Hospital Liability as a Corporation in Medical Malpractice

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Abstract. The basic idea behind compulsory representation must be a direct or financial link between the offending physician and the co-responsible. The responsible subject depends on the person who actually gives work to, dismisses, pays, and supervises the doctor concerned. In this case, the responsible subject is the hospital or the legal entity that owns the hospital. A hospital is a business process owned by a foundation, and that foundation is the subject of responsibility. This means that the management team will represent the foundation in making a lawsuit or being sued.

Keywords: Hospital Liability · Corporations · Medical Malpractice

1 Introduction

The increasing number of lawsuits against malpractice (with the amount of compensation getting more spectacular every day), especially since the enactment of Law Number 8 of 1999 concerning Consumer Protection, seems to be getting more and more disturbing. The current situation in our hospital world is very similar to the malpractice crisis that hit the United States about 40 years ago, when hospitals were first considered not immune to all forms of lawsuits. Previously, hospitals were treated as social institutions with impunity based on the doctrine of charitable immunity. The consideration was that punishing hospitals to pay compensation was tantamount to reducing their assets, which in turn would reduce their ability to help many people (Sofwan Dahlan, 2011).

The reason for this current situation is that many hospitals have started to forget their social functions and are managed like an industry with modern management, complete with risk management. Therefore, it is expected of hospitals to treat claims for compensation as a form of business risk and take it into account to either bear the risk themselves (risk financing retention) or transfer said risk to insurance companies (risk financing transfers) through malpractice insurance programs.

This crisis is clearly unfavorable for the management and development of the hospitals, and therefore needs to be watched out for. Most importantly for hospital managers and owners, however, before a malpractice lawsuit is proven, any dispute that arises between a healthcare recipient and a healthcare provider can be a problem; Occurrence of adverse events primarily (harm caused by treatment rather than the patient's underlying disease). According to Winardi (1994), conflict is defined as a discrepancy in

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understanding of the situation regarding certain points of view or because of emotional antagonisms. So, the various conflicts that plague our hospital world today do not have to be seen as extraordinary things, so they should not be treated disproportionately. On the positive side, conflicts and arguments can increase creativity, innovation, intensity of effort, group cohesion, and reduce tension.

The hospital world has to be candid and very aware of this possibility of conflict, because in reality, there are still many weaknesses and shortcomings in implementing good clinical governance, besides not being able to perfectly meet the principles in designing a safer healthcare system to prevent or at least reduce the occurrence of adverse events.

The conflict itself will only occur if there are preconditions or predisposing factors, for example, in the form of adverse events, which is essentially a gap between the patient's expectations when choosing a hospital and the reality they get following medical efforts. Meanwhile, the trigger factors include differences in perception, ambiguous communication, or individual styles that can come from the doctors (arrogant or curt manner, reluctance to provide information, etc.) or from the patients themselves (patients who have temperamental characteristics or are chronic complainers). In addition, high tariffs can also trigger complaints and claims for services that are less than perfect. In fact, from the author's experience as a legal consultant at a private hospital, an interesting finding was obtained that it is not uncommon for the triggers to come from negative speculative assessments from the doctors' colleagues on the occurrence of adverse events, which they might want to take advantage of (for example, so that they can be considered superior or smarter by patients).

Regarding the difference in perception, it is usually due to the patient's inability to understand medical logic, in which medical effort is full of uncertainty and the results cannot be calculated mathematically because they are strongly influenced by other factors beyond the doctor's control; for example, the body's resistance; the body's defense mechanism; The nature and degree of pathogenicity of the disease; the stage of the disease; the quality of the drug; the individual response to the drug (as a consequence of the medical world's failure to find pharmacogenomic drugs that are in accordance with the genetic constitution of each patient), and patient compliance in following the procedures and advice of doctors and nurses. Many people think that medical efforts made by doctors are the only variables that can affect the patient's illness or condition. In their opinion, if these efforts are correct, the patient's condition should not worsen and new problems should not arise. But the fact is, even the best and most expensive medical efforts cannot guarantee healing and vice versa. Instances where doctors misdiagnose and automatically follow up with therapy errors, yet patients are actually able to recover thanks to the body's own defense mechanism are not uncommon. Therefore, it is not wrong if there are some experts who say "medicine is a science of uncertainty and an art of the probability".

Inadequate understanding of medical effort is still exacerbated by the lack of understanding of the law; for example, regarding the form of engagement that occurs following the agreement of a therapeutic relationship, which consequently gives rise to rights and obligations for each party. Not many people understand that the engagement occurring between the healthcare receiver and the healthcare provider is an in spanning verbinten

is (effort engagement). As a legal consequence, the hospital is not obligated to realize results (in the form of healing), only to make efforts according to the standard of care, which is a level of medical service quality that reflects the application of science, skills, consideration, and proper attention as done by doctors in general in dealing with the same situations and conditions (Hubert Smith). That level of quality is hoped to solve the patient's health problems, However, doctors and hospitals are not necessarily to be blamed when these expectations are not met, or when undesirable events or medical risks occur.

2 Research Method

This type of research is legal research with a normative juridical methodology. The purpose of applying the normative approach in this research is to discuss and compare regulations regarding the export of minerals and raw materials. The regulations that are used as comparisons in the study are PP No. 1 of 2017 concerning the 4th Amendment to PP No. 23 of 2010 concerning the Implementation of Mineral and Coal Mining Business Activities, PERMEN ESDM No. 5 of 2017 concerning Increasing Value Added Minerals Through Domestic Processing and Refining Activities and PERMEN ESDM No. 6 of 2017 concerning Procedures and Requirements for Providing Recommendations for the Implementation of Overseas Sales of Minerals resulting from Processing and Refining.

3 Findings and Discussion

1. Adverse Event and Malpractice
   In criminal cases, it is the duty of the Public Prosecutor to prove the fulfillment of the crime element, consisting of a despicable act (actus reus) and a wrong mental attitude (mens rea), which is the background of said despicable act. Liability, when proven, is always personal and personal and cannot be transferred to another party. It should be noted here that, initially, in various countries that adhere to the Common Law System, malpractice is categorized as a tort (civil wrong against a person or property), so that there are no penalties for doctors who commit malpractice but to pay compensation. However, there have been recent efforts (although cases are still very rare) to criminalize doctors, especially for malpractice cases that result in death. These efforts can certainly increase the confidence of NGOs here, which have always preferred to bring malpractice cases to criminal trials, especially since such an action is possible given the existence of Article 359 of the Criminal Code, which is a waste basket article.

   Whereas in civil cases, it is agreed that "the one who argues (that the doctor is guilty) is the one who proves." Thus, the plaintiff (patient) must prove the existence of the four D elements of malpractice; namely Duty, Dereliction of duty, Direct causal relationship between damages and breach of duty and damages. Of course, the most difficult thing for plaintiffs is to prove the last factor, direct causation. But this element and the other of cheating he does not have to prove three elements (e.g., the finding of scissors or tweezers in the patient's stomach). The Res Ipsa Loquitur doctrine (the thing speaks for itself) can automatically prove the existence of malpractice. The

civil liability can be borne by the doctor concerned or, under certain conditions, can be transferred to another party based on the doctrine of vicarious liability (Sofwan Dahlan, 2011).

Approximately 2.9% to 3.7% of inpatients experience Adverse Events in the form of:

a. Extension of hospitalization.
b. Disability when leaving the hospital.
c. Permanent disability
d. Adverse drug events.
e. Wound infection.
f. Death.

Most of the adverse events mentioned above are caused by errors (diagnostic, treatment, preventive, and others) that can be prevented, so they are called preventable adverse events. Only about 27.6% of preventable adverse events can be categorized as malpractice (negligence or culpa). So if it is calculated, it is actually a very small part of the adverse event that can be associated with malpractice, while the rest is an adverse event that does not include a violation of law; whether it is an error of commission (taking an action that should not be done) or an error of omission (not taking an action that should be taken).

Presumably, what is described above is in line with Perrow's theory (the Perraw's Normal Accident Theory), which states that:

a. Accidents are unavoidable in certain asterns.
b. In a complex and high-tech industry, accidents are normal.

It should be realized that the implementation of health services in hospitals is a difficult, complicated, and complex job that requires technological assistance (methods, tools, and drugs). So, in relation to patient safety efforts, the National Patient Safety Foundation concludes that:

a. Patient safety is defined as an effort to avoid and prevent adverse events caused by the service process and to improve the quality of outcomes.
b. Patient safety is not only focused on people, equipment, or departments, but also the interaction of various components and systems.

The above matters should be understood by the patient and their lawyers before deciding to sue, in addition to understanding the legal logic as stated below:

a. The therapeutic relationship between the patient and the hospital is a contractual relationship. Therefore, all the principles in the contract apply, especially the utmost good faith principle.

b. The engagement that arises as a consequence of a therapeutic relationship is a type of engagement in which the hospital is only obliged by law to provide the right effort (inspanning), not results (resultaat).
c. Adverse events that occur do not automatically become evidence of malpractice. Proof of malpractice requires the existence of four D elements (Duty, Dereliction of duty, Damage and Direct Causation between damage and dereliction of duty) or else there must be facts that can really speak for themselves (Res Ipsa Loquitur).
d. Misdiagnosis cannot be said to be malpractice as long as the doctor, in making the diagnosis, has complied with the provisions and procedures. People need to understand that the most difficult part of a doctor's job is to make a diagnosis, and diagnostic tools (even the most sophisticated ones) are only meant to reduce the number of errors. That's why it is not surprising that misdiagnosis in America remains high (around 17%). One of the most important things is whether the misdiagnosis occurs because of carelessness in carrying out the diagnostic procedure or not.
e. Doctors can be criminally prosecuted if their actions meet the penal formulation.
f. The elements (mens rea and actus reus).
g. Criminal responsibility is always individual and personal and cannot be transferred to other parties (both individuals and corporations).
h. Doctors can also be sued if the patient suffers losses due to the doctor's breaking of promise or because of their actions against the law (onrechtmatige-daad).
i. Civil liability for the occurrence of malpractice committed by doctors can be transferred based on the doctrine of vicarious liability.

2. Compensation due to Malpractice

   In carrying out their services, hospitals are not always able to provide results as expected by all parties. Sometimes these services actually cause significant loss; such as lifelong disability, paralysis, blindness, deafness, or even death. However, the hospital does not need to worry because as long as what it does is correct (according to applicable standards), adverse events that occur can only be considered as part of medical risk or as something that is unavoidable, so the hospital should not be responsible for the losses suffered by patients, be they material or immaterial. It is different if adverse events occur due to errors that can actually be associated with malpractice, whether it is intentional, reckless, or negligent.

   The Health Law is intended to provide protection for everyone for any consequences that arise, both physical and non-physical. Physical losses are losses caused by the absence or failure of all or part of the body's organs, which in legal language are called material losses. Meanwhile, non-physical losses are related to the dignity of a person, which in legal language is called immaterial losses. The question now is, who should be responsible for the loss? Doctors, hospitals, foundations, or all three?

   To answer the questions above, it is necessary to first understand:

a. The types of liability.
b. The pattern of therapeutic relationships that occur.
c. The pattern of working relationships between doctors and hospitals.

Regarding the types of liability (according to civil law) there are many known types, including:

a. Contractual liability
   This type of liability arises because of an act of breaking a promise, namely not carrying out an obligation or not fulfilling the rights of another party as a result of a contractual relationship. In relation to the therapeutic relationship, obligations or achievements that must be carried out by healthcare providers are in the form of efforts, not results. Therefore, doctors here are only responsible for medical efforts that do not meet the standards, or in other words, medical efforts that can be categorized as civil malpractice.
b. Liability in tort
   This type of liability is a liability that is not based on a contractual obligation but on an unlawful act (onrech-tmatige daad).

   The notion of being against the law is not only limited to actions that are against the law, one's own legal obligations, or the legal obligations of others, but also actions that are contrary to good decency and are contrary to the thoroughness that should be done in the association of life with other people or other people's objects (Hogeraad, 1919).

   The concept of liability in tort actually comes from Article 1382 of the Napoleonic Civil Code, which states: "Anyone who causes damages through his own behavior must provide compensation, if at least the victim can prove a causal relationship between the fault and damages." This concept is in line with Article 1365 of the Civil Code, which fully states: "Every unlawful act that causes harm to another person requires the person who caused the loss because of his mistake to compensate for the loss."

   In this type of liability, a hospital or doctor may be sued for damages for the occurrence of an error that falls within the category of tort (civil damage to persons or property, whether intentional or negligent). Examples of actions by a hospital or doctor that may result in liability include, among others, divulging medical secrets; euthanasia; or carelessness in making medical efforts so that the patient dies or suffers a disability.
c. Strict liability
   This type of liability is not a contractual obligation but a tort liability (onrecht-tmatige daad).

   The concept of illegality is not limited to acts that violate the law, one's own legal obligations, or the legal obligations of others, but also includes morality and due diligence in relation to life with another person or foreign object. (Hogeraad, 1919).

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d. Vicarious liability
   This type of liability arises due to mistakes made by subordinates. In relation to medical services, the hospital as an employer can be held accountable for mistakes made by health workers who work in a subordinate position or employee. It is different if health workers, for example, doctors, work as partners (attending physicians) so that their position is at the same level as a hospital.

   This vicarious liability doctrine is in line with Article 1367 of the Civil Code, which states: "A person is not only responsible for losses caused by his own actions, but also for losses caused by the actions of people who are his dependents or caused by goods that are under his supervision."

   The pattern of the working relationship between health workers and the hospital, which will also determine the pattern of the therapeutic relationship with the patients who seek treatment at the hospital, determines whether the hospital can be the subject of joint responsibility.

Regarding the working relationship between doctors and hospitals, there are several patterns, including:

a. Doctor as employee.
b. Doctor as attending physician (partner).
c. Doctor as independent contractor.

Each of the patterns of the relationship mentioned above will greatly determine whether the hospital or the doctor can be directly responsible for the losses caused by the doctor's error and to what extent the doctor's liability can be transferred to the hospital based on the doctrine of vicarious liability.

3. Corporate Liability & Vicarious Liability
   At the beginning of its history, a hospital was nothing more than an institution (recipient of donations from philanthropists) that only provided food and beds for patients who needed hospitalization. The presence of partner doctors in the hospital had a tremendous impact on improving the quality of services. Now, things have really changed dramatically. Hospitals now provide not only food and lodging but also various kinds of professionals to support functions, including the functions of skilled and professional nursing services, specialist diagnosis and therapy, pre and postoperative care, and many other services. It cannot stop there because each hospital also continues to compete to improve and develop itself into an institution with total and comprehensive services (health tourism). However, the consequence is that not only the quality of medical services, medical support, and public services

has increased, but also increased corporate liability and vicarious liability arising from the mistakes of hospital staff.

a. Corporate Liability

It is actually quite difficult to distinguish between corporate liability and vicarious liability, because in certain situations, corporate liability may be interpreted as vicarious liability. The concept of corporate liability itself was actually developed from the understanding that hospitals are artificial entities that can carry out legal actions, through individuals who are members of them and who act for and on behalf of them, so that hospitals can become direct subjects of corporate liability when employees, non-employee staff, administrative personnel, or regular employees fail to implement appropriate hospital policies; for example, failing to implement a nosocomial infection prevention policy or failing to prevent incompetent doctors from treating patients.

Although not always true, corporate liability can be applied when the hospital does not take managerial steps that can be accounted for in certain areas, including:

1) Hospital equipment, supplies, medicine and food.
2) Hospital environment.
3) Safety procedures.
4) Selection and retention of employees and conference of staff privileges.
5) Responsibilities for supervision of patient care.

b. Vicarious Liability

In general, hospitals are not responsible for the mistakes of non-organic doctors (non-employee physicians) who only use hospital facilities to treat their own patients using staff privileges. They are independently responsible for mistakes that have harmed their patients. Even though they are responsible independently, an agreement with the hospital can be made to, for example, jointly bear compensation based on the proportion agreed by both parties if the doctor loses in court. Without a special agreement, non-employee physicians (e.g., partner doctors) are generally fully and independently liable.

Under vicarious liability, a hospital (though as an artificial being it has done nothing wrong) could be sued for the mistakes of the biodoctors working at the facility. This doctrine is in line with Article 1367 of the Civil Code, which states: "A person is not only responsible for losses caused by his own actions but also for losses caused by the actions of people who are his dependents or caused by materials that are under his control."

In order to apply the doctrine of vicarious liability, the following preconditions have to be met, namely:

This means that the doctors and the hospital must establish an economic relationship, for example, a master-servant or employer-employee relationship. The evidence of a direct (economic) relationship, among others, is as follows: the existence of a fixed salary; the authority of the hospital to control and impose sanctions; and the authority to appoint and dismiss doctors.

This means that a doctor's injury to a patient must fall within the obligations and responsibilities of the employer's hospital by a legitimate relationship. If a

physician acts outside his or her duties and responsibilities (for example, outside the clinical privileges given by the Director on the recommendation of the Credentials Committee from the Medical Committee), any loss due to his or her negligence shall be must be borne himself.

The concept of transferring liability to the hospital (in its position as master or employer) is based, among others, on the following thoughts:

a. To provide assurance to the aggrieved patient that they will certainly be able to find a defendant who has the ability to pay (solvent defendant or deeper pocket).
b. To provide feedback to the hospital management so that they have a greater sense of responsibility in managing and controlling doctors so that they are willing to provide better medical services so that there is no loss to patients.

Although in essence, there is no difference if the subject of vicarious liability is the hospital or the legal entity that owns the hospital, because the imposition of compensation on the hospital will automatically reduce the assets of the legal entity that is the owner, and vice versa. However, from a juridical-formal perspective, the answer to the question above may be very important so that each party understands each other's position as well as to avoid the possibility of a misaddress lawsuit.

4 Conclusion

The basic concept in the teaching of representative obligation must have a direct or economic relationship between the doctor who makes the mistake and the party who is the subject of joint responsibility. The responsible subject depends on the person who actually gives work to, dismisses, pays, and supervises the doctor concerned. In this case, the responsible subject is the hospital or the legal entity that owns the hospital.

In relation to foundations, as long as the hospital is a business activity of the foundation which is carried out by the executor and appointed by the governing body of the foundation, the foundation will be the subject of joint responsibility. As it is known, based on the Foundation Law, the management team is fully responsible for the management of the foundation, both for the interests and objectives of the foundation, As well as judicial and extra-judicial representatives of the Foundation, in accordance with the principles of Persona Standy in Judiciary. This means that management will represent the foundation in the event of litigation or being sued. If the hospital is established by a foundation or an association, then the joint responsibility is not with the foundation or association concerned but with the hospital (which in this case is represented by the board of directors). The responsibility of the foundation or association (as shareholder) is limited to the shares it owns and does not touch the other assets of the foundation or association that owns the hospital.

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