LIABILITY ISSUES FOR MANAGED CARE ENTITIES*

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I. Introduction

During the past several years, the financing and delivery of health care in the United States have been dramatically altered due to substantial changes in the economy of the marketplace. Under the prior delivery system, euphemistically referred to as the free lunch system, medical care was delivered without regard to cost containment and, on many occasions, without regard to medical necessity. The result was continued high costs during a period when the general economy was experiencing deflation. Since that time, economic conditions and attitudes driving the health care marketplace have been altered drastically. Formerly the providers had control of the delivery of health care based upon their professional judgment, now a new system of managed care has emerged. The attitudes of employers and group health insurers in the private sector have caused this demand for managed care.[1] As a consequence, new cost control and cost reduction methods have been instituted in an attempt to prevent continued health care inflation.

As new systems have emerged from the initial first generation of discounts toward the era of managed care, it is clear that the present direction of the health care marketplace is shifting toward prepared provider organizations (PPOs), health maintenance organizations (HMOs), and utilization management companies. These systems are viewed by many segments of the

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[1] See *infra* section II for definition of managed care.

marketplace as the vehicle for the provision of actual managed care. In the private sector of the health care marketplace, managed care has been embraced by providers and insurance companies as a product. Employers, both alone and in conjunction with business coalitions, are beginning, as part of a national trend, to embrace managed care. They are establishing health care purchasing organizations (HPOs) in an effort to acquire quality, cost-efficient health care for their employees.

The federal government, the ultimate purchaser of health care for the Medicare consumer, has used the HMO as its initial model of managed care and is now embracing the PPO model of managed care as a vehicle to provide quality, cost-efficient health care to Medicare beneficiaries through its recent PPO demonstration project. The shift in the health care marketplace toward managed care modifies or intensifies legal issues of the prior system and creates a multiplicity of new legal issues. If managed care is a new health care delivery system reflecting or creating new social attitudes, the legal system must necessarily adjust. The initial stages of this adjustment will be discussed in this article.

II. Managed Care

If managed care will create new financial systems, ethical issues and, for the purposes of this article, legal issues, it should be defined. Due to the evolving nature of managed care, expansive definitions could be misleading. Therefore, a global definition, to be refined with the evolution of managed care, is necessary.

Initially, managed care was perceived to be a combination of providers offering discounts from customary charges and retrospective utilization review programs for medical procedures and ancillary testing. As a result of this definition, antitrust issues were pervasive in the legal health care literature. More important to the evolving definition of managed care was the health care marketplace reaction to discounts as managed care. A significant portion of that marketplace still view managed care as discount medicine. Judging by the tenor of the discussion of managed care by employers, business coalition staff members, analysts, physicians, hospitals, and other providers, it is clear that many participants in the health care industry retain the impres-

sion that HMOs employ cheaper physicians, pay low capitation or discounted fees for service to manage care. They view PPOs as merely serving as a conduit for provider discounts. More problematic is the purchaser's belief that the discounts obtained in managed care are exaggerated because the providers are gaming the system to create the illusion of reduced costs. The continued increase in health care costs generates more purchaser enthusiasm toward this viewpoint.

The more sophisticated definition of managed care, and the definition that should serve as the foundation of the transition from discount managed care to the actual managing of medical care, is providing the patient with the appropriate care in the appropriate level of care.

Managed care, reduces *costs*, not necessarily *price*. Managed care is based upon the premise that a system that provides patients with appropriate care in the appropriate level of care will reduce the cost of health care irrespective of price. Managed care presupposes a network in compliance with certain basic criteria, with the expertise to recognize and the strength to implement the appropriate care in the appropriate level of care. Although the *price* per unit of care is an important factor, the real expenditures result from the *amount of care* a patient receives at those prices.

This definition of managed care creates a number of significant liability issues that result from a health care system providing patients with the appropriate care in the appropriate level of care. The basic criteria for an entity to be a managed care network may be found in the criteria of the accreditation program of the American Association of Preferred Provider Organizations (AAPPO).[2] Although intended for PPOs, these criteria were established to measure the PPOs' transition from discount PPOs toward actual managed care and therefore these criteria apply to managed care organization generally. These criteria are as follows:

1. Managed Care Network
2. Provider Selection Criteria
3. Payment Methodologies and Levels

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[2] American Association of Preferred Provider Organizations Accreditation Criteria Releases.

4. Utilization Management
5. Quality Assurance
6. Management/Administrative Capability and Information Systems
7. Legal Structure
8. Financial Solvency

For purposes of the discussion of liability issues of managed care entities, provider selection criteria and utilization management are the areas that pose significant liability risks.

III. Theories of Liability Relating to Provider Selection (Criterion 2 of the AAPPO Accreditation Program).

To be a managed care system, an entity must establish *and enforce* selection criteria for *all* of the providers in its network. Quality, cost-efficient providers are the basis of managing health care. Obviously, physicians who perform only necessary surgeries, those physicians who perform services correctly the first time and require fewer readmissions, and specialized hospitals performing specialized services save money. Inappropriate services, those that are not necessary, no matter how well performed, are not cost-effective.

The health care marketplace is now beginning to recognize the need for provider selection criteria and is concerned that managed care networks may not have originally established or enforced selection criteria for all providers in their networks. There is now a marketplace perception that, on most occasions, due to internal politics, the panel of the managed care network has been open to all members of the medical staff of a sponsoring hospital or to any physician responding to a solicitation. In addition, the marketplace seems to hold the belief that many networks hospitals are engaged based not on quality but because they are part of a sponsoring health system or merely because they agree to discount their charges. Employers evaluating these networks fear that the selection criteria of many HMOs and PPOs have been compromised due to these and other factors and that the same poor quality, inefficient providers who contributed to the inflation of the past are participating in the managed care network of HMOs and PPOs.

To deal with this perception many HMOs and PPOs have tightened their selection criteria for *all* providers. Thus, they are

using their utilization management systems and the data that they have collected to begin eliminating the poor quality and/or inefficient providers. It is understood that, to market their network, HMOs and PPOs must be able to demonstrate they have obtained the quality, cost-efficient providers and have systems to eliminate those providers who are unable to meet the high standards set forth in their selection criteria.

Provider selection criteria and the enforcement of such criteria create a significant area for liability issues to arise; first in the initial selection process, then in the maintenance of credentialing, and finally in the removal or failure to remove a provider from the managed care network. As a result, regardless of their organizational form, Independent Practice Association (IPA) model HMOs and PPOs may become additional party defendants in medical malpractice claims against one of their panel providers. Organizational liability of the IPA model HMO or PPO entity for medical malpractice, as related to provider selection criteria, may be based on the legal theories of: (1) vicarious liability for physician negligence, based either on the doctrine of respondeat superior or ostensible agency; and (2) corporate negligence, based on the failure to exercise reasonable care in selecting or supervising the negligent physician.[3]

A. *Vicarious Liability*

The doctrine of vicarious liability imposes legal responsibility on a person or an entity for the negligent acts or omissions of another because of a special relationship between the two.[4] This

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[3] At least one state, New Jersey, has by statute sought to expressly immunize HMOs from malpractice liability. N.J. STAT. ANN. § 26:2J-25(c)-(d) (West 1987). The statute provides:

> c. Any health maintenance organization authorized under this act shall not be deemed to be practicing medicine and shall be exempt from the provision of chapter 9 of Title 45, Medicine and Surgery, of the Revised Statutes relating to the practice of medicine.
>
> d. No person participating in the arrangements of a health maintenance organization other than the actual provider of health care services or supplies directly to enrollees and their families shall be liable for negligence, misfeasance, nonfeasance or malpractice in connection with the furnishings of such services and supplies.

Id. Thus far, however, the liability issues discussed in this article remain applicable to most IPA model HMOs and PPOs throughout the country.

[4] W. PROSSER & W. KEETON, THE LAW OF TORTS § 69 (5th ed. 1984).

liability may be imposed regardless of the first party's blameless conduct.[5]

1. Respondeat Superior

Under the doctrine of respondeat superior, an employer is vicariously liable for the negligence of an employee acting within the scope of his employment.[6] The doctrine does not apply, however, if the negligent party is an independent contractor.[7] Therefore, it is critical whether the culpable party is an employee or independent contractor. One key indicia is the extent of the employer's right to control the worker.[8] This control may be as extensive as the right to direct the work step-by-step or as limited as the right to control the hours of work.[9] A master-servant relationship may exist despite an understanding that the employer will not exercise any actual control over the worker.[10]

Until recently, the control test prevented the application of the doctrine of respondeat superior to physicians, since it was

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[5] *Id.*

[6] RESTATEMENT (SECOND) OF AGENCY § 219 (1958). *See also* Sloan v. Metropolitan Health Council, 516 N.E.2d 1104 (Ind. Ct. App. 1987) (corporation held vicariously liable for malpractice for the acts of its employee-physician where the agency or employment relationship exists). A unanimous appellate court reversed the summary judgment entered below in favor of the defendants, doing business as Metro-Health Plan, a staff model HMO providing health care services through its employed physicians, and remanded the case for trial on the HMO's liability under a respondeat superior theory. *Sloan*, 516 N.E.2d at 1109. The court deemed a "non sequitur" the HMO's defense that because

> a corporation could not secure a license to practice medicine; . . . it cannot be liable for the action of its employed agents and servants who may be so licensed. Similar logic would dictate that a city cannot be liable for the negligence of its employees in driving automobiles since the city cannot hold a driver's license . . . .

Id. at 1108. Furthermore, the court found "no logical basis for denying liability under proper circumstances on the ground that the professional must exercise professional judgment that the principal may not properly control." *Id.* at 1109.

[7] RESTATEMENT (SECOND) OF AGENCY § 250 (1958).

[8] Annotation, *Liability of Hospital or Sanitarium for Negligence of Surgeon or Physician*, 69 A.L.R. 2D 320 (1960) [hereinafter *Liability of Hospital*]; *see also* RESTATEMENT (SECOND) OF AGENCY § 220 (1958).

[9] Stewart v. Midani, 525 F. Supp. 843, 849 (N.D. Ga. 1981) (right to control includes the right of the employer to dictate the hours of work, not simply the right to control medical treatment decisions).

[10] RESTATEMENT (SECOND) OF AGENCY § 220 comment d (1958). A full-time cook remains a servant although there is an understanding the employer will exercise no control over the cooking. *Id. See also Sloan*, 516 N.E.2d 1104.

generally held that laymen could not directly control a physician due to the skill and judgment inherent in the practice of medicine.[11] A distinction was sometimes made, however, between a physician's administrative acts, which could result in vicarious liability, and medical acts which were exempt from the doctrine.[12] This distinction was abandoned in *Bing v. Thunig*,[13] which held a physician's employment status must be determined through an analysis of the same factors, including the degree of control, as any other employee.[14]

Staff model HMOs customarily employ physicians to provide medical care to HMO patients. Where the employment relationship exists it is clear that the HMO will be liable for the malpractice of its employee-physicians. The IPA model HMO, or any non-staff model HMO, and the PPO do not customarily employ physicians or exercise control over treatment decisions or hours of work. These physicians may provide services to non-HMO and non-PPO patients and to other health care institutions. These characteristics support a view that the IPA model HMO physician and the PPO physician are independent contractors. The IPA model HMO and the PPO, however, customarily require preauthorization of many elective hospital admissions and concurrent review of lengths of stay and fees for both inpatient and outpatient treatments may be set by the organization. Failure to abide by HMO or PPO regulations may result in a provider's removal from the provider panel. These factors may, in future cases, provide evidence of an employer-employee relationship.

A degree of control similar to that exercised by IPA model HMOs and PPOs was sufficient to establish a master-servant relationship between a physician and a hospital in *Mduba v. Benedictine Hospital*.[15] The lower court found that the physician, who was under contract with the hospital to operate an emergency room, was an independent contractor.[16] On appeal, the court held the physician was an employee as a matter of law on the grounds that the physician's fees were based on rates set forth in his contract

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11 *Liability of Hospital, supra* note 8, at 322.
12 *Id.* at 317.
13 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957).
14 *Id.* at 667, 143 N.E.2d at 9, 163 N.Y.S.2d at 12.
15 52 A.D.2d 450, 384 N.Y.S.2d 527 (App. Div. 1976).
16 *Id.* at 452, 384 N.Y.S.2d at 528.

and because he was required to comply with the rules and regulations of the hospital's governing board.[17]

Just as the physician in *Mduba*, the fees of a physician in an IPA model HMO or PPO are contractually determined and the physician is bound to comply with organizational regulations. *Mduba*, however, has not been generally followed as a rationale to achieve vicarious liability. The decision has been criticized for using insufficient evidence of control in establishing a master-servant relationship.[18] The fact that the physician is required to provide services in accordance with organizational bylaws "would not seem . . . ordinarily [to] be sufficient to create an employer-employee relationship."[19] Other jurisdictions have found similar levels of control to be "not inconsistent with an independent contractor relationship."[20]

Due to the difficulties in defining what is sufficient employer control for a master-servant relationship, courts increasingly base their analyses on other factors, including the custom of the industry, the skill of the worker, the method of payment,[21] and the ownership of instrumentalities.[22] These factors should support the view that an IPA model HMO physician and a PPO physician are independent contractors. Although courts generally cite the custom of the industry and the skill of the worker as additional relevant factors in analyzing a master-servant relation-

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17 *Id.* at 453-54, 384 N.Y.S.2d at 529-30.

18 1 S. PEGALIS & H. WACHSMAN, AMERICAN LAW OF MEDICAL COMMENT, MALPRACTICE § 3.28 (1980 & Supp. 1989). *See also* Comment, *Hospital Liability for Physician Malpractice: The Impact of Hannola v. City of Lakewood*, 47 OHIO ST. L.J. 1077, 1079-84 (1986).

19 PEGALIS & WACHSMAN, *supra* note 18, § 3.28.

20 Overstreet v. Doctors Hosp., 142 Ga. App. 895, 897, 237 S.E.2d 213, 215 (Ct. App. 1977) (hospital had no right to control specific medical techniques utilized and only limited control over the quality of care).

21 RESTATEMENT (SECOND) OF AGENCY § 220 (1958). *See also* Stewart v. Midani, 525 F. Supp. 843, 849 (N.D. Ga. 1981). *Stewart* listed eight factors frequently considered in determining whether a physician is an employee of a hospital: (1) the right to direct the work step-by-step; (2) whether the contract is to perform a service or accomplish a task; (3) the right to control the time of work; (4) the right to inspect the work; (5) the provision of equipment; (6) the right to terminate the contract; (7) the skill of the worker; and (8) the method of payment. *Id.*

22 "Instrumentalities of work include the equipment and supplies used by the worker as well as the worksite itself." RESTATEMENT (SECOND) OF AGENCY § 220 (1958).

ship,[23] these factors are essentially components of the control test. In most jurisdictions, however, an analysis of skill and custom is not dispositive on the issue of vicarious liability.[24]

Method of payment is central to the analysis of employment status. Traditionally, fee-for-service practice is a strong indicator of an independent contractor relationship.[25] Due to the increasing number of health care providers and the resulting competition, however, more physicians are abandoning fee-for-service practices and becoming salaried employees of hospitals, HMOs, and other corporations. Payment by salary is ordinarily considered proof of a master-servant relationship.[26] IPA model HMO physicians and PPO physicians continue to receive payment on a fee-for-service basis. In addition, unlike staff model HMO or hospital staff physicians, these providers may continue to accept patients from other referral sources. Therefore, retention of fee-for-service payment, as well as nonexclusive affiliation with the HMO or PPO, provides evidence that the physician will be deemed an independent contractor.

Ownership and provision of the instrumentalities of work are also relevant in establishing employment status.[27] In the health care area, such instrumentalities may include clinic facilities, medical equipment, and administrative and clerical services. Based on hospital ownership of instrumentalities, emergency room physicians have frequently been held to be hospital employees rather than independent contractors.[28] Since many

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[23] *See Stewart*, 525 F. Supp. at 849; Moore v. Chesapeake & Ohio Ry. Co., 493 F. Supp. 1252, 1261 (S.D. W. Va. 1980), *aff'd*, 649 F.2d 1004 (4th Cir. 1981) (distinct occupation factor and skill factor involved in operating cafeteria).

[24] *See, e.g.*, Beeck v. Tucson Gen. Hosp., 18 Ariz. App. 165, 500 P.2d 1153 (Ct. App. 1972).

[25] *See Liability of Hospital*, *supra* note 8, at 325.

[26] *See* RESTATEMENT (SECOND) OF AGENCY § 220 comment h (1958); *see also* Sloan v. Metropolitan Health Council, 516 N.E.2d 1104 (Ind. Ct. App. 1987); Suhor v. Medina, 421 So.2d 271, 273 (La. Ct. App. 1982) (physician paid a monthly salary is an employee of defendant hospital).

[27] RESTATEMENT (SECOND) OF AGENCY § 220 comment k (1958).

[28] Irvine v. Doctors Hosp., 415 So.2d 55, 56 (Fla. Dist. Ct. App. 1982) (hospital furnished all support personnel, supplies, and medicines); *Suhor*, 421 So.2d at 273 (hospital furnishes all physical facilities, equipment, supplies, and support personnel); Mehlman v. Powell, 281 Md. 269, 274-75, 378 A.2d 1121, 1124 (1977) (hospital provided premises for emergency room); *cf. Beeck*, 18 Ariz. App. 165, 500 P.2d 1153 (hospital provided facilities, administrative services, and other instrumentalities to radiologist).

HMOs also provide clinic facilities, medical equipment, and ancillary personnel, they could similarly incur liability.[29]

IPA model HMOs and PPOs do not generally furnish these instrumentalities to their panel providers. The physicians continue to work from their own private offices, using their own equipment and personnel. Inpatient services utilize instrumentalities provided by the hospital, not by the IPA model HMO or the PPO. Marketing, contract procurement, and negotiation and reimbursement are the only administrative functions typically provided by the organization. Although the marketing function may be relevant to establishing an ostensible agency, it is most likely insufficient to apply the traditional respondeat superior doctrine.

2. Ostensible Agency

An increasing number of jurisdictions are adopting the doctrine of ostensible agency. Under this theory, an entity is held liable "for the acts, errors, and omissions of independent contractor physicians and other health professionals, if, considering all the facts and circumstances surrounding a case, a patient reasonably believes that the physician is an employee of the hospital."[30]

The determinative issues necessary to establish ostensible agency "are . . . whether the [entity], through its acts, created the appearance that an agency relationship existed between the [entity] and the negligent physician[31] and . . . whether the patient reasonably relied upon that appearance to his detriment or injury."[32]

Ostensible agency has often been applied to medical malpractice cases, most frequently to establish an ostensible agency between a hospital and an emergency room physician.[33] Factors

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29 Meyer, *Group Prepaid Health Plan Liability When Physician Provider Malpractices*, 6 N.M. L. REV. 79, 90 (1975); *see also Sloan*, 516 N.E.2d 1104.

30 Jeddeloh, *The Ostensible Agency Doctrine: More to the Point Than Darling*, 20 Hosp. Law 49 (1987).

31 Phoenix & Schlueter, *Hospital Liability for the Acts of Independent Contractors: The Ostensible Agency Doctrine*, 30 ST. LOUIS U.L.J. 875, 879 (1986).

32 *Id.*

33 Mduba v. Benedictine, 52 A.D.2d 450, 384 N.Y.S.2d 527 (App. Div. 1976); Adamski v. Tacoma Gen. Hosp., 20 Wash. App. 98, 579 P.2d 970 (Ct. App. 1978); *see also* Seneris v. Haas, 45 Cal.2d 811, 291 P.2d 915 (1955) (anesthesiologist); Stan-

supporting ostensible agency in such cases are the contractor's performance of an inherent function of the employer,[34] the restriction on patient choice of provider,[35] and the holding out of the contractor as an employee.[36]

The first issue that must be established under the theory of ostensible agency is the determination of whether the conduct of the entity and its independent practitioners created an apparent agency relationship. Courts have analyzed a variety of factors to determine whether the impression of ostensible agency has been created. One factor is the degree of patient's involvement in a selection of a physician. For example, in *Grewe v. Mount Clemens Hospital*,[37] the court framed the question as whether the plaintiff upon admission to the hospital

> was looking to the hospital for treatment for his physical ailments or merely viewed the hospital as the situs where his physician would treat him for his problems. A relevant factor in this determination involves resolution of the question of whether the hospital provided the plaintiff with Dr. Katzowitz or whether the plaintiff and Dr. Katzowitz had a patient-physician relationship independent of the hospital setting.[38]

The court found that even where the physician is an independent contractor not subject to the hospital's control that fact "is not of critical importance to the patient who is the ultimate victim of that physician's malpractice."[39] In this case, the record failed to indicate

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hope v. Los Angeles College of Chiropractic, 54 Cal. App. 2d 141, 128 P.2d 705 (Ct. App. 1942) (chiropractor); Williams v. Saint Claire Medical Center, 657 S.W.2d 590 (Ky. Ct. App. 1983) (anesthesiologist).

[34] Themins v. Emmanuel Lutheran Charity Bd., 54 Or. App. 901, 908, 637 P.2d 155, 159 (Ct. App. 1981) (orthopedic surgeon in emergency room performs inherent function of hospital); *Adamski*, 20 Wash. App. at 112, 579 P.2d at 977 (emergency room physician is "an integral part of the total hospital function or enterprise").

[35] Smith v. Saint Francis Hosp., 676 P.2d 279, 282 (Okla. Ct. App. 1983) (in absence of preexisting patient-physician relationship and resulting reliance on institution for medical care, hospital may not deny responsibility for acts of independent contractor emergency room physician).

[36] Capan v. Divine Providence Hosp., 287 Pa. Super. 364, 369-70, 430 A.2d 647, 649 (Super. Ct. 1980) (jury could reasonably have found that the defendant hospital held out the physician as an employee by providing his services on an on call basis for dealing with emergencies occurring within the hospital).

[37] 404 Mich. 240, 273 N.W.2d 429 (1978).

[38] *Id.* at 251, 273 N.W.2d at 433.

[39] *Id.* at 252, 273 N.W.2d at 433-34.

the plaintiff received any notice from hospital or the physician and the relationship between the physician and the hospital was one of independent contractor.[40]

Several courts have found the existence of ostensible agency where the patient could reasonably believe the independent contracting professionals were part of the hospital where the hospital advertised itself as a full-service facility for the provision of health care services.[41] In *Mehlman v. Powell*,[42] the court permitted recovery for negligence when an emergency room patient reasonably believed the emergency room was part of the hospital.[43] The court stated the patient "desired medical services and equally obviously was relying on Holy Cross Hospital to provide them."[44] The resolution of the case for the plaintiffs resulted from the court's finding that the patient could reasonably infer that the hospital emergency room "was in fact an integral part of the institution" and that a patient could not presume "that the procedures and departments of a complex, modern hospital . . . are in fact franchised out to various independent contractors."[45] In three other recent cases, trial court decisions dismissing the lawsuit against the hospital were reversed on appeal, where the appellate courts found that the hospitals had held themselves out to the public as full-service facilities offering, in these cases, emergency room services with the appearance that they were operated by hospital staff.[46]

In addition, the decisions in both *Hannola* and *Adamski* were based in part upon the fact that patients requiring emergency care do not choose the emergency department physician and therefore must rely to a greater extent upon the selection of the emergency

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40 *Id.* at 253, 273 N.W.2d at 434.

41 Schagrin v. Wilmington Medical Center, Inc., 304 A.2d 61 (Del. Super. Ct. 1973); Mehlman v. Powell, 281 Md. 269, 378 A.2d 1121 (1977); Hannola v. City of Lakewood, 68 Ohio App. 2d 61, 426 N.E.2d 1187 (Ct. App. 1980); Adamski v. Tacoma Gen. Hosp., 20 Wash. App. 98, 579 P.2d 970 (Ct. App. 1978).

42 281 Md. 269, 378 A.2d 1121 (1977).

43 *Id.* at 275, 378 A.2d at 1124.

44 *Id.* at 274, 378 A.2d at 1124.

45 *Id.*

46 Schagrin v. Wilmington Medical Center, Inc., 304 A.2d 61 (Del. Super. Ct. 1973); Hannola v. City of Lakewood, 68 Ohio App. 2d 61, 426 N.E.2d 1187 (Ct. App. 1980); Adamski v. Tacoma Gen. Hosp., 20 Wash. App. 98, 579 P.2d 970 (Ct. App. 1978).

room physician by the hospital.[47] The court in *Adamski* placed particular emphasis on the nature of the service involved, in this case emergency care, observing that the emergency department physicians performed an inherent function of the hospital's overall enterprise, for which the hospital bears some responsibility.[48]

Courts have consistently held that an emergency room physician performs an inherent function of a hospital, "without which the hospital could not properly achieve its purpose."[49] These courts have reasoned that patients treated in hospital emergency rooms draw no line between the corporate entity and the medical staff.[50] The patient expects only "that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility."[51]

It is unclear, however, how far courts are willing to extend the theory of ostensible agency on the basis that the care provided by certain hospital departments is thought to be indispensable to the function of a hospital. For example, in *Johnson v. Saint Bernard Hospital*,[52] the plaintiff, relying on a state statute requiring that hospitals provide emergency service, argued that the hospital should be held derivatively liable for the negligence of an independent emergency department physician.[53] The court disagreed, finding the statute was not sufficiently broad "to impose upon the hospital the duty to assume the responsibility for the practice of medicine within an independently operated emergency department facility."[54]

An additional factor supporting creation of an ostensible agency is the holding out of the independent contractor as an employee. Holding out may be evidenced by the wording of medical

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[47] *Hannola*, 68 Ohio App. 2d at 65, 426 N.E.2d at 1190; *Adamski*, 20 Wash. App. at 111-12, 579 P.2d at 977.

[48] *Adamski*, 20 Wash. App. at 112, 579 P.2d at 977.

[49] *Id.* at 112, 579 P.2d at 977 (quoting Beeck v. Tuscon Gen. Hosp., 18 Ariz. App. 165, 170, 500 P.2d 1153, 1158 (Ct. App. 1972)); *see also* Bing v. Thunig, 2 N.Y.2d 656, 666, 143 N.E.2d 3, 8, 163 N.Y.S.2d 3, 11 (1957); Capan v. Divine Providence Hosp., 287 Pa. Super. 364, 368-70, 430 A.2d 647, 649-50 (Super. Ct. 1980).

[50] *Capan*, 287 Pa. Super. at 369, 430 A.2d at 649 (patient relies on the institution for care and cannot be expected to "inquire of each person who treated him whether he is an employee of the hospital or an independent contractor").

[51] *Bing*, 2 N.Y.2d at 666, 143 N.E.2d at 8, 163 N.Y.S.2d at 11.

[52] 79 Ill. App. 3d 709, 399 N.E.2d 198 (App. Ct. 1979).

[53] *Id.* at 715, 399 N.E.2d at 203.

[54] *Id.*

releases,[55] patient bills,[56] laboratory reports,[57] or by the appearance of the corporation's name on the building where the physician works.[58] If the provider performs an inherent function of the institution, the patient is more likely to be misled through an apparent agency. Thus, vicarious liability may arise merely from an organization's failure to give notice that the physician is not an employee.[59]

A close reading of these and other decisions suggest that another indicia upon which the courts base a finding of ostensible agency is whether the patient was ever informed of the actual relationship between facility and independent contractor. In *Mehlman*, *Grewe*, and *Adamski*, the courts noted that the hospitals failed to inform or in any way notify the patient of the physician's independent contractor status.[60] In *Arthur v. Saint Peter's Hospital*,[61] the court found that a patient's natural inclination to assume that the physician is an agent of the hospital is justified unless the hospital notifies the patient of the physician's independent contractor status.[62] The courts have generally declined to impute such knowledge to the patient. Courts have presumed that a patient comes to the hospital expecting to receive health care from the hospital and that the pa-

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55 Brown v. Moore, 247 F.2d 711, 720 (3d Cir. 1971) (release form authorizing sanitarium to administer electroshock therapy permits inference the institution held out physicians administering treatments were employees).

56 *Id.* at 720-21 (sanitarium billed for professional fees); Howard v. Park, 37 Mich. App. 496, 501, 195 N.W.2d 39, 41 (Ct. App. 1972) (patient was billed on hospital stationery with physician's name on it).

57 Lundberg v. Bay View Hosp., 175 Ohio St. 133, 134, 191 N.E.2d 821, 822 (1963) (pathology reports appeared under both physician and hospital names).

58 Stanhope v. Los Angeles College of Chiropractic, 54 Cal. App. 2d 141, 145-46, 128 P.2d 705, 707-08 (Ct. App. 1942) (technician in charge of x-ray laboratory was ostensible agent of chiropractic college because laboratory was located in college building and nothing indicated the laboratory was not an integral part of the college).

59 Seneris v. Haas, 45 Cal.2d 811, 832, 291 P.2d 915, 927 (1955); Williams v. Saint Claire Medical Center, 657 S.W.2d 590, 596 (Ky. Ct. App. 1983); Capan v. Divine Providence Hosp., 287 Pa. Super. 364, 368-70, 430 A.2d 647, 649 (Super. Ct. 1980). *But see* Beeck v. Tuscon Gen. Hosp., 18 Ariz. App. 165, 171, 500 P.2d 1153, 1159 (Ct. App. 1972) (medical release form stating that staff physicians are independent contractors does not resolve question of fact regarding employment status).

60 Mehlman v. Powell, 281 Md. 269, 274-75, 378 A.2d 1121, 1124 (1977); Grewe v. Mount Clemens Hosp., 404 Mich. 240, 253, 273 N.W.2d 429, 434 (1978); Adamski v. Tacoma Gen. Hosp., 20 Wash. App. 98, 115, 579 P.2d 970, 979 (Ct. App. 1978).

61 169 N.J. Super. 575, 405 A.2d 443 (Law Div. 1979).

62 *Id.* at 583, 405 A.2d at 447.

tient is unaware of the status of a hospital-based physician as an independent contractor.[63] The patient will not typically be held to a duty to inquire with respect to the nature of the relationship between the hospital and physician, and therefore hospitals must take affirmative steps to indicate to their patients the precise nature of the relationship between the facility and its independent practitioners.[64]

Restrictions on a patient's choice of provider suggest a stronger basis for ostensible agency.[65] By limiting subscriber choice to panel members, HMO and PPO plans are interposed between the patient and physician. The resulting contract between the provider and the HMO or PPO and the absence of a contract directly between the patient and the provider may bear on the application of the ostensible agency doctrine. Lack of a direct contractual relationship between patient and provider is analogous to the relationship between emergency room patients and physicians. In *Smith v. Saint Francis Hospital, Inc.*,[66] the plaintiff was treated in the defendant's hospital emergency room by a private physician with staff privileges.[67] The court concluded that the absence of a preexisting patient-physician relationship, as well as the resulting reliance on the institution itself to provide medical care, was sufficiently compelling evidence to support creation of an ostensible agency.[68] Thus, where patient selection of a physician is completely foreclosed, courts are likely to find

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63 *See Mehlman*, 281 Md. 269, 378 A.2d 1121; *Arthur*, 169 N.J. Super. 575, 405 A.2d 443.

64 *See Capan*, 287 Pa. Super. 364, 430 A.2d 647.

65 These restrictions may also violate some state insurance laws. Irmen, *Preferred Provider Organizations: Legal Aspects*, 40 J. Mo. Bar 149, 154 (Apr.-May 1984). *See, e.g.*, Mo. Ann. Stat. § 375.936(11)(b) (Vernon Supp. 1990). The statute defines as unfair discrimination the

> [m]aking or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever, including any unfair discrimination by not permitting the insured full freedom of choice in the selection of any duly licensed physician. . . .

Id.

66 676 P.2d 279 (Okla. Ct. App. 1983).

67 *Id.* at 280-81.

68 *Id.* at 282; *see also* Beeck v. Tucson Gen. Hosp., 18 Ariz. App., 165, 170, 500 P.2d 1153, 1158 (Ct. App. 1972); Adamski v. Tacoma Gen. Hosp., 20 Wash. App. 98, 112, 579 P.2d 970, 977 (Ct. App. 1978).

an ostensible agency between the health care organization and the treating physician.

Compared to many emergency room patients, who have no choice of provider and are simply treated by the next available physician, IPA model HMO and PPO patients usually have a limited choice of physician. This may be significant since emergency room patients who have been given some choice of physician have been less successful in establishing institutional liability than was the plaintiff in *Smith*.[69] The plaintiff's father in *Holland v. Eugene Hospital*,[70] for example, was given the choice of any physician currently on the hospital staff to treat his son's injuries.[71] His choice of the codefendant established a sufficient patient-physician relationship to preclude hospital liability.[72] Thus, even a limited choice of physician may serve as a defense from liability for the IPA model HMO and the PPO.

The same result may occur even when the patient's choice remains unexercised. In *Vanaman v. Milford Memorial Hospital*,[73] the plaintiff's mother was given the choice of any staff physician, but declined to exercise that choice.[74] On appeal the supreme court held that a question of fact remained as to whether the hospital merely referred the patient to the codefendant physician in his private capacity or whether he was performing an inherent function of the hospital in providing emergency care.[75] In many states, the inherent function of an HMO may be the delivery of care and therefore, the referral to an IPA model HMO physician could be deemed an ostensible agency. However, because the inherent function of PPOs is not the delivery of care, a PPO could be found to only provide referral services and thus create no ostensible agency.

To determine whether a patient could reasonably rely upon ostensible agency between facility and practitioner, the courts have engaged in an intensive review of the particular facts of each case. Several factors seemed to recur in court opinions concerning ostensible agency in the judges' efforts to determine whether apparent

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69 *Smith*, 676 P.2d 279.

70 127 Or. 256, 270 P.2d 784 (1928).

71 *Id.* at 258, 270 P.2d at 785.

72 *Id.* at 261-62, 270 P.2d at 786.

73 262 A.2d 263 (Del. Super. Ct.), *rev'd*, 272 A.2d 718 (Del. 1970).

74 *Id.* at 266.

75 Vanaman v. Milford Mem. Hosp., 272 A.2d 718, 722 (Del. 1970).

agency existed. In an early case involving ostensible agency, *Stanhope v. Los Angeles College of Chiropractic*,[76] the court found a radiologist to be the ostensible agent of the hospital even though he was an independent contractor and billed in his own name.[77] The court held that a sign over the door to the laboratory, which read Los Angeles X-Ray Laboratory, obviated any duty the patient may have had to determine independently whether the physician was an employee or an independent contractor, particularly since the plaintiff was in critical need of immediate care.[78] Other courts have assessed whether hospital garments and insignia worn by independent contractors fail to adequately distinguish between them and employees of the hospital so that an apparent agency relationship is established.[79] The courts have reviewed the method of patient referral and have distinguished between the patient who had a preexisting relationship with the physician[80] and the patient whose referral was so controlled by the hospital that ostensible agency existed.[81]

Two recent cases amply illustrate the fact-intensive approach of the courts to ostensible agency, and effectively summarize the way courts analyze the theory with respect to hospitals and their independent practitioners.[82] In *Porter v. Sisters of Saint Mary*,[83] the United States Court of Appeals for the Eighth Circuit ultimately declined to determine whether ostensible agency is an accepted doctrine in Missouri.[84] Nevertheless, the decision provides an analysis of the way courts determine the existence of ostensible agency.

In *Porter*, a patient with a suspected collapsed lung was rushed to the Saint Joseph Hospital emergency room.[85] The emergency room physician employed by the hospital confirmed that Porter's lung had collapsed, however, he declined to provide treatment.[86] Instead, the physician told the patient that he had summoned Dr.

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76 54 Cal. App.2d 141, 128 P.2d 705 (Ct. App. 1942).

77 *Id.* at 144-46, 128 P.2d at 707-08.

78 *Id.* at 145-46, 128 P.2d at 707-08.

79 Greene v. Rogers, 147 Ill. App.3d 1009, 498 N.E.2d 867 (App. Ct. 1986).

80 *See, e.g.*, Grewe v. Mount Clemens Hosp., 404 Mich. 240, 273 N.W.2d 429 (1978).

81 *See* Howard v. Park, 37 Mich. App. 496, 195 N.W.2d 39 (Ct. App. 1972).

82 Porter v. Sisters of Saint Mary, 756 F.2d 669 (8th Cir. 1985); Sztorc v. Northwest Hosp., 146 Ill. App.3d 275, 496 N.E.2d 1200 (App. Ct. 1986).

83 756 F.2d 669 (8th Cir. 1985).

84 *Id.* at 673.

85 *Id.* at 670.

86 *Id.*

Schneider, saying that Dr. Schneider was "our best person for the job" or that "[h]e's our best man. . . ."[87] Porter could have assumed that Dr. Schneider was a Saint Joseph Hospital employee, while he was in fact an independent contractor and director of the hospital's trauma center.[88] Dr. Schneider's office was not located at the hospital and all bills for patients whom he treated were sent from his private office.[89]

Porter's claim of ostensible agency rested on four factors: (1) hospital personnel obtained consent for the doctor to treat and perform surgery on him;[90] (2) the possibility that he may have considered Dr. Schneider an employee of the hospital based upon occasional similarity of hospital personnel uniform;[91] (3) the occasional use of name tags used by medical staff personnel;[92] (4) the statement made that "[h]e's our [hospital's] best man. . . ."[93]

The court summarily dismissed Porter's claim that the hospital represented Dr. Schneider as its employee by obtaining a signed consent to treatment form from Porter.[94] The court stated that "[t]he consent forms Porter signed nowhere indicate that Dr. Schneider was an agent of Saint Joseph Hospital."[95] The similarity in dress between hospital personnel and independent doctors, the court found, is not unusual in the hospital setting, nor is the use of hospital identification tags by independent practitioners.[96] In this specific instance, the court noted that Dr. Schneider, having been called to the hospital from home, was dressed casually, in contrast to the nurses and other hospital personnel who were wearing uniforms and name tags.[97] The court did caution, however, that had Dr. Schneider worn a tag identifying him as an employee, ostensible agency might have existed.[98]

In this case, the critical evidence supporting Porter's ostensible

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87 *Id.*
88 *See id.* at 670-71.
89 *Id.* at 670.
90 *Id.* at 673.
91 *Id.*
92 *Id.*
93 *Id.*
94 *Id.*
95 *Id.*
96 *Id.*
97 *Id.* at 673 n. 4.
98 *Id.* at 673.

agency claim was the statement that Dr. Schneider was "our best person for the job."[99] The court looked, however, at the context in which the comment was made and determined that in an emergency room situation a patient would assume that comment referred to any private physician who was on call at the hospital.[100] Porter saw Dr. Schneider only briefly that evening and it was several days before he consented to elective surgery by Dr. Schneider.[101] By that time, Dr. Schneider was clearly the person providing medical care and not the hospital.[102] Dr. Schneider saw the patient in his office away from the hospital.[103] Since the injury arose out of that surgery, the court ruled that all the pertinent facts at the time of the surgery reasonably indicated to Porter that Dr. Schneider was, in fact, an independent practitioner.[104] Therefore, the court dismissed the plaintiff's ostensible agency claim.[105]

Another case that reveals the courts are fact conscious in this area of the law is *Sztorc v. Northwest Hospital*.[106] In *Sztorc*, a patient's physician referred her to the radiology group for therapy following a mastectomy.[107] The patient experienced gradual loss of function in her arm and was later told she sustained permanent nerve damage due to over exposure to radiation.[108] The patient sued the hospital, but a trial court dismissed the case based on facts that indicated the staff of the x-ray department was neither the actual nor apparent agent.[109] The Illinois Court of Appeals, however, reversed the decision and remanded the case to the jury for trial.[110]

The court balanced the evidence indicating the independent contractor relationship against factors that suggested an agency relationship.[111] The court found, on the one hand, that none of the radiologists were employed by the hospital; that all of the radiation equipment belonged to the group, which was solely responsible for

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99 *Id.*
100 *Id.* at 673-74.
101 *Id.* at 674.
102 *Id.*
103 *Id.*
104 *Id.* at 674-75.
105 *Id.* at 675.
106 146 Ill. App.3d 275, 496 N.E.2d 1200 (App. Ct. 1986).
107 *Id.* at 276, 496 N.E.2d at 1200.
108 *Id.*, 496 N.E.2d at 1200-01.
109 *Id.*, 496 N.E.2d at 1201.
110 *Id.* at 279, 496 N.E.2d at 1202.
111 *Id.*

its maintenance and repair; and that the group billed and collected payments directly from its patients.[112] Evidence tending to support the claim of ostensible agency included the fact that the x-ray department was located in the hospital on its main floor and that there was no dress code or other identification by which the public could differentiate radiation group personnel from hospital employees.[113] The court held that the facts do not indicate, as a matter of law, that no agency relationship existed and therefore, a trial based on those facts must occur.[114]

The foregoing cases demonstrate that, in order for a plaintiff to recover under the doctrine of ostensible agency, he must establish that the entity caused the plaintiff to justifiably rely on evidence that an independent practitioner was the agent of such entity; and that such evidence caused plaintiff's subsequent reliance on the skill of the ostensible agent to the plaintiff's detriment.

Two recent opinions issued by the Texas Court of Appeals delineate the issues that courts will address in determining whether ostensible agency exists. In *Nicholson v. Memorial Hospital System*,[115] the plaintiff entered the emergency room of the defendant hospital and allegedly requested that the hospital recommend a physician to treat his jaw.[116] The hospital contacted a physician who admitted and treated the plaintiff.[117] During the hospitalization, the plaintiff developed a tissue infection of the mouth.[118] The plaintiff sued the hospital, alleging that the hospital failed to exercise reasonable care in recommending the physician and that both the hospital and the physician failed to properly care for his injury.[119] During the litigation, the plaintiff raised the issue that the hospital was liable for the actions of the physician under the doctrine of ostensible agency.[120] In ruling on the plaintiff's appeal of the trial court's dismissal of the case, the Texas Court of Appeals found that the plaintiff failed to establish what the appellate court characterized as the three elements of ostensible agency: a reasonable belief the agent is acting

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112 *Id.* at 277, 496 N.E.2d at 1201.
113 *Id.*
114 *Id.* at 279, 496 N.E.2d at 1202.
115 722 S.W.2d 746 (Tex. Ct. App. 1986).
116 *Id.* at 748.
117 *Id.*
118 *Id.*
119 *Id.*
120 *Id.* at 749.

with the principal's authority; a belief generated by an act or omission of the principal; and justifiable reliance on the representation of authority.[121]

The appellate court found that the physician was not a hospital emergency room physician, but rather an independent physician with staff privileges permitting him to admit and treat private patients at the hospital.[122] The physician also directly billed his patients for his services.[123] The court found that the hospital made no representations to the public with respect to the employment of the physician by the hospital.[124] In addition, the court found that an unknown person had given the plaintiff the name of the physician, and the plaintiff requested the hospital to contact that physician.[125] The physician subsequently admitted the plaintiff into the hospital as his private patient.[126] Therefore, consistent with the cases discussed elsewhere in this section, the evidence in this case overwhelmingly demonstrated that ostensible agency did not exist. The hospital made no representations, expressed or implied, that the physician was anything other than a private attending member of the medical staff. The hospital did not bill for physician services, the physician billed for them directly. The patient was found to have a preexisting relationship with the physician which worked contrary to any claim by the patient that the hospital controlled or substantially directed the choice of physician for the patient.

In another Texas case, the court did find ostensible agency to exist. Nevertheless, the facts in this case are consistent with other decisions in which ostensible agency was established. In *Smith v. Baptist Memorial Hospital Systems*,[127] the plaintiff brought a medical malpractice action against a hospital and a professional association that supplied emergency room physicians to the hospital pursuant to a contract between the hospital and the association.[128] The hospital moved to dismiss the case, relying on a contractual provision disclaiming liability for the negligent acts of the emergency room

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121 *Id.* at 750 (citations omitted).
122 *Id.*
123 *Id.*
124 *Id.*
125 *Id.*
126 *Id.*
127 720 S.W.2d 618 (Tex. Ct. App. 1986).
128 *Id.* at 620.

physician.[129] The trial court granted the defendant hospital's motion to dismiss, but the Texas Court of Appeals reversed.[130]

The appellate court ruled initially that public policy concerns preclude hospitals from artificially disclaiming liability for malpractice in the emergency room.[131] The court then found genuine issues of fact with respect to the ostensible agency claim in the plaintiff's lawsuit.[132] The court determined that the physician appeared to be the hospital's agent, not an independent contractor, and that the patient relied on the apparent agency in undergoing the alleged negligent treatment.[133] The court specifically found that ostensible agency may have existed because the hospital had contracted with the association to staff its emergency room; the emergency room physician was employed by the association; the patients entering the emergency room were treated by the physician, and they had no way to determine, and were not obligated to determine, whether the physician was an independent contractor; and the hospital directly billed the patient for the services of the emergency room physician.[134] Based on those facts, the court reversed the dismissal of the case and remanded the case to the trial court for trial on the issue of ostensible agency.[135]

These two Texas appellate court decisions continue a trend of finding ostensible agency to exist where the physician, although technically an independent contractor, provides customarily hospital-based medical care, most commonly in the emergency room and the radiology department, while generally declining to find that ostensible agency exists where private attending physicians provide care elsewhere in the hospital on an inpatient basis.

The *Smith* decision is also notable in its discussion of the issues regarding the vicarious liability of the association for the physician's acts.[136] The court discussed the liability under the theory of respondeat superior for knowingly employing negligent physicians whose negligence in performing the employment contract cause injury to a

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129 *Id.* at 623-24.
130 *Id.* at 627.
131 *Id.* at 624.
132 *Id.* at 624-25.
133 *Id.*
134 *Id.* at 625.
135 *Id.* at 627.
136 *Id.* at 626-27.

third party.[137] The court also addressed the issue of liability under the doctrine of corporate negligence with respect to the hospital's obligation to review the qualifications of the association and the association's employed physicians who provide emergency room services to hospital patients.[138]

Recently, a Pennsylvania court decided to extend the doctrine of ostensible agency beyond the hospital to the HMO. In *Boyd v. Albert Einstein Medical Center*,[139] the court reversed a lower court dismissal of a case against an HMO based on ostensible agency concluding that "the facts indicate an issue of material fact as to whether the participating physicians were ostensible agents of the HMO."[140] The court analyzed the issues based upon the determining factors of the previously cited hospital cases. The court considered whether the entity, through its agents, created the appearance that an agency relationship existed between the entity and the negligent physician.[141] The court further considered whether the patient reasonably relied upon the appearance to his detriment or injury.[142] To these questions the court answered:

> In our opinion, because appellant's decedent was required to follow the mandates of HMO and did not directly seek the attention of the specialist, there is an inference that the appellant looked to the institution for care and not solely to the physicians; conversely, that appellant's decedent submitted herself to the care of the participating physicians in response to an invitation from HMO.[143]

It is important to note that the court referred to the HMO as "the institution."[144]

Other recent cases declined to find the HMO liable under the ostensible agency theory. *Williams v. Good Health Plus, Inc.*,[145] held that the HMO did not hold itself out as providing medical care and noted that Texas law does not confer the right to practice medicine

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137 *Id.* at 626.
138 *Id.* at 627.
139 377 Pa. Super. 609, 547 A.2d 1229 (Super. Ct. 1988).
140 *Id.* at 621, 547 A.2d at 1235.
141 *Id.* at 619-20, 547 A.2d at 1234.
142 *Id.*
143 *Id.* at 621, 547 A.2d at 1235.
144 *Id.*
145 743 S.W.2d 373 (Tex. Ct. App. 1987).

on an HMO.[146]

The court in *Boyd* noted that, in an earlier decision, it had "introduced the concept of ostensible agency . . . based . . . upon 'the changing role of the hospital in society [which] creates a likelihood that patients will look to the institution' for care."[147] Those IPA model HMOs that become the institution as in *Boyd*, that hold out the independent contractor as an employee[148] and that restrict provider selection,[149] are susceptible to the application of the ostensible agency theory. These circumstances could lead to the liability of an IPA model HMO due to the fact that a physician performs the inherent function of an HMO and because the patient directly pays the HMO.

A PPO may be less susceptible to liability based upon the theory of ostensible agency, however, the potential for exposure still exists. The PPO could be protected from application of the ostensible agency theory due to its fee-for-service nature. In the PPO environment the patient or the patient's insurance company customarily pays the provider and the patient usually sees the provider in the provider's private office and therefore appears to establish an independent provider-patient relationship. These cases, however, are fact-sensitive and, in the future, a strong PPO could become the institution for care and hold out the independent contractors as employees as it restricts provider selection. An exclusive provider organization (EPO), sometimes defined as a PPO without out of network benefits, further restricts provider selection and could be even more susceptible to the application of the ostensible agency theory.

To protect against the imposition of liability based upon the

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146 *Id.* at 378; *see also* Utterback v. United States, 668 F. Supp. 602 (W.D. Ky. 1987); Barrett v. Samaritan Health Servs., 153 Ariz. 138, 735 P.2d 460 (Ct. App. 1987); Richmond County Hosp. Auth. v. Brown, 257 Ga. 507, 361 S.E.2d 164 (1987); Johnson v. Sumner, 160 Ill. App. 3d 173, 513 N.E.2d 149 (App. Ct.), *cert. denied*, 117 Ill.2d 544, 517 N.E.2d 1086 (1987); Albain v. Flower Hosp., No. L-87-290 (Ohio Ct. App. Nov. 4, 1988); Bailey v. Fletcher, No. 10857 (Ohio Ct. App. 2d Dist. Nov. 3, 1988); Thomas v. Raleigh Gen. Hosp., 358 S.E.2d 222 (W. Va. 1987).

147 Boyd v. Albert Einstein Medical Center, 377 Pa. Super. 609, 620, 547 A.2d 1229, 1234 (Super. Ct. 1988) (quoting Capan v. Divine Providence Hosp., 287 Pa. Super. 364, 368, 430 A.2d 647, 649 (Super. Ct. 1980)).

148 *See* Capan v. Divine Providence Hosp., 287 Pa. Super. 364, 430 A.2d 647 (Super. Ct. 1980).

149 *See* Vanaman v. Milford Mem. Hosp., 262 A.2d 263 (Del. Super. Ct.), *rev'd*, 272 A.2d 718 (Del. 1970); Hannola v. City of Lakewood, 68 Ohio App. 2d 61, 426 N.E.2d 1187 (Ct. App. 1980); *Boyd*, 377 Pa. Super. 609, 547 A.2d 1229.

ostensible agency theory, the entity should enact policies, procedures, and other measures designed to inform the patient of the exact relationship between the entity and the practitioner. These policies, procedures, and other measures should include the following:

(a) The entity should conduct an investigation and analysis of its existing contracts, both written and oral, its referral policy, both recommended and actual, its marketing materials, billing procedures, signage, stationery materials, manner of dress of employees, and independent contractors and consent forms.

(b) If the investigation discloses that this material may be used to infer an unintended relationship between the entity and its practitioners, corrective action should be taken immediately.

(c) The entity should enact written policies with respect to contracting. These policies should set forth a review procedure to assure that, unless intended otherwise, contracts with practitioners reflect an independent contractor relationship. Existing contracts with independent contractors, both written and oral, should be reviewed by counsel to insure that the contracts specify the type of relationship intended between the entity and practitioner. Oral contracts should be reduced to written form.

(d) The entity should enact a written referral policy for referrals to practitioners who perform services as independent contractors. The policy should instruct employees and independent contractors of the proper manner to provide for a referral to avoid indicating to a patient that the referred practitioner is employed by the entity.

(e) The entity should provide its marketing, advisory, and public relations departments or agencies with written guidelines to avoid the possibility that the entity's advertising will create unintended relationships between the entity and its practitioners.

(f) The entity should enact written policies pertaining to billing, signage, and stationery materials used by the entity and by the independent contractors, and should possibly establish a dress code, recommended or required, to avoid creating the unintended impression of a relationship between the entity and its independent practitioners.

(g) The entity should prepare the written consent forms to be used by the practitioners within the entity. The consent forms used by the independent contractors should be distinct from

those used by the institution, if any, and include the proper notation of the practitioners' independent contractor status.

The successful implementation of an informative written program may provide evidence during litigation that the entity did not create the appearance of an agency relationship and that the patient could not have reasonably believed that the independent practitioner was an employee of the entity.

B. *Corporate Negligence*

Hospital malpractice exposure due to physician activities has been significantly expanded by the courts through the development and application of the corporate negligence doctrine. Due to the provider selection process of the IPA model HMOs and the Preferred Provider Organizations, the extension of the doctrine to HMOs and PPOs is probable. Actually, based upon the rationale of these cases, the application of the corporate negligence doctrine to IPA model HMOs and PPOs is logical and more appropriate.

1. Hospital Liability Under the Corporate Negligence Theory

The corporate negligence doctrine redefined the hospital's legal duty toward the patient by rejecting the notion that the hospital is merely an innkeeper providing facilities for its physicians to conduct their medical practice. Instead the courts have held that the hospital owes a duty to the patients it serves. This duty is derived from the custody of the patient by the hospital. Therefore, the liability of a hospital under corporate negligence has not been derived from the medical negligence of physicians, but rather rests on the hospital's separate independent duty to protect the patient from harm. The hospital's responsibility for its patients' welfare extends well beyond merely refraining from causing harm. As a result, hospitals have been held liable for failing in their duty of care to its patient by not providing the proper overall surveillance of the quality of patient care services; failing to properly review and investigate the credentials and expertise of medical staff applicants, in otherwords, negligence in granting privileges; and failing to protect their patients from malpractice

by members of its medical staff when it knows or should have known, through reasonable care, that such malpractice was likely.

Hospital corporate negligence results from a failure to use reasonable care in maintaining the facility, providing medical instruments and equipment, or selecting and supervising medical personnel.[150]

The leading case in the area of corporate negligence is *Darling v. Charleston Community Memorial Hospital*.[151] The plaintiff in *Darling* suffered immediate complications and an eventual amputation due to the negligent application of a leg cast in the emergency department of a private Illinois hospital.[152] The court held that the defendant hospital owed an independent duty of care to the patient apart from that of the private physician, which the hospital breached by failing to require examination by a qualified member of the staff, to review the treatment received by the plaintiff, and to require the use of consultants as appropriate to provide the proper care for the patient.[153]

Darling was the first, and has been the most widely followed case recognizing the hospital's obligation to oversee the quality of patient care services. The court stated:

> Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. They regularly employ on a salary basis a large staff of physicians, nurses and interns, as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such services if necessary, by legal action. Certainly, the person who avails himself of "hospital facilities" expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility.[154]

The *Darling* case also established the use of hospital licensing regulations, accreditation standards, and hospital bylaws as evidence of the standard of care to which the hospital will be held and as evi-

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150 Note, *Corporate Negligence—Wisconsin Hospital Held to Owe a Duty To Its Patients To Select Qualified Physicians*, 65 MARQ. L. REV. 139, 143 (1981); Southwick, *The Hospital's New Responsibility*, 17 CLEV. MARSHALL L. REV. 146, 152 (1968).

151 33 Ill.2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966).

152 *Id.* at 328-29, 211 N.E.2d at 255-56.

153 *Id.* at 333, 211 N.E.2d at 258.

154 *Id.* at 332, 211 N.E.2d at 257 (quoting Bing v. Thunig, 2 N.Y.2d 656, 666, 143 N.E.2d 3, 8, 143 N.Y.S.2d 3, 11 (1957)).

dence "that the medical profession and other responsible authorities regarded as both desirable and feasible that a hospital assume certain responsibilities for the care of the patient."[155]

Other courts, citing *Darling*, have recognized the independent duty of hospitals with respect to patient care. It is important to note, however, that hospitals are not perceived by the courts as a guarantor of the adequacy of care. The negligent acts of an independent physician remain the sole responsibility of that physician. Decisions since *Darling* have focused primarily on the hospital's overall monitoring system for the appointment and retention of staff physicians. Specifically, the hospital must exercise reasonable care in the selection of its medical staff by obtaining reasonably available information of prospective staff members in connection with their licensing, credentials, and any prior negligent conduct.

In *Joiner v. Mitchell County Hospital Authority*,[156] a patient complaining of chest pains was seen by the defendant physician, an independent member of the medical staff at Mitchell County Hospital.[157] The physician prescribed medication but advised the patient that the condition was not serious and sent him home.[158] The patient's condition worsened, and the patient died while on his way back to the hospital.[159] The plaintiff sued the hospital for its independent negligence in permitting an incompetent physician to remain on its medical staff.[160] The Georgia Supreme Court rejected the hospital's claim that it was relieved of liability by delegating its authority to review potential medical staff members to the members of the current staff. The court held that, to the contrary, the medical staff acted as an agent for the hospital.[161] The court stated:

> If the physician was incompetent and the [hospital] knew, or from information in its possession that such incompetency was apparent, then it cannot be said that the [hospital] acted in good faith and with reasonable care permitting the physician

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155 *Id.*

156 125 Ga. App. 1, 186 S.E.2d 307 (Ct. App. 1971), *aff'd*, 229 Ga. 140, 189 S.E.2d 412 (1972).

157 *Id.* at 1, 186 S.E.2d at 308.

158 *Id.*

159 *Id.*

160 *Id.* at 1-2, 186 S.E.2d at 308.

161 Mitchell County Hosp. Auth. v. Joiner, 229 Ga. 140, 143, 189 S.E.2d 412, 414 (1972).

to become a member of the staff.[162]

In *Joiner*, the court found the hospital negligent for failing to establish appropriate screening mechanisms to determine the competency of its medical staff members.[163] Hospitals have also been found liable for negligence caused by a staff physician if the plaintiff can prove that the hospital knew or should have known of the physician's prior incompetence pursuant to a credentials review program that is in place but that was negligently implemented.

Hospital liability for failure to obtain information necessary to properly screen the competency of its medical staff is vividly illustrated in the case of *Gonzales v. Nork*.[164] In *Gonzales*, the hospital had no actual knowledge of Dr. Nork's incompetency until nearly three years after his operation on Mr. Gonzales.[165] In addition, after acquiring such knowledge, the hospital promptly restricted Dr. Nork's surgical privileges which caused his resignation from the medical staff.[166] Nevertheless, the court found that the hospital should have restricted Dr. Nork prior to his surgery on Mr. Gonazles, holding that the hospital

> by virtue of its custody of the patient, owes him a duty of care; this duty includes the obligation to protect him from acts of malpractice by its independently retained physician who is a member of the hospital's staff, if the hospital knows or *has reason to know*, or *should have known* that such acts were likely to occur.[167]

This would be so regardless of whether the hospital actually knew the relevant facts with respect to the physician's competency.[168]

In *Gonzales*, the hospital's liability for negligence rested on its failure to be aware of Dr. Nork's lack of skill, its failure to have a system for acquiring such knowledge, and its failure to make proper use of the knowledge available to it in the form of the records of Dr. Nork's patients. As in *Joiner*, the hospital claimed freedom from liability on the grounds that it is the medical staff that is responsible

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162 *Id.*

163 *Id.* at 142-43, 189 S.E.2d at 414.

164 No. 228566, slip op. (Cal. Super. Ct. Nov. 27, 1973), *rev'd on other grounds*, 60 Cal. App. 3d 728, 131 Cal. Rptr. 717 (1976), *rev'd*, 20 Cal.3d 500, 573 P.2d 458, 143 Cal. Rptr. 240 (1978).

165 *Id.*

166 *Id.*

167 *Id.*

168 *Id.*

for reviewing the professional work performed in the hospital.[169] The court found that "this argument is in flat opposition to the views of Mr. Charles [M.] Jacobs, Assistant Director of JCAH and a lawyer [currently president of InterQual Incorporated]. Mr. Jacobs says: 'Delegating authority to its medical staff for performance for specific quality maintenance functions does not, of itself, relieve a hospital of its ultimate responsibility. . . .' "[170]

Hospital corporate negligence, unlike respondeat superior and ostensible agency, does not depend on the type of relationship between the physician and the hospital. For example, in *Purcell v. Zimbelman*,[171] the defendant physician was a private practitioner selected by the plaintiff to perform cancer surgery.[172] The defendant was clearly an independent contractor, no evidence was presented indicating that he may have been an actual or apparent agent of the hospital.[173] Nevertheless, the hospital, which was aware of four previous malpractice actions against the physician, was held ultimately responsible for the quality of care provided in the institution.[174]

In *Purcell*, the plaintiff brought an action for negligence against Dr. Purcell and Tucson General Hospital for the loss of a kidney, loss of sexual function, permanent colostomy, and urinary problems as the result of an abdominal surgical procedure known as a pull-through operation.[175] The court held that the hospital had an independent duty to its patients to supervise the competence of physicians on its medical staff, and that in discharging this duty, the hospital is held to a standard of care based on what it knew or should have known regarding the physician's skill.[176] The court found the hospital failed to properly monitor Dr. Purcell's performance in failing to restrict his privileges when it had actual knowledge of his inability to perform the particular surgical procedure involved

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169 *Id. See* Joiner v. Mitchell County Hosp. Auth., 125 Ga. App. 1, 186 S.E.2d 307 (Ct. App. 1971), *aff'd*, 229 Ga. 140, 189 S.E.2d 412 (1972).

170 *Gonzales*, No. 228566, slip op.

171 18 Ariz. App. 75, 500 P.2d 335 (Ct. App. 1972).

172 *Id.* at 79, 500 P.2d at 339.

173 *Id.* at 79-80, 500 P.2d at 339-40.

174 *Id.* at 81, 500 P.2d at 341; Binford, *Malpractice and the Prepaid Health Care Organization*, 3 WHITTIER L. REV. 337, 348-49 (1981).

175 Purcell v. Zimbelman, 18 Ariz. App. 75, 80, 500 P.2d 335, 340 (Ct. App. 1972).

176 *Id.* at 80-81, 500 P.2d at 340-41.

in this case.[177] The finding that the hospital had actual notice of Dr. Purcell's incompetence was based on evidence that two prior pull-through operations performed by him had resulted in lawsuits and that two other surgical procedures performed by Dr. Purcell had also resulted in lawsuits.[178] Over the hospital's objection against the introduction of these other lawsuits into evidence at the *Purcell* trial, the court found such prior evidence relevant to the hospital's failure to act upon prior knowledge with respect to Dr. Purcell's competency to perform particular procedures.[179]

The doctrine of corporate negligence is clearly illustrated by several other recent court decisions. One is a 1982 California case, *Elam v. College Park Hospital*.[180] In *Elam*, a doctor was granted surgical privileges at a hospital in 1975, after the hospital had verified his degree, his license, and his privileges at two other hospitals.[181] Between 1975 and the date of surgery, that was the basis of this suit, the doctor's work at the hospital was routinely reviewed by a Medical Care Evaluation Committee at the hospital.[182] The Committee never reported any concern about the doctor's competence.[183] From 1974 to 1976, however, there were three other cases against the doctor that the hospital had failed to discover.[184] The court held for the plaintiff, finding that the hospital breached its duty to the patient of taking reasonable steps to secure a competent medical staff by selecting, reviewing, and continuously evaluating its staff physicians.[185]

The court noted that case precedent established that a hospital has a duty of reasonable care to protect its patients from harm.[186] The court noted several provisions from the California Health and Safety Code and Administrative Code that recognize hospital accountability for the quality of medical care provided and the contin-

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177 *Id.* at 83, 500 P.2d at 343.
178 *Id.* at 83-84, 500 P.2d at 343-44.
179 *Id.* at 84-85, 500 P.2d at 344-45.
180 132 Cal. App.3d 332, 183 Cal. Rptr. 156 (Ct. App. 1982).
181 *Id.* at 336, 183 Cal. Rptr. at 158.
182 *Id.*
183 *Id.*
184 *Id.* at 337, 183 Cal. Rptr. at 158.
185 *Id.* at 340-41, 183 Cal. Rptr. at 161.
186 *Id.* at 340, 183 Cal. Rptr. at 161.

uing competency of the medical staff.[187] The court recognized, from a policy standpoint, that the hospital is in the best position to evaluate the competence of physicians and that the hospital is the only institutional vehicle available to coordinate the delivery of health care of reasonable quality to large numbers of people.[188] The breach of these duties by College Park Hospital constituted negligence.[189]

In 1981, the Supreme Court of Wisconsin decided *Johnson v. Misericordia Community Hospital*.[190] In 1975, Dr. Salinsky performed surgery at Misericordia and was sued for malpractice by the patient, Johnson.[191] Johnson reached a pretrial settlement with Salinsky, but continued to press charges against the hospital.[192] In 1973, Dr. Salinsky applied for full surgical and orthopedic privileges at Misericordia.[193] On his application, however, Salinsky denied previous suspension, reduction, revocation, or nonrenewal of any medical staff privileges.[194] He also failed to provide the requested information concerning his liability insurance and past and present carriers.[195] Family Hospital withdrew Dr. Salinsky's privileges for hip related procedures in 1973 and required a qualified consultation before any open procedure.[196] Saint Anthony's Hospital refused Dr. Salinsky's privileges in 1971.[197] Mount Sinai Hospital reduced his status to that of courtesy physician in general practice in 1963.[198] In addition, numerous malpractice suits were instigated against Dr. Salinsky.[199]

The court once again found for the plaintiff, upholding the plaintiff's contentions that the hospital was negligent in granting orthopedic privileges to Dr. Salinsky and for failing to investigate his abilities and qualifications, which failures contributed to the pa-

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187 *Id.* at 341-42, 183 Cal. Rptr. at 161-62 (citing CAL. HEALTH & SAFETY CODE §§ 1250, 32125, 32128 (West 1973, 1975 & Supp. 1990)).
188 *Id.* at 344-45, 183 Cal. Rptr. at 163-64.
189 *Id.* at 346-47, 183 Cal. Rptr. at 165.
190 99 Wis.2d 708, 301 N.W.2d 156 (1981).
191 *Id.* at 709-10, 301 N.W.2d at 158.
192 *Id.* at 710-11, 301 N.W.2d at 158.
193 *Id.* at 712, 301 N.W.2d at 159.
194 *Id.*
195 *Id.* at 713, 301 N.W.2d at 159.
196 *Id.* at 717, 301 N.W.2d at 161.
197 *Id.* at 718, 301 N.W.2d at 161-62.
198 *Id.* at 717, 301 N.W.2d at 161.
199 *Id.* at 719, 301 N.W.2d at 162.

tient's injuries.[200] The court held that Johnson only had to prove that the hospital did not make any effort to investigate Dr. Salinsky.[201] At a minimum, the hospital was charged with having knowledge of information which could have been readily obtained.[202] There was credible evidence that the hospital, had it exercised ordinary care, would not have appointed Dr. Salinsky to its medical staff.[203]

In order to protect an institution against imposition of liability based upon the corporate negligence doctrine, it is necessary to institute programs that provide for organizational, quality, and clinical controls. The corporate negligence theory which involves negligent selection of providers is based on an independent, nondelegable duty of the institution to use reasonable care in appointing staff physicians. In addition to establishing organizational negligence, however, some associated physician malpractice must be shown.[204] A plaintiff faces the difficulty of proving two concurrent negligent acts, as well as establishing that the negligent selection was the proximate cause of the patient's injuries.[205] For example, in *Ferguson v. Gonyaw*,[206] the court determined that the defendant hospital did not meet its standard of care in appointing the physician to the medical staff.[207] The plaintiff, however, failed to prove staff privileges would have been denied if the hospital had used reasonable care in evaluating the physician.[208] The physician's successful completion of approved residence and licensing requirements precluded a finding of hospital liability.[209] Additional proximate cause issues may result from the remoteness in time between the selection of the physician and the eventual malpractice.[210] An institution may prove lack of proximate cause by introducing evidence that the physician involved

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200 *Id.* at 744-45, 301 N.W.2d at 174.

201 *Id.* at 739, 301 N.W.2d at 172.

202 *Id.* at 745, 301 N.W.2d at 174.

203 *Id.* at 743, 301 N.W.2d at 174.

204 Purcell v. Zimbelman, 18 Ariz. App. 75, 83, 500 P.2d 335, 343 (Ct. App. 1972); Binford, *supra* note 174, at 345.

205 Meyer, *supra* note 29, at 85; Binford, *supra* note 174, at 345; Annotation, *Hospital's Liability for Negligence in Selection or Appointment of Staff Physician or Surgeon*, 51 A.L.R.3D 983 (1973) [hereinafter *Hospital's Liability*].

206 64 Mich. App. 685, 236 N.W.2d 543 (Ct. App. 1975).

207 *Id.* at 697-99, 236 N.W.2d at 550-51.

208 *Id.* at 699, 236 N.W.2d at 551.

209 *Id.* at 698-99, 236 N.W.2d at 550-51.

210 *Hospital's Liability*, *supra* note 205, at 983.

exercised "the highest type of professional care" during the intervening period.[211]

Defining the appropriate standard of care for selection of physicians presents an additional evidentiary problem. A plaintiff alleging negligent selection must prove the institution knew or should have known the physician was unqualified.[212] This proof requires not only what steps were actually taken by the institution to select the physician, but also what steps should have been taken.[213] To define the appropriate standard of care for a hospital's selection of providers, courts have relied on the institution's own bylaws,[214] state licensing requirements,[215] practices at other reputable hospitals,[216] and JCAHO guidelines.[217]

In the area of corporate negligence, which addresses the negligent supervision of providers, the plaintiff must be prepared to show either that institutional action to anticipate and prevent the physicians' negligence was possible, or that prompt action after the incident would have minimized injuries.[218] Proximate cause issues may preclude a finding of liability based on an isolated incident of provider malpractice. For example, proof of negligent supervision will be difficult if the malpracticing physician has no prior history of negligent treatment or suspicious complications, was practicing within his own specialty, and was performing necessary surgery.[219]

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211 Benedict v. Saint Luke's Hospital, 365 N.W.2d 499, 505 (N.D. 1985) (hospital will not be liable for negligent selection where the physician exercised the care and skill ordinarily possessed by other emergency room physicians).

212 Meyer, *supra* note 29, at 85; Binford, *supra* note 174, at 345; *Hospital's Liability*, *supra* note 205, at 984.

213 *Hospital's Liability*, *supra* note 205, at 984.

214 Johnson v. Misericordia Community Hosp., 99 Wis.2d 708, 726, 301 N.W.2d 156, 165 (1981).

215 *Id.* at 743-44, 301 N.W.2d at 174; Darling v. Charleston Community Hosp., 33 Ill.2d 326, 332, 211 N.E.2d 253, 257 (1965).

216 *Misericordia*, 99 Wis.2d at 738, 301 N.W.2d at 171.

217 *Darling*, 33 Ill.2d at 331-32, 211 N.E.2d at 257.

218 Hospital corporate negligence includes a duty to " 'supervise' the attending physician in certain circumstances, to require the attending physician to seek consultation in problem cases, and to remove him from a case in extreme situations. . . ." Southwick, *supra* note 150, at 146. *See also Darling*, 33 Ill.2d 326, 211 N.E.2d 253.

219 Fiorentino v. Wenger, 19 N.Y.2d 407, 227 N.E.2d 296, 280 N.Y.S.2d 373 (1967). "[A] hospital may be held liable in tort for permitting its facilities to be used by an unlicensed person or by a licensed person committing an act of malpractice with the knowledge of the hospital or under such circumstances putting it on notice of such wrongful act." *Id.* at 411, 227 N.E.2d at 297, 280 N.Y.S.2d at 375.

Some commentators have recognized the substantial supervisory capacity of hospitals in assuring quality health care.[220] This capacity places the hospital in a better position than either consumers or regulatory boards to monitor and control the activities of physicians. The hospital can observe medical care as it is being provided. It can utilize other medical staff members to make judgments about the quality of that care. Finally, the hospital can use a wide variety of sanctions to control potentially negligent physicians; these sanctions may include professional education, proctoring requirements, and limitation or revocation of staff privileges.

2. IPA Model HMO and PPO Liability for Corporate Negligence Under the Corporate Negligence Doctrine

As provider selection becomes a significant issue for managed care systems, the extension of the doctrine of corporate negligence to IPA model HMOs and PPOs is more probable. Based on the rationale of the corporate negligence cases, the application of this doctrine to the IPA model HMO and the PPO is logical and more appropriate. Although these entities do not have custody of the patient, which would give rise to a duty to protect the patient from harm, duties to protect the patient may arise from the provider selection process in combination with the limitation or restriction of the patient's choice of provider.

The provider selection by the entity combined with the limitation and restriction of the patient's choice of provider should create a duty on the part of the HMO or PPO to properly review and investigate the credentials and expertise of provider panel applicants.[221] These limitations should create the additional duty to protect its subscribers from malpractice by members of its provider panel when it knows or should have known, through reasonable care, that such malpractice was likely.[222]

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220 Note, *Hospital Corporate Liability: An Effective Solution to Controlling Private Physician Incompetence?*, 32 RUTGERS L. REV. 342, 376 (1979). *See also* Hunter, *Medical Malpractice by Emergency Physicians and Potential Hospital Liability*, 75 KY. L.J. 633 (1986-87).

221 *See* Joiner v. Mitchell, 125 Ga. App. 1, 186 S.E.2d 307 (Ct. App. 1971), *aff'd*, 229 Ga. 140, 189 S.E. 412 (1972); Ferguson v. Gonyaw, 64 Mich. App. 685, 236 N.W.2d 543 (Ct. App. 1975); Johnson v. Misericordia Community Hosp., 99 Wis.2d 708, 301 N.W.2d 156 (1981).

222 *See* Purcell v. Zimbelman, 18 Ariz. App. 75, 500 P.2d 335 (Ct. App. 1972);

Therefore, an IPA model HMO and a PPO should be deemed to have a duty to protect patients from foreseeable harm by determining provider panel competency, continuously evaluating its provider panel, monitoring provider performance, and taking corrective action.

This view was expressed in *Harrell v. Total Health Care, Inc.*,[223] where a Missouri Court seemed to indicate that an IPA model HMO undertook these duties and would be subject to the corporate negligence doctrine.[224]

The court in *Harrell* seemed to extend the corporate negligence doctrine to IPA model HMOs by its statement that the doctrine "is not a theory limited to claims against hospitals. . . . The duty of care to protect patients from foreseeable risk of harm, however, finds a common ground" in both hospitals and IPA model HMOs.[225] The *Harrell* court discussed the genesis of the duty as it becomes applicable to the IPA model HMO. The court stated:

> A subscriber to Total Health Care, or to any other prepaid medical services plan, expects and assumes that the plan will cover the expenses of medical care. In order to realize the benefit of the Total Health Care plan, the subscriber must, under the plan terms, accept treatment by physicians Total Health Care has approved. Although Total Health Care argued otherwise, the evidence shows that a subscriber does not have unlimited choice of a specialist physician. In order to be assured that payment of the charges will be made by Total Health Care, the subscriber must go to the physician to whom he is referred by his primary care physician and the specialist must have contracted with Total Health Care. The fact that the subscriber may select some other doctor and pay for the services outside the Total Health Care coverage is irrelevant.[226]

Elam v. College Park Hosp., 132 Cal. App.3d 332, 183 Cal. Rptr. 156 (Ct. App. 1982); Gonzales v. Nork, No. 228566, slip op. (Cal. Super. Ct. Nov. 19, 1973), *rev'd on other grounds*, 60 Cal. App. 3d 728, 131 Cal. Rptr. 717 (1976), *rev'd*, 20 Cal.2d 500, 573 P.2d 458, 143 Cal. Rptr. 240 (1978).

[223] No. WD 39809, slip op. (Mo. Ct. App. W. Dist. Apr. 25, 1989), *aff'd*, 781 S.W.2d 58 (1989).

[224] *Id.* at 9.

[225] *Id.*

[226] *Id.* at 9-10.

The *Harrell* fact situation is comparable to most IPA model HMOs. The court's analysis indicates that the courts may now be willing to impose the requisite duties on IPA model HMOs and PPOs necessary for the application of the corporate negligence doctrine. Although the case was dismissed based upon a technical aspect of the Missouri law, the court's conclusion in *Harrell* appears to be an appropriate extension of the corporate negligence doctrine to HMOs. The court concluded

> that under the evidence viewed most favorably to plaintiff's cause, a case of liability for [corporate] negligence was made based on proof that Total Health Care conducted no investigation of Dr. Witt's competence, that his record of malpractice claims was such that a prudent person would recognize his lack of competence and under the evidence Total Health Care failed to discharge its duty to plaintiff as a subscriber to its services to prevent a foreseeable risk of harm.[227]

In addition, many IPA model HMOs and PPOs market their products claiming they determine provider panel competency, continuously evaluate the provider panel, monitor provider performance, and take corrective action. These claims, together with the assertions concerning their utilization management programs, may cause the courts to more readily impose these functions as duties. Finally, although the states where willing provider statutes are in force may appear to provide a defense for PPOs, these statutes still permit and in some instances require the PPOs to establish reasonable provider selection criteria. Certainly competence is a reasonable criterion and therefore these statutes would not appear to alleviate the imposition of these duties.

3. Insurance Company and Employer Liability Under the Corporate Negligence Doctrine

There is an increasing concern among insurance companies and employers that their participation in managed care creates an exposure to liability. Depending on the degree of participation by insurance companies and employers, there is potential exposure to malpractice liability. One basis for the imposition of such liability upon insurers and employers is the corporate negligence doctrine.

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227 *Id.* at 11.

As mentioned previously, if insurance companies and employers, either alone or in concert with others, establish HMOs or PPOs, the degree of exposure to liability based upon the corporate negligence doctrine is significant. There is, however, potential for exposure merely by the actions of an insurance company or an employer engaging a managed care entity for its insureds or employees and creating incentives in the policy or benefit plan that have the effect of restricting the choice of provider by insureds or employees.

The rationale of the corporate negligence doctrine suggests its application to insurers or employers, who direct their insureds or employees to providers, may be appropriate in the right case. Although the insurer and the employer do not appear to have custody of the patient, which gives rise to a duty to protect the patient from harm, the duty to protect the patient may arise from the selection by the insurance company or the employer of the managed care entity in combination with the limitation or restriction of the patient's choice of provider. In circumstances where the employer has restricted its employees to one managed care entity, this duty could be enhanced.

The selection of the managed care entity, combined with the limitation and restriction of the patient's choice of provider, should create a minimal duty on the part of the insurer or employer to properly review and investigate the expertise of the managed care entity and its provider selection process. Failure to properly investigate the managed care entity, including its provider selection criteria and the entity's enforcement of such criteria, combined with the limitation and restriction of the patient's choice of provider, could result in liability for the insurance company or employer under the corporate negligence theory.

Insurance companies and employers, however, could be insulated from a provider's malpractice. The provider, the managed care entity, and the hospital are all positioned to absorb the liability before it attaches to an insurer or employer. The protections described below and contractual protections should be implemented to take advantage of this positioning and further protect the insurer and employer. The more involved in the managed care process the insurer and employer become, the more potential there is for liability.

4. Protection from the Imposition of Liability Based Upon the Corporate Negligence Doctrine

To protect against the imposition of the corporate negligence doctrine, the IPA model HMOs and PPOs should enact several measures designed to fulfill their obligations and avoid negligence in the selection and recredentialing of providers. These measures should include the following:

(a) The entity should conduct an investigation and analysis of its existing provider selection criteria, its contracts, both written and oral, its method of investigation of applicants, its documentation of such investigations, its recredentialing procedures, its provider monitoring systems, and its marketing materials.

(b) If the investigation discloses that these procedures are not adequate, corrective action should be taken immediately.

(c) The entity should enact a written Provider Selection Program based upon specific criteria and adhere to the Provider Selection Program without exception unless a reasonable written justification for deviation can be established.

(d) The entity should enact written procedures for the independent investigation of applicants to the provider panel and document the investigation of each such application.

(e) The entity should enact written procedures and a written schedule for the recredentialing of provider panel members; it should adhere to the recredentialing schedule and document such recredentialing.

(f) The entity should enact procedures and create a system to independently monitor provider performance including a routine review of malpractice actions, disciplinary actions, and other relevant matters.

(g) The entity should require provider malpractice insurance, enact procedures to independently verify such insurance, and enact procedures to monitor that such insurance remains in force.

(h) The entity should enact procedures to determine the establishment and enforcement of risk management programs in hospitals and other facilities.

The insurance company or employer contracting with a managed care entity should conduct a similar investigation and analysis of the managed care entity to be assured that provider selection cri-

teria exist and are enforced and monitored in accordance with the foregoing guidelines.

It is significant that hospitals, IPA model HMOs, PPOs, insurance companies, and employers are not guarantors of care by their provider panels and, under the corporate negligence doctrine, they are held liable only when they have actually been negligent. Rigorous adherence to these policies should provide evidence that a provider's malpractice case was not due to the negligence of these entities in carrying out their duties to establish the proper provider selection process, to determine provider panel competency, to evaluate the provider panel, or to monitor provider performance and take corrective action.

5. Health Care Quality Improvement Act of 1986

HMOs, PPOs, and other entities that establish panels of health care providers must eliminate unfit, poor quality, and over-utilizing providers in order to remain economically competitive and to reduce the likelihood of malpractice on the part of panel providers which may be attributed to the HMO or PPO. Actions to terminate providers, however, are customarily balanced against the potential for antitrust litigation by such terminated providers, particularly where decisions to terminate a panel provider are based upon deliberations by fellow practitioners. The case that focused attention on these issues occurred in May of 1988.

a. *Patrick v. Burget*

The Supreme Court of the United States, in its unanimous decision in *Patrick v. Burget*,[228] may have chilled local physician participation in the hospital peer review process. Significant physician reluctance to participate in the hospital peer review process, as well as in the peer review systems established by virtually all managed care systems, may be anticipated as a result of both the actual grounds upon which the Supreme Court based its decision and those issues which it declined to consider.

(1) The Facts

Timothy A. Patrick, M.D., a general and vascular surgeon,

228 108 S. Ct. 1658, *reh'g denied*, 108 S. Ct. 2921 (1988).

served as an employee of the Astoria Clinic and was a member of the medical staff of Columbia Memorial Hospital (CMH), the only hospital in Astoria.[229] Patrick was invited to become a partner of the Clinic after one year as an employee.[230] Patrick declined and instead commenced an independent medical practice in competition with the surgical practice of the Clinic.[231] Patrick, however, did retain his staff privileges on the medical staff of CMH.[232]

The Supreme Court's interpretation of the facts of the *Patrick* case was significant to the 8-0 outcome.[233] The Supreme Court found that during the period after Patrick ceased to be an employee of the Clinic

> the physicians associated with the Astoria Clinic consistently refused to have professional dealings with him. Petitioner [Patrick] received virtually no referrals from physicians at the Clinic, even though the Clinic at times did not have a general surgeon on its staff. Rather than refer surgery patients to petitioner, Clinic doctors referred them to surgeons located as far as 50 miles from Astoria. In addition, Clinic physicians showed reluctance to assist petitioner with his own patients. Clinic doctors often declined to give consultations, and Clinic surgeons refused to provide back-up coverage for patients under petitioner's care. At the same time, Clinic physicians repeatedly criticized petitioner for failing to obtain outside consultations and adequate back-up coverage.[234]

The executive committee of the medical staff of CMH, chaired by the Clinic surgeon, initiated a review of Patrick's staff privileges.[235] The committee voted to recommend the termination of his staff privileges on the ground that Dr. Patrick's care of patients was below the standards of CMH.[236] During the course of this process, Patrick commenced litigation against the partners of the Clinic.[237] Patrick contended in his lawsuit that the partners of "the Clinic had

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229 *Id.* at 1660.
230 *Id.*
231 *Id.*
232 *Id.*
233 Justice Blackmun took no part in the decision.
234 Patrick v. Burget, 108 S. Ct. 1658, 1660-61, *reh'g denied*, 108 S. Ct. 2921 (1988).
235 *Id.* at 1661.
236 *Id.*
237 *Id.*

initiated and participated in the hospital peer review proceedings to reduce competition from petitioner [Patrick] rather than to improve patient care."[238] The partners in the Clinic denied this assertion.[239] The jury, however, concurred with Patrick and returned verdicts against the partners in the Clinic based upon two antitrust claims and awarded $650,000 to Patrick.[240] This award was tripled as required by law in antitrust cases.[241]

The case was appealed by the partners of the Clinic. Although the court of appeals found substantial evidence that the partners of the Clinic "acted in bad faith in the peer review process," the court of appeals overturned the jury's decision on the grounds that the conduct of the partners in the Clinic was immune from antitrust scrutiny under the state action doctrine.[242] The state action immunity defense exempts certain activities which would ordinarily be prohibited by the antitrust laws.[243]

(2) The Decision

The Supreme Court reversed the appellate court decision based upon a narrow interpretation of law. The Court decided that an action must meet a two part test to be immune from the antitrust laws based upon the state action doctrine.[244] The first part of the test requires the action to be in accordance with " 'clearly articulated and affirmatively expressed . . . stated policy.' "[245] The second part of the test requires the anticompetitive conduct to be " 'actively supervised by the State itself.' "[246] The Court stated "[o]nly if an anticompetitive act of a private party meets both of these requirements is it fairly attributable to the State," and thereby immune from antitrust scrutiny.[247]

The Court concluded it was unnecessary to determine if the

238 *Id.*
239 *Id.*
240 *Id.*
241 *Id.*
242 *Id.* at 1661-62.
243 Patrick v. Burget, 800 F.2d 1498, 1505 (9th Cir. 1986) (citing Parker v. Brown, 317 U.S. 341 (1943); Hoover v. Ronwin, 466 U.S. 558 (1984)), *rev'd*, 108 S. Ct. 1658 (1988).
244 Patrick v. Burget, 108 S. Ct. 1658, 1662, *reh'g denied*, 108 S. Ct. 2921 (1988).
245 *Id.* at 1663 (citations omitted).
246 *Id.* (citations omitted).
247 *Id.*

State of Oregon had clearly articulated a state policy with respect to the peer review process.[248] The Court determined there were sufficient grounds to decide the case on the basis that the second part of the test had not been satisfied because there was a lack of active supervision by the state of the peer review process.[249] The Court noted that neither the state nor any of its branches reviewed "or even could review—private decisions regarding hospital privileges to determine whether such decisions comport with the state regulatory policy and to correct abuses."[250]

Patrick v. Burget is a landmark case for the issues the Court decided and for those that it failed to address. The Court in *Patrick* did not define what a "clearly articulated and affirmatively expressed" state policy is with respect to peer review.[251] The Court also failed to decide under what conditions, if any, participation by a physician in the peer review process in bad faith might still exempt the physician from liability.[252] The significant aspect of the Court's failure to determine the bad faith issue is important due to the impact of the Health Care Quality Improvement Act of 1986 (Act).[253] Under the Health Care Quality Improvement Act of 1986, physicians' actions with respect to peer review activities would be immunized from liability if the action was taken "in the reasonable belief that the action was in the furtherance of quality health care,"[254] and "in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts. . . ."[255]

Therefore, although the Health Care Quality Improvement Act of 1986 was enacted subsequent to and, in fact, in response to the initiation of the activities in the *Patrick* case, the Court could have indicated its view with respect to the immunization of bad faith activities during the peer review process. Since it did not, there remains an unresolved issue with respect to antitrust liability for bad faith participation in the peer review process.

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248 *Id.*
249 *Id.*
250 *Id.*
251 *See id.* (Court did not have to reach that issue).
252 *See generally* Patrick v. Burget, 108 S. Ct. 1658, *reh'g denied*, 108 S. Ct. 2921 (1988).
253 42 U.S.C. §§ 11101-11152 (Supp. 1989).
254 *Id.* § 11112(a)(1).
255 *Id.* § 11112(a)(4).

(3) Future Participation by Local Physicians in the Peer Review Process

It appears that local physicians may decline to participate in the peer review process where such participation involves the review of competitors. In addition, based on the uncertainty of this decision, physicians may decline to participate in the local peer review process under any circumstances. It is probable that the perception in the physician community will be that the *Patrick* case has substantially enhanced the risk of litigation directed personally against the physician participants by those practitioners defeated in the peer review process.

"There is no doubt," according to William L. Amos, Jr., M.D., President of MedStrategies, Ga. Inc., "that the *Patrick* decision will chill physicians' willingness to perform peer review as well as utilization review, quality assurance or any other evaluation of other physicians."[256] He believes the impact of *Patrick* will be especially pronounced in small medical communities.[257] "The effect in a small medical community of a peer review decision against one of only a few doctors in a particular specialty is far greater than against a doctor in that specialty in a large city like Chicago or Atlanta,"[258] notes Dr. Amos. "It is crucial that the hospital and managed care system be absolutely sure that there is no anticompetitive motivation behind the peer review process, particularly in small communities."[259] Dr. Amos states, "one suggestion in small towns would be to contract out the review process to large organizations. However, in my experience, the small town physician will fight that process."[260]

JCAHO and Medicare require hospitals to perform peer review, and the law in some states requires that managed care systems provide utilization review, quality assurance programs, or both. Dr. Amos acknowledges the conflict between such requirements and the decision in *Patrick*, observing that

> physicians, especially those on hospital committees who are not reimbursed for peer review activities, will be loath to put

256 Telephone interview with William L. Amos, Jr., M.D., President of MedStrategies, Ga. Inc. (1989).
257 *Id.*
258 *Id.*
259 *Id.*
260 *Id.*

> themselves on the line without clear guidelines as to what is and is not against the law. Physicians simply cannot, and will not, agree to perform these peer review services in light of *Patrick* where such significant liability is determined on a case by case basis.[261]

Courts are beginning to examine state involvement in hospital medical staff and other physician peer review decisions to determine whether, in light of the decision in *Patrick*, there is sufficient state participation to render such peer review activity immune from federal antitrust liability. In *Bolt v. Halifax Hospital Medical Center*,[262] an action filed by a physician whose clinical privileges were revoked, the appellate court found review by Florida courts was sufficient active state supervision of peer review cases and held several hospitals and physicians and their medical staffs were exempt from antitrust liability.[263] The court determined that the degree to which the Florida courts are willing to scrutinize hospital action regarding the appointment of physicians to the hospital medical staffs and the granting of privileges constitutes active supervision sufficient to immunize such activity under the state action doctrine.[264] The *Bolt* case appears to ignore the strong language of the Supreme Court in *Patrick* regarding the active supervision requirement applied in *Patrick*.[265] Significantly, on May 16, 1989, the full appellate court panel of twelve judges remanded the case to federal district court, although in connection with an issue unrelated to the state action immunity issue.[266] Nevertheless, a final decision has not been rendered in *Bolt*.

In the case of *Jiricko v. Coffeyville Memorial Hospital Medical Center*,[267] the court examined whether the involvement of the State of Kansas in peer review proceedings was sufficient to meet the active supervision requirement and afford protection from federal an-

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261 *Id.*

262 851 F.2d 1273 (11th Cir.), *reh'g granted, opinion vacated*, 861 F.2d 1233 (11th Cir. 1988) (en banc), *reinstated in part on rehearing and remanded*, 874 F.2d 255 (11th Cir. 1989) (en banc).

263 *Id.* at 1275-77, 1284.

264 *Id.*

265 Patrick v. Burget, 108 S. Ct. 1658, 1664, *reh'g denied*, 108 S. Ct. 2921 (1988).

266 Bolt v. Halifax Hosp. Medical Center, 874 F.2d 755, 756 (11th Cir. 1989) (en banc).

267 700 F. Supp. 1559 (D. Kan. 1989).

titrust liability.[268] The court stated that there are three ways a state may supervise the process: establish a state program of active supervision of peer review decisions; provide a regulatory authority to the state board of medical examiners to approve or disapprove private privilege decisions; or establish a state authority to initiate judicial proceedings against hospitals that do not comply with statutory requirements.[269] Under these guidelines, the court found that Kansas did not actively supervise peer review decisions and held that the peer review activity was not considered immune from antitrust liability.[270]

Although the Health Care Quality Improvement Act of 1986[271] provides a deterrent, in the form of payment of reasonable attorney fees in the defense of a lawsuit "if the claim or claimant's conduct during the litigation of the claim, was frivolous, unreasonable, without foundation, or in bad faith,"[272] these standards are difficult to prove, and a victory and reward of attorneys' fees would be little compensation in comparison to the amount of time expended by the practitioner in preparation of a defense. Moreover, if the hospital's peer review process does not comply with the Act, the path to the courthouse could be more tempting. In many states the award of the attorney's fees may not be a deterrent at all.

(4) A Stimulant to Outside Review

It appears that the *Jiricko* decision in combination with the considerations cited earlier in this section should spawn more significant usage by hospitals and health care delivery systems of contractors performing clinical surveys to assess a physician's performance. During the past several years the growth of these companies has been substantial.

The real dangers raised by the *Patrick* case are that: (1) a peer review body composed of physicians who are competitors of the physician under review will be suspect; and (2) unless there is active state involvement in the quality maintenance process, federal antitrust jurisdiction is not avoided. Some states, including New York, may pass the test. In New York, hospitals must collect

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268 *Id.* at 1560.
269 *Id.* at 1562 (citing Patrick v. Burget, 486 U.S. 94 (1988)).
270 *Id.* at 1563.
271 42 U.S.C. §§ 11101-11152 (Supp. 1989).
272 *Id.* § 11113.

and report quality-related data to the State,[273] and credential determinations of a private hospital can be appealed to a special tribunal.[274]

In states lacking such active involvement in the peer review process, exposure to liability may be avoided where no trace of anticompetitive motive is suggested. Charles M. Jacobs, President of InterQual, stated, "[p]hysician reviewers must be free of any possible financial benefit from the result, and the review technique must meet stringent tests of objectivity and clinical credibility."[275] "The review process itself must be exquisitely documented, with a clear audit trail supporting every conclusion," added Joanne Lamprey, InterQual's Senior Vice President.[276] InterQual has been performing surveys of physician performance under contract to hospitals and medical staffs for over twelve years, usually after the internal peer review process has uncovered problematic performance. No hospital or physician member of a peer review panel has occasioned any liability when the process is conducted pursuant to such principals, according to these InterQual executives.[277]

The engagement of a neutral contractor to perform private clinical review of a physician's performance should decrease the causes of action available to a practitioner defeated in the peer review process. The practitioners performing clinical surveys are customarily not local physicians with a personal or business interest in the termination of the privileges of a potential plaintiff. In addition, the bad faith argument is difficult to sustain against a neutral third party serving as the determinator of the quality of the medical services provided to the physician's patients. This, of course, will not prevent lawsuits. Participants in the process, however, will be protected from liability.

It is important to understand that although physicians may hesitate to serve on their hospital's peer review program due to the potential liability, it is unlikely that this decision will deter physicians from serving as employees or independent contractors

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273 N.Y. PUB. HEALTH LAW § 2805 (Consol. 1987).

274 *Id.* § 2801(b).

275 Telephone interview with Charles M. Jacobs, President, InterQual and Joanne Lamprey, Senior Vice President, InterQual (1989).

276 *Id.*

277 *Id.*

of utilization management companies or companies providing clinical surveys.

b. The Act

On November 14, 1986, Congress enacted the Health Care Quality Improvement Act of 1986.[278] Finding that "the increasing occurrence of medical malpractice and a need to improve the quality of medical care have become nation wide problems" which can be remedied through effective professional peer review, that "the threat of . . . liability under . . . federal antitrust law unreasonably discourages physicians from participating in effective professional peer review," and that "there is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review," Congress established immunity for persons and entities involved in good faith peer review of physicians.[279]

Section 11111(a)(1) of the Act provides:

> If a professional review action . . . of a professional review body meets all the standards specified in section 11112(a) of this title, . . . [then] the professional review body, any person acting as a member or staff to the body, any person under contract or other formal agreement with the body, and any person who participates with or assists the body with respect to the action, shall not be liable [under federal or state law].[280]

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278 42 U.S.C. §§ 11101-11152 (Supp. 1989). Section 11112 provides:

> (a) In general
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> For purposes of the protection set forth in section 11111(a) of this title, a professional review action must be taken—
>
> (1) in the reasonable belief that the action was in the furtherance of quality health care,
>
> (2) after a reasonable effort to obtain the facts of the matter,
>
> (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
>
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).
>
> A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 11111(a) of this title unless the presumption is rebutted by a preponderance of the evidence.

Id. § 11112.

279 *Id.* § 11101.

280 *Id.* § 11111(a)(1).

Certain exceptions are specifically enumerated elsewhere in the Act. The Act defines professional review action as

> an action or recommendation of a professional review body . . . which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician.[281]

The term clinical privileges includes any circumstances pertaining to the furnishing of medical care permitted by a health care entity.[282] "The term 'professional review body' means a health care entity and the governing body or any committee . . . [thereof] which conducts professional review activity."[283] The term health care entity means, among other things, an entity, expressly including, but not limited to a health maintenance organization or group medical practice, "that provides health care services and that follows a formal peer review process for the purpose of furthering quality health care."[284] Therefore, the Act provides immunity from liability under state and federal law, including antitrust statutes, for HMOs and probably PPOs, and their committees and individual committee members, when they participate in peer review activities conducted in good faith and in an effort to further the quality of care provided through the entity.

In order for an HMO or PPO to effectively comply with the requirement that adequate notice and hearing procedures be afforded to the physician,[285] a notice and hearing procedure for HMO or PPO panel providers, which are subject to a professional review action, should be enacted pursuant to the specific terms of section 11112(b) of the Act. The requirements of that section include notice to the physician stating that the action has been proposed, the reasons for the proposed action, that the physician has a right to request a hearing, any time limit in which to request such hearing, and a summary of the rights in the hearing.[286] Upon the physician's

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281 *Id.* § 11151(9).
282 *Id.* § 11151(3).
283 *Id.* § 11151(11).
284 *Id.* § 11151(4)(A)(ii).
285 *Id.* § 11112(a)(3).
286 *Id.* § 11112(b)(1)(A)-(b)(1)(C).

timely request for a hearing, the physician must be given notice of the place, date, time of the hearing, and a list of the witnesses expected to testify on behalf of the HMO or PPO.[287]

The hearing shall be held, in the discretion of the entity, either before an arbitrator acceptable to the physician and the entity, a hearing officer appointed by the entity, or a panel of individuals appointed by the entity.[288] At the hearing, the physician has the right to representation by an attorney, to have a record made of the proceedings, to call, examine, and cross examine witnesses, to present evidence determined relevant by the hearing officer, and to submit a written statement at the close of the hearing.[289] The physician should also have the right to receive the written recommendation of the arbitrator, officer, or panel, the basis thereof, and the right to receive a written decision of the entity and the basis for the decision.[290] Significantly, failure to meet the conditions described above shall not, in itself, constitute failure to provide adequate notice and hearing procedures required for a valid professional review action which is a condition of immunity under the Act.[291] It would appear that an HMO or PPO can afford itself, its committees, and committee members that perform peer review activities the maximum protection of the immunities provided in the Act if the notice and hearing procedures follow the provisions of the Act.

IV. Theories of Liability Relating to Utilization Management (Criterion 4 of the AAPPO Accreditation Program)

The utilization management program is a significant attraction of the managed care entity to the purchaser of health care. The primary interest of HCFA in PPOs revolved around the PPOs' ability to manage health care through a strong utilization management program. As a result, employers are beginning to recognize that to be a managed care system an entity must establish and *effectively operate* a utilization management system to monitor the quality of treatment rendered and identify and minimize inappropriate use of services or facilities. Managed care systems with effective utilization management systems are: (1) reviewing

287 *Id.* § 11112(b)(2).
288 *Id.* § 11112(b)(3).
289 *Id.* § 11112(b)(3)(C).
290 *Id.* § 11112(b)(3)(D).
291 *Id.* § 11112(b).

cases prospectively, concurrently, and retrospectively, and performing the case management function; (2) identifying quality and cost efficient providers; (3) monitoring quality and effective treatment rendered to patients; (4) assisting in the design of benefit plans that channel patients to quality, cost efficient providers and the most appropriate level of care; and (5) encouraging cost-consciousness among patients.

The critical element of utilization management is information that, combined with education, guides patients and providers toward properly assessing and using the health care system.

Many utilization management programs established by managed care entities, however, have come under attack as ineffective or nonexistent. A primary focus of this attack is the traditional local utilization review system operated by the local physicians. Although certain local systems may effectively use peer pressure to successfully assess and enforce quality and reduce utilization, the trend in the marketplace is moving away from this traditional practice. The reason for this market shift is that, although many managed care systems continue the preexisting internal review systems, many purchasers of health care consider these systems to be the fox guarding the chicken coop. According to Robert Becker, M.D., Chairman of the Board of Healthcare COMPARE, a leading utilization management company, purchasers fear that referral patterns and friendships among physicians compromise utilization review.[292]

There are many instances where the referral pattern of physicians has been altered to punish those physicians performing the utilization management function. As a result, the health care market has become saturated with outside utilization management companies to avoid the pitfalls of traditional peer review. It appears the marketplace has determined that the lack of a utilization management program or an inefficient system without data probably disqualifies an entity from being a managed care system. The utilization management function performed by or on behalf of a managed care entity is a necessity and is probably its most significant potential for liability.

Managed care systems have adopted a variety of utilization

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[292] Telephone interview with Robert Becker, M.D., Chairman of the Board, Healthcare COMPARE (1989).

management procedures including mandatory pre-authorization for elective admissions, review of length of stay, and monitoring of laboratory and other tests. IPA model HMOs additionally use capitation and incentive bonuses as methods of utilization management. These different methods of utilization management may result in different risks to the entity. For purposes of legal analysis, utilization management programs are generally classified as retrospective, concurrent, or prospective.

Retrospective utilization management programs analyze data on hospital admissions, patterns of treatment, and utilization of certain procedures. Liability for patient injuries from negligent retrospective review by the managed care entity are unlikely. The corporate negligence doctrine, however, may be applied in the event of patient injuries where the managed care entity failed to act upon information gained, or which should have been gained, through retrospective review.[293]

Liability for personal injury is more likely to result from either prospective or concurrent utilization management than from retrospective utilization management. Under a prospective review system, most nonemergency hospital admissions must receive prior approval and an initial approved length of stay is assigned. Concurrent review systems or case management monitor the appropriate lengths of stay and evaluate the need to curtail or extend hospitalization. Either of these review procedures may result in litigation if the patient believes injury has resulted from a denial of necessary treatment. In addition, the corporate negligence doctrine may apply if the patient is able to prove the managed care entity permitted unnecessary surgery or permitted an unqualified physician to provide care despite information gained in prospective or concurrent review.

The landmark case of *Wickline v. State*,[294] is the first case dealing with the issue of whether a third party payor may be held liable to a plaintiff-patient in a medical malpractice case by virtue of performing utilization management functions.

In *Wickline*, the patient consulted a physician with respect to

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293 *See supra* section III(B) for discussion of corporate negligence.

294 192 Cal. App. 3d 1630, 239 Cal. Rptr. 810 (Ct. App.), *cert. granted*, 727 P.2d 753, 231 Cal. Rptr. 560 (1986), *review dismissed, cause remanded*, 741 P.2d 613, 239 Cal. Rptr. 805 (1987).

circulatory problems in her legs.[295] The physician recommended surgery and the California Medicaid program, known as the Medi-Cal program, which conducts utilization management, approved the surgery and a post-operative length of stay.[296] Prior to discharge, the physician requested an eight day extension due to post-surgical complications.[297] Despite the attending physician's request, the Medi-Cal physician consultant only authorized a four day extension.[298] The patient was discharged after the four day period without further requests from the attending physician to extend the hospitalization.[299] Nine days after discharge, the patient was readmitted in an emergent condition and her right leg required amputation.[300] Wickline sued Medi-Cal, claiming that it was negligent in failing to grant the eight day extension originally requested by her physician, causing premature discharge, and the resultant damages.[301]

Reversing the decision of the trial court, which had entered a judgment against the Medi-Cal program for $500,000, the California Appeals Court ruled that the decision to discharge a patient from the hospital is the sole responsibility of the patient's treating physician and not that of a third party payor, emphasizing that at the end of the four day extension, the physician did not seek a further extension but rather discharged the patient based on the physician's own evaluation at the time.[302] The court stressed, however, that a third party payor could be found liable for injuries resulting from an arbitrary or unreasonable decision regarding disapproved requests for medical care. The court stated:

> Third party payers of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms as, for example, when appeals made on a patient's behalf for medical or hospital care are arbitrarily ig-

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295 *Id.* at 1634, 239 Cal. Rptr. at 812.
296 *Id.* at 1635, 239 Cal. Rptr. at 812.
297 *Id.* at 1636, 239 Cal. Rptr. at 813.
298 *Id.* at 1638, 239 Cal. Rptr. at 814.
299 *Id.* at 1639, 239 Cal. Rptr. at 815.
300 *Id.* at 1641, 239 Cal. Rptr. at 816-17.
301 *Id.* at 1633, 239 Cal. Rptr. at 811.
302 *Id.* at 1644-45, 239 Cal. Rptr. at 819.

nored or unreasonably disregarded or overridden.[303]

The court warned that while "cost consciousness has become a permanent feature of the health care system, it is essential that cost limitation programs not be permitted to corrupt medical judgment."[304]

There are two conclusions that can be drawn from this court's opinion, both of which are consistent with established principles of law. First, the physician who signs a discharge order in reliance upon an adverse utilization management determination remains responsible for the patient's premature discharge and for any resulting injury. Second, the utilization management company that obtains the concurrence of the attending physician will be in a strong position to say that it was the attending physician and not the utilization management company that made the final decision to discharge the patient, and that the determination of the utilization management company is nothing more than an expression of opinion in which the physician ultimately concurred.

There is a third issue which was not directly involved in the *Wickline* case, but to which the court made reference. Those engaged in the utilization management traditionally have taken the position that their decisions are made not for the purposes of determining the course of treatment, but rather for the limited purpose of determining the question of payment. A denial of treatment payment is usually accompanied by a statement that it is a determination made only with respect to payment, and that only the patient in consultation with the physician can determine the course of treatment. Similar language is often included in PPO and HMO provider contracts. Such a statement, while it may be literally true, may not afford much protection to a utilization management company in court. Today, as a practical matter, for many people a denial of payment may be in reality a denial of treatment. The courts could treat denials of payment as a denial of care. The court in *Wickline* recognized this reality when, in describing the utilization review process, it said:

> A mistaken conclusion about medical necessity following retrospective review will result in the wrongful withholding of payment. *An erroneous decision in the prospective review process, on the other hand, in practical consequences, results in the withholding of*

303 *Id.* at 1645, 239 Cal. Rptr. at 819.

304 *Id.* at 1647, 239 Cal. Rptr. at 820.

necessary care, potentially leading to a patient's permanent disability or death.[305]

Although the decision was ultimately decided against the patient, the court did make it clear that in an appropriate case a reviewer or a health care payor could be held liable when its activities result in a patient not receiving care which should have been provided.[306]

While the appellate court decision in *Wickline* clearly reaffirms the physician's responsibility for all decisions with respect to the medical care of the physician's patients, the language of the decision could serve as a basis for future courts to assert malpractice liability against third party payors. This liability would appear to extend to other entities, including hospitals, HMOs, PPOs, and other managed care systems that perform utilization management and make assessments and recommendations with respect to the extent, type, or duration of health care services to be provided to a patient.

The hypothetical situation that could result in liability to a utilization management entity performing the utilization management function could be as follows: the patient enters the hospital, has a procedure, and physician requests an eight day post-operative extension due to complications. The utilization management entity grants a four day extension and at the end of four days the physician requests an additional four day extension that is denied by the utilization management entity. The utilization management entity proclaims that the "medical determination is in the hands of the physician" but declines to pay for the extra four days. The physician requests that the patient stay the extra four days in the hospital. The patient cannot afford the extra four days and leaves the hospital. Soon the patient is readmitted and the result is amputation of her leg. In this case a court could hold the economic realities of the denial of payment for the additional hospital stay governed medical care and hold the entity liable for damages. The physician would not be liable for malpractice because the physician requested that patient stay for the additional period.

The entity performing the utilization management described in the previous paragraph could be a utilization management company, an IPA model HMO, a PPO, an insurance company, or an employer. In addition, unless carefully protected, the IPA model

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305 *Id.* at 1634, 239 Cal. Rptr. at 812 (emphasis added).
306 *Id.* at 1645, 239 Cal. Rptr. at 819.

HMO, the PPO, the insurance company, or the employer contracting with a utilization management company could be liable in the event of the insolvency of the utilization management company. Therefore, the protections described in this section and the contractual protections described in the next paragraph are important both to the entity performing the utilization management and to those contracting with such an entity.

Protection against the imposition of liability based upon the utilization management function is similar to protection from ostensible agency. In conjunction with the measures enacted for protection from ostensible agency, an institution should enact additional measures to ensure that its operation of utilization management does not supersede the physician-patient relationship by governing the level of medical care and rendering the institution liable. These additional measures should include the following:

(a) The entity should conduct an investigation and analysis of its policies, contracts, consent forms, marketing materials, utilization management manuals, and monitoring systems to assure licensure of its employees/independent contractors and appeal procedures.

(b) If the investigation discloses that this material provides the impression that the entity is governing the level of medical care for patients, corrective action should be undertaken immediately.

(c) The entity should obtain insurance coverage to protect against the imposition of liability arising from the performance of the utilization management function. Self-insured entities should actuarially consider potential liability for utilization management and reflect this in contribution to the insurance trust. The entity should also obtain indemnifications from providers for liability under utilization management procedures.

(d) Entities contracting with others to perform utilization management should investigate the utilization management company to determine its solvency, determine its insurance coverage, obtain the appropriate indemnification, obtain insurance coverage, continually monitor the solvency and the insurance coverage of the utilization management company, and determine if the utilization management company has established the policies, procedures, and measures described in this section.

(e) The entity should enact written policies with respect to the

operation of the utilization management function. These policies should include written scripts for operators instructing personnel on methods of avoiding the impression that the entity, through utilization management, is governing the level of medical care for patients.

(f) The entity should prepare and review all written forms, contracts, and other similar items which are used in the utilization management program. All relevant consent forms signed by patients should reflect the authority to release medical records for the purposes of utilization management.

(g) The entity should provide its marketing, advisory, and public relations departments or agencies with written guidelines to avoid the possibility that the entity's advertising will create the unintended impression that the entity, through utilization management, governs the level of medical care for patients.

(h) Utilization management manuals, other utilization management materials distributed to physicians, and any contracts between the entity and the physician that include utilization management services should contain a disclaimer acknowledging that the physician bears the sole responsibility for medical decisions regarding the patients of the physician.

(i) All utilization management determinations should be made by personnel with the requisite license or other evidence of the proper degree of skill to make such decisions. The appeal of any utilization review decision should be reviewed by a physician who, due to the physician's specialty, is competent to render an opinion with respect to the services that are subject to the appeal.

(j) Pre-admission review should not be required for emergency care.

(k) The mechanism for the appeal of a utilization management decision should be set forth in writing and clearly communicated to all physicians subject to utilization management.

(l) The entity should establish a continuous monitoring procedure to ensure compliance with the foregoing measures.

(m) Whenever possible, the entity should obtain the concurrence of the attending physician. Utilization management is not a process for denying care and it should not be conducted in a confrontational manner. It is a process for educating physicians concerning the appropriate use of resources. Its long term benefits are achieved through its educational function. *In addition, one of the best shields against utilization management lia-*

bility is evidence that the attending physician concurred in the reviewer's determination.

(n) There should be no denial without prior consultation with the attending physician. The attending physician has seen the patient and may be familiar with his medical history over many years. A court may be reluctant to accept the idea that a physician who knows only what appears on the chart is better equipped to make decisions for the patient than the attending physician who knows the patient and his medical history.

(o) Denials and the reasons for denials should be documented. Litigation is a lengthy process and the reviewer should be able to demonstrate the reasons for a denial without relying on memory. In addition, stating the reasons in writing will force the individual reviewer to base the denial on substantial grounds.

(p) Determinations must be prompt. The patient's condition may force the physician to choose between risking liability by delaying necessary treatment and risking nonpayment for the services. Furthermore, a physician who has had to wait three weeks to be denied a request for pre-certification may be so angered by the delay that he is unable to discuss rationally the reasons for the denial, and is likely to cooperate with, if not recommend, the patient's bad faith and negligence lawsuit against the reviewer and the payor.

(q) The entity should not generally deny a course of treatment recommended by an attending physician in the face of the physician's persistent disagreement. It may be wise to direct the treatment from an inpatient to an outpatient setting, to require a second opinion, to shorten the length of stay, or to recommend the consideration of an alternative or more conservative course of treatment, but it is rarely wise to deny a particular course of treatment if the attending physician adamantly persists in the belief that a particular course of treatment must be taken even after he has been presented with all the reasons for changing that belief. To undertake such a serious responsibility in the face of known determined opposition is to create a record which will be difficult to defend in the event of an unfavorable outcome. The potential financial benefits are rarely worth such a risk.[307]

It should be noted that in *Wickline*, the patient did not sue the

307 *See Schnitzer, Potential Liability in the Utilization Review Process*, reprinted by The Brighton Consulting Group (1986).

physician.[308] Nonetheless, the physician could have been sued for malpractice or medical abandonment. Thus, in practice, if a utilization management orders discharge of a patient or refuses to authorize an admission, both the physician and the organization may be liable for any resulting harm. Despite the utilization management company's decision, the physician still has a duty to care adequately for the patient. The physician's only alternatives are to absorb the cost of treating the patient or to persuade the patient to pay for the medical care.[309]

Many standard insurance policies do not cover joint and several liability for panel physician malpractice. Since the problem of joint and several liability is most severe when one party is underinsured, managed care entities should require that all physicians carry a reasonable malpractice insurance policy and shall monitor physicians to be sure the policy is in force. In addition, the managed care entities themselves may obtain a wrap-around insurance policy, which covers organizational exposure.[310]

Indemnity agreements, where panel physicians agree to assume all financial liability for medical malpractice, may limit financial risk to the managed care entities. The majority of medical malpractice policies specifically exclude contractually assumed liability such as that undertaken pursuant to an indemnity agreement.[311] This problem is further complicated by some malpractice insurers' refusal to cover managed care entities providers for liability resulting from negligent utilization review.[312] Thus, physicians may not only be unable to indemnify managed care entities for liability arising from the physician's negligence, but they may be unable to obtain a recip-

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308 Wickline v. State, 192 Cal. App. 3d 1630, 1633, 239 Cal. Rptr. 810, 811 (Ct. App.), *cert. granted*, 727 P.2d 753, 231 Cal. Rptr. 560 (1986), *review dismissed, cause remanded*, 741 P.2d 613, 239 Cal. Rptr. 805 (1987).

309 "To date, a physician's financial situation has not been incorporated into the standard to which a physician is held. This may be due, in part, to the fact that in the past, physicians have not had to render treatment to patients without the opportunity for reimbursement." Comment, *California Negotiated Health Care: Implications for Malpractice Liability*, 21 S.D.L. REV. 455, 464 n.68 (1984).

310 Such coverage includes a model Contingent Malpractice Coverage policy for a group practice HMO. Binford, *supra* note 174, at 356.

311 *See, e.g.*, professional liability insurance policy issued through the Illinois State Medical Insurance Services, Inc.

312 LEMKIN & RICH, PPO'S: UTILIZATION REVIEW, ATTORNEYS AND PHYSICIANS EXAMINE PREFERRED PROVIDER ORGANIZATIONS 54-55 (1984).

rocal indemnification from the organization for its negligent utilization review.

The American Medical Association has proposed model legislation, the "Third Party Payor Responsibility Act," which would impose liability upon utilization management for damages arising out of a utilization management decision leading to unreasonable delay, reduction, or denial of care. The model bill is reproduced as *Appendix A*.

APPENDIX A

AMA MODEL BILL

October 1986
IN THE GENERAL ASSEMBLY
STATE OF _____

An Act

To Impose Liability and Financial Responsibility For Injuries to Patients Consequent to Review Decisions by Third-Party Payor Be it enacted by the People of the State of _____:

Section 1. Title. This Act shall be known and may be cited the "Third Party Payor Responsibility Act."

Section 2. Purpose. The Legislature hereby finds and declares that:

(a) Third party payor requirements such as readmission certification, utilization restrictions, and length of stay limitations, all as a condition of payment, may serve as a barrier between the insured or beneficiary and his physician, in that treatment decisions may be unduly influenced by payment considerations rather than medical necessity;

(b) Third party payor requirements for prior and concurrent approval of medical and surgical services should be reasonable, both in scope and in application; and

(c) Insureds or beneficiaries injured as a result of unreasonable requirements or their application should have recourse against such third party payors.

Section 3. Liability.

(a) Where the contract between an insurer, nonprofit hospital service plan, health care service plan, health maintenance organization, or self-insurer and the insured is issued or delivered in this state and contains a provision whereby in non-emergency cases, the insured is required to be prospectively evaluated through a pre-hospital admission certification, pre-inpatient service eligibility program, or any similar pre-utilization review or screening procedure prior to the delivery of contemplated hospitalization, inpatient or outpatient health care, or medical services which are prescribed or ordered by a duly licensed physician who possesses admitting and clinical staff privileges at a health care

facility, the insurer, nonprofit hospital service plan, health care service plan, health maintenance organization, third-party administrator, independent contractor, self-insurer or utilization review committee shall be held liable to any beneficiary covered by such contract for injury incurred or resulting from decisions which result in unreasonable delay, reduction, or denial of medically necessary services or care as recommended by a duly licensed physician.

(b) The damages shall be limited to the injuries which are the result of the unreasonable delay, reduction or denial together with reasonable attorneys' fees and court costs.

(c) Any requirement that the insured be prospectively evaluated through a pre-hospital admission certification, pre-inpatient service eligibility program, or any similar pre-utilization review or screening procedure shall be inapplicable to an emergency determined as such by the attending physician in his medical judgment.

(d) Any entity designated as a "utilization and quality control peer review organization" pursuant to 42 U.S.C. § 1320c-1 shall be held liable to any beneficiary whose care or treatment is required to be scrutinized or reviewed by the review organization for injury incurred or resulting from the review organization's unreasonable delay, reduction, or denial of medically necessary services or care as recommended by a duly licensed physician.

Section 4. Insurance.

(a) Any insurer, nonprofit hospital service plan, health care services plan, or other entity or person which provides coverage for medical or surgical services or expenses, which uses a utilization review committee shall maintain or cause to be maintained sufficient insurance applicable to all actions of that committee which may cause or contribute to injury sustained by any insured person or beneficiary on account of an action, decision or recommendation made by the committee.

(b) For the purposes of this section:

(1) "Utilization review committee" means a person designated or entity established to review medical or surgical services rendered to a covered person as to necessity for the purpose of recommending or determining whether the services should be

covered or provided by the insurer, plan or other entity or person;

(2) "sufficient insurance" means liability insurance covering the committee and any member thereof acting on behalf of the committee for a policy limit of not less than three million dollars ($3,000,000).

Section 5. Effective Date. This Act shall become effective immediately upon being enacted into law.

Section 6. Severability. If any provision of this Act or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of the Act which can be given effect without the invalid provision or application, and to that end, the provisions of this Act are declared to be severable.