



1-1-1998

All True Histories Contain Instruction: Why HMOs Cannot Avoid Malpractice Liability through Independent Contracting with Physicians

Jennifer S. Anderson

University of the Pacific, McGeorge School of Law

Follow this and additional works at: <https://scholarlycommons.pacific.edu/mlr>



Part of the [Law Commons](#)

Recommended Citation

Jennifer S. Anderson, *All True Histories Contain Instruction: Why HMOs Cannot Avoid Malpractice Liability through Independent Contracting with Physicians*, 29 MCGEORGE L. REV. 323 (1998).

Available at: <https://scholarlycommons.pacific.edu/mlr/vol29/iss3/4>

This Comments is brought to you for free and open access by the Journals and Law Reviews at Scholarly Commons. It has been accepted for inclusion in McGeorge Law Review by an authorized editor of Scholarly Commons. For more information, please contact mgibney@pacific.edu.

All True Histories Contain Instruction: Why HMOs Cannot Avoid Malpractice Liability Through Independent Contracting With Physicians

Jennifer S. Anderson*

"All true histories contain instruction; though, in some, the treasure may be hard to find"¹

No one can deny that the face of American health care has changed dramatically over the past two decades.² Although the health care industry continues to rank among the most prosperous industries in the country,³ health care delivery has undergone major transformations. Traditional indemnity insurance plans have largely given way to Health Maintenance Organization (HMO) plans.⁴

Controversy accompanies change and one of the greatest controversies surrounding the explosive growth of the HMO industry has been the distribution of tort liability between doctors and managed care entities.⁵ For many years, HMOs were shielded from all tort liability by the Employee Retirement Income Security Act of 1974 (ERISA),⁶ a federal statute enacted in part to encourage employee-

* J.D., University of the Pacific, McGeorge School of Law, to be conferred 1999; B.A., Psychology, California State University, Chico, 1992. Thanks to my brother, Dan, for giving me the inspiration to write this Comment.

1. ANN BRONTË, AGNES GREY (1847), *quoted in* COLUMBIA DICTIONARY OF QUOTATIONS (Colum. Univ. Press 1993).

2. See Laura H. Harshbarger, Note, *ERISA Preemption Meets the Age of Managed Care: Toward a Comprehensive Social Policy*, 47 SYRACUSE L. REV. 191, 218 (1996) (outlining the tremendous growth of the HMO industry in the United States since the 1970s).

3. See CASTLE CONNOLLY MEDICAL LTD., THE CASTLE CONNOLLY GUIDE TO THE ABCS OF HMOs, HOW TO GET THE BEST FROM MANAGED CARE 14 (1997) [hereinafter THE ABCS OF HMOs] (noting that in 1996, 14% of the nation's gross national product was consumed in health care costs).

4. See GEORGE ANDERS, HEALTH AGAINST WEALTH 13 (1996) (stating that HMOs are currently enjoying an enrollment boom of 100,000 new members per week); Michael Jonathan Crinfeld, *Tilting at HMOs*, 17 CAL. LAW. 46, 48 (1997) (explaining that the managed care industry regulates health care for 150 million Americans).

5. See generally Diana Joseph Bearden & Bryan J. Maedgen, *Emerging Theories of Liability in the Managed Health Care Industry*, 47 BAYLOR L. REV. 285 (1995) (exploring issue., problems and trends in the distribution of malpractice liability between physicians and HMOs); John R. Penhallegon, *Emerging Physician and Organization Liabilities Under Managed Health Care*, 64 DEF. COUNS. J. 347 (1997) (discussing the theories of physician and HMO liability which have emerged with the advent of managed care); Wm. T. (Bill) Robinson, III, *New Deep Pocket: Managed Care Entity Liability for Alleged Improper Denial of Access*, 64 DEF. COUNS. J. 357 (1997) (recognizing that the growth in the HMO industry has resulted in an attempt by the plaintiffs' bar to spread malpractice liability between doctors and managed care entities).

6. 29 U.S.C.A. §§ 1001-1461 (West 1985 & Supp. 1997).

benefits packages by immunizing plan providers from liability.⁷ Slowly, lawyers and legislators have been whittling away at the ERISA shield.⁸

Plaintiffs have realized limited success in suing HMOs for physician malpractice under theories of vicarious liability or ostensible agency.⁹ In response, managed care industry leaders have published guidelines suggesting that HMOs can avoid liability through independent contracting with plan physicians.¹⁰ These contractual relationships have become commonplace in the managed care industry.¹¹ But in the end, such efforts may prove futile.¹²

The advent of vicarious liability and ostensible agency claims against HMOs mirrors the history of claims against hospitals for physician malpractice.¹³ Although such claims were once uniformly rejected by the courts,¹⁴ plaintiffs slowly chipped away at hospital immunity to the point where even independent contractor associations with physicians would not shield hospitals from vicarious liability in all circumstances.¹⁵ HMOs should heed this warning.

In Part I, this Comment discusses both the rise of the managed care industry in the United States and the era of immunity from liability these entities have enjoyed

7. See *infra* Part III.A-B and accompanying text (detailing the enactment of ERISA, the purpose behind the legislation and how it operates to protect HMOs from malpractice liability).

8. This Comment will not discuss legislative attempts to erode ERISA's protection of HMOs. However, by way of example, in 1996 more than 1,000 bills relating to the regulation of HMOs were introduced in state legislatures. David Mechanic, *Managed Care as Target of Distrust*, 277 J. AM. MED. ASS'N 1810, 1810 (1997). For further detail on this subject, see Tracy E. Miller, *Managed Care Regulation: In the Laboratory of the States*, 278 J. AM. MED. ASS'N 1102 (1997).

9. See *infra* Part III.C and accompanying text (describing how the judicial erosion of ERISA's broad protection of HMOs has resulted in limited success for plaintiffs bringing vicarious liability claims against managed care companies).

10. See, e.g., Alan Rutkin & Erica Garay, *How to Negotiate Contracts In an Era of Managed Care*, 25 MANAGED CARE WK., July 15, 1996, at 1056 [hereinafter *How to Negotiate Contracts*] (suggesting that HMOs attempt to avoid vicarious liability claims by including an express provision in physician contracts stating that physicians are independent contractors, not employees of the HMOs); see also *McDonough v. U.S. Steel Corp.*, 324 A.2d 542, 545 (Pa. Super. Ct. 1974) (acknowledging that employers are not generally liable for torts committed by independent contractors); RESTATEMENT (SECOND) OF TORTS § 409 (1965) (providing a general principle of tort law that the employer of an independent contractor cannot be held liable for injuries resulting from the acts of the independent contractor).

11. See *infra* notes 184-85 and accompanying text (stating that independent contractor relationships are the most popular arrangement used between HMOs and physicians).

12. See *infra* Parts III.D - IV (arguing that HMOs should not be protected from malpractice liability through independent contracting with physicians).

13. See *infra* Parts II.A, III.A (explaining the complete liability shields enjoyed by both hospitals and HMOs in the past); *infra* notes 71-77 and 137-44 (noting that the liability shields enjoyed by both entities were largely based on mistake); *infra* Parts II.B, III.C (outlining the erosion in immunity from liability experienced by both entities); *infra* Part II.C and accompanying notes (illustrating that both entities faced the erosion of their immunity from liability by entering into independent contractor relationships with physicians).

14. See *infra* Part III.A (outlining the "charitable immunity doctrine" which once shielded hospitals from liability).

15. See *infra* Part II.D (explaining the rationale used by courts for imposing vicarious liability on hospitals for physician malpractice despite independent contractor relationships between the two).

under ERISA.¹⁶ Part I also explores reasons why malpractice suits against physicians are not sufficient to redress patient injuries.¹⁷ Part II outlines the advent of vicarious liability claims against hospitals for staff-physician malpractice.¹⁸ Part III illustrates how patient claims against HMOs have paralleled the hospital claims up to a certain point.¹⁹ The section concludes by showing that the parallel should continue; i.e., that HMOs should not be able to shield themselves from liability through independent contract relationships with physicians.²⁰

I. THE HEALTH MAINTENANCE ORGANIZATION INDUSTRY

A. *The Rise of the HMO Industry in the United States*

Most Americans receive their health care coverage through employee benefits packages whereby the employer pays all or part of the premiums for employee policies.²¹ Until recently, most employees became covered by indemnity-type insurance plans.²² But employers were frustrated with the rapid rise in premium costs.²³ The escalating costs of health care led to a federal response.²⁴

16. See *infra* Part I.A-B (giving an overview of the HMO industry by discussing the rise of the managed care industry in the United States and the immunity from suit these entities have enjoyed under ERISA).

17. See *infra* Part I.C (opining that malpractice suits against physicians are not sufficient to satisfy patient claims).

18. See *infra* Part II (discussing how hospitals went from entities completely immune from liability to entities which could not even shield themselves from liability through independent contracting with physicians).

19. See *infra* Part III.A-D (illustrating that, like hospitals, HMOs once enjoyed a blanket immunity from suit and observing that both entities tried to protect themselves through independent contracting with physicians as the immunity began to erode).

20. See *infra* Parts III.C-IV (arguing that HMOs should not be able to avoid vicarious liability claims through independent contracting with physicians).

21. See Thomas A. Moore & Matthew Gaier, *HMO Liability—Part III: ERISA Preemption*, N.Y.L.J., Sept. 2, 1997, at 3 (noting that most people become members of their HMOs through their employment); see also M. William Salganik, *Most Workers Under Managed Care Plans; 80% Are Covered in This Region*, BALTIMORE SUN, Jan. 21, 1997, at C1 (stating that 80% of employees in the Washington, D.C.—Baltimore region are covered by HMO plans and that the national figures are similar).

22. Until the 1980's, most people who received health care coverage as part of an employee benefits package were covered by indemnity plans. See THE ABCS OF HMOS, *supra* note 3, at 13-14. Under indemnity plans, patients would visit their doctor, pay the bill and then seek reimbursement from their insurance company at a later date. *Id.* Physicians and hospitals billed on a fee-for-service basis and were reimbursed according to a "usual and customary" fee schedule. *Id.* The fee schedule was based on local average charges for the particular service, leaving the patients to pay for any charges falling above the average. *Id.* Critics of indemnity insurance charged that the plans left doctors with "built-in incentives . . . to do more and to charge more" since regardless of who paid the bills under an indemnity system (the insurance company, the patient or both), doctors always received the amount requested for their services. *Id.*

23. See ANDERS, *supra* note 4, at 16-17 (providing an example of employer frustration by telling the story of Edward Hennessy, chairman of Allied Signal, who was very disturbed to find in 1987 that expenses for employee health benefits had been increasing at a rate of 39% per year).

24. See THE ABC'S OF HMOS, *supra* note 3, at 16 (acknowledging that the Health Maintenance Organization Act of 1973 was a Congressional response to the continually increasing costs of health care).

In 1973, Congress passed the Health Maintenance Organization Act²⁵ to ensure that American workers would not lose their medical coverage as a result of the rising cost of employee medical benefits.²⁶ The Act mandated that employers with twenty-five or more employees had to provide coverage for their workers from a federally qualified HMO.²⁷ With this federal legislation in place, HMOs were ready to take over the marketplace.²⁸

Contrary to what most people believe, HMOs are not strictly insurance companies.²⁹ They do not compensate doctors on a fee-for-service basis as did the traditional indemnity plans.³⁰ Rather, HMOs are a system of “organizing, delivering and financing health care.”³¹

Health Maintenance Organizations achieve this comprehensive control in a number of ways. First, a managed care plan organizes groups of doctors to provide all medical services for members of the plan.³² Under most managed-care plans, doctors are not reimbursed according to the services they provide.³³ Rather, the doctors and the HMOs negotiate prior to treatment to determine the amounts that will be paid for various procedures.³⁴ Under many managed care models, doctors are paid based on a “capitation” system whereby they receive a fixed rate for

25. 42 U.S.C.A. §§ 300e to 300e-17 (West 1971 & Supp. 1997).

26. See S. REP. NO. 93-129 (1973) (expressing concern over the fact that national health care expenditures increased by 188% between 1960 and 1971, and noting that since many Americans were unable to afford this basic necessity, President Nixon encouraged the development of HMOs to increase overall access to health care in the United States).

27. See 42 U.S.C.A. § 300e(c)(1)(A)-(B) (West Supp. 1997) (defining a federally qualified HMO as one demonstrating financial stability, sufficient protection from the risk of insolvency and sufficient administrative and managerial organization); *id.* § 300e-9 (West 1991 & Supp. 1997) (requiring that any employer with at least 25 employees provide a health benefit plan and acknowledging that offering employees coverage under an HMO is sufficient to avoid the civil penalties imposed on employers who do not comply with the statutory mandate).

28. They may have done just that. Currently, 73% of American workers are covered by a managed care plan and the number of employees enrolled in managed care plans quadruple the number enrolled in indemnity plans. See THE ABCS OF HMOs, *supra* note 3, at 17, 20.

29. See *id.* at 16 (noting that in addition to providing the typical insurance function of paying medical bills, managed care organizations also organize and deliver the care a patient receives).

30. See Bearden & Maedgen, *supra* note 5, at 290-91 (1995) (comparing the fee-for-service method of reimbursement under indemnity insurance plans with reimbursement under HMO plans which involves a fixed payment by the patient combined with a pre-negotiated arrangement between the plan and its physicians); see also *Kampmeier v. Sacred Heart Hosp.*, No. CIV.A.95-7816, 1996 WL 220979, at *2 n.2 (E.D. Pa. May 2, 1996) (contrasting indemnity plans with HMO plans by noting that the former typically use retrospective review of procedures while the latter review payment requests prospectively and concurrently).

31. THE ABCS OF HMOs, *supra* note 3, at 16.

32. See *id.* at 35 (explaining that the managed care company selects the doctors its members can choose under the plan).

33. See Amy Sessler, *HMOs Institute Incentives Aimed at Emphasizing Preventative Care*, BOSTON GLOBE, Sept. 21, 1997, at 7 (acknowledging that before the advent of the HMO industry, doctors were typically paid on a fee-for-service basis, but that under managed care, doctors are now paid according to a fixed rate for each patient).

34. See Bruce D. Platt & Lisa D. Stream, *Dispelling the Negative Myths of Managed Care: An Analysis of Anti-Managed Care Legislation and the Quality of Care Provided by Health Maintenance Organizations*, 23 FLA. ST. U.L. REV. 489, 496 (1995) (explaining that the typical practice of HMOs is to negotiate a guaranteed patient flow for doctors in exchange for a discounted fixed fee for services).

treating all members of the plan who use their services during the year.³⁵ Under this system, doctors have a financial incentive to do less rather than more for patients because HMOs do not provide extra compensation for additional procedures.³⁶

Patients mistrust managed care companies and view them as putting profits before patient care.³⁷ Newspapers and magazines include numerous reports of patients who have suffered at the hands of the HMO empire.³⁸ Doctors are also critical of these corporate giants.³⁹ The justice system has added to patients' and doctors' concerns because the system has allowed HMOs to avoid answering for their wrongs.⁴⁰

B. The ERISA Shield

The Employee Retirement Income Security Act of 1974 (ERISA)⁴¹ controls the administration of employee benefit packages and the rights of those covered under such plans.⁴² This Act applies to any employee benefits plan as long as the plan was

35. See Gregg Easterbrook, *America's Top HMOs, Healing the Great Divide, How Come Doctors and Patients Ended Up on Opposite Sides?*, U.S. NEWS & WORLD REP., Oct. 13, 1997, at 64 (noting that under capitation, HMOs pay physicians a "fixed fee" of about \$150 per year for each patient enrolled in the plan, regardless of how much treatment the patients need or receive); see also ANDERS, *supra* note 4, at 26 (explaining how physician reimbursement by capitation works).

36. See THE ABCS OF HMOs, *supra* note 3, at 14-15 (revealing that the indemnity system gave doctors the incentive "to do more and to charge more," and noting that an additional problem under indemnity plans is that they are geared toward treating—rather than preventing—illness).

37. See Alex Pham, *HMOs Seek to Cure Image Malady Study: Few Horror Stories Have Damaged Industry*, BOSTON GLOBE, June 12, 1997, at C1 (reporting that only tobacco companies are ranked lower than HMOs on a list of industries that serve consumers).

38. See Morton Kondracke, *With Problems Mounting in Health Care System, Time is Right for Major Surgery*, SACRAMENTO BEE, Nov. 1, 1997, at B8 (noting that horror stories about people dying due to financial decisions made by HMOs show up daily in the newspapers); see also Glenda Winders, *When HMO Says No, Patient Really Pays*, STATE J.-REG. (Springfield, IL), Jan. 21, 1998, at 5 (outlining the inferior orthopaedic care received by the author under an HMO plan as compared to prior orthopaedic care she received under an old indemnity-type plan).

39. See Alicia Ault Barnett, *Who Needs the Middleman? Third-Party Players in the Doctor-Patient Relationship*, BUS. & HEALTH, Jan. 1, 1997, at 34 (discussing the recent surge in "provider sponsored organizations"—managed care entities developed and run by doctors who are fed up with practicing in the managed care setting); Michael Johnson, *Forces Behind HMO Regulation*, SACRAMENTO BEE, Nov. 7, 1997, at B7 (reporting that because of their discontent, California medical professionals spent \$3.5 million in 1996 on ballot initiatives aimed at tightening up regulation of HMOs).

40. See NBC News Sunrise: *Profile: Growing Dissatisfaction with Managed Care is Fostered by Delayed Treatment, Often at Patients' Expense* (NBC television broadcast, Dec. 2, 1997) (illustrating the frustration felt by patients who are left without recourse against HMOs due to the ERISA "loophole" that allows the entities to escape liability in most circumstances); see also *infra* Part III.A - B (providing an explanation of how ERISA works to allow HMOs to escape liability).

41. See 29 U.S.C.A. §§ 1001-1461 (West 1985 & Supp. 1997).

42. See Robert Armand Perez, Sr., *Health Administration Responsibility Project, ERISA Litigation Fundamentals* (visited Jan. 31, 1998) <<http://www.harp.org/perez.htm>> (outlining the basics of the comprehensive ERISA legislation).

established by or is maintained by an employer.⁴³ Employee benefit packages that provide health care are covered by ERISA.⁴⁴

In enacting ERISA, Congress intended to protect employee rights.⁴⁵ This Act does not mandate that employers provide employee benefits packages.⁴⁶ But in an effort to persuade them to do so, Congress granted employers and the companies chosen to provide their benefits, "substantial immunities from liability."⁴⁷ Ironically, Congress' actions may have hurt employees by leaving them without redress against an industry which would later dominate American health care.⁴⁸

C. Why Not Just Sue Doctors For Medical Malpractice?

Common sense dictates that the doctor who administers sub-standard health care should alone be liable for malpractice. While some of the traditional policy rationales of the vicarious liability doctrine would seem to support that notion, other policy considerations justify a shared risk between doctors and HMOs.⁴⁹ For example, when doctors are paid on a "capitated" basis,⁵⁰ they have a financial incentive not to order tests or perform additional procedures for their patients.⁵¹ It may

43. See *id.*

44. An employee welfare benefit plan is defined under ERISA as "any plan, fund, or program which [is] . . . established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries . . . medical, surgical, or hospital care or benefits . . ." 29 U.S.C.A. §1002(1) (West 1997).

45. See Harshbarger, *supra* note 2, at 217 (asserting that although protection of employee rights was not the only reason for Congress' enactment of ERISA, the legislative history suggests that such a purpose was paramount).

46. See HEALTH ADMINISTRATION RESPONSIBILITY PROJECT, ERISA OUTLINE, (visited Jan. 31, 1998) <<http://www.harp.org/erisa.htm>> (stating that rather than dictating to employers that they had to provide employee benefits plans, the statute gave them attractive incentives to do so).

47. *Id.*

48. See *infra* notes 139-44 and accompanying text (explaining how Congress ended up hurting employees by enacting ERISA). At least one author suggests that since HMOs were few in number when ERISA was enacted, it is unlikely that Congress could have anticipated the impact this legislation would have on American workers. See Harshbarger, *supra* note 2, at 218.

49. See RICHARD A. EPSTEIN, CASES AND MATERIALS ON TORTS 455 (6th ed. 1995) (demonstrating that since the early nineteenth century, the "deep pocket" was used as the main rationale for holding a master liable for the negligence of a servant and noting that this rationale was justified because most servants were too poor to satisfy claims by injured plaintiffs); John Dwight Ingram, *Vicarious Liability of an Employer-Master: Must There Be a Right of Control?*, 16 N. ILL. U. L. REV. 93, 94 (1995) (citing the "deep pocket" principle as one of the main rationales for the imposition of vicarious liability). This rationale does not seem to translate well to the physician context, because physicians, if not independently wealthy, are usually covered by large malpractice insurance policies. But see Robert Pear, *HMOs Reject Malpractice Liability*, TAMPA TRIB., Nov. 17, 1996, at 1 (predicting that the number of vicarious liability claims against HMOs will increase in the future because managed care entities have such deep pockets).

50. See *supra* notes 35-36 and accompanying text (discussing the capitated system of physician reimbursement).

51. See *supra* note 36 and accompanying text (noting that under a capitated system, doctors have a financial incentive to provide patients with fewer services).

not be fair solely to blame doctors for their failure to treat when the entities that pay them have made it lucrative to do less for the patient.⁵²

Additionally, some HMOs severely limit a patient's access to specialists, thereby forcing general practitioners to offer specialized treatment that may fall outside their area of expertise.⁵³ Managed care companies also advertise that they provide the best possible medical care, thus implying that doctors in the plan are either employees of the HMO or that they were carefully screened before joining the network.⁵⁴ If that is the case, allowing doctors to carry the entire liability burden cannot be justified.⁵⁵

II. THE ADVENT OF HOSPITAL LIABILITY FOR THE MALPRACTICE OF STAFF PHYSICIANS

Much recent writing has been devoted to the study of vicarious liability claims against HMOs for the malpractice of plan physicians.⁵⁶ The advent of vicarious liability claims against HMOs has mirrored the advent of such claims against hospitals.⁵⁷ Both entities enjoyed periods of immunity from liability and in both cases such immunity was based on mistake or oversight.⁵⁸ Both entities have witnessed an erosion of their liability shield due in part to a basis in policy which fails to satisfy the times.⁵⁹ Both entities have responded by attempting to avoid liability through independent contracting with physicians.⁶⁰ But hospitals have

52. See Sara Mars, *The Corporate Practice of Medicine: A Call for Action*, 7 HEALTH MATRIX 241, 261 (1997) (describing the dilemma physicians face under capitated reimbursement plans; they have a financial incentive not to treat, yet they bear the majority of the risk for malpractice when the decision not to treat turns out to be wrong).

53. See Pear, *supra* note 49, at 1 (revealing that the use of generalists has a great influence over the care a patient receives under an HMO plan).

54. See *id.* (suggesting that there is some hypocrisy in the way HMOs aggressively market themselves and then seek to avoid liability for the malpractice of plan physicians).

55. See *infra* notes 222-32 and accompanying text (arguing that the way an HMO advertises its physicians should have a bearing on the entity's vicarious liability for physician malpractice).

56. See generally Brooks Richardson, Comment, *Health Care: ERISA Preemption and HMO Liability—A Fresh Look at ERISA Preemption in the Context of Subscriber Claims Against HMOs*, 49 OKLA. L. REV. 677 (1996) (discussing vicarious liability claims against HMOs under ERISA); O. Mark Zamora, *Medical Malpractice and Health Maintenance Organizations: Evolving Theories and ERISA's Impact*, 19 NOVA L. REV. 1047 (1995) (examining vicarious liability claims against HMOs under theories of *respondeat superior* and ostensible agency); William A. Chittenden, III, *Malpractice Liability and Managed Health Care: History and Prognosis*, 26 TORT & INS. L.J. 451 (1991) (providing a historical analysis of vicarious liability claims against HMOs and predicting the future success of such claims).

57. See *infra* Parts II - III (drawing a parallel between vicarious liability claims against hospitals and those against HMOs).

58. See *infra* Parts II.A, III.A and accompanying notes (outlining the immunity from liability and illustrating that in both cases the immunity was based on mistake).

59. See *infra* Parts II.B, III.C and accompanying notes (explaining the erosion of immunity from liability both entities have suffered).

60. See *infra* notes 90-102, 184-85 and accompanying text (noting that both hospitals and HMOs have used independent contracting with physicians to avoid vicarious liability claims).

learned that clever contracting will not save them from vicarious liability claims.⁶¹ Because of their similarity to hospitals, managed care entities should suffer the same fate.

A. *A Liability Shield for Hospitals: The Doctrine of Charitable Immunity*

In the early part of the twentieth century, as patient care moved from the home to centralized hospitals,⁶² hospitals began to face suits for physician malpractice.⁶³ These early claims did not present much of a problem for hospitals, however, because hospitals were protected by the doctrine of charitable immunity.⁶⁴ This doctrine allowed non-profit organizations, including not-for-profit hospitals, to escape liability for the negligent acts of employees.⁶⁵ The policy rationale for this immunity was twofold: First, because hospitals provided a helpful service to people (sometimes without charge) they should not have suffered the consequences of injuries that resulted from their kindness.⁶⁶ A second rationale, applicable only in cases of physician malpractice, was that no master-servant relationship existed between hospitals and physicians, and thus, vicarious liability did not apply.⁶⁷

61. See *infra* notes Part II.D (providing an explanation for why courts eventually disallowed hospitals to shield themselves from liability through independent contracting with physicians).

62. See Cassandra P. Priestley, *Hospital Liability for the Negligence of Independent Contractors: A Summary of Trends*, 50 J. MO. BAR 263, 263 (1994) (noting that this change in the location of patient care accompanied other drastic changes in health care such as the routine performance of what were once considered extraordinary procedures).

63. Although hospitals are obviously sued for reasons outside physician malpractice, this Comment focuses on the doctrine of charitable immunity as applied to malpractice cases.

64. See John Dwight Ingram, *Liability of Medical Institutions for the Negligence of Independent Contractors Practicing on their Premises*, 10 J. CONTEMP. HEALTH L. & POL'Y 221, 221 (1993) (chronicling the tradition of hospital immunity under this doctrine).

The doctrine of charitable immunity did not apply solely to hospitals. See, e.g., *Coolbaugh v. St. Peter's Roman Catholic Church*, 115 A.2d 662, 663-664 (Conn. 1955) (holding that a charitable organization is "not responsible in damages to those who seek its benefits for any injury they may suffer through the negligence of its servants or agents" and applying the doctrine of charitable immunity to protect a church from liability for the negligence of its sexton).

65. See Jeanne Darricades, Comment, *Medical Peer Review: How is it Protected by the Health Care Quality Improvement Act of 1986?*, 18 J. CONTEMP. L. 263, 265-66 (1992) (explaining the charitable immunity doctrine as applied to hospitals).

66. See *Morrison v. Henke*, 160 N.W. 173, 175 (Wis. 1916) (stating that "[s]ince [a hospital] ministers to those who cannot pay as well as those who can, thus acting as a good Samaritan, justice and sound public policy alike dictate that it should be exempt from the liability attaching to masters whose only aim is to engage in enterprises of profit or self-interest"); see also *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (referring to this principle as an "implied waiver" and explaining that such a waiver results when an individual benefits from a relationship with a charity, exempting the charity from liability for negligence in the performance of charitable acts).

67. See *Schloendorff*, 105 N.E. at 93 (labeling the relationship of physician to hospital as one of an "independent contractor").

Although the doctrine originally applied only to charitable care,⁶⁸ it was eventually extended to protect hospitals from liability even in cases brought by “paying patient[s].”⁶⁹ In its heyday, the doctrine was available in cases that would, in modern times, shock the conscience.⁷⁰

Charitable immunity, as applied in the United States, was based on a jurisprudential mistake.⁷¹ It was first used in *McDonald v. Massachusetts General Hospital*⁷² where the court reasoned that the public and private donations used to support the hospital created a charitable trust fund which could not be diverted to pay obligations to plaintiffs.⁷³ The *McDonald* court based its decision on an English case, *Holliday v. St. Leonard's*,⁷⁴ which itself took the doctrine from dictum of an earlier English case.⁷⁵ Neither the *Holliday* nor the *McDonald* courts realized that the dictum from the earlier case had been expressly overruled.⁷⁶ Regardless of the oversight, the *McDonald* case was the catalyst for a long period of hospital immunity.⁷⁷

68. See *Powers v. Mass. Homoeopathic Hosp.*, 109 F. 294, 296 (1st Cir. 1901) (noting that in traditional cases involving the maxim of *respondeat superior*, a necessary element of the claim was that the master turned a profit, and concluding that since charitable hospitals provided the services of their doctors for free, no claim against the charitable institution could be brought).

69. *Id.* at 295; see *id.* (explaining that although plaintiff's counsel attempted to distinguish her case from prior cases on the ground that plaintiff did pay the hospital for her care, the court found the difference to be immaterial).

70. See, e.g., *Evans v. Lawrence & Mem'l Associated Hosp., Inc.*, 50 A.2d 443, 445 (Conn. 1946) (applying the doctrine of charitable immunity in a case where the plaintiff's infant child was killed when a hospital handyman, assigned to assist in the pharmacy, filled six baby bottles with boric acid rather than the dextrose solution typically used for feeding).

71. See *Bing v. Thunig*, 143 N.E.2d 3, 6-7 (N.Y. 1957) (outlining the mistaken use of the doctrine by English and American courts).

72. 120 Mass. 432 (1876).

73. See *McDonald*, 120 Mass. at 436 (reasoning that the trust could not be held liable without a finding of negligence on the part of the hospital in its role as administrator of the trust); *Bing*, 143 N.E.2d at 5 (explaining that the *McDonald* decision was premised on faulty reasoning).

74. 142 Eng. Rep. 769 (1861).

75. See *Bing*, 143 N.E.2d at 5 (explaining the historical misuse of the charitable immunity doctrine and citing *Duncan v. Findlater*, 7 Eng. Rep. 934 (1839) as the first English case to use the doctrine of charitable immunity).

76. See *Mersey Docks and Harbour Bd. Trustees v. Gibbs*, 11 H.L.Cas. 686 (1866) (overruling *Duncan*); see also *Bing*, 143 N.E.2d at 5 (pointing out the fact that by the time the *McDonald* case was decided, the *Holliday* decision had already been reversed).

77. The doctrine of charitable immunity has been used to shield a hospital from malpractice liability as recently as this decade. See, e.g., *Bagley v. Fulton-DeKalb Hosp. Auth.*, 455 S.E.2d 325, 327 (Ga. 1995) (retaining the doctrine of charitable immunity for hospitals when the patient actually receives charity care and noting that while plaintiff did pay \$2.00 for the services she received at the defendant hospital, the actual value of those services was over \$20,000).

B. *The Immunity Begins to Erode*

Then-Judge Cardozo set the stage for the erosion of the charitable immunity doctrine in a case that, ironically, used the doctrine to shield a hospital from liability.⁷⁸ In *Schloendorff v. Society of New York Hospital*, Judge Cardozo distinguished between acts of a hospital staff which were medical and those which were administrative.⁷⁹ According to *Schloendorff*, hospitals would continue to enjoy immunity from liability only for medical acts.⁸⁰ Judge Cardozo's rationale for this distinction was that acts performed by doctors and nurses were professional acts not subject to control by a hospital administration.⁸¹ Courts struggled with the distinction, and as case law developed, confusion grew deeper.⁸²

The distinction was eventually abandoned, as illustrated in *Bing v. Thunig*.⁸³ The court in *Bing* abandoned more than the mere medical/administrative rule, however. It also criticized both arguments justifying charitable immunity. While recognizing the importance of charitable hospitals, the court noted that modern hospitals were run like businesses and were less likely to be destroyed by lawsuits than were their predecessors.⁸⁴ The court also rejected the rationale that there was no master-servant relationship between the institutions and the physicians who practiced there.⁸⁵ This rationale had been premised on the fact that hospitals had no ability to control the high level of professional skill exercised by physicians in carrying out their duties.⁸⁶ The *Bing* court questioned that premise, noting that employers of other highly skilled professionals did not enjoy a similar immunity.⁸⁷

78. See *Schloendorff*, 105 N.E. at 92 (applying the charitable immunity doctrine to bar a suit by a plaintiff who had been operated on without her consent).

79. See *id.* at 94-95 (explaining the necessity of the medical/administrative distinction).

80. See *id.* at 95 (abandoning the doctrine of charitable immunity in cases where administrative acts of the hospital staff resulted in patient injury).

81. See *id.* at 94 (asserting that a hospital could not control the professional acts of doctors and extending charitable immunity to the medical acts of nurses because such acts were necessarily performed under the direction of a physician).

82. *Bing*, 143 N.E.2d at 4-5 (outlining the confusing holdings in this area). For example, *Iacono v. New York Polyclinic Med. Sch. & Hosp.*, 58 N.Y.S.2d 244, 245 (1945), held that placing an improperly capped hot water bottle onto a patient was administrative. *Sutherland v. New York Polyclinic Med. School & Hosp.*, 75 N.Y.S.2d 135, 137 (1947), on the other hand, held that keeping a hot water bottle on a patient for too long a period was medical. The case of *Necolayff v. Genesee Hosp.*, 61 N.Y.S.2d 832, 836 (1946), held that giving a blood transfusion to the wrong patient was administrative, while *Berg v. New York Soc. for Relief of the Ruptured & Crippled*, 154 N.Y.S.2d 455, 456 (1956), held that it was a medical mistake to give the wrong blood to the right patient.

83. See *Bing*, 143 N.E.2d at 5.

84. See *id.* at 7 (explaining that although hospitals were rightfully concerned that a negligence judgment against them would discourage donations and thus limit the facility's ability to serve, such concerns were no longer legitimate in modern society).

85. See *id.* at 6 (expressing disagreement with this line of reasoning).

86. See *Schloendorff*, 105 N.E. at 94 (asserting that a hospital has no control over the professional services rendered by a physician).

87. See *Bing*, 143 N.E.2d at 6 (questioning why hospitals should enjoy immunity from vicarious liability when employers of other skilled professionals, such as engineers and airline pilots, do not).

The court abandoned the doctrine of charitable immunity for hospitals and adopted instead a traditional test of *respondeat superior* when determining a hospital's liability for physician negligence.⁸⁸ Thus, the court joined a growing number of jurisdictions that were embracing the *respondeat superior* test.⁸⁹

C. *The Protection of Independent Contractor Relationships with Physicians*

The demise of the doctrine of charitable immunity left courts with the problem of determining under what circumstances hospitals could be liable for staff-physician malpractice.⁹⁰ To avoid liability, hospitals began to enter into independent contractor arrangements with their medical staff.⁹¹ These contracts expressly stated the existence of the independent contractor relationship.⁹² Doctors under such contracts were not paid an annual salary.⁹³ Nor did the hospitals exercise any control over the manner in which they exercised their professional services.⁹⁴

Some courts, perhaps hesitant to compel hospitals to take on liability for their physicians, found independent contractor relationships where none existed.⁹⁵ For example, in *Brown v. Moore*⁹⁶ the court refused to hold the owners of a hospital liable for the negligence of a physician despite the fact that the physician was a salaried employee of the hospital.⁹⁷ The court in *Brown* focused solely on the fact

88. *Id.* at 8 (declaring, "[T]he test should be, for these institutions, whether charitable or profit-making, as it is for every other employer, was the person who committed the negligent injury-producing act one of its employees and, if he was, was he acting within the scope of his employment.").

89. *See generally* *Durney v. St. Francis Hosp.*, 83 A.2d 753 (Del. 1951) (abandoning the charitable immunity doctrine in the state of Delaware); *Rickbeil v. Grafton Deaconess Hosp.*, 23 N.W.2d 247 (N.D. 1946) (disallowing a hospital to be protected by the charitable immunity doctrine in a libel case); *Avellone v. St. John's Hosp.*, 135 N.E.2d 410 (Ohio 1956) (abolishing the doctrine of charitable immunity for hospitals in the state of Ohio); *Foster v. Roman Catholic Diocese*, 70 A.2d 230 (Vt. 1950) (rejecting the doctrine in the state of Vermont).

90. *See Clark v. Southview Hosp. & Family Health Ctr.*, 628 N.E.2d 46, 52 (Ohio 1994) (acknowledging the dilemma Ohio courts faced after abolishing the charitable immunity doctrine).

91. *See Ingram, supra* note 64, at 223 (pointing out the fact that the contracts were entered so that patients who were previously treated by salaried employees would not have the same opportunities to sue hospitals for physician malpractice); *see also Priestly, supra* note 62, at 264 (acknowledging that the independent contracts were "clearly a sham to avoid liability"); *see supra* note 3 and accompanying text (explaining that under general principles of tort law, employers of independent contractors cannot be held liable for injuries resulting from the acts committed by the independent contractors).

92. *See Priestly, supra* note 62, at 264 (recognizing the explicit terms of the contracts).

93. *See id.* (asserting that doctors were not paid on a salaried basis since that form of payment was indicative of an employment relationship).

94. *See id.* (noting that by distancing itself from control of a doctor's professional services a hospital was lessening the chances of a court finding an ostensible agency relationship).

95. *See, e.g., Brown v. Moore*, 143 F. Supp. 816 (W.D. Pa. 1956), *rev'd*, 247 F.2d 711 (3rd Cir. 1957) (finding an independent contractor relationship between a hospital and physician where no such contract had been entered).

96. *See id.*

97. *See id.* at 819 (placing importance on the fact that "[the doctor] was paid an annual salary, subject to the usual withholding deductions").

that the hospital did not control how the physician carried out his professional services.⁹⁸

Later courts devised tests to determine whether the independent contractor status of a physician could be imposed to shield hospitals from liability for malpractice.⁹⁹ According to one court, an independent contractor relationship existed whenever a patient was admitted to the hospital by his own doctor.¹⁰⁰ On the other hand, if a patient was admitted to a hospital through the emergency room, with no choice as to treating physician, the physician would be regarded as a servant or agent of the hospital and typical *respondeat superior* principles would apply.¹⁰¹ Such distinctions were short-lived, however, because courts began to impose liability on hospitals for physician malpractice regardless of the employment status of doctors.¹⁰²

D. Hospital Liability Despite Independent Contractor Relationships

Just as public policy eroded the charitable immunity doctrine,¹⁰³ public policy later disallowed independent contractor relationships to shield hospitals from liability for physician malpractice.¹⁰⁴ Although clearly contrary to general principles

98. See *id.* at 821 (asserting that by hiring a doctor, the hospital was not attempting to heal patients itself, but rather was providing patients with a professional who had the sole responsibility of supplying medical care). It should be noted that this line of reasoning would almost certainly have failed to satisfy the *Bing* court. Having drawn a parallel between physicians and airline pilots, the *Bing* court recognized that neither group's professional activities were actually controlled by their employers. Despite that fact, airline companies were never granted blanket immunity from vicarious liability claims. *Bing*, 143 N.E.2d at 6.

99. See, e.g., *Vanman v. Milford Mem'l Hosp., Inc.*, 262 A.2d 263, 265 (Del. 1970), *rev'd*, 272 A.2d 718 (Del. 1970) (devising a test which imposed independent contractor relationships on physicians based on the status of the patient).

100. See *id.* (stating that under these circumstances, the doctor is merely considered a member of the "staff" of the hospital and the hospital would not be liable for his or her negligence).

101. See *id.* L.S. Rogers states: "Such a physician usually stands in a position with respect to the hospital which, under the normal tests of the existence of the master-servant relationship, would call for a ruling that he was the hospital's servant. In other words, such a doctor is normally paid a salary by the hospital . . ." *Id.* (quoting L.S. Rogers, Annotation, *Liability of a Hospital or Sanitarium for Negligence of a Physician or Surgeon*, 69 A.L.R.2d 305, 309 (1960)).

102. See *infra* Part II.D (explaining how hospitals came to be liable for the physician malpractice despite the independent contractor relationships they established with doctors).

103. See *infra* Parts IIB - D (outlining the reasons courts gave for the demise of hospital immunity from liability).

104. The *Martell* court declared: "[T]he question . . . is just as clearly a public policy question The issue of hospital liability is simply taken one step farther when the question is whether the hospital may be held liable for the acts of physicians in the hospital's emergency room when the physicians are independent contractors rather than employees." *Martell v. St. Charles Hosp.*, 523 N.Y.S.2d 342, 349-50 (1987).

of tort law,¹⁰⁵ by the 1980s hospitals could be held liable for physician malpractice irrespective of the contractual relationship between the parties.¹⁰⁶

Courts were able to achieve these results by applying another doctrine of tort law commonly referred to as the ostensible agency theory.¹⁰⁷ The most frequently cited explanation of this theory is found in the Second Restatement of Torts, section 429 which reads:

One who employs an independent contractor to perform services for another which are accepted in the reasonable belief that the services are being rendered by the employer or by his servants, is subject to liability for physical harm caused by the negligence of the contractor in rendering such services, to the same extent as though the employee were supplying them himself or by his servants.¹⁰⁸

105. See *McDonough v. U.S. Steel Corp.*, 324 A.2d 542, 545 (Pa. 1974) (recognizing the general rule that employers are not liable for torts committed by independent contractors).

106. See *Smith v. St. Francis Hosp., Inc.*, 676 P.2d 279, 283 (Okla. 1983) (holding that a hospital could not deny responsibility for the malpractice of emergency room physicians based on their independent contractor status); *Themins v. Emanuel Lutheran Charity Bd.*, 637 P.2d 155, 159 (Or. 1981) (denying the defendant hospital's motion for summary judgment where a material issue of fact existed regarding whether the hospital held its physicians out as employees of the hospital); *Hannola v. City of Lakewood*, 426 N.E.2d 1187, 1190 (Ohio 1980) (holding that a hospital could not avoid liability for physician malpractice despite the independent contractor status of staff physicians); *Adamski v. Tacoma Gen. Hosp.*, 579 P.2d 970, 974 (Wash. 1978) (recognizing that, "The experience of the courts has been that the application of hornbook rules of agency to the hospital-physician relationship usually leads to unrealistic and unsatisfactory results, at least from the standpoint of the injured patient."). For a more complete listing of the jurisdictions abandoning the independent contractor basis for hospital immunity from liability, see *Martell v. St. Charles Hosp.*, 523 N.Y.S.2d 342, 350 (1987).

107. Gregory T. Perkes, Casenote, *Medical Malpractice—Ostensible Agency and Corporate Negligence—Hospital Liability May be Based on Either Doctrine of Ostensible Agency or Doctrine of Corporate Negligence*, 17 St. MARY'S L.J. 558, 560-63 (1986) (acknowledging the way courts have used the doctrine of ostensible agency).

108. RESTATEMENT (SECOND) OF TORTS § 429 (1965). It should be noted that a second theory frequently cited as a basis for finding hospital liability for the negligence of physicians, agency by estoppel, will not be discussed in this Comment. This theory, found in § 267 of the Second Restatement of Agency, differs from the ostensible agency theory in that the former requires the plaintiff's reliance on representations as to employment made by the principal. See RESTATEMENT (SECOND) OF AGENCY § 267 (1957); see, e.g., *Jackson v. Power*, 743 P.2d 1376, 1380 (Alaska 1987) (discussing the differences between agency by estoppel and ostensible agency). The two theories have often been cited by courts in the same breath and have, in that context, been frequently misapplied. *Id.* Additionally, some courts have questioned the extent to which any patient in a hospital even cares about the employment status of the treating physician, let alone relies on such status. See also *Capan v. Divine Providence Hosp.*, 430 A.2d 647, 649 (Pa. 1980) (asserting that "[i]t would be absurd to require . . . a patient to be familiar with the law of respondeat superior and so to inquire of each person who treated him whether he is an employee of the hospital or an independent contractor.").

Under this theory, even a doctor who is an independent contractor is nonetheless, "an agent of the hospital with respect to the patient."¹⁰⁹ Many justifications have been given for this treatment,¹¹⁰ but two may apply in the HMO context.¹¹¹

The first justification for holding a hospital liable for the negligence of an independent contractor physician is based on two policy rationales that focus on the way a patient views the delivery of health care. First, patients are more likely to choose a particular hospital than an individual physician when seeking acute medical care.¹¹² Thus, it would be unjust to deny patients a remedy for any harm incurred at a facility chosen as best capable to address particular needs. Some courts have noted the inequity in allowing a secret contract between a hospital and a physician to bind patients who are not privy to that contract.¹¹³ The patients' lack of knowledge as to their doctor's contractual status justifies a finding of ostensible agency even where the hospital had no right to control the physician's actions.¹¹⁴

The second justification, found in section 429 of the Restatement (Second) of Torts,¹¹⁵ allows the court to find an ostensible agency relationship whenever the hospital has held itself out as being the employer of its staff physicians.¹¹⁶ A hospital holds itself out as such "when the hospital acts or omits to act in some way which leads the patient to a reasonable belief he is being treated by the hospital or one of its employees."¹¹⁷

109. *Capan*, 430 A.2d at 649.

110. See *Mehlman v. Powell*, 378 A.2d 1121, 1124 (Md. 1977) (deciding that the patient's reliance on the hospital for care and the fact that there was no indication that the treating physician was not an employee were significant facts in rejecting the hospital's claim of immunity); see also *Grewe v. Mt. Clemens Hosp.*, 273 N.W.2d 429 (Mich. 1978) (finding the patient's expectations and the fact that no notice was given of the hospital-physician relationship important).

111. See *infra* notes 189-233 and accompanying text (applying the justification used to hold hospitals liable for the malpractice of independent contractor physicians to the HMO context).

112. See *Capan*, 430 A.2d at 649 (noting that patients often enter such facilities seeking a variety of professional medical services rather than the attention of a single doctor).

113. See *id.* (citing *Mduba v. Benedictine Hosp.*, 384 N.Y.S.2d 527, 529 (1976), for the proposition that it is unfair to bind patients to contracts of which they are unaware).

114. An employer's ability to control the actions of an independent contractor is a very significant factor in most ostensible agency contexts. See John Dwight Ingram, *Vicarious Liability of an Employer-Master: Must There Be a Right of Control?*, 16 N. ILL. U. L. REV. 93, 110 (1995) (proclaiming that where an employer has a right to control an employee's activities, most courts are willing to impose vicarious liability on the former). However, the *Hardy* court stated:

[The hospital] places physicians in a position where they serve and treat members of the general public, persons who undoubtedly have no knowledge of the hospital's lack of authority to control. If persons in this context seek and accept [the hospital's] services, we regard that it would be unjust to allow [the hospital] to contract away liability for the negligence of its physicians, particularly where such an agreement is beyond the knowledge or perception of the patient.

Hardy v. Brantley, 471 So. 2d 358, 372 (Miss. 1985).

115. See *supra* note 108 and accompanying text (quoting RESTATEMENT (SECOND) OF TORTS § 429 (1965)).

116. See *Capan*, 430 A.2d at 649 (recognizing that one factor justifying a finding of an ostensible agency relationship is a hospital's "holding out" of a physician as its own employee).

117. *Adamski v. Tacoma Gen. Hosp.*, 579 P.2d 970, 979 (Wash. 1978).

An ostensible agency relationship exists if the patient has a *reasonable belief* that the physician is employed by the hospital.¹¹⁸ A reasonable belief can be the product of the way the hospital presented itself in its advertising.¹¹⁹ Courts were hesitant to allow hospitals to avoid liability once they had competed for the patient's business through advertising.¹²⁰ Especially significant to courts were advertisements that promoted the hospital as providing "skilled professionals" or a "full service facility."¹²¹ Hospitals could not distance themselves from the acts of physicians whose expertise the institutions had touted in an effort to get patients in the door.¹²²

Societal changes and public policy often compel abandonment of long-standing legal principles. Perhaps no industry has undergone as significant a shift in potential liability as the hospital industry. Once shielded from liability by the charitable immunity doctrine, the industry now finds itself accountable for the negligence of physicians with whom it has carefully contracted for the purpose of avoiding liability. This transition was based on sound policy and should be used by courts to increase the accountability of HMOs for physician malpractice.

III. THE ADVENT OF HMO LIABILITY FOR THE MALPRACTICE OF PLAN PHYSICIANS

The erosion of hospital immunity from liability was a necessary response to changing conditions in the area of health care.¹²³ As more patients looked to hospitals rather than individual physicians for health care, courts found it unjust to allow hospitals to contract their way out of liability.¹²⁴ Today, Americans increasingly rely on HMOs for their overall health care.¹²⁵ As more Americans fall under

118. See Priestly, *supra* note 62, at 265 (distinguishing the showing of reasonable belief necessary for a court to find an ostensible agency relationship from the more stringent requirement of affirmative reliance when the doctrine of agency by estoppel is applied).

119. See *id.* (noting that advertisements are important in both the ostensible agency and agency by estoppel contexts).

120. See *Hardy*, 471 So.2d at 371 (recognizing the inequity in the way hospitals advertised the quality of their physicians and then denied any relationship to them when it came to liability for their malpractice).

121. See Priestly, *supra* note 62, at 265 (noting the importance courts placed on such advertisements).

122. See *id.* (explaining that courts thought it would be inequitable to allow hospitals to escape liability for physician malpractice when they obtained a benefit by featuring the skill of the physicians in advertising).

123. See *supra* Part II.B - D (outlining the decline in hospital immunity from vicarious liability for physician malpractice).

124. See *supra* notes 112-14 and accompanying text (explaining the fact that more people were looking to individual hospitals rather than individual physicians as one basis for disallowing hospitals to shield themselves through independent contracting with physicians).

125. See David S. Hilzenrath, *Backlash Builds Over Managed Care: Frustrated Consumers Push for Tougher Laws*, WASH. POST, June 30, 1997, at A1 (acknowledging the continuously growing number of Americans who rely on HMOs for their health care).

the managed care umbrella,¹²⁶ it becomes evident that it is unfair to shield this enormous industry from accountability to its customers.

Courts are again faced with an industry of health care giants which have enjoyed a long period of immunity from liability and which now seek to avoid a new-found theory of liability for physician malpractice.¹²⁷ Specifically, courts are again faced with entities attempting to avoid vicarious liability claims through independent contractor relationships with physicians.¹²⁸ Just as these contractual arrangements failed to protect hospitals from liability for physician malpractice,¹²⁹ so should they fail to protect HMOs.¹³⁰ There is a lesson to be learned here, the challenge is to find it.

A. A Liability Shield for HMOs: ERISA

The expansive growth in the managed care industry brought with it a predictable surge of lawsuits against HMOs.¹³¹ Like hospitals, these entities were shielded from liability.¹³² However, in this instance, immunity came not from the common law, but from ERISA.¹³³

The relevant provision of ERISA in the context of claims against HMOs states that "the provisions of this subchapter . . . shall supersede any and all laws insofar as they may now or hereinafter relate to any employee benefit plan."¹³⁴ This provision has preempted many actions brought against HMOs, including state law

126. See *supra* notes 2-4 and accompanying text (illustrating the tremendous growth in recent years of the managed care industry in the United States).

127. See *infra* Parts III.A - IV and accompanying text (pondering the issue of HMO liability for physician malpractice).

128. See *supra* notes 184-85 and accompanying text (illustrating that the managed care industry has taken great strides to enter into independent contractor relationships with physicians).

129. See *supra* Part II.D (explaining how hospitals came to be vicariously liable for physician malpractice despite their efforts to shield themselves through independent contractor relationships with physicians).

130. See *infra* Parts III.C - IV and accompanying notes (arguing that HMOs should not be able to avoid vicarious liability for physician malpractice through independent contracting with plan physicians).

131. See Rodd Zolkos, *As Managed Care Expands, Liability Exposures Also Grow*, BUS. INS., July 29, 1996, at 3 (stating that "[a]s managed care grows, related liability exposures are growing . . ."); see also Joe Neidzielski, *Shift to Managed Care Creating New Exposures*, NAT'L UNDERWRITER LIFE & HEALTH, FIN. SERVICES EDITION, Oct. 7, 1996, at 5 (recognizing that the more people who are covered under managed care plans, the more such plans will be subject to lawsuits).

132. See *infra* notes 134-44 and accompanying text (examining how ERISA has worked as a liability shield for HMOs).

133. See *infra* notes 134-44 and accompanying text (discussing the immunity from liability enjoyed by HMOs under ERISA).

134. ERISA § 514(a) (West 1997); 29 U.S.C.A. § 1144(a) (West 1985).

actions for vicarious liability.¹³⁵ HMOs have worn this language like a badge, using it to tout their immunity from suit.¹³⁶

Whereas charitable immunity was largely based upon jurisprudential mistake,¹³⁷ the provisions of ERISA that shield HMOs from liability were the result of legislative oversight. When ERISA was enacted in 1974, HMOs were no where near the force in health care that they are today.¹³⁸ ERISA was enacted to create uniform pension laws among the states and to protect employees from employers who might be unwilling to disperse benefits.¹³⁹ It is unlikely Congress imagined that by immunizing HMOs from liability they would hurt employees who were left without redress for the wrongs of managed care entities.¹⁴⁰

Federal officials have recognized irony in the fact that this legislation, intended to protect workers, now fails to protect them from malpractice.¹⁴¹ Even some managed care executives have admitted that the protection is beyond Congressional intent.¹⁴² Although many are calling for Congressional reform of the Act,¹⁴³ courts and lawyers have found ways around ERISA's broad protections.¹⁴⁴

135. See, e.g., *Schwartz v. FHP Int'l Corp.*, 947 F. Supp. 1354, 1359 (D. Ariz. 1996) (holding that plaintiff's claims for vicarious liability against the defendant HMO "related to" the administration of health plan benefits and thus were preempted by ERISA).

136. See Robert Pear, *HMOs Reject Malpractice Liability*, TAMPA TRIB., Nov. 17, 1996, at 1 (stating that "[h]ealth maintenance organizations . . . are telling courts across the country that they cannot be held responsible for medical malpractice in cases involving patients who receive care through an employee-sponsored health plan" and quoting G. William Scott, a senior attorney in the United States Labor Department, as stating "[t]his is the defense that HMOs are raising for everything now. Whenever they are sued, they say, 'We have no liability because we were administering an employee benefit plan.'").

137. See *supra* notes 71-77 and accompanying text (explaining why the doctrine of charitable immunity was a mistaken doctrine).

138. See Harshbarger, *supra* note 2, at 218 (explaining that when Congress was debating ERISA in 1972, there were fewer than 40 HMOs in existence in the United States, as opposed to over 600 by the mid-1990's).

139. See Stuart Auerback, *Law Guarding HMOs from Suit Challenged; Patients Find Doctors Easier to Sue*, WASH. POST, Dec. 17, 1996, at Z8 (noting that while ERISA has served its purpose in protecting pension plans, it has not been very effective in regulating health plans).

140. See Harshbarger, *supra* note 2, at 218 (addressing the fact that HMOs were a rare entity at the time ERISA was enacted and suggesting that Congress could not have predicted how popular they would become).

141. See Pear, *supra* note 136, at 1 (acknowledging the Labor Department's dissatisfaction with the current state of the law and noting that in the past few years, the federal government has filed *amicus curiae* briefs in at least six malpractice actions against managed care organizations).

142. See Auerback, *Law Guarding HMOs*, *supra* note 139, at Z8 (quoting Arthur Rosenfeld, Vice President and Regional Counsel for Kaiser in Oakland, as saying, "I don't think Congress ever intended [ERISA] to be as broad as the courts have interpreted it.").

143. See *id.* (citing Labor Secretary Robert Reich as saying that ERISA should be changed to allow patients to sue HMOs). In his most recent State of the Union Address, President Clinton noted the large number of Americans covered by HMO plans, and called for reform in numerous areas under a proposed Consumers Bill of Rights. See President William J. Clinton, *State of the Union* (visited Jan. 31, 1998) <<http://www.whitehouse.gov/WH/SOTU98/address.html>>.

144. See *HMO Vicarious Liability Claims*, MANAGED CARE WK., Oct. 30, 1995, available in 1995 WL2409211 (stating that, "[c]ourts are increasingly less disposed to apply the Employee Income Security Act's (ERISA) broad preemptive powers").

B. How ERISA Preemption Works

The typical malpractice suit against an HMO is brought by a plaintiff claiming that the entity is vicariously liable for the negligence of a plan physician.¹⁴⁵ Since these suits are usually brought in state court, the HMO files for removal to federal court.¹⁴⁶ In response to most plaintiffs' argument that a claim of vicarious liability is a state law claim, HMOs argue that although the plaintiff's claim may not raise a federal issue on its face as required by *Franchise Tax Board v. Construction Laborers Vacation Trust*,¹⁴⁷ suits against HMOs administering employee benefits fall under the "complete preemption" doctrine.¹⁴⁸ This doctrine recognizes that Congress has preempted an area of law so completely that any action arising within its scope is automatically considered federal in nature.¹⁴⁹ "The Supreme Court has ruled that ERISA is such an area, and that state law claims are preempted by ERISA provided they 'relate to' an ERISA plan."¹⁵⁰

When the case is removed to federal court, the HMO will move to dismiss, arguing again that ERISA preempts the action.¹⁵¹ This preemption argument is premised on ERISA section 514(a),¹⁵² which states, "the provisions of this subchapter . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . ."¹⁵³ The Supreme Court has extended the scope of this provision by holding that it may be used to preempt both state statutory and common-law claims as long as they "relate to" an employee benefit plan.¹⁵⁴

145. See, e.g., *Butler v. Wu*, 853 F. Supp. 125 (D.N.J. 1994) (pertaining to a case wherein an administrator of patient's estate brought a vicarious liability claim against U.S. Healthcare, Inc., alleging malpractice of a plan physician).

146. See, e.g., *Blum v. Harris Methodist Health Plan*, No. CIV.A. 3:97-CV-0374P, 1997 WL 452750 at *1 (N.D. Tex. July 31, 1997) (explaining that the defendant HMO removed the case to federal court on the grounds that the suit was preempted by ERISA).

147. 463 U.S. 1, 9-12 (1983).

148. See *Blum*, No. CIV. A. 3:97-CV-0374P, 1997 WL 452750 at *1 (discussing the complete preemption doctrine).

149. See *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63-64 (1987) (acknowledging Congress' power to legislate an area of the law so completely as to make any claim arising in that area an issue solely for the federal courts to decide).

150. *Blum*, No. CIV.A. 3:97-CV-0374P, at *1 (citing *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987)).

151. See, e.g., *Ricci v. Gooberman*, 840 F. Supp. 316, 316-18 (D.N.J. 1993) (discussing the defendant HMO's motion to dismiss under ERISA § 514(a)).

152. See 29 U.S.C.A. § 1144(a) (West 1997).

153. *Id.* (emphasis added).

154. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987) (extending ERISA's preemptive power to cover state common-law claims that relate to employee benefit plans).

A court must then determine whether a vicarious liability claim sufficiently “relates to” an employee benefit plan to warrant preemption.¹⁵⁵ The potential breadth of such language makes the test difficult to apply.¹⁵⁶ However, the Supreme Court offered some guidance in this area when it clarified that a state law “relate[s] to” an employee benefit plan when “it has a connection with or reference to such a plan.”¹⁵⁷

For some courts, vicarious liability claims fell naturally within this language.¹⁵⁸ One court reasoned that since the outcome of plaintiff’s claim ultimately rested on the relationship between the physician and the HMO, the action certainly “related to” the benefit plan and was thus, preempted.¹⁵⁹ That court found that allowing such claims would ultimately hurt the consumer since health care costs would surely rise if both the physician and the HMO were required to carry malpractice insurance.¹⁶⁰ Another court found a vicarious liability claim to “relate to” an employee benefit plan because any malpractice claim against an HMO would necessarily involve an inquiry into whether agents of the HMO lived up to the promises of quality offered by the entity.¹⁶¹ Thus, ERISA appeared to protect HMOs from claims of vicarious liability for physician malpractice.

C. *The Immunity Begins to Erode*

Although the Supreme Court has recognized the widespread implications of ERISA section 514(a)’s “relate to” provision,¹⁶² it has also indicated that the section has limits.¹⁶³ Unfortunately, the Court has not adequately defined those limits, leaving the task in the hands of lower federal courts.¹⁶⁴ The delegation of this duty

155. See *Ricci*, 840 F. Supp. at 317 (stating that “[t]he applicability of ERISA preemption in this case thus turns on whether a state tort claim premised on a vicarious liability theory ‘relates to’ U.S. Healthcare’s employee benefit plan”).

156. See *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990) (noting that “[ERISA’s] preemption clause is conspicuous for its breadth”).

157. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983).

158. See, e.g., *Ricci*, 840 F. Supp. at 317 (finding plaintiff’s vicarious liability claim against the defendant HMO to relate to plaintiff’s employee benefit plan).

159. See *id.* (alluding that, absent the preemption issue, no remedy is available against the HMO if the physician was an independent contractor, while the plaintiff might be able to recover if it could be shown the physician was an employee of the managed care entity).

160. See *id.* (noting that in using this reasoning, the court was persuaded by the defendant HMO’s brief).

161. See *Dukes v. United States Health Care Sys., Inc.*, 848 F. Supp. 39, 41 (E.D. Pa. 1994, *rev’d* 57 F.3d 350 (3d Cir. 1995)) (holding that plaintiff’s vicarious liability claim did relate to the employee benefit plan since it would force the court to look at the terms of the health plan); see also *Visconti v. U.S. Health Care*, 857 F. Supp. 1097, 1102 (E.D. Pa. 1994) (following the reasoning of the *Dukes* court).

162. See *FMC Corp.*, 498 U.S. at 58 (recognizing the enormous breadth of the “relate to” provision).

163. See *Shaw*, 463 U.S. at 100 n.21 (recognizing that “[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law ‘relates to’ the plan”).

164. *Id.* (stating that “[w]e express no views about where it would be appropriate to draw the line.”).

has led to the creation of a subtle distinction, much like the one used in the hospital context.¹⁶⁵

Lower federal courts have developed a distinction that does not guarantee a successful lawsuit for plaintiffs, but does allow plaintiffs to have their claims remanded for trial in the state courts.¹⁶⁶ Plaintiffs prefer state courts to federal courts because state juries are thought to be more sympathetic to individuals and less sympathetic to corporate defendants.¹⁶⁷ This is especially true in the context of ERISA litigation.¹⁶⁸

*Prihoda v. Shpritz*¹⁶⁹ illustrates the distinction that may allow plaintiffs a state forum. In remanding plaintiff's vicarious liability claim against an HMO, the court first relied on ERISA section 502(1)(B),¹⁷⁰ ERISA's "civil enforcement provision."¹⁷¹ This provision outlines three situations in which a plaintiff can sue an HMO: "[T]o recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan."¹⁷² The court noted that this provision is the one which actually allows defendants to remove a case to federal court under the complete preemption doctrine.¹⁷³ The court then explained that ERISA section 514(a) creates "conflict preemption" which does not create federal jurisdiction.¹⁷⁴ Rather, "conflict preemption" serves merely as a defense to a plaintiff's claim arising under ERISA.¹⁷⁵

165. See *supra* notes 78-82 and accompanying text (discussing the distinction which has evolved in the hospital liability context).

166. See, e.g., *Yanez v. Humana Med. Plan, Inc.*, 969 F. Supp. 1314 (S.D. Fla. 1997) (granting plaintiff's motion to remand vicarious liability claims against the HMO back to state court despite ERISA).

167. See Paul M. Barrett, *Justices Expand Certain Authority of Federal Judges*, WALL ST. J., Mar. 4, 1992, at B8 (noting that because of the sympathy plaintiffs receive in state courts, corporate defendants usually prefer to have their cases tried in federal courts); see also Neal Miller, *An Empirical Study of Forum Choices in Removal Cases Under Diversity and Federal Question Jurisdiction*, 41 AM. U. L. REV. 369, 443 (1992) (suggesting several reasons why plaintiff's attorneys prefer the state court forum; among those reasons are the less restrictive procedural rules of state courts and a notion that federal judges are more arrogant than their state counterparts).

168. See Charles P. Efflandt, *An Overview of Civil Litigation Under ERISA*, 59 J. KAN. B.A. 24, 28 (1990) (explaining the reasons that ERISA plaintiffs enjoy state forums as "familiarity with the court, a more expeditious resolution of the dispute, and the hope that a state court's sympathies will lie more with the plaintiff insofar as ERISA's technical issues and defenses are concerned"); see also Rodd Zolkos, *As Managed Care Expands Liability Exposures Also Grow*, BUS. INS., July 29, 1996, at 3 (asserting that plaintiffs are purposefully drafting their vicarious liability claims against HMOs in such a manner that the claims will remain in state court since that forum typically results in larger jury awards).

169. 914 F. Supp. 113 (D. Md. 1996).

170. See 29 U.S.C.A. § 1132(a)(1)(B) (West 1997).

171. *Prihoda v. Shpritz*, 914 F. Supp. 113, 117 (D. Md. 1996).

172. 29 U.S.C.A. § 1132 (West 1997).

173. *Prihoda*, 914 F. Supp. at 117 (explaining that suits brought in state courts under this provision are "recharacterized" as federal and are thus, completely preempted).

174. *Id.* (citing the Supreme Court in *Caterpillar, Inc. v. Williams*, 482 U.S. 386, 398 (1987), as saying, "The fact that a defendant might ultimately prove that a plaintiff's claims are pre-empted does not establish that they are removable to federal court.").

175. See *Rice v. Panchal*, 65 F.3d 637, 640 (7th Cir. 1995) (illustrating the differences between complete preemption and conflict preemption).

From this, the court reasoned that if a plaintiff's suit against an HMO related to the "quantity" of benefits conferred under the plan, it fell under ERISA's civil enforcement provision and was preempted.¹⁷⁶ A suit related to the "quality" of benefits did not fall under ERISA section 502 and could not be removed to federal court.¹⁷⁷ Using this reasoning, many courts have remanded vicarious liability claims against HMOs where the claims are concerned with the quality of benefits received under an employee benefit plan.¹⁷⁸

Much like the medical/administrative distinction that arose in the hospital liability context,¹⁷⁹ this distinction is already being criticized for its difficulty in application.¹⁸⁰ At least one court has recognized that a claim relating to a decision to deny benefits under a health plan (raising an issue of the quantity of benefits) may ultimately relate to the quality of care provided.¹⁸¹ This distinction may give way to a bright line rule allowing these suits to proceed in state court. Courts have already put forth policy rationales that would seem to justify such a shift.¹⁸²

D. Independent Contractor Relationships Between Physicians & HMOs

Because state courts are typically more favorable to individual plaintiffs who take on corporate giants like HMOs,¹⁸³ the managed care industry has devised strategies for avoiding liability in this hostile setting. For example, HMOs have been

176. *Prihoda*, 914 F. Supp. at 118.

177. *See id.* (finding that plaintiff's claims concerned the quality of benefits and holding that plaintiff's motion to remand should thus be granted).

178. *See Dykema v. King*, 959 F. Supp. 736 (D.S.C. 1997) (deciding plaintiff's vicarious liability claim related to the quality of benefits received under the health plan); *Kampmeier v. Sacred Heart Hosp.*, No. CIV.A. 95-7816, 1996 WL 220979, at *3 (E.D. Pa. May 2, 1996) (agreeing with plaintiffs that their vicarious liability claims related to the quality of the benefits received); *Edelen v. Osterman*, 943 F. Supp. 75 (D.C. 1996) (distinguishing plaintiff's vicarious liability claim from cases where the claim was held to relate to the quantity of benefits by noting that plaintiff's claim stemmed from negligence while the latter stemmed from administrative decisions).

179. *See supra* notes 78-83 and accompanying text (discussing the medical/administrative distinction which evolved in the hospital liability context).

180. *See Lancaster v. Kaiser Found. Health Plan, Inc.*, 958 F. Supp. 1137, 1145 (E.D. Va. 1997) (discussing the potential ambiguity in the quantity/quality distinction).

181. *See id.* (warning that the quality/quantity distinction must be used carefully because decisions regarding whether to treat may have an effect on the quality of care provided under a plan).

182. *See Edelen*, 943 F. Supp. at 77 (answering defendant's argument that malpractice claims against HMOs should be preempted by saying,

Under defendant's theory, every medical malpractice claim would fall under the exclusive jurisdiction of the federal district courts because of the ERISA preemption clause, so long as the defendant doctor was employed by an HMO. In light of the burgeoning HMO industry and the legions of potential HMO-related medical malpractice claims that can be brought by innumerable HMO participants, this Court . . . is reluctant to accept such an argument, and a fair reading of ERISA does not permit it).

183. *See supra* notes 167-68 and accompanying text (explaining that state courts are typically more favorable to individual plaintiffs than corporate entities).

urged to enter into independent contractor relationships with plan physicians.¹⁸⁴ Not surprisingly, the Independent Practice Association model of HMOs, in which all physicians within the plan are independent contractors, has become the most popular HMO model in the United States.¹⁸⁵

Case law has not settled the issue of whether managed care entities can be held vicariously liable for the malpractice of independent contractor physicians.¹⁸⁶ State courts that have actually reached the merits in these cases are split on how to approach the issue.¹⁸⁷ A look to the past might be instructive.

The policies that led to abandonment of hospital immunity from liability despite the independent contractor status of physicians¹⁸⁸ apply nicely to the HMO context.¹⁸⁹ Courts should focus on two rationales which were used previously: the patient's choice of the institution rather than a particular physician,¹⁹⁰ and the institution's practice of "holding out" the physician as an employee.¹⁹¹

1. Choice of Entity

By the late 1970's and early 1980's, hospitals could no longer shield themselves from vicarious liability claims by entering into independent contractor relationships

184. See *How to Negotiate Contracts*, *supra* note 10, at 1056 (asserting that, "Managed care plans can guard against vicarious liability by including in provider contracts a simple clause that explicitly says providers are independent contractors, not employees"); see also Neidzielski, *supra* note 131, at 5 (suggesting that to avoid liability for malpractice, HMOs should try to distance themselves from doctors and explaining that independent contractor relationships with physicians give the entities a strong chance of avoiding vicarious liability claims).

185. See THE ABCS OF HMOs, *supra* note 3, at 36 (noting the popularity of the Independent Practice Association model and comparing it to other models, including the "Staff Model" in which physicians are actual employees of the HMO, the "Group Model" in which doctors are organized into large practice groups in centralized locations, and the "Network Model" which is similar to the "Group Model" except that there are more multiple-doctor locations available).

186. See, e.g., *Raglin v. HMO III, Inc.*, 595 N.E.2d 153, 156 (Ill. 1992) (noting that the court was unaware of any cases actually holding an HMO liable for medical malpractice).

187. See *Boyd v. Albert Einstein Med. Ctr.*, 547 A.2d 1229, 1234-35 (Pa. 1988) (applying the rationale used in a case holding that a hospital could be vicariously liable for the malpractice of an independent contractor physician to the HMO context and remanding to the trial court since a material issue of fact existed as to whether the physician in this case was an ostensible agent of the HMO). But see, *Raglin*, 595 N.E.2d at 158 (focusing on the fact that the HMO retained no right to control physicians within its network in refusing to hold an HMO vicariously liable for the malpractice of a physician).

188. See *supra* Part II.D (illustrating how courts decided that hospitals could not protect themselves from vicarious liability claims through independent contracting with physicians).

189. See, e.g., *Boyd*, 547 A.2d at 1234 (explaining that one reason why hospitals could not protect themselves from malpractice liability through independent contractor relationships with physicians was that patients had begun to look to the hospitals rather than to individual physicians for their care and noting that the same rationale is applicable in the HMO context).

190. See *supra* notes 112-14 and accompanying text (acknowledging that courts justified their refusal to allow hospitals to protect themselves from vicarious liability claims by reasoning that patients were looking to hospitals rather than individual physicians for health care).

191. See *supra* notes 115-22 and accompanying text (explaining the concept of "holding out" as it applies to hospital liability).

with doctors.¹⁹² Courts placed much emphasis on the fact that people were looking to hospitals rather than individual physicians for their overall medical care.¹⁹³ Because of that, courts thought it was unjust to allow hospitals to secretly contract their way out of liability.¹⁹⁴

Today many people rely on managed care organizations rather than individual physicians for their overall health care.¹⁹⁵ In fact, most Americans receive their health care coverage through an employee benefits plan.¹⁹⁶ Additionally, 73% of American workers are enrolled in a managed care network.¹⁹⁷ And finally, over half of American workers have no choice as to the managed care plan they use, since their employers offer coverage under a single plan only.¹⁹⁸ Thus, most people have a very limited number of doctors from which they can choose and they may not be able to obtain care from their preferred physician. In short, they look to HMOs to provide their health care.

Additionally, most HMOs require a referral from a primary care physician or prior authorization from the managed care organization itself before the HMO will cover treatment by a specialist.¹⁹⁹ When a patient is denied the care of a specialist, she is left in the hands of her primary care physician, who may be ill-equipped to deal with her special needs.²⁰⁰ Since the patient is left out of the decision whether

192. See *supra* Part II.D (discussing how hospitals were denied the ability to shield themselves from vicarious liability claims through independent contractor associations with physicians).

193. See, e.g., *Mehlman v. Powell*, 378 A.2d 1121, 1124 (Md. 1977) (placing significance on the fact that patients tended to rely on hospitals for medical care); *Capan v. Divine Providence Hosp.*, 430 A.2d 647, 649 (Pa. 1980) (noting that patients frequently entered hospitals seeking a variety of professional medical services rather than the attention of an individual doctor).

194. See *Mduba v. Benedictine Hosp.*, 384 N.Y.S.2d 527, 529 (1976) (noting the inequity of allowing an unknown contract to bind an unsuspecting patient); *Capan*, 430 A.2d at 649 (following the reasoning of *Mduba*).

195. See THE ABCS OF HMOs, *supra* note 3, at 20 (citing the fact that at least 40% of patients who join HMOs are forced to give up their preferred physician because the doctor is not included as a health care provider under their plan). Under such circumstances, it is hard to see how a patient can be said to have chosen a particular doctor.

196. See *supra* note 21 and accompanying text (discussing the fact that most Americans receive their health care through their employment).

197. See THE ABCS OF HMOs, *supra* note 3, at 17 (offering various statistics about the prevalence of HMOs in the United States).

198. See *id.* at 19 (saying that fewer than 50% of American employers offer their employees more than one choice of health plans).

199. See Lloyd M. Krieger, *Managed Care Hurts Bond of Doctors, Patients*, STAR-TRIB. (St. Paul-Minneapolis), June 6, 1997, at 23A (asserting that while decisions regarding treatment methods previously were at the discretion of doctors and patients, now all procedures must be negotiated with an HMO before payment approval is given and noting that without approval from the PacifiCare HMO, patients have to forego needed care or pay for it themselves); see also Jay Greene, *Report Tracks HMOs Service*, ORANGE CO. REG., June 20, 1997, at C1 (citing a recent study showing that the number one complaint of HMO members is their inability to acquire access to specialists).

200. See *Special Report: Specialists at the Gate*, MED. UTILIZATION MGMT., Sept. 25, 1997, available in 1997 WL 9410746 (suggesting that primary care physicians may not be best able to handle a patient's needs). For example, stroke patients treated by a neurologist had a 36% lower death rate than those treated by a family practitioner; according to two studies, patients seeking care for heart attacks would have a much lower death rate if treated by cardiologists rather than family practitioners; and breast cancer patients treated by specialists had a

to see a specialist, it again appears that the patient looks to the HMOs, rather than an individual physician for health care.

Hospitals could not contract their way out of vicarious liability for physician malpractice since patients were choosing particular hospitals, rather than individual physicians, for their overall health care.²⁰¹ This rationale applies with great force in the HMO context. Patients must look to their managed care companies for initial treatment and continuing specialty care. Just as it was inequitable for hospitals to use independent contractor relationships to avoid malpractice liability,²⁰² it is likewise inequitable to allow HMOs to avoid liability through clever contracting. Yet in this setting, the unfairness rests not only on the injured patient, but also on the primary care physicians who practice outside their area of expertise under incentives from the HMOs.²⁰³ Some managed care companies offer primary care physicians bonuses for limiting a patient's access to care that falls outside the standard office visit.²⁰⁴ As one doctor recently said, "Bonuses like this are not only essentially bribes, they can represent the difference between having an income and not."²⁰⁵ When a business entity dictates that a doctor's professional judgement be compromised for the good of that entity, it is unfair to force doctors to shoulder the entire liability burden.²⁰⁶

2. "Holding Out"

Employers who utilize independent contractors cannot avoid immunity from liability whenever the services rendered by their independent contractors are "accepted in the reasonable belief that the services are being rendered by the employer or his servants."²⁰⁷ Courts relied on the "reasonable belief" language to find

much longer survival rate than their peers who were treated by non-specialists. *Id.*; see also ANDERS, *supra* note 4, at 228 (asserting that, "Primary-care doctors don't recognize crucial symptoms").

201. See *Capan v. Divine Providence Hosp.*, 430 A.2d 647, 649 (Pa. 1980) (explaining the use of this rationale).

202. See *supra* notes 113-14 (discussing that courts felt it was inequitable to allow an undisclosed contract between a hospital and a physician to bind a patient).

203. See Lawrence O. Gostin, *Law and Medicine*, 275 J. AM. MED. ASS'N, 1817, 1817 (1996) (lamenting the inequity of a system that allows doctors to shoulder the entire burden of malpractice suits when decisions not to treat are secretly influenced by financial incentives).

204. See Easterbrook, *supra* note 35, at 64 (revealing the way bonus systems are used by HMOs).

205. *Id.*

206. This theory is in line with one of the standard rationales for the vicarious liability doctrine, i.e., the one who profits from a transaction should bear the risk of loss from that transaction. See also, Ingram, *supra* note 114, at 94 (noting that one of the main rationales for the vicarious liability doctrine is that whoever benefits from a given activity should also bear the burdens that result from it); Young B. Smith, *Frolic and Detour*, 23 COLUM. L. REV. 444, 455-56 (1923) (listing profit among the nine traditional rationales for vicarious liability). In this context, HMOs are profiting greatly from the actions of plan physicians. See American Political Network, *Managed Care Monitor Physicians: One Doctor's Experience With Managed Care*, Oct. 6, 1997, at 10 (asserting that profits from health care are going to HMOs rather than to physicians).

207. RESTATEMENT (SECOND) OF TORTS § 429 (1965).

that hospitals held themselves out as employers of independent contractor physicians in two distinct contexts.²⁰⁸ The first was when a hospital led a patient to think she was being treated by the hospital staff.²⁰⁹ The second was when hospitals' advertisements led patients to such a belief.²¹⁰ Both are applicable in the HMO context.²¹¹

It is not hard to find actions by HMOs which lead patients to believe that their physician is employed by a managed care entity. Doctors will tell you that their decision-making has been drastically altered by HMOs.²¹² Medical decisions are frequently made with the HMO's profit, rather than the individual patient's needs, in mind.²¹³ As a result, patients are often refused access to care they want and need.²¹⁴ In many cases, the doctor, not the HMO, must explain denial of treatment to the patient.²¹⁵ Under these circumstances, it is reasonable for a patient to believe that her doctor is working for an HMO.

One court, in refusing to shield a hospital from liability for physician malpractice, noted the inequity in expecting a patient to know enough about the law to ask her treating physician whether she was an employee or independent contractor

208. See *supra* notes 117-22 and accompanying text (describing how courts interpreted the "reasonable belief" language).

209. See *Adamski v. Tacoma Gen. Hosp.*, 579 P.2d 970, 979 (Wash. 1978) (declaring that whenever a hospital acts in a manner that creates a reasonable belief in the mind of the patient that an employment relationship exists, it has held itself out as the employer of the physician).

210. See *supra* notes 119-22 and accompanying text (explaining how courts looked to a hospital's advertising to determine if it held itself out as the employer of staff physicians).

211. See *infra* notes 212-34 and accompanying text (applying the reasoning used in the hospital liability cases to the HMO context).

212. See ANDERS, *supra* note 4, at 75 (relaying the story of a pediatrician who is very frustrated with the ways HMOs alter the level of care he would otherwise provide. To illustrate: HMO patients must have blood drawn at sites other than the pediatrician's office even though his nurses are specially trained to make the experience painless for his young patrons; he is often told by HMOs that he cannot prescribe necessary drugs because they are too expensive; and it is almost impossible to get approval for his patients to see a specialist); see also Easterbrook, *supra* note 35, at 64 (suggesting that the decision to treat a patient may force a doctor to sacrifice income).

213. See ANDERS, *supra* note 4, at 77 (noting that in many instances, HMOs have steered patients who needed heart surgery to clinics which could provide the managed care companies with large discounts, as opposed to hospitals where the patients would receive superior care and inferring that at least one of the major HMOs has actually asked its doctors not to request experimental treatment for cancer patients because of cost concerns); Easterbrook, *supra* note 35, at 64 (referring to HMO health care as "for-profit medicine"); George J. Church, *Backlash Against HMOs: Doctors, Patients, Unions, Legislators are Fed Up and Say They Won't Take It Anymore*, TIME, Apr. 14, 1997, at 32 (quoting Dr. Alan Fogelman, head of the Department of Medicine at UCLA, who said, "People who are sick will be allowed to die because it is best economically.").

214. See Mechanic, *supra* note 8, at 1810 (noting that formulaic decisions about health care made by HMOs rather than by doctors often fail to take into account the differing needs and preferences of patients).

215. See Lloyd M. Krieger, *The HMO (Attrition) Plan: It's Doctors vs. Bureaucracy*, L.A. TIMES, June 1, 1997, at M2 (explaining that whenever the author (a doctor) recommends a conservative course of treatment, he is faced with patients who distrust whether his decision is based on medical judgment or what the HMO has dictated as the course of treatment).

of the hospital.²¹⁶ When a person needs medical care, the contractual status of her physician is not foremost in her mind.²¹⁷ The same rationale applies in the HMO context. Managed care entities, like hospitals, should not be allowed to shield themselves from liability by entering into independent contractor relationships with physicians.

Hospitals were also found to have “held out” physicians as their own employees through their advertisements.²¹⁸ Courts reasoned that if hospitals wanted to compete aggressively for business by touting their skilled medical staff, they could not elude liability by denying a relationship between themselves and staff physicians.²¹⁹ Especially persuasive to the courts were advertisements that publicized the institutions as providing “skilled professionals” or a “full service facility.”²²⁰ Advertisements can leave consumers with a reasonable belief that the advertising entity has some control over what occurs within its walls.²²¹

HMOs aggressively advertise for the business of health care consumers.²²² For example, one managed care company asserts that it can provide, “extensive network[s] of . . . physicians . . . all working together to bring you quality health care.”²²³ Another promises that it has made a commitment to the health of the communities it serves and that it achieves this through offering “effective partnerships with providers.”²²⁴ Yet another is simply called, “MD Health Plan.”²²⁵

216. See *Capan v. Divine Providence Hosp.*, 430 A.2d 647, 649 (Pa. 1980) (declaring that “[i]t would be absurd to require . . . a patient to be familiar with the law of respondeat superior and to inquire of each person who treated him whether he is an employee of the hospital or an independent contractor.”).

217. See *Ingram*, *supra* note 64, at 225 (doubting that any patient would refuse medical treatment solely because of the independent contractor status of their physician).

218. See *supra* notes 119-22 and accompanying text (explaining how a hospital could use advertising to hold a physician out as an employee of the hospital).

219. See *Priestly*, *supra* note 62, at 265 (noting the inequity that would result from such practices); see also *Hardy v. Brantley*, 471 So.2d 358, 371 (Miss. 1985) (acknowledging that it is unfair to bind the patient to a contract of which he is not aware).

220. See *supra* notes 121-22 and accompanying text (discussing the significance courts placed on such ads).

221. See *Priestly*, *supra* note 62, at 265 (suggesting that to protect themselves from liability, hospitals might have to go so far as to actually present written evidence to a court that the patient had knowledge of and consented to the independent contractor relationship).

222. See *Health Business*, DELANEY REP. (Dec. 1, 1997), available in 1997 WL 14732086 (noting that two prominent California HMOs had recently spent \$15-20 million on advertising); Sandy Lutz, *Tax-Exempts in New Orleans Aim to Compete Via Alliance*, MOD. HEALTHCARE, Apr. 22, 1996, at 42 (asserting that while HMOs are cutting physician reimbursement rates, they are spending millions of dollars on advertising); David R. Olmos, *Doctor Networks to Merge in Deal Worth \$2.5 Million*, L.A. TIMES, May 15, 1996, at 1 (charging HMOs with spending too much money on advertising and not enough money on patient care).

223. Health Net, (visited Feb. 3, 1998) <<http://webservr1.healthnet.com/web/general/about.htm>> (noting “Health Net is among the most respected health care companies in California. We have an extensive network of over 35,000 physicians, 600 medical groups and affiliate locations, and 4,000 pharmacies — all working together to bring you quality health care.”).

224. Mercy Health Plans Mission Statement, (visited Feb. 3, 1998) <<http://www.carechoices.com/>> (describing the services offered by the company).

225. MD Health Plan, (visited Feb. 3, 1998) <<http://www.mdhealthplan.com/>> (advertising the health plan).

On their face, these advertisements suggest an employment relationship, as did the hospital advertisements mentioned above.²²⁶ When a company says that, “We . . . all work[] together to bring you quality health care,”²²⁷ it is hard to argue that no working relationship exists between the people promising to provide the health care and the people who provide it on their behalf.

As for the company that has “effective partnerships with providers,”²²⁸ they might try to argue that such language does not infer any sort of master-servant association. However, since courts were unwilling to force patients to have knowledge of *respondeat superior* principles in the hospital-physician context,²²⁹ it is unlikely that they would now expect patients to scrutinize HMO slogans for the existence of independent contractor relationships. And as for the company named “MD Health Plan” it might be completely unreasonable to believe that such a company does not employ any physicians.²³⁰ Thus, these advertisements appear to hold physicians out as employees of HMOs.

HMOs clearly desire to distance themselves from physicians for purposes of liability.²³¹ But as a matter of marketing strategy, it might be unwise to emphasize their lack of control over physicians. After all, no company would choose a health plan for its employees if it advertised that: “We take absolutely no responsibility for the mistakes of our doctors.” But HMOs cannot have it both ways. Courts have already recognized the unfairness of allowing hospitals to compete aggressively for business while escaping liability for the negligent acts of those who bring patients through the doors.²³² Courts must recognize the same inequity in the HMO setting.

The HMO industry should not be able to use independent contractor relationships with physicians to shield themselves from liability for malpractice. If the same contractual associations were rejected by the courts as a way for hospitals to shield themselves,²³³ there is no reason why contracting should provide immunity from liability for managed care entities. The same policies that allowed patients to sue hospitals should apply to HMOs and should be used by the courts to keep managed care companies from contracting their way out of liability.

226. See *supra* note 121-22 and accompanying text (noting the weight courts gave to advertisements offering “skilled professionals” or a “full service facility”).

227. Health Net, *supra* note 223.

228. Mercy Health Plans Mission Statement, *supra* note 224.

229. See *Capan v. Divine Providence Hosp.*, 430 A.2d 647, 649 (Pa. 1980) (noting the absurdity in requiring a patient to be familiar enough with the law to be able to make inquiries about a physician’s employment status).

230. MD Health Plan, *supra* note 225.

231. See *supra* notes 184-85 and accompanying text (discussing the fact that HMOs are setting up independent contractor associations with physicians).

232. See *supra* notes 119-22 and accompanying text (discussing the role advertising played in hospitals losing their immunity from liability for physician malpractice).

233. See *supra* Part II.D (discussing the reasons why hospitals could not use independent contractor relationships to shield themselves from liability for physician malpractice).

IV. CONCLUSION

Health Maintenance Organizations eluded responsibility for physician malpractice for a long time.²³⁴ When their immunity began to erode, they entered into independent contractor relationships with their physicians.²³⁵ Under traditional principles of tort law, such tactics might work. But courts have already rejected these principles in the hospital liability context.²³⁶ After enjoying a long period of immunity from liability for physician malpractice, hospitals were made to answer for the negligent acts of those practicing within their walls. Even independent contractor relationships eventually failed to shield hospitals from liability. That evolution was based on sound policy considerations.

Those same rationales dictate that in today's complex health care system, HMOs must be made to answer for physician malpractice.²³⁷ Courts should reject industry attempts to avoid liability through independent contracting and recognize HMOs for what they are — entities that control the way doctors deliver health care in America. Because of the size and strength of the HMO industry in the United States today, courts should loosen managed care organizations' grip on consumers.

234. *See supra* Parts III.A - B (describing the immunity from liability HMOs have enjoyed under ERISA).

235. *See supra* notes 184-85 and accompanying text (illustrating that HMOs have attempted to avoid liability for physician malpractice through independent contracting with physicians).

236. *See supra* Part II.D (explaining why hospitals were unable to protect themselves from liability for physician malpractice through independent contracting with physicians).

237. *See supra* notes Parts III.D - IV (arguing that like hospitals, HMOs should not be able to avoid liability for physician malpractice).