

MALPRACTICE IN THE MANAGED CARE INDUSTRY

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INTRODUCTION

In view of the increased costs of providing health care services during the past twenty years, there have evolved during this time an increased number of managed health care systems, i.e., organizations, which attempt, primarily through putting economic pressures on providers, to restrict the utilization of health care services by enrollees in the system.¹ This in turn, has led to new areas of liability based on such theories as bad faith breach of contract, corporate negligence, ostensible agency, and various other tort doctrines. This Article attempts to elucidate and explain some of the basic theories pertaining to such emerging areas of liability.²

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1. Although most of such systems are health maintenance organizations ("HMOs"), due in large part to federal subsidies and similar motivations, other alternative systems such as preferred provider organizations ("PPOs") have also evolved. This Article relates primarily to systems such as HMOs, which significantly restrict provider access.

2. Prior to the 1987 U.S. Supreme Court case of *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), the major cause of action instituted against HMOs was the tort of bad faith breach of contract. This tort, which originated in the insurance context, was based on the theory that by withholding care, treatment and/or payment, the HMO had breached the covenant implied in every such contract of good faith and fair dealing. Bad faith suits not only allowed for substantial damages due to emotional distress, but also, in many cases, led to punitive damages. Numerous cases based on such theory were brought against HMOs in the late 1970s and early 1980s. See Stern, *Bad Faith Suits: Are They Applicable to Health Maintenance Organizations?*, 85 W. VA. L. REV. 991 (1983). See also *Rederscheid v. Comprefcare*, 667 P.2d 766 (Colo. Ct. App. 1983).

However, the *Pilot Life* decision effectively halted such actions by holding that the Employee Retirement Income Security Act of 1974 ("ERISA") preempted most state laws and remedies relating to employee benefit plans, including those arising "out of the contract" that had even an indirect effect on such plans. See *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987). As a result, if a potential plaintiff had enrolled in an HMO through an employer or employee based plan, such person was generally precluded from filing a claim in state court against either the plan or HMO based on state tort theories. Moreover, if such claim were to be filed in federal court based on federal ERISA remedies, the potential damages would be greatly reduced, since the federal statute did not allow for emotional distress or punitive damages.

Therefore, subsequent to 1987, most plaintiffs' attorneys sought alternative causes of action to either supplant or supplement a bad faith claim. In so doing, they attempted to put forth or develop theories wherein the impact on ERISA was deemed to be "too tenuous" or "too remote" to warrant preemption. See, e.g., *Greenblatt v. Budd Co.*, 666 F. Supp. 735 (E.D. Pa. 1987). If a tort suit could be characterized as a "run-of-

VICARIOUS LIABILITY

In attempting to hold the managed care system liable for the malpractice of its contracting or employee physicians, the initial cause of action generally considered derives from the theory of respondeat superior.³ In other words, if the physician in fact works for the managed care entity, there will be little or no defense to an action based on this theory: If a physician is employed on the staff of an HMO, it is generally clear that his or her actions, in terms of liability, will be attributable to the HMO for which he or she works.⁴

A more difficult question arises when a physician is a contracting provider who works on behalf of an HMO but also works on his own and/or contracts with other managed care entities and/or HMOs. Should this physician's negligence be attributed, for liability purposes, to the HMO? Does it matter that the physician is only a contracting provider who has little or few links to the HMO? Does it matter further that such a physician has certain incentives of a financial nature to limit an enrollee's access to the services of the HMO?⁵

In order to attribute liability to a provider under these circumstances, the major theory which has been utilized has been one of os-

the-mill" state law claim which did not "arise out of the contract," then it would presumably not be subject to the ERISA preemption. See *Independence HMO, Inc. v. Smith*, 733 F. Supp. 983 (E.D. Pa. 1990). Thus, it is expected that the emerging theories subsequently discussed in this Article are unlikely to be preempted by ERISA. However, some courts have been very expansive in determining the scope of the preemption and have disallowed many causes of action. See, e.g., *Rollo v. Maxicare of La.*, 695 F. Supp. 245 (E.D. La. 1988). It is therefore probable that a definitive answer as to which state tort claims are still viable must await either congressional action or subsequent United States Supreme Court decisions.

Nevertheless, it is important to emphasize that the *Pilot Life* preemption of bad faith suits pertains only to enrollees of HMOs which are covered by ERISA. An individual member of an HMO who is not enrolled based on an ERISA plan is not precluded from suing for bad faith. This would include all federal and most state employees, as well as most Medicare and Medicaid beneficiaries. Such individuals could still successfully utilize the tort of bad faith breach of contract if the HMO in question did not, in fact, provide to such enrollees "the benefit of the bargain." Such tort thus remains available to potential plaintiffs in certain instances, but is not currently viable in the majority of cases.

3. The doctrine of respondeat superior, which holds that an employer is liable for the torts of its employees, has been broadly interpreted. See, e.g., W. KEETON, D. DOBBS, R. KEETON, & D. OWEN, *PROSSER AND KEETON ON TORTS* §§ 69-71, at 499-516 (5th ed. 1984) [hereinafter *PROSSER ON TORTS*].

4. See, e.g., *Sloan v. Metropolitan Health Council of Indianapolis, Inc.*, 516 N.E.2d 1104 (Ind. Ct. App. 1987), wherein the court determined that an HMO could indeed be found vicariously liable for the negligence of its staff physician, despite the fact that the HMO entity was not itself practicing medicine as a professional corporation. See also Mullen, *FHP Loses Negligence Suit, Hikes Malpractice Fund*, *HEALTHWEEK NEWS*, Aug. 13, 1990, at 6.

5. Virtually all physicians who contract with HMOs are limited in terms of their liability to provide referrals to other specialists, laboratories, and hospitals. Furthermore, they may also be financially "docked" for doing so.

tensible agency, i.e., the notion that despite the lack of an employer-employee relationship, the apparent and/or ostensible aspects of the relationship between the physician and the HMO create in the enrollee's mind an implicit and understandable suggestion of an agency relationship.⁶ Thus, an enrollee might in fact have enrolled or continued to participate in an HMO due to brochures and/or advertisements pertaining to the availability of a certain provider group or the health care articles and/or announcements written in HMO newsletters by various contracting physicians.⁷ Moreover, a particular provider group or clinic might sell itself as an especial provider to a particular HMO: This, in turn, would create an expectancy in the minds of potential enrollees that such a group was in fact an agent and/or employee of the HMO. There have been numerous cases attributing to hospitals the negligence of physicians under circumstances wherein such physicians appear to the consumer to work for such hospitals.⁸ This theory is equally applicable to HMO cases and has been so applied in recent cases.⁹

It should be noted, however, that ostensible agency is generally applicable only when it objectively appears to an enrollee that a particular provider is in fact or in theory an agent of the HMO, and that the written materials provided to such enrollee reinforce that belief: The greater the apparent connection between the HMO and the physician, the more this theory is likely to prevail. Ostensible means apparent, and it applies equally to potential and actual enrollees: If it is "apparent" to potential and/or actual HMO members that a close nexus exists between the HMO and a provider group, and that is in

6. See *Boyd v. Albert Einstein Medical Center*, 377 Pa. Super. 609, 547 A.2d 1229 (1988). This is the only reported appellate case which has thus far specifically analyzed and then adopted this theory in the HMO context.

7. Generally speaking, the plaintiff, in attempting to show ostensible agency, will have to show an objective nexus as well as subjective reliance. However, the latter is not necessarily required in all instances. See, e.g., RESTATEMENT (SECOND) OF TORTS § 429 (1965) (see *infra* note 10 and accompanying text). Moreover, in *Boyd*, the court emphasized the element of "no choice" and the inference that the enrollee looked to the HMO entity itself for care and not solely to the physician. *Boyd*, 377 Pa. Super. at —, 547 A.2d at 1235. Thus, there was the potential for ostensible agency derived primarily from the fact that the plaintiff submitted herself to the care of the participating physician in response to an *invitation* from the HMO.

8. See, e.g., *Jackson v. Power*, 743 P.2d 1376 (Alaska 1987); *Grewe v. Mt. Clemens Gen. Hosp.*, 404 Mich. 240, 273 N.W.2d 429 (1970); *Hardy v. Brantley*, 471 So. 2d 358 (Miss. 1975); *Thompson v. The Nason Hosp.*, 370 Pa. Super. 115, 535 A.2d 1177 (1988); *Capan v. Divine Providence Hosp.*, 287 Pa. Super. 364, 430 A.2d 647 (1980); *Pamperin v. Trinity Memorial Hosp.*, 144 Wis. 2d 188, 423 N.W.2d 848 (1988).

9. See *Boyd*, 377 Pa. Super. 609, 547 A.2d 1229 (1988), *supra* note 6 and accompanying text. See also *Schleier v. Kaiser Foundation Health Plan of the Mid-Atlantic States*, 876 F.2d 174 (D.C. Cir. 1989). In *Schleier*, the defendant HMO, was held liable for the potential negligence of a non-employee, contracting physician-specialist based, at least in part, on the theory of apparent or ostensible agency.

fact a significant factor leading to the enrollment in such HMO of a particular person, then it cannot be effectively denied that, for liability purposes at least, an agency relationship does indeed exist.¹⁰ The only real question in such circumstances is the extent to which the alleged malpractice of a specific physician should, on this legal basis, be attributable to the HMO. Again, if ostensible agency is applicable, liability for the conduct of such physician is equally likely to exist.¹¹

CORPORATE NEGLIGENCE

During the past twenty years, hospitals have been often and increasingly held liable for the negligence of their independent staff physicians, based on a "corporate negligence" theory.¹² One of the

10. The legal aspects of ostensible agency are contained in two Restatements. See, e.g., RESTATEMENT (SECOND) OF AGENCY, § 267 (1958):

§ 267. Reliance upon Care or Skill of Apparent Servant or Other Agent
One who represents that another is his servant or other agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such.

Id. See also RESTATEMENT (SECOND) OF TORTS § 429 (1965):

§ 429. Negligence in Doing Work Which is Accepted in Reliance on the Employer's Doing the Work Himself

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

Id.

As noted previously, the element of reliance is a clear aspect of the Restatement (Second) of Agency definition, but is not necessarily relevant if a court adopts the Restatement (Second) of Torts definition.

11. It is also important to point out that this is one of the major bases upon which the relevant HMO (i.e., Cigna) is being sued by Kim Bergalis, the first known enrollee to have contracted the HIV (AIDS) virus from her provider. She is claiming that apparent agency could be inferred from Cigna's representations about its providers and her reliance upon the same. *Bergalis v. Cigna Dental Health of Florida, Inc.*, No. 90-1455 (Fla. Cir. Ct. Dec. 24, 1990). See *infra* notes 36-41 and accompanying text.

In addition, vicarious liability has been recently applied successfully to a hospital based on the theory of non-delegable duty. See *Jackson v. Power*, 743 P.2d 1376 (Alaska 1987). Thus, even without ostensible agency, it is possible that a court will find an HMO liable for the malpractice of a non-employee physician due to public policy considerations, holding that the HMO's duty of care to its members is simply "non-delegable."

12. See *supra* note 8 and accompanying text. See also *Rule v. Lutheran Hosp. & Homes Society of America*, 835 F.2d 1250 (8th Cir. 1987); *Meier v. Ross Gen. Hosp.*, 69 Cal. 2d 420, 445 P.2d 519, 71 Cal. Rptr. 903 (1968); *Clarke v. Hoek*, 174 Cal. App. 3d 208, 219 Cal. Rptr. 845 (1985); *Elam v. College Park Hosp.*, 132 Cal. App. 3d 332, 183 Cal. Rptr. 156 (1982); *Insinga v. LaBella*, 543 So. 2d 209 (Fla. 1989); *Darling v. Charleston Community Memorial Hosp.*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965); *Cronic v. Doud*, 168 Ill. App. 3d 665, 523 N.E.2d 176 (1988); *Copithorne v. Framingham Union Hosp.*, 401 Mass. 860, 520 N.E.2d 139 (1988); *Corleto v. Shore Memorial Hosp.*, 138 N.J. Super. 302,

major aspects of this theory derives from the notion that the corporate entity has evaluated and approved the credentials of its staff physicians and based on such evaluations, has thereby and thereafter granted them staff privileges. Thus, instead of just being a "hotel" for practicing physicians, the hospital has in fact been designated or deemed an institution which "houses" only competent physicians. Doctors who wish to admit patients to a specific hospital cannot do so without obtaining staff privileges, and this right is granted only after that hospital has positively evaluated the doctor's background, experience, and competency. Moreover, the retention and supervision of staff physicians is also subject to hospital review. If problems pertaining to a specific doctor subsequently come to light, courts have suggested that the hospital has a continuing duty to its patients to control and supervise the practice of such physician in that hospital, and that it may well be liable if foreseeable damages result from the failure to do so.¹³

With respect to managed care providers, the question arises as to whether and to what extent such principles of corporate negligence should be applicable. For example, should an HMO be liable for "credentialing" an inadequate or barely adequate physician to provide care to its enrollees? Should it matter that a specific referral physician is the only specialist available? Should it matter that a marginally acceptable hospital is the only one willing to admit HMO patients? More to the point, should it matter that the particular provider who is negligent is the only one willing to provide care pursuant to a managed care system for a particular enrollee group in a particular geographical area?

Based on past cases, the theory of corporate negligence has been applied only when the corporation itself (for example, the hospital) has been negligent in hiring, supervising and/or retaining a particular provider. When a hospital is involved, there is a relatively circumscribed group of physicians to whom credentialing must be applied.¹⁴ When an HMO is involved, the number of providers who are theoretically implicated is geometrically increased: Should an HMO be liable for failure to ferret out "marginal" physicians who have previously implied or indicated some degree of incompetence?

350 A.2d 534 (1975); *Pedroza v. Bryant*, 101 Wash. 2d 226, 677 P.2d 166 (1984); *Johnson v. Misericordia Community Hosp.*, 99 Wis. 2d 708, 301 N.W.2d 156 (1981); Hardy, *When Doctrines Collide: Corporate Negligence and Respondeat Superior*, 61 TUL. L. REV. 85 (1986-87).

13. See *supra* note 12 and accompanying text.

14. Although a number of doctors may apply for staff privileges at a specific hospital, many more will be involved in the provision of care in the HMO situation: Hospital care is limited by narrow geographical boundaries; HMO care is multi-city, multi-county, and frequently, multi-state in scope.

Should the HMO be responsible for eliminating potential incompetents? Should there be a questionnaire to all potential providers asking about prior malpractice suits against them? What is the implication of a positive response to a negative question? What if a negative response turns out to be a prevarication or an outright lie? Does the amount of detail required by a set of inquiries to its providers increase the potential liability of the managed care provider? Should more detail suggest more control? In other words, generally speaking, how can (or should) corporate negligence theories be applied to a managed care system to implicate it and/or to reduce its liability? Does corporate negligence apply more or less to a managed care entity vis-a-vis a hospital? Does it matter whether the HMO claims to certify the providers or claims not to involve itself at all with provider validation? Should either theory serve to implicate or exculpate the managed care system as far as liability is concerned?¹⁵

At least one appellate court has recently and definitively applied the concept of corporate negligence in the HMO context.¹⁶ In that instance, the court specifically held that the corporate negligence doctrine was not a theory limited to claims against hospitals, and that the duty of care to protect patients from a foreseeable risk of harm was equally applicable to HMOs. Moreover, in view of the limited choice of physicians offered to HMO enrollees, the court found that there was an unreasonable risk of harm to subscribers if the listed physicians were indeed unqualified or incompetent. Thus, the HMO was said to owe members a duty to conduct "a reasonable investigation of [doctors] to ascertain their reputation in the medical community for competence."¹⁷ Failure to do so, with unfortunate consequences, would indicate that the HMO's duty had not been discharged.

It is important to note that no court has yet determined the liability of an HMO for retention, supervision and/or firing decisions. Nevertheless, in various ways, the possibility of liability on this basis is even more compelling. How can an HMO claim that it is unaware of problems with a particular provider or provider group when it is required by law to develop and institute quality assurance systems, to

15. One corporate attorney for a major HMO has suggested that "you're damned if you do, and you're damned if you don't!" In fact, in a recent article, Alan Bloom, general counsel for Maxicare Health Plans Inc., has stated: "Checking physician credentials will lead managed care into a legal minefield. . . . Screening credentials is a fine exercise, but denying certification may result in lawsuits from physicians who believe their right to earn a living has been violated." Bloom, *The Malpractice Minefield*, MANAGED HEALTHCARE, Sept. 11, 1989.

16. See *Harrell v. Total Health Care, Inc.*, No. W.D. 39809 (Mo. Ct. App. Apr. 25, 1989) (1989 Mo. App. LEXIS 577).

17. *Id.* at 13 (pagination in accordance with LEXIS screens).

audit its providers on a regular basis, and to institute detailed grievance procedures which are constantly and consistently reviewed? If a provider has "gone wrong," how can the HMO not know? Even more significantly, how can the HMO, whether it actually knows or not, *not* be held responsible for resultant damages to its own membership?

MEDICAL MALPRACTICE

In various respects, it would seem anomalous to hold an HMO liable for the malpractice attributable to its providers. Nevertheless, this is an emerging theory of liability which, irrespective of credentialing and/or agency concepts, is evolving as a viable liability option for potential plaintiffs and their attorneys. The major issue in such cases seems to be the extent to which the HMO's system of managed care has contributed to an alleged deviation in the medical standard of care — i.e., one leading to the specific breach of duty alleged in a particular malpractice suit.¹⁸

The basic aspect of HMO liability deriving from this theory originated in the seminal case of *Darling v. Charleston Community Memorial Hospital*.¹⁹ In that case, the court emphasized the extent to which internal regulations and by-laws could and should be utilized to formulate and specify the standard of care in the hospital situation. Clearly, the failure to adhere to such articulated standards could well constitute negligence. If state laws and/or regulations were involved, such failure might even be deemed negligence per se. What, then, is the result if an HMO does not conform to basic federal, state and/or internal rules relating to such items as waiting times, quality assurance standards, testing intervals, grievance procedures, complaint forms, etc.? In a malpractice suit, if a plaintiff can prove that the HMO failed to adhere to its own minimal standards and/or those standards required by state laws and regulations, should this be presumptive proof of negligence? Should it in fact constitute negligence per se?

An HMO is generally subject to an extensive set of rules and regulations. Federal and state laws have been enacted in order to protect subscribers against the evils of under-servicing and under-

18. See, e.g., *Bush v. Dake*, No. 86-25767 (Mich. Cir. Ct. Apr. 27, 1989). See also Densford, *H.M.O.'s Warily Eye Mich. Malpractice Suit*, PHYSICIAN FIN. NEWS, Nov. 30, 1989, at 1; Meyer, *Lawyer: Suits Blaming HMO Controls for Malpractice May Have Jury Appeal*, AM. MED. NEWS, July 29, 1988, at 1; *Suit Blames HMO Capitation for Damaging Quality of Care*, AM. MED. NEWS, Sept. 4, 1987, at 1. Although the *Bush* case was settled prior to trial, the allegations against the HMO involved were substantially based on their theory.

19. 33 Ill. 2d 326, 211 N.E.2d 233 (1965).

utilization — both are potential problems where the financial solvency of an entity derives at least partially from the need to limit the accessibility and/or availability of care. Therefore, HMOs have been required by various laws and regulations to develop and enforce detailed quality assurance procedures to insure that necessary patient care is not unduly abridged. Such quality assurance procedures include specifications pertaining to the timing and indicia for various tests, the maximum periods allowed for patient appointments, the symptom criteria for mandatory referrals, and the frequency of testing for particular conditions for specified age groups.²⁰

As noted previously, the more specific the standards, the more likely that a deviation in such standards with resultant harm will result in a successful malpractice suit. On the one hand, HMOs should be (and are) encouraged to promulgate explicit procedures to maximize the probability that a managed care system will not manage care in a way which compromises the quality of care that is provided to its members. On the other hand, and ironically, the more explicit the required procedures, the greater the likelihood of liability for failure to adhere to such procedures.²¹ Perhaps this dichotomy derives from the fact that stringent regulatory requirements have developed only because of and in view of the fact that abuses have resulted from managed care systems, and that such explicit standards would not have developed without state and federal intervention. Thus, even without sufficient governmental oversight and review, the effect of statutory and regulatory provisions has been positive: They have at least provided minimum, basic standards by which potentially negligent variations should be judged.

20. The MODEL HMO ACT § 7A promulgated by the National Association of Insurance Commissioners ("NAIC"), requires that the HMO establish "reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical malpractice."

Moreover, the recommendations of the National Association of Health Maintenance Organization Regulators ("NAHMOR") explicitly states that:

The HMO shall implement an ongoing process which examines performance against standards. In the development of standards, an HMO may use as a starting point, nationally developed and/or recognized standards such as those which currently exist for well-child care, mammography, etc. . . .

NAHMOR: COMMITTEE ON QUALITY ASSURANCE § 10.1 (1988). See also the regulations promulgated pursuant to § 137 of the Knox-Keene Extensive Health Care Service Plan Act pertaining to the quality assurance standards required by California law. (CAL. ADMIN. CODE tit. 10, § 1300.70 et seq.).

21. This paradox is well-explicated in a recent article by a state regulator. See Champney, *Adoption of Standards of Care by HMO's: A Story-Problem of the Nineties for Managed Care*, 8 J. NAT'L A. HEALTH MAINTENANCE ORG. REGULATORS 10 (Aug. 1990).

QUALITY OF CARE AND COST CONTAINMENT

It is increasingly clear that one of the major problems with the concept of managed care is that it is in fact "managed;" hence, due largely to financial considerations, various restrictions are placed on subscribers and providers, thus reducing the likelihood of "quality" referrals to specialists and hospitals. This has led to several liability theories relating to the inherent nature of the HMO itself.²²

For example, in various risk-sharing HMOs it has been shown that there are more quality problems than in other health care delivery systems. In one specific official report, it has been indicated that "most HMOs . . . make incentive payments for holding down medical treatment costs;" this report also indicates that "incentive plans that shift much of the risk to provider groups or closely tie the individual treatment decisions to financial rewards pose the greatest potential threat to quality of care."²³ Thus, the greater the risk that is transferred to the provider, and the closer the financial incentives are linked to decisions about patient care, the greater the ultimate threat to quality of care.

These are not isolated instances. It has been said that "the success of the HMO and the PPO depends upon the same principle: acute provider awareness of the cost of care."²⁴ Utilization review in many HMOs and PPOs will include the requirement of pre-admission review and certification to determine whether admissions are 'medically necessary.'²⁵ Moreover, "once a physician agrees to contract with an HMO or PPO, all subsequent medical decisions will be examined with the knowledge that contractual restrictions may have altered the doctor's judgment."²⁶

What does this mean? Could it imply that a health care decision made under these circumstances has been and may always be compromised by financial or administrative constraints?²⁷ Under what

22. See GEN. ACCT. OFF. REP., MEDICAID: OVERSIGHT OF HMO'S IN THE CHICAGO AREA, Aug. 1990; GEN. ACCT. OFF. REP., MEDICARE: PHYSICIAN INCENTIVE PAYMENTS BY PREPAID HEALTH PLANS COULD LOWER QUALITY OF CARE, Dec. 1988. See also Ellwood, Jr. & Paul, *But What About Quality?*, HEALTH AFFAIRS, Spring 1986, at 135; Entin, *DRGs, HMOs and PPOs: Introducing Economic Issues in the Medical Malpractice Case*, 20 FORUM 674 (1984-85); Ludden & Berwick, *Quality of Care and the HMO Physician at Harvard Community Health Plan*, GHAA J., Spring 1986, at 28.

23. See GEN. ACCT. OFF. REP., *Medicare*, supra note 22.

24. See Entin, 20 FORUM at 682.

25. *Id.*

26. *Id.* at 684.

27. Various HMO laws specifically preclude administrative and/or financial decisions from interfering with health care judgments. See, e.g., Knox-Keene Health Care Service Plan Act, CAL. HEALTH & SAFETY CODE § 1367(g) (West 1990), which states that "medical decisions must [be] rendered by qualified medical providers, unhindered by fiscal and administrative management." But is it possible to isolate such decisions

federal or state laws and/or regulations would this be permitted or prohibited? How can health care providers or HMOs successfully insulate those considered health care decisions which are based at least in part on financial matters? Does it matter? Does the careful consideration of financial issues always preclude the careful consideration of health care issues?

Finally, it is important to note that the recent California case of *Wickline v. State*²⁸ suggests that the decision, position and/or status of a third party payor, such as an HMO, may sometimes be so inequitable, so corrupting of the basic patient-physician relationship, that the system itself may be deemed negligent. The dicta in this case, along with the result and reasoning of certain lower court cases, indicate that it is not only the physician's duty to provide the necessary care, but that third party payors can also be held liable, despite and/or because of the specific actions and/or inactions of the medical providers involved in the particular situation.²⁹

This may be the least invoked but potentially most important concept pertaining to the quality assurance system of an HMO. If a provider's incentive is to deny care, it should be up to the managed care system itself to make up for this problem.³⁰ Nevertheless, this is not likely to ever occur: The HMO wants providers to be satisfied, meaning that in most cases, denial of care is likely to be rewarded rather than reprimanded. The fiscal effects are obvious. More importantly, the overall psychological mindset of the managed care provider is positively affected only when under-utilization occurs. In such cases everyone makes money: The HMO will say that it is because of "health maintenance;" the provider will claim that it is due to "health care rationalization." Can such a system, which institutionalizes a denial of care, ever be deemed to adequate? Or will any

when the economic survival of an HMO depends so substantially on the limitation of medical procedures? And, in fact federal law and most state laws specifically recognize the need for and validity of incentive arrangements in HMOs. See, e.g., *Pulvers v. Kaiser Foundation Health Plan*, 99 Cal. App. 3d 560, 160 Cal. Rptr. 392 (1980).

28. 192 Cal. App. 3d 1630, 239 Cal. Rptr. 810 (1986). See also, Hillman, *Financial Incentives for Physicians in HMOs: Is There a Conflict of Interest?*, NEW ENG. J. MED., Dec. 31, 1987, at 1743; Note, *Wickline v. State: The Emerging Liability of Third Party Health Care Payors*, 24 SAN DIEGO L. REV. 1023 (1987). See also, *Wilson v. Blue Cross of Southern California*, 222 Cal. App. 3d 660, 271 Cal. Rptr. 876 (1990), which appears to have extended the *Wickline* rationale. Moreover, despite the ultimate result, *Wickline* itself explicitly states that third party payors can be held legally accountable when "medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms" and that cost limitation programs cannot be permitted to "corrupt" medical judgments. *Wickline*, 192 Cal. App. 3d at 1645-46, 239 Cal. Rptr. at 819-20.

29. See *Wickline*, 192 Cal. App. 3d at 1645-46, 239 Cal. Rptr. at 819-20.

30. Federal and state laws and regulations may be designed to prohibit under-utilization and to promote quality of care, but audits are few and far between.

and all deviations of care, whenever they cause harm to specific enrollees, be deemed to be intrinsically inadequate and therefore and thereby "negligent?"

TORTIOUS INTERFERENCE WITH PHYSICIAN-PATIENT RELATIONSHIP

In addition to the foregoing analysis, it is important to note that the tort of interference with physician-patient relationship may also relate to this situation — i.e., wherein the managed care system compromises the providers' relationship with an enrollee. If the financial considerations are so significant that the provider cannot adequately refer, hospitalize, or otherwise assist a patient without serious economic repercussions, it would appear that the system itself has at least negligently and perhaps recklessly interfered with the basic fiduciary relationship between the patient and the doctor. This may indeed constitute a tortious interference with the physician-patient relationship, a tort which while traditionally accepted, has not yet been definitively applied to the managed care situation.³¹ Nevertheless, this tort has recently been the basis of various complaints and has been invoked in several situations (i.e., "failure to refer cases") which have so far been settled prior to trial.³²

In attempting to elucidate this doctrine, at least one recent case has emphasized that whenever a carrier has so "intimidated" a doctor that he has further declined to treat the plaintiff, the tort of patient-physician interference may well be applicable.³³ In such instances, the patient may be deprived of the treatment of the one doctor best qualified to treat him.³⁴ As one authority has stated, "If a physician's judgment is dictated by orders from fellow professionals, or if economic sanctions tied to treatment regimens are too severe, 'impropriety' is the only concept the court must invoke to strike the arrangement."³⁵ Thus, the HMO scenario is precisely the situation

31. For further elucidation of this tort, see *Posner v. Lankenau Hosp.*, 645 F. Supp. 1102 (E.D. Pa. 1986); *Hammonds v. Aetna Casualty and Surety Co.*, 237 F. Supp. 96 (N.D. Ohio 1965); *Scheller v. American Medical Int'l, Inc.*, 502 So. 2d 1268 (Fla. Dist. Ct. App. 1987); *Cowan v. Gibson*, 392 S.W.2d 307 (Mo. 1965); *Straube v. Larson*, 287 Or. 357, 600 P.2d 371 (1979). See also RESTATEMENT (SECOND) OF TORTS §§ 766, 768 (1979); Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 460-74 (1988-89); Annotation, *Liability in Tort for Interference with Attorney-Client or Physician-Patient Relationship*, 26 A.L.R.3d 679, 683 (1969).

32. See, e.g., *Bush v. Dake*, No. 86-25767 (Mich. Cir. Ct. Apr. 27, 1989).

33. See *Hammonds*, 237 F. Supp. at 96.

34. *Id.* at 99.

35. See Hall, 137 U. PA. L. REV. at 470. It is also important to point out that judicial recognition of this tort is most likely to be acknowledged when non-commercial situations are involved. Thus:

When an ailing [patient] selects a physician to treat him, he does so with the

wherein the tort of interference with physician-patient relationship might be most effectively and meaningfully invoked.

NEGLIGENT MISREPRESENTATION

Another possible cause of action against an HMO relates to the tort of negligent misrepresentation. This is, in fact, one of the major theories instituted in the case against Cigna Dental Health of Florida, Inc., pertaining to the contraction of AIDS by an HMO member from a contracting provider.³⁶

The tort of negligent misrepresentation is defined as the making of a false representation by a party who acted unreasonably in not determining the true facts or in making the statement in the absence of necessary skill or competence to judge the accuracy of the statement.³⁷ In the AIDS case, for example, the plaintiff, Kim Bergalis, claims that a material misrepresentation was made; that such representation was negligent; that there was an intent to induce a reliance upon the statement; and that the plaintiff acted in reliance on the statement to her detriment. In that case, Ms. Bergalis specifically alleges that Cigna represented to her mother that the dental care provided would be through "quality-assured and carefully monitored private practice dental offices and dentists" and that she enrolled "in reliance upon the truth of Cigna's claims that her family would receive competent 'expert' dental care."³⁸ She then goes on to state that the representations made by Cigna regarding provider competency and "its careful monitoring practices" were representations of material fact made to induce the plaintiff and her family to enroll in the plan, and that she did in fact "rely to her detriment" on such statements.³⁹

A claim relating to misrepresentation can be made whenever an HMO advertises itself in a manner which proves to be untrue or misleading, especially when such an alleged misrepresentation relates to "quality care." Thus, just as an insurance company may negligently mislead its insurees into thinking that they have obtained a "piece of

full expectation that such physician will do his best to restore him to health, and the contract into which they enter is deserving of more attention from the law than a businessman's expectation of profit from a purely commercial transaction. . . . *The physician-patient contract is not purely commercial and should not permit a third party to effect its rupture.* . . .

Hammonds, 237 F. Supp. at 101 (emphasis added).

36. See *Bergalis v. Cigna Dental Health of Florida, Inc.*, No. 90-1455 (Fla. Cir. Ct. Dec. 24, 1990). The complaint in that case also alleges vicarious liability and corporate negligence, which have been discussed above.

37. See PROSSER ON TORTS § 107, *supra* note 3, at 745.

38. See *Bergalis*, No. 90-1455, slip op. at 8 (Fla. Cir. Ct. Dec. 24, 1990).

39. *Id.* at 10.

the rock" or at least "peace of mind" by paying their premiums, an HMO, may, by negligently suggestive advertisements, especially as made to gullible consumers, imply that it has actually approved and/or certified various contracting providers where, in fact, no such validation has occurred.⁴⁰ In the *Bergalis* case, for example, the question is likely to be: Could or should an HMO be deemed responsible, when despite positive assertions to the contrary, its failure to inquire sufficiently about provider credentials and/or to adhere to alleged quality standards results in an overall negative situation — that is, referral to and treatment by a provider who in fact ultimately communicates to an enrollee a deadly disease.⁴¹

CONCLUSION

Thus, in summary, there are a number of emerging theories of liability upon which complaints against managed care systems may legitimately be based.⁴² These include:

- 1) Vicarious Liability
- 2) Corporate Negligence
- 3) Medical Malpractice
- 4) Quality of Care
- 5) Interference with Physician-Patient Relationship
- 6) Negligent Misrepresentation

Although all such tort actions may not be present in a particular situation, the very nature of managed care suggests that many of

40. In terms of liability based on this theory, see RESTATEMENT (SECOND) OF TORTS § 552 (1977). See also *Ryan v. Kanne Lumber and Supply, Inc.*, 170 N.W.2d 395 (Iowa 1969); *Haddon View Inv. Co. v. Coopers and Lybrand*, 70 Ohio St. 2d 154, 436 N.E.2d 212 (1982).

41. A related cause of action based on misrepresentation was recently brought under the Racketeer Influenced and Corrupt Organizations Act ("RICO"), 18 U.S.C. §§ 1962(a) & (c) (1984), claiming that an HMO had committed mail and wire fraud by misrepresenting and failing to disclose financial incentives to participating physicians which were intended to discourage referrals to specialists. The trial court dismissed the action on various grounds, and such dismissal was affirmed without published opinion by the United States Court of Appeals for the Third Circuit. *Titi v. U.S. Healthcare, Inc.*, No. 88-9808 (E.D. Pa. Nov. 21, 1989), *aff'd*, 904 F.2d 696 (3rd Cir. 1990). See also Sussman, *HMO's Rethink Incentives for Physicians*, MANAGED HEALTHCARE, Jan., 1990, at 1.

42. For related articles, see Binford, *Malpractice and the Prepaid Health Care Organization*, 3 WHITTIER L. REV. 337 (1981); Oakley & Keeley, *HMO Liability for Malpractice of Member Physicians: The Case of IPA Model HMOs*, TORT & INS. L.J. 624-41 (1987); *Preferred Provider Organization Liability for Physician Malpractice*, 11 AM. J.L. & MED. 345 (1985-86); Comment, *Evolving Theories of Malpractice Liability for HMOs*, 20 LOY. U. CHI. L.J. 841 (1988-89); Note, *Managed Healthcare: HMO Corporate Liability, Independent Contractors, and the Ostensible Agency Doctrine*, 15 J. CORP. L. 535 (1989-90); Practising Law Inst., *Managed Healthcare 1989*, Course handbook No. 516 (1989).

these possible causes of action will be applicable whenever "managed care" means "lack of care" or "lack of adequate care." Moreover, it is likely that "deep pocket" theories can be invoked successfully whenever a sympathetic plaintiff is injured due to an alleged deprivation of health care services. The application and efficacy of such theories in these instances may extend, but not unduly "twist," the elemental tort theories upon which they are based.