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Impaired Physicians and the Scope of Informed Consent: Balancing Patient Safety with Physician Privacy

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IMPAIRED PHYSICIANS AND THE SCOPE OF INFORMED
CONSENT: BALANCING PATIENT SAFETY WITH
PHYSICIAN PRIVACY

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I. INTRODUCTION

A thirty-eight-year-old orthopedic surgeon comes home to his empty house following a typical ten-hour day at the hospital. Recently divorced and without children, he drops his keys at the front door and heads towards the living room with the take-out dinner he picked up on his way home. He turns on the news and pours himself a glass of red wine. Ever since his divorce, he has been drinking wine more frequently than he used to, perhaps to mask his loneliness. After his third or fourth glass of wine, he turns off the television, brushes his teeth, and goes to bed.

At five o'clock in the morning, he awakes to his alarm clock and throws on his running shoes. After his usual five-mile run, he grabs a piece of toast and heads to the hospital. Today is just like any other day for the surgeon; at eleven o'clock, he reviews the chart of a patient scheduled for a total knee-replacement. The surgeon goes into the operating room to discuss with the patient, one more time, the risks and alternatives associated with this surgery, along with its potential benefits. He asks the patient whether she has any further questions before anesthesia is administered. After the patient signs the standard informed consent form and acknowledges that she wishes to proceed with the surgery, the orthopedic surgeon leaves the room to prepare for the procedure.

Shortly after the knee-replacement surgery, the patient begins developing complications, ultimately requiring an additional surgery. Frustrated with the outcome of the original procedure, the patient chooses to have a different physician perform the second surgery. Despite all efforts during the second surgery, the patient loses full function of her leg.

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The patient begins hearing rumors about the orthopedic surgeon's recent, nasty divorce. She also sees him at local restaurants, sitting alone at the bar with a drink in front of him. After the patient calls some mutual friends of the surgeon's ex-wife, she learns that the orthopedic surgeon has developed a drinking problem since his divorce. She decides to file a medical malpractice suit, alleging that the surgeon did not obtain her informed consent before the procedure because he failed to inform her of his alcoholism.

Situations like the one described above present an important and undefined question to the medical field: whether a physician has a duty to inform his patient about his alcoholism, drug abuse, and/or mental illness (such as depression) in gaining a patient's informed consent before a procedure.¹ On one hand, we live in a country with a medical system that values patient autonomy.² We believe a patient has the right to make her own medical decisions based on a physician's adequate disclosure of the potential risks and benefits involved in a given procedure.³ The large amount of medical malpractice suits and medical regulations also demonstrate the importance we place on patient safety.⁴ On the other hand, however, we also recognize the shortcomings of the informed consent doctrine.⁵ We recognize an individual's right to privacy⁶ and that alcoholism, mental illness, and drug-related impairments are private matters deserving protection from disclosure to the public to effect recovery.⁷

This Note will argue that a physician, in gaining a patient's informed consent, does not have a duty to disclose to the patient whether he suffers, or has suffered, from alcoholism, drug abuse, or mental illness. Physicians are still human and thus deserve the right to privacy regarding such personal matters as are enjoyed by the

1. See Mary Anne Bobinski, *Autonomy and Privacy: Protecting Patients from Their Physicians*, 55 U. PITT. L. REV. 291, 376 (1994) ("The types of personal characteristics . . . requiring disclosure are undefined.").

2. See *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972) ("The root premise is the concept, fundamental in American jurisprudence, that '[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body.' " (quoting *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (1914))).

3. See *id.* at 781.

4. See, e.g., Frederick Levy et al., *The Patient Safety and Quality Improvement Act of 2005: Preventing Error and Promoting Patient Safety*, 31 J. LEGAL MED. 398-406 (2010).

5. See Sheldon F. Kurtz, *The Law of Informed Consent: From "Doctor is Right" to "Patient has Rights"*, 50 SYRACUSE L. REV. 1243, 1245 (2000).

6. See Barry R. Furrow, *Data Mining and Substandard Medical Practice: The Difference Between Privacy, Secrets and Hidden Defects*, 51 VILL. L. REV. 803, 803 (2006) ("We properly value privacy: it is a desirable end state and a precondition for identity, allowing individuals to achieve goals such as autonomy and solidarity with peers . . .").

7. See Rebecca Sara Feinberg, *The Impaired Physician: Medical, Legal, and Ethical Analysis with a Policy Recommendation*, 34 NOVA L. REV. 595, 605 (2010) ("Confidentiality is [a] key element to successful intervention and treatment.").

public generally. This Note will point out that such conditions do not have as material of an effect on the performance of medical procedures as people generally assume. Yet, if these impairments were to rise to a level such that patient safety would be compromised, liability must fall somewhere. Thus, instead of requiring physicians to disclose their personal impairments during the informed consent process, the emphasis should be placed on the hospital's duty to properly monitor its physicians' credentials. Further, disclosure through the informed consent doctrine is not the proper way to protect patients from physicians who are incapable of adequately performing medical procedures due to alcoholism, drug abuse, or mental illnesses. Rather than pointing the finger at the physician for lack of disclosure, the issue of impaired physicians involves a bigger picture that the hospital system is, itself, deficient.

Hospitals should implement methods that will incentivize physicians to get the treatment they need without the attached stigmatization. Hospitals must implement and properly maintain confidential yet effective programs designed to identify and rehabilitate physicians suffering from alcoholism, drug-dependency, and mental illnesses to ensure that those physicians practicing medicine are safely capable of doing so. This emphasis on a hospital's duty to monitor and qualify physicians provides the ideal balance of physician privacy and patient safety.

This Note will begin by exploring the history and evolution of the informed consent doctrine in the American medical field. A discussion of the characteristics of "impaired physicians" will follow. This Note will then examine the relationship between impaired physicians and the scope of the informed consent doctrine. Finally, I will articulate that the duties of a hospital to monitor and credential physicians via a corporate negligence theory strikes the proper balance between protecting a physician's privacy and patient's safety.

II. INFORMED CONSENT DOCTRINE

The informed consent doctrine is a relatively recent phenomenon principled on the American concept of autonomy.⁸ Informed consent was seen as one tool in response to the imbalance of power in the provider-patient relationship.⁹ The idea was that "requiring physicians to provide more information to their patients [would] help to

8. See Barbara L. Atwell, *The Modern Age of Informed Consent*, 40 U. RICH. L. REV. 591, 594 (2006).

9. See MARK A. HALL ET AL., *MEDICAL LIABILITY AND TREATMENT RELATIONSHIPS* 197-98 (Vicki Been et al. eds., 3d ed. 2013).

redress the power imbalance problems created by the inequality of knowledge.”¹⁰

The doctrine was originally an outgrowth of the tort of battery.¹¹ Claims for an informed consent violation amounted to an intentional and unauthorized touching of another.¹² Beginning in the 1950s, courts “viewed risk nondisclosure situations as analogous to and an extension of those battery cases where consent was fraudulently obtained.”¹³ Bringing an informed consent claim under a battery theory had significant advantages over bringing a negligence-based claim:

First, and most importantly, battery did not require the patient to prove by an expert medical witness that the defendant had deviated from an accepted medical standard of care. Second, battery did not require the patient to prove that he would have refused the treatment if he had been given the proper information. Third, battery would entitle the patient to recover damages even if the operation did not have a “bad result.” Fourth, as an intentional tort, battery might have entitled the patient to an instruction on punitive damages, which would not be available in an action based upon negligence.¹⁴

Recognizing the possibility for unnecessary liability, courts gradually began pulling away from the battery theory of informed consent and, instead, started moving toward a standard negligence theory of medical malpractice.¹⁵ The battery-based claims generally dealt more with procedures in which *no* consent was given, while the new negligence-based claims more commonly involved situations in which the consent given was *inadequate*.¹⁶ Indeed, basing an informed consent claim on a theory of negligence “more closely comports with the reality of medical practice.”¹⁷ “[D]octors’ informed consent practices require the exercise of judgment. . . . Since the treating physician retains some flexibility in determining how much information to disclose, cases based on a failure to obtain informed consent, like other medical malpractice claims, are based on negligence.”¹⁸

10. *Id.* at 198.

11. William J. McNichols, *Informed Consent Liability in a “Material Information” Jurisdiction: What Does the Future Portend?*, 48 OKLA. L. REV. 711, 714-16 (1995).

12. See Atwell, *supra* note 8, at 593 (“[The informed consent doctrine] is a natural outgrowth of the common law tort of battery that prohibits intentional unauthorized bodily contact.”).

13. McNichols, *supra* note 11, at 714.

14. *Id.* at 715.

15. See *id.*

16. See Laurel R. Hanson, Note, *Informed Consent and the Scope of a Physician’s Duty of Disclosure*, 77 N.D. L. REV. 71, 72, 75 (2001).

17. Atwell, *supra* note 8, at 595.

18. *Id.* at 595-96.

Autonomy is a fundamental American concept that is furthered by the informed consent doctrine.¹⁹ “Competent adults exercise that autonomy by deciding whether or not to consent to medical treatment.”²⁰ Judge Cardozo, in one of the pioneer cases involving informed consent, famously stated: “Every human being of adult years and sound mind has a right to determine what shall be done with his own body.”²¹ Thus, the informed consent doctrine ensures that patients “have the material information with which to make an informed choice.”²²

There are two main standards that courts apply to determine a physician’s required level of disclosure: the “reasonable patient”²³ standard and the “professional malpractice”²⁴ standard.²⁵ Under the reasonable patient standard, a physician’s required level of disclosure is that which a reasonable patient would consider “material” in making a medical treatment decision.²⁶ Some courts have argued that determining the materiality of a risk from a reasonable patient’s point of view is the best way to respect autonomy.²⁷

The professional malpractice standard defines the scope of disclosure as the information which a reasonable physician in similar circumstances would provide to a patient.²⁸ Today, about half of the states follow this standard.²⁹ The professional malpractice standard

19. *See id.* at 594-95.

20. *Id.* at 594.

21. *Schloendorff v. Soc’y of N.Y. Hosp.*, 105 N.E. 92, 93 (1914), *abrogated by Bing v. Thunig*, 142 N.E.2d 3, 7-9 (1957), *superseded by statute*, Act of May 21, 1975, ch. 109, 1975 N.Y. Laws 134-35.

22. *See Atwell, supra* note 8, at 596.

23. This is also known as the “material risk” or “patient-centered” standard.

24. This is also known as the “professional disclosure” or “reasonable physician” standard.

25. *See HALL ET AL., supra* note 9, at 205; Hanson, *supra* note 16, at 75.

26. *See HALL ET AL., supra* note 9, at 205; *see also* Hanson, *supra* note 16, at 75.

27. *See, e.g., Canterbury v. Spence*, 464 F.2d 772, 786 (D.C. Cir. 1972) (“[T]he patient’s right of self-decision shapes the boundaries of the duty to reveal. . . . The scope of the physician’s communications to the patient, then, must be measured by *the patient’s need*, and that need is the information material to the decision.” (emphasis added)); *see also* Kurtz, *supra* note 5, at 1251 (“The Canterbury patient-based standard seems more consistent with the purpose of ‘informed consent’ which includes a respect for a patient’s autonomy interest and a desire to have patients participate in the decision making process.”). “A small number of jurisdictions take an even more protective approach, requiring disclosure of information that a particular patient (as contrasted with a ‘rational patient’) would have wanted to make his or her decision.” HALL ET AL., *supra* note 9, at 205.

28. HALL ET AL., *supra* note 9, at 205; *see also* Hanson, *supra* note 16, at 75.

29. HALL ET AL., *supra* note 9, at 214. “In adopting the reasonable physician standard, courts seemed to be assuming that a competent physician acting in good faith would convey to patients information essential to their understanding of relevant risks, benefits, and alternatives, rather than simply provide the traditionally meager disclosures” Ben A. Rich, *Medical Paternalism v. Respect for Patient Autonomy: The More Things Change the More They Remain the Same*, 10 MICH. ST. U. J. MED. & L. 87, 106-07 (2006).

does not require physicians to speculate as to what the reasonable patient would want to know; instead, it applies the appropriate medical standard of care to utilize the physician's professional judgment.³⁰ Testimony from medical experts is necessary, however, because the professional malpractice standard measures disclosure according to the appropriate physician's standard of care.³¹

Under either standard of informed consent, various situations may excuse disclosure,³² including emergencies,³³ areas of common knowledge,³⁴ areas of individualized knowledge,³⁵ situations where disclosure would "foreclose rational decision' or 'pose psychological damage' to the patient,"³⁶ and occasions when a patient has waived disclosure.³⁷ Such exceptions to the doctrine are generally set up as affirmative defenses.³⁸

Regardless of which standard courts apply, the informed consent doctrine has received significant criticism.³⁹ Many studies suggest a dichotomy between disclosure and comprehension or retention.⁴⁰ As such, even when physicians disclosed sufficient information, "few patients understood or remembered what they had been told about their medical condition and treatment options."⁴¹ Additionally, there is a valid concern that excessive disclosure, often due to a fear of litigation, will result in patients foregoing medically necessary treat-

30. See *Culbertson v. Mernitz*, 602 N.E.2d 98, 103 (Ind. 1992) ("[A physician] should not be called upon to be a 'mind reader' with the ability to peer into the brain of a prudent patient to determine what such patient 'needs to know,' but should simply be called upon to discuss medical facts and recommendations with the patient as a reasonably prudent physician would.").

31. HALL ET AL., *supra* note 9, at 215; see also *Hanson*, *supra* note 25, at 75 ("Under this standard, a patient usually must present expert testimony to demonstrate that a physician, following acceptable medical practice, would have disclosed the injury-causing risk.").

32. See *Hanson*, *supra* note 25, at 73-75.

33. HALL ET AL., *supra* note 9, at 221 ("There is no duty to disclose information in an emergency situation where the patient is not competent, immediate treatment is required to prevent more serious harm, and no substitute decisionmaker is available.").

34. *Id.* at 221 ("There is no duty to disclose risks 'of which persons of average sophistication are aware.'").

35. *Id.* ("The patient cannot recover for the physician's failure to disclose a risk already known by the patient.").

36. *Id.* at 221. This is known as the "therapeutic privilege," which courts have applied only in a few circumstances. *Id.* at 221-22.

37. *Id.* at 222.

38. See *id.* ("The defendant generally has the burden of proving that an exception to the duty to inform is present.").

39. See, e.g., *Atwell*, *supra* note 8, at 597-98 ("In practice, informed consent is far from perfect."); *Kurtz*, *supra* note 5, at 1245 ("[T]he doctrine falls short of its intended purpose.").

40. See also, e.g., David A. Herz et al., *Informed Consent: Is It a Myth?*, 30 NEUROLOGY 453 (1992); Alan Meisel & Loren H. Roth, *Toward an Informed Discussion of Informed Consent: A Review and Critique of Empirical Studies*, 25 ARIZ. L. REV. 265 (1983).

41. HALL ET AL., *supra* note 9, at 202.

ments.⁴² Other scholars suggest that the doctrine of informed consent doctrine does not fulfill its “goals of patient protection” in the modern practice of medicine.⁴³ Further, the elements needed to succeed in a cause of action for lack of informed consent make recovery difficult; thus, many claims are never litigated.⁴⁴

In bringing an informed consent claim, the plaintiff will generally have to prove the following: “(1) that the medical procedure carried a specific risk that was not disclosed, (2) that the physician violated the applicable standard of disclosure, (3) that the undisclosed risk materialized, and (4) that the failure to disclose the information caused the patient’s injury.”⁴⁵

Proving materialization of the undisclosed risk and causation are often the most difficult barriers for plaintiffs.⁴⁶ One can imagine many circumstances where physicians might fail to disclose a risk without the risk ever materializing. For example, if a physician fails to disclose to a patient that a particular surgery could result in paralysis (arguably a very material risk), and paralysis never materializes, the patient would not have a valid claim against the physician. When such a situation occurs, it seems the informed consent doctrine serves the purpose of protecting patients from injury rather than its stated purpose of respecting patient autonomy.⁴⁷ To prove causation, a plaintiff must convince the court that a reasonable patient in similar circumstances would have refused the treatment had the disclosure been sufficient.⁴⁸ This requirement is often a very difficult burden of proof to satisfy and tends to raise a range of issues.⁴⁹ While the causation requirement is an objective standard, the jury is permitted to consider the plaintiff’s particular circumstances.⁵⁰ The law is still fuzzy and inconsistent regarding how much of a plaintiff’s subjective circumstances should be considered.⁵¹

42. See Barry R. Furrow, *Doctors’ Dirty Little Secrets: The Dark Side of Medical Privacy*, 37 WASHBURN L.J. 283, 293 (1998) (“Disclosure creates the risk that a patient will refuse the physician’s care because of the status or the addiction, rather than looking at the particular case and the risks posed.”). Ironically, this trend would actually compromise patient safety.

43. Atwell, *supra* note 8, at 611.

44. See, e.g., HALL ET AL., *supra* note 9, at 217.

45. *Id.*

46. See *id.*

47. “Vindicating patient autonomy is at the heart of all inadequate consent cases, whether the theory is based on battery or negligence.” McNichols, *supra* note 11, at 715.

48. HALL ET AL., *supra* note 9, at 217.

49. See *id.* at 217-18.

50. See *id.* (“[A] fact finder applying objective causation rules may take into account characteristics of plaintiff, including ‘idiosyncrasies, fears, age, medical condition, and religious beliefs.’” (quoting *Ashe v. Radiation Oncology Assocs.*, 9 S.W.3d 119, 123-24 (Tenn. 1999))).

51. See *id.*

III. IMPAIRED PHYSICIANS

*“As a result of their status [doctors] are expected to be above human failings, while proving immune to the ailments that afflict the general population. Nonetheless, to err is human and in being human doctors inevitably make mistakes in the normal course of providing care.”*⁵²

An “impaired physician is a medical doctor who suffers from alcoholism, drug addiction, or mental illness.”⁵³ The American Medical Association (AMA) uses the phrase “impaired physician” as a term of art and defines it as “the inability to practice medicine adequately by reason of physical or mental illness, including alcoholism or drug dependency.”⁵⁴ The AMA’s designation of a physician as being impaired can potentially result in the suspension or revocation of the physician’s medical license.⁵⁵

“Given the everyday work stress that medical professionals experience, it is not surprising that many physicians may turn to alcohol or substance abuse.”⁵⁶ The rate of impairment for physicians is consistent among various specialties, regions, and age ranges; “[n]o group of physicians are immune.”⁵⁷ The problem is real and the numbers are frightening. The Medical Board of California estimates that eighteen percent of the physicians in California abuse alcohol or other drugs at some point during their careers.⁵⁸ The sad fact remains: physicians have a higher rate of impairment than non-physicians, yet they have more trouble securing treatment.⁵⁹ The fear that physicians will receive some negative stigma from their peers, along with the fear of potential punishment, often causes physicians to conceal their alcoholism, substance abuse, or mental illness.⁶⁰ This pattern

52. A. Mavroforou et al., *Alcohol and Drug Abuse Among Doctors*, 25 MED. & L. 611, 612 (2006).

53. Feinberg, *supra* note 7, at 598.

54. *Id.*

55. *Id.* at 601, 613. For purposes of this note, the phrase “impaired physician” shall refer to the concept more generally (that of a physician suffering from alcoholism, drug abuse, or mental illness) rather than the term of art, as used by the AMA.

56. Ila S. Rothschild, *Law for Physicians: An Overview of Medical Legal Issues*, 21 J. LEGAL MED. 437, 440 (2000) (book review).

57. Roger S. Cicala, *Substance Abuse Among Physicians: What You Need to Know*, HOSPITAL PHYSICIAN, July 2003, at 39.

58. See Lucian L. Leape & John A. Fromson, *Problem Doctors: Is There a System-Level Solution?*, 144 ANNALS INTERNAL MED. 107, 108 (2006).

59. See Feinberg, *supra* note 7, at 599 (“Physicians have both a higher prevalence of impairment and more difficulty obtaining treatment than non-physicians.”).

60. *Id.* (“[T]he impaired physician often conceals his addiction because the stigma attached to physician impairment makes seeking help significantly more difficult than for the general population. Potential punitive responses may also play a role in inciting concealment.”).

means that physicians have a much lower likelihood of receiving the treatment they need.⁶¹

Alcoholism and substance abuse have been so stigmatized among medical professionals that discussion of the topic is taboo.⁶² Despite the high incidences of alcoholism and drug abuse among physicians, little talk is present at professional meetings, and coverage in medical school curricula is sparse.⁶³

Unsurprisingly, there is a good deal of literature arguing that physician impairment has a significant, negative impact on a physician's medical performance.⁶⁴ One study reveals that physicians who reported making a major medical mistake within the last three months were more likely to suffer from depression or struggle from alcohol or drug dependence.⁶⁵ However, as one professor at the University of Tennessee College of Medicine also suggests: "Most physician substance abusers continue to function quite well until the problem is far advanced."⁶⁶ Further, "[a]lcoholics can often remain sober during working hours for many years, even though they drink large quantities at night and on weekends."⁶⁷ Other medical literature often compares alcoholism in physicians to sleep-deprivation. Indeed, studies have revealed that physicians who have not slept in twenty-four hours (as is not entirely uncommon) have impaired "cognitive psychomotor performance to the same degree as having a 0.1% blood alcohol level."⁶⁸ Yet, there is a lack of empirical evidence demonstrating a correlation between sleep deprivation and medical errors.⁶⁹ This

61. See *id.* at 600.

62. See Cicala, *supra* note 57, at 39; see also Feinberg, *supra* note 7, at 597 ("Physician addiction is taboo, but this silence injures both the physician and his patients.").

63. Cicala, *supra* note 57, at 39.

64. See, e.g., Bobinski, *supra* note 1, at 298-99 ("The abuse of drugs and alcohol is in turn associated with higher risks of work-related performance deficits. Physicians with substance abuse problems may present several different sorts of risks to their patients."); Feinberg, *supra* note 7, at 597 ("Alcohol and drug addiction interfere with multiple functions in daily life. There is no doubt, when the addicted individuals are physicians, the interference affects their ability to practice medicine, causing their patients to receive a lower standard of care than they would otherwise receive.").

65. *Looking at Alcohol Use Disorders Among Surgeons*, PHYSICIAN'S WEEKLY (Aug. 23, 2012), <http://www.physiciansweekly.com/surgeons-alcohol-use-disorders/> [hereinafter *Alcohol Use*]. However, "the study did not identify the nature of the errors or determine the cause and effect." Carolyne Krupa, *15% of Surgeons Struggle with Alcohol Problems*, AM. MED. NEWS (Mar. 6, 2012), <http://www.amednews.com/article/20120306/profession/303069998/8/>.

66. Cicala, *supra* note 57, at 39.

67. *Id.*

68. Merit Buckley, *Imposing Liability in the United States Medical Residency Program: Exhaustion, Errors, and Economic Dependence*, 12 DEPAUL J. HEALTH CARE L. 305, 313 (2009).

69. See *id.* at 314.

logically seems to suggest that a similar correlation between alcoholism and medical errors would also be lacking.⁷⁰

Regardless, the fact remains that there is a higher percentage of physicians suffering from alcoholism or drug abuse than there is in the general population, and something must be done to address this.

IV. IMPAIRED PHYSICIANS AND THE SCOPE OF INFORMED CONSENT

Under either a professional malpractice standard or a reasonable patient standard, the exact scope of required disclosure remains gray. It is clear that informed consent requires, at a baseline, the benefits and risks of a particular medical procedure and potential medical alternatives.⁷¹ But even at this minimal level, *how much* does a physician have to disclose about the benefits, and *how significant* must a risk be to warrant disclosure? The reasonable patient standard attempts to answer this question by applying the materiality concept: whether the information would be material to the reasonable patient's decision about the treatment.⁷² Yet, this also leaves little guidance. The professional malpractice standard judges the scope of disclosure based on the applicable standard of care in the particular circumstances, but this often and simply yields a battle of expert witnesses.⁷³

The bottom line is that the exact scope of required disclosure, under either standard, remains unknown.⁷⁴ Given this level of uncertainty, coupled with increased medical litigation and attention to patient autonomy,⁷⁵ it is not surprising that the trend in the informed consent doctrine seems to be moving toward expanding the scope of disclosure.

Beyond just the disclosure of risks, benefits, and alternatives to the medical treatment, recent attempts to raise this "floor" of disclosure have been made.⁷⁶ Attention has been drawn towards disclosure of a medical treatment's economic implications and a physician's per-

70. See *Alcohol Use*, *supra* note 65 ("Although actual injury to patients from impaired physicians is incredibly rare, alcohol abuse and dependence are important factors to consider when thinking about patient safety in surgery . . .").

71. See Bobinski, *supra* note 1, at 293 ("In the past, both patients and courts have focused attention on the benefits and risks of a particular treatment . . .").

72. See Hanson, *supra* note 16, at 75.

73. See Atwell, *supra* note 8, at 596.

74. See Bobinski, *supra* note 1, at 342-43.

75. I say this hesitantly. See *supra* Part II for a critique of the informed consent doctrine.

76. See Kurtz, *supra* note 5, at 1255-56 ("In recent years, the preoccupation of the informed consent rules with disclosure of risks inherent in a proposed treatment has expanded to the disclosure of risks of not having a proposed treatment and risks associated with having treatment by a particular physician.").

sonal characteristics.⁷⁷ The personal characteristics of physicians that have been discussed as potentially warranting disclosure before medical procedures include a physician's surgical experience,⁷⁸ HIV status,⁷⁹ deterioration of skills,⁸⁰ conflicts of interest,⁸¹ and impairments.⁸² Though the majority rule does not require physicians to disclose personal characteristics, a growing minority of states are requiring such disclosures.⁸³

Although the scope of disclosure obligations continues to expand, the line must be drawn somewhere. Requiring physicians to disclose to patients that they have suffered from, or are currently suffering from, alcoholism, drug abuse, or mental illness, opens the door to a flood of other potential disclosure obligations. Sure, one could argue that alcoholism, drug abuse, or mental illness has the potential to negatively affect a physician's medical performance, and thus should be disclosed.⁸⁴ But if we are willing to say that *these* personal impairments require disclosure, where do we end? Conceivably, almost every personal attribute of a physician might be relevant

77. See *id.* at 1257-58.

78. See *Johnson v. Kokemoor*, 545 N.W.2d 495, 498, 506-07 (Wis. 1996) (proposing that a physician's lack of experience with intricate and difficult procedures may be material to a patient's decision to proceed with the particular physician, rather than the actual procedure). However, the *Johnson* principle of disclosure has not been widely expanded, as the case is seen as unique and fact-specific. See Barry R. Furrow, *Patient Safety and the Fiduciary Hospital: Sharpening Judicial Remedies*, 1 DREXEL L. REV. 439, 454 (2009); see also Emmanuel O. Iheukwumere, *Doctor, Are You Experienced? The Relevance of Disclosure of Physician Experience to a Valid Informed Consent*, 18 J. CONTEMP. HEALTH L. & POL'Y 373, 402-07 (2002).

79. See Iheukwumere, *supra* note 78, at 396.

80. See *Semeraro v. Connolly*, Civ. A. No. 92-4636, 1992 WL 392621, at *1 (E.D. Pa. Dec. 14, 1992).

81. Compare Furrow, *supra* note 78, at 452 ("Courts have been less willing to impose an obligation on physicians to disclose putative economic conflicts of interest."), with *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479, 485 (Cal. 1990) ("[A] physician who is seeking a patient's consent for a medical procedure must, in order to satisfy his fiduciary duty and to obtain the patient's informed consent, disclose personal interests unrelated to the patient's health, whether research or economic, that may affect his medical judgment.").

82. See, e.g., *Hidding v. Williams*, 578 So. 2d 1192, 1196 (La. Ct. App. 1991)

83. See, e.g., *id.* (holding that physician's failure to inform patient of physician's chronic alcohol abuse violated obligations of informed consent disclosure); *Gaston v. Hunter*, 588 P.2d 326, 351 (Ariz. Ct. App. 1978) (stating that a physician's surgical experience should be disclosed to a patient during the informed consent process).

84. See *Hidding*, 578 So. 2d at 1196 (holding that physician's chronic alcohol abuse "create[d] a material risk associated with the surgeon's ability to perform, which if disclosed would have obliged the patient to have elected another course of treatment . . ."); see also Iheukwumere, *supra* note 78, at 402 ("Certainly, the fact of a physician's alcoholism would be of significant concern to a reasonable patient, since an alcohol impaired physician, or one likely to be impaired during an invasive procedure would impact on the likelihood of a mistake during the procedure.").

to a patient in making a decision on whether to proceed with a medical intervention.⁸⁵

For example, consider a physician who skips breakfast the morning of a surgery. Should he have to inform his patient of this personal detail? If a physician skips breakfast, he will certainly become hungry (if he is not already). Surely, hunger could potentially have a negative effect on a physician's medical performance.

Even more extreme yet under the same logic, consider a physician who gets into a heated argument with his wife the night before performing surgery and is now in a bad mood. Should he be required to inform his patient of this in gaining consent before the surgery? One could also see how a bad mood might negatively affect a physician's medical performance.

And finally, consider a physician who has a ritual of listening to a certain song before every surgery for good luck. He has listened to this song before every successful surgery for the past fifteen years of his practice. The morning of his next surgery, however, he is in a rush and does not get a chance to listen to his "lucky song." Cognizant that he skipped this important step, he becomes concerned. Should the physician have to disclose this information to his patient? As outrageous as the scenario might sound, requiring disclosure of this idiosyncrasy logically follows from the current, expanding scope of the informed consent doctrine.

As demonstrated above, expanding the disclosure obligations to include a physician's alcoholism, drug abuse, or mental illness has the potential to create unintended bounds.⁸⁶ The process of obtaining informed consent from a patient will likely transform from an explanation of the potential risks associated with a procedure to a laundry-list-reading of the physician's personal life.⁸⁷ In fact, for this exact reason, the Supreme Court of Pennsylvania refused to expand the doctrine of informed consent to include mandatory disclosure of a physician's alcoholism.⁸⁸ As explained in *Kaskie v. Wright*, "[t]o do so, where the absent information consists of facts personal to the treating physician, extends the doctrine into realms well beyond its original boundaries."⁸⁹ Such an expansion of the doctrine will likely make

85. See *Kaskie v. Wright*, 589 A.2d 213, 217 (Pa. Super. Ct. 1991) (affirming summary judgment for defendant physician in an informed consent claim, rhetorically asking: "Are patients to be informed of every fact which might conceivably affect performance in the surgical suite?").

86. See *id.*

87. See *Bobinski*, *supra* note 1, at 295 ("A seemingly infinite number of provider characteristics combine to determine the physician's ability to deliver appropriate care to a particular patient at any given moment.").

88. *Kaskie*, 589 A.2d at 217.

89. *Id.*

any attempt at line-drawing very difficult,⁹⁰ and patients will likely become so overwhelmed with information to the point that they decline many important medical procedures.

Though physicians are undoubtedly held to higher expectations than the general public and are bound by fiduciary obligations to their patients,⁹¹ it is easy to forget that physicians are still human. Physicians make mistakes and have struggles in their personal lives just like everyone else. Because alcoholism, drug abuse, and mental illnesses are such personal and sensitive issues, physicians will have even more incentive to conceal or deny any such problems if they know they will have to share these details with their patients. The result will be even more physicians who are unable to seek the treatment they need due to conscious denial or concealment.⁹² Further, because physicians are even more likely to keep their impairments invisible, as has been indicated, requiring physicians to disclose such impairments to patients in the informed consent process will likely be a fruitless expansion of the doctrine.

This is not to say that a patient who receives substandard care from a physician who suffered from alcoholism, drug abuse, or mental illness is without legal recourse against that physician.⁹³ However, such recourse does not create a separate legal issue under the informed consent doctrine.⁹⁴ Legal remediation for substandard care is still an option for patients who are injured by their physicians' negligence.⁹⁵ As the Court of Appeals of Arizona properly held as a matter of law in *Ornelas v. Fry*:

[T]he fact that [the physician] may have been an alcoholic at the time of the surgery on [the patient] does not create in and of itself a separate issue or claim of negligence. It is only when that alcoholism translates into conduct falling below the applicable standard of care that it has any relevance.⁹⁶

90. See *id.* (explaining that expansion of the informed consent doctrine to include disclosure of a physician's alcoholism will make limitations not easily definable).

91. See Furrow, *supra* note 78, at 444.

92. See Feinberg, *supra* note 7, at 598 ("It is [the] risk to patients that makes physician impairment incompatible with the practice of medicine. And it is this incompatibility that leads the impaired physicians to further conceal their addiction . . .").

93. See *Duttry v. Patterson*, 771 A.2d 1255, 1259 (Pa. 2001) ("[I]nformation personal to the physician, whether solicited by the patient or not, is irrelevant to the doctrine of informed consent. Our holding should not, however, be read to stand for the proposition that a physician who misleads a patient is immune from suit. . . . [We do not] see a need to expand this doctrine into a catchall theory of recovery since other causes of action provide avenues for redress to the injured patient.").

94. See *Ornelas v. Fry*, 727 P.2d 819, 823 (Ariz. Ct. App. 1986).

95. See *Duttry*, 771 A.2d at 1259 ("For example, it is conceivable that a physician's lack of experience in performing an operation would support a plaintiff's case in negligence.").

96. *Ornelas*, 727 P.2d at 823.

Additionally, it is undisputed that the doctrine of informed consent is based on the concept of autonomy. Under the most patient-friendly standard of the doctrine, a physician informs a patient of the material risks associated with the procedure in order to facilitate an informed decisionmaking process.⁹⁷ However, to allow practicability of the doctrine, the materiality of a risk must be limited to risks specifically related to the medical procedure itself.⁹⁸ Determining the materiality of a risk specifically related to the medical procedure has already proven to be a difficult task.⁹⁹ If we further consider the physician's personal characteristics to be a material risk, the doctrine will eventually prove unworkable because of undefined boundaries.¹⁰⁰

By disclosing the risks "specifically germane to surgical or operative treatment,"¹⁰¹ a patient is able to exercise his "right to determine what shall be done with his own body."¹⁰² This limitation to the concept of materiality accomplishes the doctrine's intended goal: autonomy.¹⁰³ However, considering a physician's impairment to be a material risk is not concerned with autonomy, it concerns something entirely separate: patient safety.

The arguments in favor of expanding the informed consent doctrine to impose a disclosure obligation of the physician's alcoholism, drug abuse, or mental illnesses all implicitly center around the same general argument: such physician impairments negatively affect a physician's performance of medical procedures, thereby compromising the safety of the patient.¹⁰⁴ Yet, the informed consent doctrine

97. See Atwell, *supra* note 8, at 594-95.

98. The informed consent doctrine should not be expanded "to include matters not specifically germane to surgical or operative treatment." *Kaskie v. Wright*, 589 A.2d 213, 217 (Pa. Super. 1991); see also *Semeraro v. Connolly*, Civ. A. No. 92-4636, 1992 WL 392621 (E.D. Pa. Dec. 14, 1992).

99. See HALL ET AL., *supra* note 9, at 217-18; Iheukwumere, *supra* note 78, at 392 ("Subsequent to *Canterbury* many important informed consent decisions came down addressing the materiality of information in divergent ways . . ."); see also Feinberg, *supra* note 7, at 621 ("There is no clear consensus in the courts or in the medical literature about physician disclosure and the informed consent process.").

100. See *Kaskie*, 589 A.2d at 217 (refusing to expand the informed consent doctrine to include matters not specifically germane to the surgical treatment because such expansion would "extend[] the doctrine into realms well beyond its original boundaries" and limitations would not be easily definable).

101. *Kaskie*, 589 A.2d at 217.

102. See *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (1914), *abrogated by* *Bing v. Thunig*, 142 N.E.2d 3, 7-9 (1957), *superseded by statute*, Act of May 21, 1975, ch. 109, 1975 N.Y. Laws 134-35.

103. Kurtz, *supra* note 5, at 1251.

104. See, e.g., *Hidding v. Williams*, 578 So. 2d 1192, 1198 (La. Ct. App. 1991) (determining that the physician's abuse of alcohol "increased [the] potential for injury during surgery"); Feinberg, *supra* note 7, at 597 (stating that physician impairment results in "patients . . . receiv[ing] a lower standard of care than they would otherwise receive"); *Furrow*, *supra* note 42, at 293 ("Certainly an alcoholic surgeon may have an impairment that might seriously affect performance and thus success rate."); Iheukwumere, *supra* note 78,

was not developed with the purpose of ensuring patient safety.¹⁰⁵ The doctrine was simply intended to allow patients to weigh the potential risks against the potential benefits of a specific medical procedure in order to informatively decide for themselves whether they wish to proceed with the procedure.¹⁰⁶ However, within this informed decisionmaking process, the patient must be able to assume that the physician will operate in a reasonably safe manner; the patient must be able to proceed under an assumption that the physician's alcoholism, drug abuse, or mental illness will not pose a significant risk.¹⁰⁷

The solution to such a dilemma is not an expansion of the informed consent doctrine. If a physician is truly impaired by alcoholism, drug abuse, or a mental illness such that it will significantly and negatively affect his performance of medical procedures to a degree that would compromise patient safety, the physician should not be able to simply disclose this information to a patient and avoid any potential liability. The informed consent doctrine should not be expanded such that it can be used strategically as a liability "out" where physicians are truly unfit to perform medical procedures. Instead, stepping back and considering the bigger picture is necessary.

V. DUTIES OF THE HOSPITAL: A CORPORATE NEGLIGENCE THEORY

*"[With impaired physicians,] the goal is to eliminate the risk to the patient, not simply to inform the patient and let the patient choose."*¹⁰⁸

Despite various opinions in medical literature, something we know for sure is that physicians who are currently suffering or have suffered from alcoholism, drug abuse, or mental illness may pose threats to patient safety by performing medical operations.¹⁰⁹ If such impairment reaches a level where patient safety would be compromised, the solution is not disclosure through expanded informed con-

at 402 ("[A]n alcohol impaired physician . . . would impact on the likelihood of a mistake during the procedure."); see also *Judice v. Hosp. Serv. Dist. No. 1*, 919 F. Supp. 978, 984 (E.D. La. 1996) (holding that the discovery of alcohol in a physician's system just prior to surgery raised valid concerns about the risk to public safety).

105. "[P]atient autonomy is at the heart of all inadequate consent cases . . ." McNichols, *supra* note 11, at 715.

106. See Atwell, *supra* note 8, at 596 ("Informed consent, then, is designed to protect patients by ensuring that they have the material information with which to make an informed choice.")

107. See Bobinski, *supra* note 1, at 302 (discussing other personal physician conflicts: "we want to ensure that patients receive good quality care of sufficient amount, duration, and scope regardless . . .").

108. Furrow, *supra* note 42, at 293.

109. See Feinberg, *supra* note 7, at 598.

sent obligations, but rather a bigger-picture solution: placing a duty on hospitals to properly credential and monitor physicians.¹¹⁰

A hospital's duty to non-negligently credential and monitor physicians is an obligation that is part of a larger conception known as the "corporate negligence theory."¹¹¹ Under the corporate negligence theory, a hospital can be held directly liable for injuries to patients resulting from substandard medical care.¹¹² The reasons for such a theory are obvious: as blame for sub-quality medical treatment continues to be placed directly on the treating physicians, hospitals will be free of any duty (and thus any incentive) to try and prevent medical errors.¹¹³

Consider the nature of the modern hospital. Hospitals are big businesses, spending millions marketing themselves through "expensive advertising campaigns." They provide a range of health services, and the public expects emergency care, radiological and other testing services, and other functions as a result of hospitals' self-promotion. And yet the legal relationships in the hospital are byzantine, creating two strongly autonomous management structures side by side: a hospital administrative structure in parallel with the hospital medical staff, which operates as a staff of independent contractors. The very existence of this odd structure shields hospitals from liability under agency law rules for the errors of their physicians, *even when it is the hospital systems that have allowed the physicians to fail*.¹¹⁴

The concept of placing liability directly on a hospital under a corporate negligence theory has long been argued as an abdication of the medical practice; "only an individual properly educated and licensed, and not a corporation, may practice medicine."¹¹⁵ Traditionally, hospitals were seen as merely the structure under which physicians operated.¹¹⁶ Nonetheless, in 1965, the Supreme Court of Illinois announced its decision to impose liability directly on a hospital for inju-

110. See Furrow, *supra* note 42, at 293 ("[D]isclosure of [the physicians'] limitations may be of questionable efficacy . . . It risks destroying provider privacy while reducing the pressure on state authorities and hospitals to monitor their physicians and set proper and reasonable standards for practice.").

111. See Judith M. Kinney, *Tort Law—Expansion of Hospital Liability Under the Doctrine of "Corporate Negligence"*—Thompson v. Nason Hospital, 591 A.2d 703 (Pa. 1991), 65 TEMP. L. REV. 787, 792 (1992).

112. HALL ET AL., *supra* note 9, at 481 ("Direct or 'corporate' liability contrasts with vicarious liability in that it imposes on hospitals a duty of care owed directly to patients with respect to medical judgment.").

113. See Furrow, *supra* note 42, at 459.

114. *Id.* (emphasis added).

115. Darling v. Charleston Cmty. Mem'l Hosp., 211 N.E.2d 253, 256 (Ill. 1965).

116. See Pedroza v. Bryant, 677 P.2d 166, 169 (Wash. 1984) ("The hospital's role is no longer limited to the furnishing of physical facilities and equipment where a physician treats his private patients and practices his profession in his own individualized manner.").

ries resulting from physician error.¹¹⁷ *Darling v. Charleston Community Memorial Hospital* has since been seen as the seminal case for imposing direct liability on a hospital via a corporate negligence theory for substandard medical care.¹¹⁸

A hospital's duty to non-negligently credential its physicians is the critical first step to addressing the issue of impaired physicians. This duty "entails reviewing physicians' competency and performance history before admission to the medical staff and periodically (typically every two years) thereafter."¹¹⁹ The Supreme Court of Wisconsin in *Johnson v. Misericordia Community Hospital* described the *minimum* requirements for a hospital (or the hospital's credentialing committee) in investigating and evaluating an applicant's qualifications for hospital privileges:

[A] hospital should, at a minimum, require completion of the application and verify the accuracy of the applicant's statements Additionally, it should: (1) solicit information from the applicant's peers, including those not referenced in his application, who are knowledgeable about his education, training, experience, health, competence and ethical character; (2) determine if the applicant is currently licensed to practice in this state and if his licensure or registration has been or is currently being challenged; and (3) inquire whether the applicant has been involved in any adverse malpractice action and whether he has experienced a loss of medical organization membership or medical privileges or membership at any other hospital. The investigating committee must also evaluate the information gained through its inquiries and make a reasonable judgment as to the approval or denial of each application for staff privileges.¹²⁰

Additionally, in 1986, the National Practitioner Data Bank (NPDB) was established as part of the Healthcare Quality Improvement Act¹²¹ and was designed to provide licensing and credentialing entities with a more uniform body of information regarding discipli-

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

118. HALL ET AL., *supra* note 9, at 481. "Conventional forms of direct liability entail primarily administrative, not medical, functions such as maintaining safe premises, sterile equipment, and adequate rules and regulations. *Darling* is recognized as extending direct corporate liability to substandard medical care rendered by independent doctors. Hospitals thus can be found liable for some act of negligence on their part with respect to patient care decisions made by independent doctors . . ." *Id.*

119. *Id.* at 482.

120. *Johnson v. Misericordia Cmty. Hosp.*, 301 N.W.2d 156, 174-75 (Wis. 1981).

121. Healthcare Quality Improvement Act of 1986, 42 U.S.C. §§ 11101-11152 (2006).

nary actions taken against physicians.¹²² Especially following the establishment of this databank, the duty to properly credential physicians makes clear that a hospital cannot simply plead ignorance with respect to a physician's information in granting that physician privileges.¹²³ Imposing this duty on hospitals also means that if a hospital chooses to grant privileges to a physician who has suffered from alcoholism, drug abuse, or mental illness in the past, the hospital bears the risk of such impairments resurfacing. Through the credentialing process, the hospital should be regarded as having been put on notice about potential relapses that may occur and thus should be charged with taking necessary, continual steps to prevent such occurrences. Further, a hospital should be free to grant privileges to a physician currently undergoing treatment for alcoholism, drug abuse, or mental illness; however, it should be presumed that the hospital underwent investigative measures to ensure that this physician is able to safely practice medicine.¹²⁴ The AMA has made clear that it opposes the discrimination against otherwise capable physicians solely because "the physician is either presently, or has in the past, been under the supervision of a medical licensing board in a program of rehabilitation."¹²⁵

Hospitals must be charged with granting privileges to only those physicians capable of safely practicing medicine. This may entail a standardized screening evaluation for current alcoholism, drug abuse, or mental illness. When this evaluation is conducted at the commencement of the credentialing process, it will be regarded as nondiscriminatory and can be a step towards removing the stigmatization of such impairments in the medical profession. In a case for negligent credentialing, evidence to show a breach of this duty would

122. "The comprehensive reporting system requires medical boards to report licensure revocations, suspensions, restrictions, censures, reprimands, probation, and licenses surrendered relating to the physician's professional competence or professional conduct. The statutory restrictions of the ADA do not insulate impaired physicians from being reported to the NPDB." Yuri N. Walker, *Protecting the Public: The Impact of the Americans with Disabilities Act on Licensure Considerations Involving Mentally Impaired Medical and Legal Professionals*, 25 J. LEGAL MED. 441, 447 (2004).

123. See Elisabeth Ryzen, *The National Practitioner Data Bank: Problems and Proposed Reforms*, 13 J. LEGAL MED. 409, 411, 419 (1992) ("Hospitals are required to query the Data Bank before granting physicians privileges. . . . Failure to request information [from the NPDB every two years] means the hospital will be presumed to have knowledge of any information in the Data Bank concerning the applicant in any subsequent lawsuit."). Nonetheless, the consistency of the NPDB regarding the reporting of physician impairments needs improvement. See POLICIES RELATED TO PHYSICIAN HEALTH § H-355.992 (Am. Med. Ass'n 2011) ("Our AMA will continue to monitor the issue of reporting impaired physicians to the National Practitioner Data Bank and will seek further clarification of ambiguities or misinterpretations of the reporting requirements for impaired physicians.").

124. See Katharine A. Van Tassel, *Blacklisted: The Constitutionality of the Federal System for Publishing Reports of "Bad" Doctors in the National Practitioner Data Bank*, 33 CARDOZO L. REV. 2031, 2057 (2012); see also Kinney, *supra* note 111, at 793-95 (discussing actual or constructive notice triggering a hospital's duties to act).

125. POLICIES RELATED TO PHYSICIAN HEALTH, *supra* note 123, § H-275.949.

include the hospital's own bylaws on credentialing physicians, state licensing regulations, the Joint Commission's Standards for Hospital Accreditation,¹²⁶ common law, and other relevant authorities.¹²⁷

The hospital's duty to non-negligently credential physicians is generally accepted by the courts as part of the obligations of hospital administration.¹²⁸ However, an affirmative duty on the hospital to monitor its physicians has been seen as more controversial.¹²⁹ Several courts have rebuffed any duty to contemporaneously monitor treatment decisions made by its physicians, reasoning that it would constitute an unlawful interference of the physician-patient relationship.¹³⁰

Starting at the local level, under a corporate negligence theory, a hospital must be much more active in monitoring its physicians to ensure those practicing medicine are safely capable of doing so.¹³¹ Given that the hospital should have non-negligently credentialed its physicians, it will be charged as being on notice of any potential red flags in the physician's record of past or current alcoholism, drug abuse, or mental illness. The hospital should have a heightened affirmative duty to monitor these physicians.

In order to adequately monitor physicians, general awareness of the prevalence of impaired physicians must increase.¹³² Hospitals' risk management committees should go through training and education programs on the potential signs of alcoholism, drug abuse, or mental illnesses. Similar information should be distributed to all hospital staff so that everyone is aware of the symptoms to look for in potentially impaired physicians. The frequent monitoring of these high-risk physicians, then, should include frequent in-person interviews, self-evaluations, and anonymous peer-review programs.

To ensure that such monitoring programs are effective, however, hospitals also need to have a system in place that guarantees confi-

126. See JOINT COMMISSION, www.jointcommission.org (last visited June 29, 2014).

127. See Kinney, *supra* note 111, at 790-91.

128. See HALL ET AL., *supra* note 9, at 482. *But see* Paulino v. QHG of Springdale, Inc., 386 S.W.3d 462, 467 (Ark. 2012) (refusing to recognize a claim for negligent credentialing on the basis that regulatory oversight of hospitals is sufficient).

129. See HALL ET AL., *supra* note 9, at 482.

130. See, e.g., Gafner v. Down East Cmty. Hosp., 735 A.2d 969, 979-80 (Me. 1999).

131. *Id.* at 979 (quoting Pedroza v. Bryant, 677 P.2d 166, 168-69 (Wash. 1984)) ("The doctrine of corporate negligence has . . . been utilized by courts to require hospitals to exercise reasonable care to insure that the physicians selected as members of hospital medical staffs are competent. [Those courts] have also held that hospitals have a continuing duty to review and delineate staff privileges so that incompetent staff physicians are not retained."). "Health care's casual approach to monitoring physician performance contrasts markedly to that of other professions whose conduct affects the public welfare. Commercial pilots, for example, must pass both physical and performance examinations every year." Leape, *supra* note 58, at 109.

132. See Feinberg, *supra* note 7, at 597 ("Physician addiction is taboo, but this silence injures both the physician and his patients.").

dentiality and includes penalty waivers.¹³³ Because many physicians already conceal any impairment they may have for fear of potential penalties and stigmatization from their peers, hospitals must ensure that all monitoring policies are conducted with the utmost respect for the physician's confidentiality.¹³⁴ Upon discovering alcoholism, drug abuse, or mental illnesses in physicians, hospitals should motivate those physicians to seek recovery through participation in treatment programs.¹³⁵ Every state has a form of a physician health program designed specifically for physicians suffering from alcoholism or substance abuse.¹³⁶ Completion of such a program should be a prerequisite for waiving the penalty of a complete revocation of hospital privileges, which will encourage physicians to obtain the treatment they need but all so often do not get.

Imposing liability on hospitals for negligent credentialing and monitoring of physicians, rather than expanding the doctrine of informed consent, will place the task of determining the competency of physicians with the party in the more capable position to do so: the hospital.

VI. CONCLUSION

*"The real issue is whether the physician is likely to perform well, regardless of an impairment or other personal characteristic."*¹³⁷

Physicians suffering from alcoholism, drug abuse, or mental illnesses may be perfectly capable of performing medical treatments to the necessary standard of quality.¹³⁸ However, should such impairments rise to a level such that the safety of the patient is compromised, liability must fall somewhere in order to ensure proper preventative measures are taken and injured patients are not left without legal recourse.

The prevalence of physicians suffering from alcoholism, drug abuse, or mental illnesses is a sad reality that cannot continue to be ignored.¹³⁹ However, attempting to solve such a large-scale issue by expanding the scope of disclosure obligations under the informed consent doctrine would be both impracticable and counterintuitive. Such an expansion would be inconsistent with the original purpose of

133. See Feinberg, *supra* note 7, at 608.

134. See *id.*

135. See *id.* at 607-09.

136. See Cicala, *supra* note 57, at 43-44.

137. Furrow, *supra* note 42, at 293.

138. See *id.* ("[A disclosure obligation] raises a difficult causation question, since alcoholism may not always impair a physician's performance.")

139. See generally Feinberg, *supra* note 7, at 605 (discussing the prevalence of alcoholism, drug abuse, and similar impairments in the medical field).

informed consent and would render the doctrine so lacking in certainty that it would eventually prove completely unworkable.

Further, confidentiality is an essential element for the proper identification of, treatment of, and recovery from alcoholism, drug abuse, and mental illness. Patients want to be sure that impaired physicians, incapable of safely practicing medicine, are identified and obtain the treatment they need. Yet, requiring physicians to disclose to patients that they suffer from, or have suffered from, such impairments would be entirely illogical to achieve such a goal.

Addressing the issue of impaired physicians is part of a much larger web of actors than can be remedied through the informed consent doctrine. Awareness to the problem of impaired physicians must increase generally within the medical profession. State medical boards and the Joint Commission on Accreditation of Health Care Organizations must cooperate with hospitals so that they have the necessary tools and information to begin the process.

Rather than expanding the informed consent doctrine, liability should be placed on the hospital under a corporate negligence theory when a hospital negligently credentials and monitors its physicians. The hospital is in the best position to ensure the competency of the physicians performing medical treatments, not the patient. Such a structure would protect the privacy of the physician and encourage detection and rehabilitation while having the effect of increasing patient safety on a broader scale.

