be used as evidence of the duties of care owed to patients.

D. "Chain of Command" Failures

Darling foreshadowed so-called "chain of command" failures as an additional basis for hospital agency liability. One of the two grounds on which the *Darling* court's affirmance was based was the nursing staff's failure to bring the plaintiff's leg infection to the attention of hospital administration and medical staff in order to rectify the condition.[50] Chain of command failures as a fully developed liability theory would emerge much later.[51]

E. Teeth for the JCAHO

A very positive effect of *Darling* was to confirm and strengthen the role of JCAHO as an accrediting body and to give teeth to its accreditation standards, especially those relating to quality management, peer review, and medical staff credentialing. The same can be said of equivalent state and local hospital licensing regulations. From 1965 forward, hospitals understood that non-compliance with these standards would bring with it exposure to substantial liabilities as well. Compliance made a quantum leap, albeit for negative motives.

F. Hospital Professional Liability Insurance Crises

Darling was a significant factor for subsequent cyclical crises in the hospital professional liability (HPL) market. The rule of direct hospital liability, announced for the first time in *Darling,* eventually touched off the first of several HPL insurance crises beginning in the 1970s. These crises deepened as *Darling*'s imposition of direct liability was adopted by more and more state court jurisdictions.

G. Imputability of Knowledge of Peer Review Information

In an extreme factual situation, the *Darling* rationale was used to expand a hospital's corporate responsibility for quality of care by imputing to the hospital knowledge of all material facts that could have been discovered in the course of medical staff credentialing.[52]

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50. *Darling,* 211 N.E.2d at 258.

51. Holton v. Mem'l Hosp., 679 N.E.2d 1202, 1208-09 (1997). Repeated failure of defendant hospital's nursing staff to timely and accurately report plaintiff's decline into paresis was deemed to have been the proximate cause of preventing attending physicians from correctly diagnosing and timely and efficaciously treating plaintiff's condition. The evidence supported the jury's verdict against the defendant hospital based on agency liability theory. The case was ultimately remanded for a new trial on other grounds.

52. *See* Johnson v. Misericordia Cmty. Hosp., 301 N.W. 2d 156, 175 (Wis. 1981). An applicant for a medical staff appointment to a hospital lacking JCAHO accreditation lied on

H. Offensive Uses of Darling

There is a growing number of cases in which *Darling's* imposition upon hospitals of a direct duty to assume responsibility for the care of patients in order to safeguard and improve care has been used offensively, or in sword-like fashion.[53] The *Darling* holding has been held to trump other colliding rights and issues in a variety of factual settings.

Darling's core holding has been used to successfully uphold an Illinois private (i.e. non-governmental) hospital's wide discretion in rejecting an initial medical staff appointment application without resort to a full-blown hearing where medical staff bylaws do not confer such rights.[54] It has also served as a basis for overturning the former judicially created "corporate practice of medicine doctrine" which had previously prohibited the formal employment of physicians by licensed hospitals in Illinois.[55] Finally, *Darling* has served as a basis for upholding the constitutionality (alleged separation of powers violation) under the Illinois Constitution of year 2000 amendments to the Illinois Hospital Licensing Act. These amendments expressly permit *ex parte* communications between a hospital on the one hand, and its patients, employees, and treating medical staff members on the other, in the context of pending or potential medical malpractice claims.[56] This holding effectively nullified the prior *Petrillo* case ruling which prohibited such communications.[57]

CONCLUSION

The impact of *Darling* and its progeny over the last four decades has transformed hospital liability jurisprudence and will likely continue to do so. But *Darling* has also helped to bring about a quantum leap improvement over time in the quality of health care in the United States. That is a very good thing, indeed, for all health care consumers.

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his application. The investigation would have revealed his prior disciplinary actions and ten prior medical malpractice actions.

53. *See infra,* notes 54-56.

54. See Mauer v. Highland Park Hosp., 232 N.E.2d 776, 779 (Ill. App. Ct. 1967); Barrows v. Northwestern Mem'l. Hosp., 525 N.E.2d 50, 51-52 (Ill. 1988).

55. *See* Berlin v. Sarah Bush Lincoln Health Ctr., 688 N.E.2d 106, 109 (Ill. 1997).

56. *See* Burger v. Lutheran Gen. Hosp. 759 N.E.2d 533, 549, 557-58 (Ill. 2004).

57. *See* Petrillo v. Syntex Laboratories, Inc., 148 Ill.App.3d 581, 587 (Ill. App. Ct. 1986).