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Jay Jyoti Chaudhuri

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MANAGED CARE ORGANIZATIONS IN NORTH CAROLINA: TORT LIABILITY THEORIES AND DEFENSES

INTRODUCTION

On a recent episode of the television series *Chicago Hope* the fictional doctor Aaron Shutt prescribes a costly drug for a manic-depressive patient named Artie because the patient reacts violently to two drugs covered by a health maintenance organization ("HMO").¹ However, the HMO representative refuses to cover the new and expensive drug prescribed by Dr. Shutt. Without the medication, Artie attempts suicide, and Dr. Shutt later pulls the HMO representative into the patient's hospital room. "It's your fault!" Artie shouts out. "I'm not a name on your list. I'm a human being, for God's sake."² The HMO representative apologizes and leaves. Dr. Shutt reacts by saying, "[t]his is wrong, and you know it," although the representative has gone.³ Though this scenario is fictional, *Chicago Hope*, like other medical dramas on television,⁴ illustrates two points. First, managed care has become an integral part of American medicine. Second, in spite of managed care's effort to hold down costs, the public believes that the quality of medical care has been sacrificed.

Managed care is rapidly altering the practice of American medicine.⁵ Today, more than seventy-five percent of the physicians in this country practice medicine in a managed care organization ("MCO") or take care of managed care patients.⁶ Furthermore, the rate of patient enrollment in MCOs continues to escalate, with almost sixty million Americans currently enrolled in HMOs and another

I would like to thank Professor Mark W. Morris and Danielle Tuohey Bennett for their comments on earlier drafts of this article.

1. Caryn James, *On the Doctor Shows, Public Health Enemy No. 1*, N.Y. TIMES, Nov. 8, 1998, § 2, at 30.

2. *Id.*

3. *Id.*

4. *Id.* (discussing other medical dramas such as *L.A. Doctors*, *Becker*, and *E.R.*, which have addressed the public's frustration with HMOs).

5. See generally Brian P. Battaglia, *The Shift Toward Managed Care and Emerging Liability Claims Arising From Utilization Management and Financial Incentive Arrangements Between Health Care Providers and Payers*, 19 U. ARK. LITTLE ROCK L.J. 155 (1997) (discussing the emergence of managed care).

6. See GENIE JAMES, MAKING MANAGED CARE WORK 93 (1997) (discussing the number of physicians in managed care organizations).

ninety million in other types of managed care plans.⁷ In fact, *Newsweek* estimates that over one hundred million Americans will receive care from some sort of MCO by the year 2000.⁸

The term "managed care" generally describes a number of organizations. These include HMOs and independent practice associations ("IPAs") that contain the costs and utilization of health care services by using physicians as "gatekeepers" for hospitalization and specialists for treatment and requiring prepayment by subscribers for services.⁹ The idea of such cost containment appears to have worked thus far. In 1994, national health care costs increased just 6.4% per year compared to an average increase in health care costs of 14.6% per year from 1980 to 1985, and 12.6% from 1985 to 1990.¹⁰

While the reduction of costs highlights the advantages of managed care, the negative aspects of MCO's quality of care have proliferated in the media and the public. Kafkaesque and nightmare stories abound in the popular press; many examples of substandard patient care are found in books.¹¹ The public increasingly believes that the care provided through MCOs is inferior to traditional fee-for-service care.¹² Responding to such growing dissatisfaction with managed care, President Bill Clinton proposed a national Patient's Bill of Rights in his 1998 State of the Union address.¹³

The national MCO trends are mirrored in North Carolina. Today, more than three million North Carolinians are enrolled in some sort of MCO plan.¹⁴ Furthermore, enrollment in full-service HMOs rose

7. Robert Pear, *Laws Won't Let H.M.O.'s Tell Doctors What to Say*, N.Y. TIMES, Sept. 17, 1996, at A12.

8. See Ellyn Spragins, *Does Your HMO Stack Up?*, NEWSWEEK, June 24, 1996, at 56, 56 (reporting that enrollment in HMOs has climbed from 6 million in 1976 to 53.3 million in 1995 and is projected to reach 103.2 million by 2000).

9. See PHYSICIANS IN MANAGED CARE: A CAREER GUIDE 22 (Mark A. Bloomberg & Steven R. Mohlie eds., 1994) (describing the various types of managed care organizations).

10. Timothy N. Troy, *Does Managed Care Work?*, MANAGED HEALTHCARE, July 1996, at 21, 25.

11. See, e.g., GEORGE ANDERS, *HEALTH AGAINST WEALTH: HMOs AND THE BREAKDOWN OF MEDICAL TRUST* (1996) (describing many horrific examples of substandard HMO care).

12. See Stuart Auerbach, *Managed Care Backlash: As Marketplace Changes, Consumers are Caught in the Middle*, WASH. POST, June 25, 1996, at Z12 (discussing a study reporting that 53% of respondents felt that the healthcare system was getting worse while only 38% believed that it was improving).

13. In his State of the Union address, President Clinton said:

You have the right to know all your medical options, not just the cheapest. You have the right to choose the doctors you want for the care you need. You have the right to emergency room care, wherever and whenever you need it. You have the right to keep your medical records confidential.

Julie Martin & Mark Blaine, *Patients Forcing New Laws on HMOs*, ASHEVILLE CITIZEN-TIMES, Apr. 8, 1998, at A1.

14. See Pam Silberman, Editorial, *Health Care Changing: N.C. Patients Need Protections*, WILMINGTON MORNING STAR, Jan., 16, 1998, at A13 (noting that more than one million resi-

forty percent from 1991 to 1996.¹⁵ In spite of the enrollment growth in MCOs, experts believe that North Carolina law provides insufficient protection for patients. A recent examination of state laws to protect HMO enrollees gave North Carolina a grade of C-minus.¹⁶ Not surprisingly, like the outcry at the national level, angry doctors and patients in North Carolina are voicing their concerns.¹⁷ Doctors have threatened to flee their HMOs, leaving patients in the lurch.¹⁸ Patients have experienced low-quality care due to managed care abuses.¹⁹ In response, the state's trial lawyers and doctors are seeking legislation that would expand the liability of HMOs.²⁰

Nationally, during the 1998 mid-term elections, both Democrats and Republicans scrambled to respond to enormous public resent-

dents are enrolled in full-service HMOs and more than two million in preferred provider organizations ("PPOs")).

15. Martin & Blaine, *supra* note 13, at A1.

16. See Silberman, *supra* note 14, at A13 (discussing a study conducted by the Cecil G. Sheps Center for Health Research at the University of North Carolina at Chapel Hill and the North Carolina Institute of Medicine); see also Editorial, *Barely Passing: A UNC Study Says North Carolina's HMOs Must Be Better Regulated in Order to Protect Consumers From Bottom-Line Decision Making*, THE CHAPEL HILL HERALD, May 2, 1997, at 4 (noting that North Carolina is one of only two states that has no minimum benefits package for HMO plans).

17. Catherine Clabby, *Patient Complaints Put Managed Care Under the Knife*, NEWS & OBSERVER (Raleigh, N.C.), Sept. 13, 1998, at A27 (noting that a Mason-Dixon poll of North Carolinians showed 56% of men and 76% of women as rating the performance of their HMOs as only fair or poor).

18. See Catherine Clabby & Joel B. Obermayer, *HMO Fee Cuts Anger Doctors*, NEWS & OBSERVER (Raleigh, N.C.), Feb. 1, 1998, at A1 (noting that HMOs Healthsource and Blue Cross and Blue Shield cut doctors' fees).

19. Dr. Roger Shetterly, an ophthalmologist in Hendersonville, North Carolina, shared one story about his patient. A woman who had spontaneously lost sight was referred to the Hendersonville ophthalmologist by another doctor. Shetterly examined the woman and found she was legally blind. She had a detached retina, which required emergency surgery. Shetterly referred her to a specialist in the type of surgery the woman needed. Had the woman gone to the surgeon, "he would have probably taken her into surgery that night and done the surgery then," said Shetterly. Rather, the woman couldn't keep the appointment because the doctor wasn't a provider for her managed care company. The managed care company listened to her situation over the telephone and sent her to another doctor, which brought more delays, even though the woman finally received surgery a day later. The patient never recovered her sight in that eye. Shetterly says, "they referred her to someone of their choice without consulting me. Here I'm the responsible doctor losing control of the patient to a nonmedical person telling them that's who they have to go to This patient is being guided to another specialist only because of a financial relationship with the HMO, not because he is qualified to do that kind of work." Martin & Blaine, *supra* note 13, at A1.

20. See Catherine Clabby, *Opening HMOs to Lawsuits*, NEWS & OBSERVER (Raleigh, N.C.), Mar. 26, 1998, at A1 (discussing proposed legislation in North Carolina to expand tort liability of HMOs); see also Martin & Blaine *supra* note 13, at A1 (discussing proposals to open HMOs to lawsuits); see also Catherine Clabby, *Calls Growing for HMO Reforms*, NEWS & OBSERVER (Raleigh, N.C.), Oct. 11, 1998, at A1 (discussing a poll which noted that eighty percent of North Carolinians believed that HMOs should be held legally liable for complications that occur when medical treatments are denied).

ment against managed care.²¹ Perhaps the best example of translating such public anger into a hot political issue was the 1998 United States Senate race in North Carolina.²² "I think it just infuriates people that medical decisions, things that affect their lives and their children's lives, are being made by some bureaucrat sitting behind some computer screen up in Hartford, Connecticut," Democratic nominee John Edwards, a telegenic, forty-five year-old trial lawyer, intoned in his television commercial.²³ Then-candidate Edwards never stopped talking about the issue ever since he noticed that people got angry almost every time he mentioned managed care.²⁴

In short, the fact remains that while MCOs can save patients money in monthly premiums, they can cost patients in the long run. Yet, MCOs encounter minimal litigation for medical accidents, namely because current tort principals focus on the physician while shielding the MCO, and federal law supports these tort defenses with the Employee Retirement Income Security Act preemption.²⁵ In North Carolina, no court has issued a definitive ruling on whether an MCO can be held liable for the negligence of member-physicians. This Comment argues that MCOs should be liable for negligent patient care and for their member-physicians' malpractice. Part I of this Comment provides a brief discussion of the three types of MCO models most popular today. Part II examines the theories that are available under North Carolina law to impute vicarious liability to MCOs based on member-physicians' malpractice. Part III looks at alternatives to vicarious liabilities, such as how MCOs can be held directly liable for their own tortious conduct. Finally, Part IV evaluates possible MCO defenses

21. See Amy Goldstein & Terry Neal, *Health Care Uproar Has Hill Scrambling: Polls Favor Action on "Patient's Rights"*, WASH. POST, May 31, 1998, at A1 (discussing a public opinion poll which suggests that nine out of ten Americans favor candidates willing to tighten the reins on HMOs); see also Peter T. Kilborn, *Voter's Anger at H.M.O.'s Plays as Hot Political Issue*, N.Y. TIMES, May 17, 1998, § 4, at 1 (discussing how candidates in primaries and general elections for governor and Congress typically promoted access to more doctors, a right to appeal managed care organizations' decisions, and freedom to sue the organization for malpractice).

22. See Lizette Alvarez, *Health Issues Dominate Senate Race*, N.Y. TIMES, July 5, 1998, § 1, at 10 (discussing Edwards' effective use of the HMO issue); see also Helen Dewar, *North Carolina's Stark Clash*, WASH. POST, July 11, 1998, at A1 (noting that the managed care issue was addressed initially by proposed Democratic legislation and later found its place in the Republican campaign).

23. Alvarez, *supra* note 22, § 1, at 10.

24. *Id.* In response to the Edwards' ads, The Health Benefits Coalition, a national group of corporations dominated by the insurance industry began running ads. One radio ads begins with the sound of a man laughing. "America's trial lawyers are laughing all the way to the bank," says the announcer. "For years, they've gotten rich filing lawsuit, after lawsuit, after lawsuit." Rob Christensen, *Managed Care Fuels Early Ad War in Senate Race*, NEWS & OBSERVER (Raleigh, N.C.), June 4, 1998, at A1.

25. 29 U.S.C. § 1001-1461 (1994).

that have rendered much of the negligent managed care organizations immune to lawsuits.

I. STANDARD HMO MODELS

Before assessing the consequences of imposing tort liability on MCOs, it is important to first understand their basic structure. MCOs are most commonly represented by HMOs, which can be categorized into one of three basic models.²⁶ In the "staff" model, the HMO directly employs health care providers, such as physicians and nurses.²⁷ These providers are salaried employees of the HMO and exclusively devote their services to the HMO enrollees; they do not maintain a private practice.²⁸ Finally, the HMO owns and operates the facilities and equipment used in patient treatment.²⁹

In the "group model," the HMO contracts with a medical group practice that in turn delivers health care to the organization's enrolled members.³⁰ The physicians in the group, acting as independent contractors for the HMO, care for HMO members at the group's health care facility in exchange for a set monthly fee for each enrollee.³¹ The HMO usually pays the group so-called "capitated" (or set amount) fees, and the group, in turn, pays its participating physicians base salaries and bonuses.³² Finally, the group may still maintain relations with its private patients, adding a fee-for-services component to its practice.³³

The final model is the "independent practice association" (IPA) model.³⁴ Under this model, the HMO contracts with an independent physician group, usually a partnership or corporation comprised of independent practicing physicians, that in turn provides services to the HMO enrollees.³⁵ In this model, physicians practice in their own sep-

26. Michael Kanute, Comment, *Evolving Theories of Malpractice Liability for HMOs*, 20 LOY. U. CHI. L.J. 841, 842 (1989).

27. *Id.* at 844; see also Kate T. Christensen, *Ethically Important Distinctions Among Managed Care Organizations*, 23 J.L. MED. & ETHICS 223, 224 (1995) (summarizing the structural features of HMOs that maximize the ethical treatment of patients).

28. Kanute, *supra* note 26, at 842-43 (citing J. MICHAELS, LEGAL ISSUES IN THE FEE-FOR-SERVICE/PREPAID MEDICAL GROUP vi (1982)).

29. William A. Chittenden, III, *Malpractice Liability and Managed Health Care: History and Prognosis*, 26 TORT & INS. L.J. 451, 452 (1991).

30. Kanute, *supra* note 26, at 843 (citing MICHAELS, *supra* note 28, at v); see also DONALD K. FREEBORN & CLYDE R. POPE, PROMISE AND PERFORMANCE IN MANAGED CARE: THE PREPAID GROUP PRACTICE MODEL 21 (1994) (describing the HMO "group model").

31. See Christensen, *supra* note 27, at 225 (noting that some HMOs act as independent contractors).

32. *Id.* at 224.

33. Kanute, *supra* note 26, at 843 (citing MICHAELS, *supra* note 28, at v).

34. Chittenden, *supra* note 29, at 452.

35. G. WHITTED & P. TORRENS, MANAGING CORPORATE HEALTH CARE EXPENSES 256 (1986).

arate facilities and many times continue to practice outside of the HMO.³⁶ The HMO pays the IPA a capitation fee, and the IPA compensates the participating physicians based on separate contracts between the IPA and the individual physicians.³⁷ Therefore, the HMO has no direct employment relationship with the medical provider.

II. VICARIOUS LIABILITY

Under the doctrine of vicarious liability, liability may be imposed on a "blameless" person for the conduct of the tortfeasor based on that person's relationship to the tortfeasor.³⁸ Depending on the degree of control exercised by HMOs over member-physicians under any of the three models,³⁹ North Carolina courts could hold HMOs vicariously liable. Like hospitals,⁴⁰ HMOs can be subject to vicarious liability claims based on three tort theories: (1) respondeat superior, (2) apparent agency, and (3) nondelegable duties.⁴¹

A. *Respondeat Superior*

The most common example of vicarious liability involves the theory of respondeat superior.⁴² Under this doctrine, the master may be held liable for torts committed by the servant or employee who acts within the scope of his or her employment.⁴³ The justification for this doctrine is based on the deliberate allocation of risk.⁴⁴ That is, as a practical matter, the employer should incur the risk of loss because it can better absorb and distribute the cost to society at large.⁴⁵ In North Carolina, courts must address two important questions in determining whether HMOs are vicariously liable under the doctrine of respondeat

36. Chittenden, *supra* note 29, at 452.

37. See Diana J. Bearden & Bryan J. Maedgen, *Emerging Theories of Liability in the Managed Health Care Industry*, 47 BAYLOR L. REV. 285, 293 (1995) (discussing the theory of vicarious liability in the context of managed care and analyzing cases applying the theory).

38. See generally W. PAGE KEETON ET AL., PROSSER AND KEATON ON THE LAW OF TORTS § 69 (5th ed. 1984) (explaining and illustrating vicarious liability); CHARLES E. DAYE & MARK W. MORRIS, NORTH CAROLINA LAW OF TORTS § 23.10 (1991) (defining vicarious liability).

39. See *supra* Part I (discussing the three types of HMO models).

40. See generally DAVID A. LOGAN AND WALTER A. LOGAN, NORTH CAROLINA TORTS § 12.10, at 280-85 (1996) (discussing vicarious liability of hospitals for the acts of physician-agents).

41. See Mark S. Mandell, *Hospital Liability: Four Theories*, TRIAL, May 1992, at 16, 17.

42. See generally KEETON ET AL., *supra* note 38, § 69, at 499-501 (explaining and illustrating respondeat superior); see also DAYE & MORRIS, *supra* note 38, § 23.20, at 385-391 (explaining and illustrating respondeat superior).

43. See RESTATEMENT (SECOND) OF AGENCY § 219 (1958) (stating that an employer will be held liable for an employee acting within the scope of employment); see also DAYE AND MORRIS, *supra* note 38, § 23.20, at 387 ("Under the doctrine of respondeat superior, an employer is liable only when the employee's tortious conduct is within the scope of his employment . . .").

44. KEETON ET AL., *supra* note 38, § 69, at 500-501.

45. *Id.*

superior: (1) whether the tortfeasor is an employee or independent contractor of the HMO; and (2) if the tortfeasor is an employee, whether he was acting within the scope of his employment.⁴⁶

A logical starting point is an inquiry into whether the tortfeasor is an employee. According to the decision of the court in *Wood v. Miller*,⁴⁷ an employer-employee relationship exists where the employer "retains the right to control and direct the manner in which the details of the work are to be executed."⁴⁸ In addition, North Carolina courts have identified other factors in determining whether an employer-employee relationship exists. The factors are whether the person employed: (1) possessed special skills, knowledge or training in the execution of the work; (2) could use assistants he or she thought proper; (3) had full control over his or her assistants; and (4) selected his or her own time for doing the work.⁴⁹ While the North Carolina Supreme Court has stated that "[n]o particular one of these factors is decisive in itself,"⁵⁰ the key question still remains: whether the employer controlled or had the right to control the manner in which the alleged tortfeasor conducted his or her work.⁵¹

In North Carolina, a hospital, either charitable or for-profit, may be held liable for the negligence of a physician acting as its agent during the agency.⁵² If the hospital did not employ the physician but merely granted privileges to use hospital facilities, or if the physician did not perform any act within the general course of employment at the time of alleged injury, then, North Carolina courts will not find the hospital vicariously liable because the physician is not the hospital's agent.⁵³ In contrast, because an HMO supposedly exercises less control over its physicians than a hospital might exercise, liability under a theory of respondeat superior remains more difficult to establish.

46. See RESTATEMENT (SECOND) OF AGENCY § 219 (1958) (stating the elements for respondeat superior); see also KEETON ET AL., *supra* note 38, § 69, at 499-500 (discussing the principle of respondeat superior); see also DAYE & MORRIS, *supra* note 38, § 23.20, at 385 (defining the principle of respondeat superior).

47. 226 N.C. 567, 39 S.E. 608 (1946). See also DAYE AND MORRIS, *supra* note 38, § 23.20, at 386 (comparing an employee to an independent contractor).

48. *Wood*, 226 N.C. at 569, 39 S.E.2d at 609.

49. *Doud v. K & G Janitorial Service*, 69 N.C. App. 205, 211-212, 316 S.E.2d 664, 669 (1984) (quoting *Hayes v. Board of Trustees Elon College*, 224 N.C. 11, 16, 29 S.E.2d 137, 140 (1944)).

50. *Youngblood v. North State Ford Truck Sales*, 321 N.C. 380, 385, 364 S.E.2d 433, 438 (1988).

51. *Id.* at 384, 363 S.E.2d at 437.

52. *Rabon v. Rowan Memorial Hosp., Inc.*, 269 N.C. 1, 21, 152 S.E.2d 485, 499 (1967). See also *Willoughby v. Wilkins*, 65 N.C. App. 626, 634-637, 310 S.E.2d 90, 95-96 (1983) (finding that respondeat superior could apply when the physician had contract of employment with the hospital; the contract guaranteed a specified number of days of leave; the work schedule was subject to the hospital's approval; and the physician promised not to maintain a private practice).

53. *Smith v. Duke Univ.*, 219 N.C. 628, 14 S.E.2d 643 (1941).

In light of the control test required under North Carolina law, the vicarious liability of an HMO for the torts of its physician rests on the structure of the organization. Staff model HMOs are most vulnerable to the respondeat superior argument because they directly employ their physicians.⁵⁴ Aside from the general degree of control, other factors indicative of the application of respondeat superior include the compensation of wages,⁵⁵ the ownership of the instrumentalities used to deliver the health care to patients,⁵⁶ and the language used in contracts.⁵⁷ Like staff model HMOs, a group model HMO could lend itself to liability if similar factors are found in the organizational structure. These factors include capitation payments to the group, the physicians' use of the HMO's facilities in delivering care to enrolled patients, and the HMO's control over referrals to the physicians.⁵⁸

With the IPA model, however, it is much less likely that North Carolina courts will find a HMO vicariously liable for the actions of the medical professional. Physicians usually maintain a separate private practice apart from the health plan members and therefore are considered independent contractors.⁵⁹ In *Raglin v. HMO Illinois, Inc.*,⁶⁰ the Appellate Court of Illinois held that an HMO which operates as an IPA model is not subject to vicarious liability based on respondeat superior.⁶¹ The *Raglin* court reasoned that an IPA model HMO does not directly employ its own physicians; instead, the HMO contracts with independent medical groups who, in turn, employ individual

54. See *Sloan v. Metropolitan Health Council*, 516 N.E.2d 1104 (Ind. Ct. App. 1987). In this case, a staff model HMO attempted to avoid liability by claiming that its physicians practiced medicine independently. Moreover, it argued that, as a corporation, it was not entitled to practice medicine under state common law. *Id.* at 1108. The court rejected the latter argument holding that "[t]he circumstances establish an employment relationship where the employee performed acts within the scope of his employment." *Id.* at 1109. The court also evaluated the structure of the HMO, emphasizing that the physician had signed an "employment contract" and that the physicians were compensated on a salary basis and had agreed not to practice outside the HMO. *Id.* at 1105. Cf. *Willoughby*, 65 N.C. App. at 626, 310 S.E.2d at 90 (holding that an employment relationship could exist between a hospital and physician when the physician had a contract of employment with the hospital).

55. See *Schleier v. Kaiser Foundation Health Plan*, 876 F.2d 174, 177 (D.C. Cir. 1989) (identifying payment of wages as one of several factors in establishing "master-servant" relationship); see also *Bearden & Maedgen*, *supra* note 37, at 301 (noting that payments are more similar to salaries than fee-for-service payments).

56. *Bearden & Maedgen*, *supra* note 37, at 301-302.

57. *Id.* at 302 (suggesting that contractual language between the HMO and the enrollee that places the HMO in the position of preapproving physician recommendations for hospitalization or tests might support a finding that the HMO has sufficient control for the imposition of liability).

58. See *Dunn v. Praiss*, 606 A.2d 862, 868 (N.J. Super. Ct. App. Div. 1992) (holding an HMO liable because the physician was not free to accept or reject particular patients, and the physician examined patient at HMO's office).

59. *Raglin v. HMO Illinois Inc.*, 595 N.E.2d 153, 156 (Ill. App. Ct. 1992).

60. *Id.*

61. *Id.*

providers.⁶² Therefore, the *Raglin* court considered the medical groups and their employee-providers as independent contractors in relationship to the HMO.⁶³

Nonetheless, commentators have suggested that an IPA model could be liable if it exercised a sufficient amount of control over the provider.⁶⁴ Many IPA model HMOs, for example, use such methods as preauthorization of hospital admissions, patient reviews, and credentialing programs.⁶⁵ Thus, the applicability of respondeat superior will depend on the North Carolina courts' analysis of the particular relationship between the HMO and its physicians.

B. Apparent Agency

Compared to the theory of respondeat superior, where the element of control is essential, the concept of apparent or ostensible agency emphasizes appearances.⁶⁶ The apparent agency theory is based on Section 429 of the Restatement (Second) of Torts, which states:

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.⁶⁷

Thus, this doctrine focuses on the patient's expectations as to the source of treatment. In North Carolina, an HMO subscriber must satisfy three elements to establish vicarious liability through the doctrine of apparent agency.⁶⁸ First, the patient must look to the institution, rather than the individual physician, for health care.⁶⁹ Second, the

62. *Id.*

63. *Id.*

64. See, e.g., Chittenden, *supra* note 29, at 456 (arguing that HMOs should be liable where control exists over physicians).

65. *Id.* at 456-57.

66. See Earlene P. Weiner, Note, *Managed Health Care: HMO Corporate Liability, Independent Contractors, and the Ostensible Agency Doctrine*, 15 J. CORP. L. 535, 546 (1990) (noting that the crucial determinant under principles of apparent agency is whether the agent appears to act on behalf of the principal).

67. RESTATEMENT (SECOND) OF TORTS § 429 (1965); see also RESTATEMENT (SECOND) OF AGENCY § 267 (1958), which provides:

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.

68. See RESTATEMENT (SECOND) OF TORTS § 429 (1965) (defining the apparent agency theory); cf. *Hoffman v. Moore Regional Hosp., Inc.*, 114 N.C. App. 248, 441 S.E.2d 567, *disc. rev. denied*, 336 N.C. 605, 447 S.E.2d 391 (1994) (stating that a hospital may be held vicariously liable based upon the doctrine of apparent agency where the hospital represented to the patient that the doctor was its agent and the patient relied on the representation).

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

HMO must "hold out" the physician as its employee.⁷⁰ Finally, the patient must have justifiably relied upon the HMO in some way on this belief.⁷¹

Since the physician's status as an employee or independent contractor does not determine liability, the apparent agency doctrine of vicarious liability can apply to all three HMO models.⁷² This doctrine is especially attractive to plaintiffs attempting to impute liability to an IPA model HMO, which is not subject to liability based on respondeat superior. In *Boyd v. Albert Einstein Medical Center*,⁷³ the Superior Court of Pennsylvania held that an IPA model HMO may be subject to vicarious liability even though the health care provider acted as an independent contractor.⁷⁴ In this case, the plaintiff and his wife participated in a health care plan offered by the defendant HMO.⁷⁵ The defendant's health plan limited its subscribers' choice of physicians to those names provided in a directory.⁷⁶ When the plaintiff's wife found a lump in her breast, she contacted her primary-care HMO physician. He referred the plaintiff's wife to a specialist, who also participated in the defendant HMO.⁷⁷ As a result of the specialist's negligent performance of a breast biopsy and the primary care physician's misdiagnosis, the plaintiff suffered a heart attack and died.⁷⁸

The *Boyd* court began its opinion by acknowledging that the theory of apparent agency had been recognized and applied in the hospital setting.⁷⁹ In applying this theory to the IPA model HMO, the court outlined the two elements of the doctrine: (1) whether the patient looked to the institution rather than the individual physician for care; and (2) whether the HMO held the physician out as an employee.⁸⁰ The court then applied the facts to these two elements. The *Boyd* court concluded that the plaintiff's wife submitted herself to the care of her primary-care physician as a result of an invitation from the HMO.⁸¹ The court cited several factors to prove that the plaintiff rea-

70. RESTATEMENT (SECOND) OF TORTS § 429.

71. RESTATEMENT (SECOND) OF AGENCY § 267 (1958). Cf. *Hoffman*, 114 N.C. App. at 252, 407 S.E.2d at 570 (holding that plaintiff had not relied on any representation where there was no evidence that she would have done anything differently had she known that the doctor was not an employee of the hospital).

72. *Weiner*, *supra* note 66, at 546.

73. 547 A.2d 1229 (Pa. Super. Ct. 1988).

74. *Id.* at 1235.

75. *Id.* at 1229.

76. *Id.* at 1230.

77. *Id.*

78. *Id.*

79. *Id.* at 1231.

80. *Id.* at 1232 (quoting *Capan v. Divine Providence Hosp.*, 430 A.2d 647, 649 (Pa. Super. Ct. 1980)).

81. *Id.* at 1235.

sonably could have looked to the defendant HMO for her medical care, and that she believed the HMO "held out" the physician as its employee.⁸² First, the court emphasized the HMO's advertising and marketing campaign which presented the organization as "a total care program."⁸³ Moreover, the court noted that the HMO advertised its rigorous selection and accreditation process for physician providers.⁸⁴ Finally, the court observed that the primary-care physician's role was defined as the "gatekeeper into the health care delivery system."⁸⁵ That is, an HMO enrollee can see an HMO-listed specialist only upon referral by the enrollee's primary-care physician.⁸⁶ The court reasoned that because the plaintiff "was required to follow the mandates of [the] HMO and did not directly seek the attention of the specialist, there is an inference that [plaintiff] looked to the institution for care and not solely to the physicians."⁸⁷ Thus, the court concluded the plaintiff could maintain an action against the HMO based on the theory that the specialist was the HMO's apparent agent.⁸⁸

In contrast to Pennsylvania law, North Carolina's doctrine of apparent agency is based upon the patient's justifiable reliance upon representation.⁸⁹ As applied in a hospital setting, the critical inquiry is whether the patient would have elected to seek treatment elsewhere or done anything differently had the patient known the physician was not an employee of the hospital.⁹⁰ Likewise, to hold an HMO vicariously liable through apparent agency in North Carolina, the plaintiff must pay particular attention to the reliance element.

C. *Non-delegable Duty*

Aside from respondeat superior or agency concepts, North Carolina courts may use another tool to hold an HMO vicariously liable for a physician's malpractice: the non-delegable duty doctrine. Applying this doctrine, HMOs could be liable for their member-physicians' malpractice since HMOs have a non-delegable duty to provide quality medical care.⁹¹

82. *Id.* at 1232-33.

83. *Id.* at 1232, n.6.

84. *Id.* at 1233.

85. *Id.*

86. *Id.* at 1235.

87. *Id.*

88. *Id.*

89. *Hoffman*, 114 N.C. App. at 252, 441 S.E.2d at 570.

90. *Id.*

91. Some attorneys associate the doctrine of "duty" with direct liability based in negligence. In fact, Daye and Morris note this ambiguity: "In some of the cases purporting to apply these exceptions, it appears that the employer's liability is actually based on his own negligence rather than negligence imputed to him under the doctrine of *respondeat superior*." However, it can be properly classified as a vicarious liability concept because the basis for the liability stems from

North Carolina courts have recognized that the non-delegable duty reflects the public policy demands that certain obligations are of such importance that employers should not be shielded from liability.⁹² In *Medley v. North Carolina Dept. of Corrections*,⁹³ the North Carolina Supreme Court held that the state has a non-delegable duty to provide adequate medical services to inmates.⁹⁴ The court reasoned that the public has a duty to take care of the prisoner, "who cannot by reason of the deprivation of his liberty, care for himself."⁹⁵

The most notable non-delegable duty case involving the health care setting is *Jackson v. Power*.⁹⁶ In this case, the Alaska Supreme Court held that a hospital has an independent and non-delegable duty to provide non-negligent medical care in its emergency room.⁹⁷ Although the physician was classified as an independent contractor, the court held the hospital vicariously liable for the doctor's malpractice because a hospital's duty to provide proper non-negligent care is similar to the common carrier's non-delegable duty of safety to its passengers.⁹⁸

North Carolina courts could look to the non-delegable duty analysis in *Jackson*, which would protect patients from substandard care. In North Carolina, the importance of providing adequate medical services to inmates under *Medley* rivals the importance of HMO providing proper health care. As discussed below, North Carolina courts have already stated concerns about health care quality and have imposed certain duties on hospitals to guarantee patient safety.⁹⁹ Therefore, in North Carolina, patients subscribing to HMOs could be as deserving of protection from inadequate medical care as inmates in a prison.

the tort of another. *DAYE & MORRIS*, *supra* note 38, § 23.31, at 393. *See also* *KEETON ET AL.*, *supra* note 38, § 71, at 511 (also noting that non-delegable duty is a vicarious liability concept).

92. *DAYE & MORRIS*, *supra* note 38, § 23.31, at 392-93; *see* *Royal v. Dodd*, 177 N.C. 206, 209-11, 98 S.E. 599, 600-02 (1919) (observing that certain dangers raise the duty which the employer can not escape liability); *see generally* *KEETON ET AL.*, *supra* note 38, § 71, at 512 ("It is difficult to suggest any criterion by which the non-delegable duty character of such duties may be determined, other than the conclusion of the courts that the responsibility is so important to the community that the employer should not be permitted to transfer it to another.").

93. 330 N.C. 837, 412 S.E.2d 654 (1992).

94. *Id.* at 330 N.C. at 845, 412 S.E.2d at 659.

95. *Id.* at 842, 412 S.E.2d at 657-58 (quoting *Spicer v. Williamson*, 191 N.C. 487, 490, 132 S.E. 291, 293 (1926)).

96. 743 P.2d 1376 (Alaska 1987).

97. *Id.* at 1385.

98. *Id.* at 1384.

99. *See* *Blanton v. Moses H. Cone Hosp.* 319 N.C. 372, 375, 353 S.E.2d 455, 457 (1987) (stating that a hospital may be liable if it has breached a duty of care it owes to a patient); *see also* *DAYE & MORRIS*, *supra* note 38, § 23.40, at 396-97 (observing that hospitals have a duty to use reasonable care in the treatment of their patients).

III. DIRECT LIABILITY FOR MEMBER-PHYSICIAN MALPRACTICE

In North Carolina, HMOs should face direct liability under three theories. First, HMOs should face direct liability for tortious conduct under the doctrine of corporate negligence. Furthermore, HMOs should be held directly liable for patients' injuries when the injuries are caused by the HMO's negligent selection or retention of an incompetent member-physician. Finally, HMOs should be held directly liable where utilization review procedures cause patient harm.

A. *The Duty of Patient Care*

The early perspective under North Carolina law recognized that hospitals provided facilities rather than services.¹⁰⁰ Early cases, for example, imposed a duty on hospitals to provide appropriate equipment.¹⁰¹ As the role of hospitals expanded to include full-service treatment, patients began to look to institutions rather than individual physicians as health care providers. Responding to the public's changing view of hospital duties, the North Carolina Court of Appeals expanded the "corporate negligence" doctrine of direct liability in *Bost v. Riley*.¹⁰² The court stated:

In contrast to the vicarious nature of *respondeat superior*, the doctrine of "corporate negligence" involves the violation of a duty owed directly by the hospital to the patient. Prior to modern times, a hospital undertook, "only to furnish room, food, facilities for operation, and attendants, and [was held] not liable for damages resulting from the negligence of a physician in the absence of evidence of agency, or other facts upon which the principle of *respondeat superior* [could have been] applied." In contrast, today's hospitals regulate their medical staffs to a much greater degree and play a much more active role in furnishing patients medical treatment.¹⁰³

More recently, the North Carolina courts elaborated on these reasons for expanding the doctrine of corporate negligence to include direct liability of a hospital for patient care. First, a hospital's general obligation to "make a reasonable effort to monitor and oversee the treatment" of a patient includes a duty to obtain informed consent from

100. See *Smith v. Duke Univ.* 219 N.C. 628, 634, 14 S.E.2d 643, 647 (1941) (holding that a hospital only has a duty "to furnish room, food, facilities for operation, and attendance, and is not liable for damages resulting from the negligence of a physician in the absence of evidence of agency.") (citations omitted).

101. See *Payne v. Garvey*, 264 N.C. 593, 595, 142 S.E.2d 159, 161 (1965) (hospital has a duty to provide standard equipment, to inspect the equipment, and to correct any defects); see also *Starnes v. Charlotte-Mecklenburg Hosp. Auth.*, 28 N.C. App. 418, 421, 221 S.E.2d 733, 736 (1976) (holding that institutions must provide equipment reasonably suited for the intended use), overruled by *Harris v. Miller*, 335 N.C. 379, 438 S.E.2d 731 (1994).

102. 44 N.C. App. 638, 262 S.E.2d 391, *disc. rev. denied*, 300 N.C. 194, 269 S.E.2d 621 (1980).

103. *Id.* at 645, 262 S.E.2d at 395 (emphasis added) (citations omitted).

the patient before a risky medical procedure.¹⁰⁴ Second, there is a duty to set up an effective mechanism for the immediate reporting of any situation that created a threat to the health of a patient.¹⁰⁵

Under the doctrine of corporate negligence, then, a plaintiff could argue that an HMO must satisfy the duty to guarantee that its health care providers are delivering sufficient medical services. Statutory requirements subject HMOs to the duty to monitor the quality of patient services. Federally-qualified HMOs must have quality assurance programs which allow them to review the health care provided to patients.¹⁰⁶ Furthermore, an HMO may have marketed a quality assurance program to attract new patients.

B. *The Duty to Properly Select and Retain Medical Staff*

North Carolina courts have recognized that health care institutions have a duty to act prudently when selecting an employee or agent. The leading case on this issue is *Blanton v. Moses H. Cone Memorial Hospital, Inc.*¹⁰⁷ In *Blanton*, the defendant hospital negligently performed three operations on the plaintiff.¹⁰⁸ The plaintiff sued the Moses H. Cone Memorial Hospital for negligently granting clinical privileges to a doctor to perform operations without investigating whether the doctor was qualified to perform them.¹⁰⁹ At the trial court level, the defendant prevailed because the plaintiff failed to state a claim for relief.¹¹⁰ However, the Court of Appeals reversed.¹¹¹

In affirming the appellate court's ruling, the North Carolina Supreme Court relied on the general evolution of the law and the hospital's own actions.¹¹² The court found that the hospital should be held liable for negligence because it allowed an unqualified doctor to

104. *Campbell v. Pitt Cty. Mem'l Hosp., Inc.*, 84 N.C. App. 314, 325, 352 S.E.2d 902, 908 (1987), *aff'd by an equally divided court*, 321 N.C. 260, 265-66, 362 S.E.2d 273, 276 (1987), *overruled in part on other grounds*, *Johnson v. Ruark Obstetrics*, 327 N.C. 283, 395 S.E.2d 85 (1990). *But see Clark v. Perry*, 114 N.C. App. 297, 442 S.E.2d 57 (1994) (holding that the court has yet to extend the doctrine of corporate negligence in order to impose upon a hospital the duty to obtain a patient's informed consent before treatment when the patient is admitted by a private physician for surgery).

105. *Campbell*, 84 N.C. App. at 322, 352 S.E.2d at 907.

106. The United States Code states that "each HMO shall . . . (6) have organizational arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for its health services which program (A) stress health outcomes, and (B) provides review by physicians and other health professionals of the process followed in the provision of health services." 42 U.S.C. 300(c)(6)(1994).

107. 319 N.C. at 372, 354 S.E.2d at 455.

108. *Id.*

109. *Id.* at 373, 354 S.E.2d at 456.

110. *Id.* at 372, 354 S.E.2d at 455.

111. 78 N.C. App. 502, 337 S.E.2d 200 (1985).

112. *Blanton*, 319 N.C. at 374-75, 354 S.E.2d at 457-58.

perform operations in the hospital.¹¹³ In addition, the court found that the hospital failed to abide by the enforcement standards of the Joint Commission on the Accreditation of Hospitals, which ensures quality patient care.¹¹⁴ Finally, the court noted that the hospital permitted an unqualified physician to perform surgery without requiring that the physician be supervised or assisted by a properly qualified member of its medical staff.¹¹⁵ As a result of this landmark decision, the *Blanton* court established the appropriate framework for determining whether liability for negligent selection exists.

North Carolina courts have limited the standard of care in physician selection to hospitals. However, a Missouri court was the first to recognize that HMOs have a similar duty to use reasonable care when choosing their member-physicians. In *Harrell v. Total Health Care, Inc.*,¹¹⁶ the plaintiff patient, a member of an HMO, consulted her HMO primary-care physician for treatment of urinary stress incontinence.¹¹⁷ After examining the patient, the primary-care physician decided that the patient should see a urologist.¹¹⁸ According to the HMO regulations, the primary-care physician selected a urologist from a directory provided by the HMO.¹¹⁹ Subsequently, the urologist negligently performed surgery on the patient.¹²⁰ As a result, the patient brought an action against the HMO under the corporate negligence theory.¹²¹

The *Harrell* court evaluated the HMO's physician-approval procedure. In the early stages of the process, the HMO would mail invitational brochures to potential doctors, and would then send an application to any doctors who wanted to participate.¹²² This application procedure differed depending on whether the applicant was a primary-care physician or specialist.¹²³ A six-member credential committee evaluated the application for irregularities when the applicant was a primary-care physician.¹²⁴ A three-member committee analyzed the application in a similar manner when the applicant was a specialist.¹²⁵ Both committees failed to look at applicant's standing in the medical community, conduct interviews of the applicant, or check

113. *Id.* at 376, 354 S.E.2d at 458.

114. *Id.*

115. *Id.* at 377, 354 S.E.2d at 458.

116. *Harrell v. Total Health Care, Inc.*, 781 S.W.2d 58 (Mo. 1989).

117. *Id.*

118. *Id.*

119. *Id.* at 60.

120. *Id.*

121. *Id.* at 59.

122. *Id.* at 60.

123. *Id.* at 59-60.

124. *Id.* at 59.

125. *Id.*

references.¹²⁶ The committees only determined whether the applicant possessed a medical license, had admitting privileges at some hospitals, and could prescribe drugs.¹²⁷ In other words, the HMO would accept a physician unless the application seemed abnormal.¹²⁸

As a result of this practice, the *Harrell* court held that the HMO was potentially liable for the negligent selection of the urologist who negligently performed surgery on the plaintiff.¹²⁹ The court reasoned:

In this arrangement where Total Health Care collects a premium for the expense of medical care and limits the choice by the subscriber to physicians acceptable to Total Health Care, there is an unreasonable risk of harm to subscribers if the physicians listed by Total Health Care include doctors who are unqualified or incompetent. The presence of that risk gives rise to a common law duty owed by Total Health Care to conduct a reasonable investigation of physicians to ascertain their reputation in the medical community for competence.¹³⁰

The language used by the *Harrell* court is very similar to the reasoning found in *Blanton*. Both the *Blanton* court and the *Harrell* court found liability of health care institutions under the corporate negligence doctrine.¹³¹ By applying the legal principles of these cases, North Carolina courts could hold HMOs directly liable for failing to adequately select physicians.

C. Utilization Review

North Carolina courts could also hold HMOs liable for utilization review. As discussed in the Introduction, HMOs are profitable and attractive to consumers because they can cut medical care costs; however, HMO cost-cutting schemes can also harm patient care.¹³² The primary cost-containment method used by HMOs is utilization review.¹³³ There are two types of utilization review. The first is prospective review or precertification, which mandates a physician to

126. *Id.*

127. *Id.* at 61.

128. *Id.*

129. *Id.* at 59.

130. *Id.* at 63.

131. Compare *Blanton*, 319 N.C. at 373, 354 S.E.2d at 457 (holding that hospital had a duty to exercise reasonable care in retention and selection of medical staff and duty to periodically review and monitor staff's competency) with *Harrell*, 781 S.W.2d at 59 (deciding that risk of harm to patients gives rise to common-law duty to conduct reasonable investigation of member-physicians' competency).

132. See *supra* notes 11-24 and accompanying text.

133. Utilization management system includes various techniques: (1) utilization review; (2) identifying quality and cost efficient providers, (3) monitoring treatment, (4) designing benefit plans that "channel" patients to low-cost, quality providers, and (5) encouraging cost-consciousness among plan members. Richard A. Hinden & Douglas L. Elden, *Liability Issues for Managed Care Entities. The Dark Side of Health Care Containment: Emerging Legal Issues in Managed Care*, 14 SETON HALL LEGIS. J. 1, 51 (1990).

contact an HMO representative before admitting a patient to a hospital.¹³⁴ With this review, an HMO representative or so-called "gate-keeper" approves or denies the request for admission and limits the length of stay for the patient in the hospital.¹³⁵ The second type of review is the notification scheme; this requires the physician to contact the HMO for concurrent review, both before admitting a patient to the hospital and during the patient's hospital stay.¹³⁶

In 1986, the Court of Appeals of California recognized HMO liability based on utilization review. In *Wickline v. California*,¹³⁷ the plaintiff patient, with back and leg problems, sought treatment from her physician.¹³⁸ Due to an unsuccessful physical therapy, the physician sent the patient to the hospital and consulted a vascular surgeon.¹³⁹ The specialist diagnosed the plaintiff with a disease called Leriche's Syndrome and concluded that the plaintiff needed surgery.¹⁴⁰

The plaintiff patient received medical assistance under the California medical assistance known as Medi-Cal.¹⁴¹ Like many HMOs, this program employed a notification program which required the approval of the doctor's diagnosis and authorization for both the patient's admission to a hospital and the recommended surgery.¹⁴² Medi-Cal authorized the plaintiff for ten days of initial hospitalization.¹⁴³ After the surgery, the plaintiff experienced complications that resulted in two more surgeries, and the physician requested an eight-day hospital extension.¹⁴⁴ The Medi-Cal consultant, a general surgeon, denied the request and granted a four-day extension based only on the information provided by a Medi-Cal nurse over the phone.¹⁴⁵

After her discharge, the plaintiff's condition deteriorated; she lost circulation in her leg and developed a major infection.¹⁴⁶ The physician unsuccessfully attempted to treat the infection with medication.¹⁴⁷ As a result, the physician amputated the patient's leg.¹⁴⁸ In the treating physician's expert medical opinion, the patient's leg

134. Paul J. Feldstein et. al., *Private Cost Containment: The Effects of Utilization Review Programs on Health Care Use and Expenditures*, 318 NEW ENG. J. MED., 1310, 1311 (1988).

135. Hinden & Elden, *supra* note 133, at 52.

136. *Id.*

137. 239 Cal. Rptr. 810 (Ct. App. 1986), *rev'd and superseded*, 727 P.2d 753 (Cal. 1986), *cert. dismissed and remanded*, 741 P.2d 613 (Cal. 1987).

138. *Id.* at 812.

139. *Id.*

140. *Id.*

141. *Id.*

142. *Id.*

143. *Id.* at 813.

144. *Id.*

145. *Id.*

146. *Id.* at 816.

147. *Id.*

148. *Id.*

would not have been amputated if the eight-day extension had been granted since the circulatory problems and infection would have been discovered and treated at the initial stage.¹⁴⁹

In her complaint, plaintiff Wickline alleged that the State of California negligently caused her early release from the hospital by ending her medical eligibility according to its utilization review process.¹⁵⁰ The Court of Appeals of California overturned a verdict in favor of the plaintiff, holding that the defendant could not be held liable for the plaintiff's injuries as a matter of law.¹⁵¹ The court based its decision on three factors. First, the court found that the plaintiff's discharge after the four-day extension complied with the standard of care for physicians in the community.¹⁵² Second, the court found that the statute regulating Medi-Cal allowed the use of utilization reviews which denied benefits "in accordance with the usual standards of medical practice in the community."¹⁵³ Third, the court found that the utilization review used by Medi-Cal was not the determinative cause of the plaintiff's injuries since her doctor could have extended her hospital stay if he considered it necessary.¹⁵⁴ Although the court did not impose liability on the defendant, it noted that:

The patient who requires treatment and who is harmed when care which should have been provided is not provided should recover for the injuries suffered from all those responsible for the deprivation of such care, including, when appropriate, health care payors. Third party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost-containment mechanisms¹⁵⁵

Therefore, the *Wickline* case left the door open that a health care payor, such as an HMO, may be held directly liable where improper utilization reviews cause harm to its plan members.

Four years after *Wickline*, the Court of Appeals of California rejected the restrictive causation analysis in *Wilson v. Blue Cross*.¹⁵⁶ In *Wilson*, the plaintiff, who suffered from depression, drug dependency, and anorexia, entered the hospital seeking help.¹⁵⁷ The physician determined that the plaintiff needed three to four weeks of hospitalization.¹⁵⁸ After ten days of treatment, the defendant insurance

149. *Id.* at 817.

150. *Id.* at 811.

151. *Id.* at 818.

152. *Id.* at 818-819.

153. *Id.* at 819.

154. *Id.*

155. *Id.*

156. 271 Cal. Rptr. 876 (Cal. Ct. App. 1990).

157. *Id.* at 877.

158. *Id.*

company informed the doctor that it would not pay for any further hospital care.¹⁵⁹ Because the patient could not afford the further care, he was discharged from the hospital.¹⁶⁰ Twenty days later, the patient committed suicide.¹⁶¹

The plaintiff's parents brought an action against the insurance company and the treating physician.¹⁶² Although the defendant argued that public policy warrants the protection of health care entities which conducted utilization reviews, the court distinguished this situation from *Wickline*.¹⁶³ In this case, the court noted that no statutory authority required the use of such procedures.¹⁶⁴ More importantly, the *Wilson* court rejected the *Wickline* causation reasoning and applied the causation analysis found in section 431 of the Restatement (Second) of Torts.¹⁶⁵ Under this Restatement principle, an "actor's . . . conduct is a legal cause of harm to another if . . . his conduct is a substantial factor in bringing about the harm" ¹⁶⁶ In *Wilson*, the court held that the insurance company's decision to deny further hospitalization was, in fact, a "substantial factor in bringing about the decedent's demise."¹⁶⁷ Thus, the defendant insurance company could be found directly liable because denial of further hospitalization created a triable issue as to whether the insurance company's action was "a substantial factor in the patient's death."¹⁶⁸ Accordingly, summary judgment was inappropriate in this case.¹⁶⁹

Of course, it is uncertain if these cases would have any effect on North Carolina law. However, North Carolina courts have applied the substantial-factor causation analysis in other contexts, although it has never adopted the Restatement.¹⁷⁰ In *Brown v. Neal*,¹⁷¹ the court discussed the legal cause in a case involving a motorcycle accident:

The doctrine of proximate cause which determines the existence of liability for negligence is especially applicable to liability for a particular items of damage. To hold a defendant responsible for plaintiff's injuries, defendant's negligence must have been a *substantial factor*,

159. *Id.*

160. *Id.* at 877-78.

161. *Id.* at 878.

162. *Id.* at 880.

163. *Id.* at 884.

164. *Id.*

165. *Id.* at 883. See RESTATEMENT (SECOND) OF TORTS § 431 (1965) (explaining standard for determining point at which actor's negligent conduct meets the legal cause of harm to another).

166. RESTATEMENT (SECOND) OF TORTS § 431 (1965).

167. *Wilson*, 271 Cal. Rptr. at 883.

168. *Id.* at 884-85.

169. *Id.* at 885.

170. *Hedrick v. Rains*, 344 N.C. 729, 477 S.E.2d 171 (1996) (per curiam).

171. 283 N.C. 604, 197 S.E.2d 505 (1973).

that is, a proximate cause of the particular injuries for which plaintiff seeks recovery.¹⁷²

Therefore, if a North Carolina HMO's cost-containment scheme injures a patient, the HMO could be liable through the *Wickline-Wilson* legal analysis and North Carolina causation principles.

V. DEFENSES TO TORT LIABILITY

A. ERISA Preemption

The primary defense to imposing liability on an HMO for substandard patient care is the Employee Retirement Income Security Act ("ERISA").¹⁷³ In 1974, Congress passed ERISA in order to establish uniform national standards for employee benefit plans and preempted state regulation of these plans. Congress adopted this law mainly because of its concern that corrupt, incompetent pension managers were squandering the money entrusted to them.¹⁷⁴ While ERISA sets stringent standards for employee benefit plans, the law also severely limits the remedies available to workers.¹⁷⁵ In fact, ERISA has been enormously successful, with ERISA plans now the leading source of payment for health services nationwide. It is estimated that three out of four managed care plans are ERISA-qualified.¹⁷⁶

1. Pertinent Sections of ERISA: 502(a)(1)(B) and 514(a)

ERISA provides two methods for preemption that bar state courts and legislatures from holding a defendant HMO liable for negligence. Section 502(a) provides members of benefit plans with a private cause of action against their insurer regarding delivery of benefits.¹⁷⁷ Under section 502(a)(1)(B), a plan member can bring a civil action in federal or state court for three reasons: (1) to recover benefits due to him or her under the plan's terms; (2) to enforce his or her rights under the plan's terms; or (3) to clarify his or her rights to future benefits under the plan's terms.¹⁷⁸ After the member's claim is made, the court determines if the cause of action falls into one of these three categories of complaints.¹⁷⁹ If the claim satisfies one of these requirements,

172. *Id.* at 611, 192 S.E.2d at 509 (emphasis added) (quoting *Gillikin v. Burbage*, 263 N.C. 317, 139 S.E.2d 753 (1965)).

173. 29 U.S.C. §§ 1001-1461 (1994).

174. Robert Pear, *Judges Deplore Law That Shields HMOs*, N.Y. TIMES, July 15, 1998, at A1.

175. *Id.*

176. Barry R. Furrow, *Symposium Article: Managed Care Organizations and Patient Injury: Rethinking Liability*, 31 GA. L. REV. 419, 494 (1997).

177. 29 U.S.C. § 1132(a) (1994).

178. 29 U.S.C. § 1132(a)(1)(B) (1994).

179. See Seema R. Shah, Comment, *Loosening ERISA's Preemptive Grip on HMO Medical Malpractice Claims: A Response to Pacificare of Oklahoma v. Burrage*, 80 MINN. L. REV. 1545,

ERISA completely preempts it.¹⁸⁰ As a result of this preemption, the member is provided very limited remedies.

The second preemption provision is found in Section 514(a). It expressly states that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . ."¹⁸¹ Whether a state claim "relates to" an employee benefit plan has been the subject of many court decisions.¹⁸² However, an exception to section 514(a), known as the "savings clause,"¹⁸³ allows state laws regulating insurance to get around this preemption. Nonetheless, the "deemer clause,"¹⁸⁴ precludes this interpretation by mandating that self-insured employee benefit plans qualified under ERISA cannot "be deemed to be an insurance company or other insurer"¹⁸⁵

Because ERISA statutes are sometimes confusing, an example of how an HMO defendant would utilize an ERISA preemption clause should be helpful. Assume that the plaintiff has health coverage through her HMO, which she received as part of a benefits package from her employer.¹⁸⁶ Her ears have been hurting for some time. A physician for the HMO concludes that the plaintiff's ears suffer from wax build-up and cleans her ears by injecting a solution from a syringe into her ear canals.¹⁸⁷ As an HMO technician injects the solution into the plaintiff's left ear, the plaintiff hears a loud, popping sound and feels some pain.¹⁸⁸ Later, the plaintiff visits another doctor who informs her that her eardrum was punctured and she would suffer from permanent disability because of the wrong diagnosis.¹⁸⁹

The plaintiff sues the HMO in state court, claiming negligence on the state common law theory of vicarious liability.¹⁹⁰ That is, the

1547 (1996) (providing a perspective on ERISA's uniformity goals through an administrative cost analysis).

180. See *Dukes v. U.S. Healthcare*, 57 F.3d 350, 354 (3d Cir. 1995) (finding that ERISA did not preempt plaintiff's vicarious liability malpractice claim against U.S. Healthcare).

181. 29 U.S.C. § 1144(a) (1994).

182. See *Shaw v. Delta Air Lines Inc.*, 463 U.S. 85, 96-97 (1983) (deciding that a state law "relates to" an employee benefit plan if it has "a connection with or reference to such a plan."); *FMC Corp. v. Holliday*, 498 U.S. 52, 57-58 (1990) (noting that "the preemption clause is conspicuous for its breadth"); *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985) (holding that a state law is not precluded from preemption even if it is consistent with ERISA's regulations).

183. 29 U.S.C. § 1144(b)(2)(A) (1994).

184. 29 U.S.C. § 1144(b)(2)(B) (1994).

185. *Id.*

186. The facts of this example are loosely based on the case of *Haas v. Group Health Plan, Inc.*, 875 F. Supp. 544, 546 (S.D. Ill. 1994).

187. *Id.*

188. *Id.*

189. *Id.*

190. *Id.*

HMO is liable for the negligent action of its employee, the physician. Because the plaintiff's health coverage was part of an employee benefit plan, the HMO asserts that ERISA governs and preempts the plaintiff's state law claim.¹⁹¹ The HMO removes the case to federal court for resolution of the preemption issue.¹⁹²

2. Vicarious Liability Claims Against HMOs

At this point, federal courts are split.¹⁹³ Some courts have held that ERISA does preempt the plaintiff's vicarious liability claim. In such case, the plaintiff is unable to proceed in her claim against the HMO for the physician's negligence. Consequently, the plaintiff must resort to suing the physician directly for negligence. In taking this approach, the plaintiff's recovery is limited to the negligent physician's personal assets and insurance coverage. These sources are often times insufficient to compensate the plaintiff for the injury she suffered.¹⁹⁴ Fortunately, in spite of the disagreements among federal courts concerning ERISA preemption, a federal district court in North Carolina is amenable to vicarious liability suits by the plaintiff.¹⁹⁵

Before discussing the North Carolina case, it is important to first review the influential decision of *Dukes v. U.S. Healthcare*.¹⁹⁶ *Dukes* marks the first time a circuit court addressed whether an HMO may be held vicariously liable for negligence of its physicians.¹⁹⁷ In *Dukes* the court discussed the application of preemption under section 502 and its relation to ERISA.¹⁹⁸ The plaintiffs contended that the only benefit received from the HMO was membership in the plan.¹⁹⁹ On

191. *Id.*

192. *Id.*

193. Compare *Prihoda v. Shpritz*, 914 F. Supp. 113, 117-18 (D. Md. 1996) (allowing vicarious liability action to proceed because ERISA did not preempt action against physicians and HMO for physicians' failure to diagnose cancerous tumor) with *Butler v. Wu*, 853 F. Supp. 125, 129-30 (D. N.J. 1994) (indicating that plaintiff's claim premised on vicarious liability with HMO were preempted by ERISA).

194. It is important to note that many states do not mandate medical malpractice insurance. Some doctors find the cost of malpractice too high and thus carry limited or no coverage. F. Christopher Wethly, Note, *New York Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.: Vicarious Liability Malpractice Claims Against Managed Care Organizations Escaping ERISA's Grasp*, 37 B.C. L. REV. 813, 815 n.29 (1996). These physicians may simply declare bankruptcy leaving the injured plaintiff with little compensation. *Id.*

195. As one author aptly notes, "The resultant uncertainty [of ERISA preemption] has led to a situation in which a plaintiff bringing a malpractice suit against a managed care organization might find that his or her recovery depends upon the fortuity of living in a particular district — or indeed, appearing before a particular judge within that judicial district who is amenable to such suits." *Id.* at 859.

196. 57 F. 3d at 350.

197. Natalie Zellner, Note, *Duking It Out: Beating the Complete Preemption of ERISA Under Dukes v. U.S. Healthcare, Inc.*, 14 GA. ST. U. L. REV. 925, 942 (1998).

198. 57 F. 3d at 354-55.

199. *Id.* at 356.

the other hand, U.S. Healthcare, the defendant HMO, argued that the definition of benefit is the medical care itself.²⁰⁰ Therefore, contended U.S. Healthcare, ERISA preempts the plaintiffs' claims. The court held that "quality control of benefits, such as the health care benefits provided here, is a field traditionally occupied by state regulation and we interpret the silence of Congress as reflecting an intent that it remain such."²⁰¹ In its reasoning, the court distinguished between plan-created rights to care and the right to adequate quality care:

The plaintiffs are not attempting to define new "rights under the terms of the plan"; instead, they are attempting to assert their already-existing rights under the *generally-applicable state law of agency and tort*. Inherent in the phrases, "rights under the terms of the plan" and "benefits due . . . under the terms of the plan" is the notion that the plan participants and beneficiaries will receive something to which they would not be otherwise entitled. But patients enjoy the right to be free from medical malpractice regardless of whether or not their medical care is provided through an ERISA plan.²⁰²

The court noted the difference between the quantity of benefits promised under a welfare plan and the quality of those benefits.²⁰³ It observed that the quality of care can be so substandard that it translates into a denial of benefits.²⁰⁴ For example, the plan could describe a benefit in terms that are quality-based, such as a commitment that all x-rays will be evaluated by radiologists with a certain level of training. Therefore, the court concluded that the poor quality of medical care is not a benefit issue under ERISA.²⁰⁵

In North Carolina, a federal court case has echoed the reasoning found in *Duke*. In *Santitoro v. Evans*,²⁰⁶ participants in health benefits plans brought an action in state court against a physician and the HMO which employed the physician.²⁰⁷ The plaintiffs alleged that the defendant HMO should be vicariously liable for the conduct of the physician under the theory of respondeat superior.²⁰⁸ The defendant HMO argued that the claim should be removed to federal court and preempted under ERISA.²⁰⁹ The court analyzed whether the plaintiffs' claim fell under section 502(a), which authorizes participants and

200. *Id.*

201. *Id.*

202. *Id.* at 358 (emphasis added).

203. *Id.*

204. *Id.*

205. *Id.* at 358-59.

206. 935 F. Supp. 733 (E.D.N.C. 1996).

207. *Id.* at 735.

208. *Id.*

209. *Id.*

beneficiaries to bring an action to recover benefits under a plan.²¹⁰ Using the same reasoning in *Duke*, the court said the plaintiffs' claim did not fall within the purview of section 502(a) because it "*relates to quality, rather than quantity*, of benefits plaintiffs received under the plan."²¹¹ The court concluded that the plaintiffs sought "to hold defendants liable for breaches of duties related to medical care imposed by state tort law, rather than breaches of the duties contractually imposed by the plans."²¹²

3. Direct Liability Claims Against HMOs

Few, if any, claims for direct malpractice negligence claims against employer-sponsored HMOs have successfully skirted ERISA preemption.²¹³ Recently, a federal district court in Virginia addressed a direct negligence claim against an HMO based upon establishing and using a financial incentives program.²¹⁴ That is, the financial incentives program rewarded physicians for not ordering tests or treatments.²¹⁵ The court ruled that ERISA preempts claims for direct negligence because the claims are directly "related to" the administration and regulation of the health care benefit plan.²¹⁶ Furthermore, the court noted that to allow these claims to proceed would oppose the congressional intent behind ERISA.²¹⁷

However, in *Santitoro*, the North Carolina federal district court did not allow ERISA to preempt a direct negligence claim against the HMO based on negligent hiring and retention of the physician.²¹⁸ Compared to the Virginia federal court case, the *Santitoro* court noted that the plaintiffs did not assert claims against the HMO for wrongful administration under the health care benefit plan.²¹⁹ The *Santitoro* court noted that the plaintiffs sought quite the opposite: they claimed damages for the physicians' alleged medical malpractice and other malfeasance related to the provision of those benefits.²²⁰ Therefore, the court concluded that the plaintiffs sought to hold defendants liable

210. *Id.* at 736.

211. *Id.* (emphasis added).

212. *Id.*

213. Chrys A. Martin, *Developments in Managed Care*, SA93 AL-ABA 217, 221 (1996).

214. *Lancaster v. Kaiser Foundation Health Plan of Mid-Atlantic States, Inc.*, 958 F.Supp. 1137 (E.D. Va. 1997).

215. *Id.* at 1140.

216. *Id.* at 1150.

217. *Id.*

218. *Santitoro*, 935 F.Supp. at 737.

219. *Id.* at 736.

220. *Id.*

for breaches of duties *related* to medical care imposed by state tort law.²²¹

While the *Santituro* decision provides some hope for plaintiffs filing lawsuits against North Carolina HMOs, many federal courts continue to disagree on which kinds of medical errors trigger preemption and which will allow a malpractice suit against a managed care organization. It is for this exact reason that many federal judges are urging Congress this year to consider changes to ERISA.²²²

B. *Prohibition on the Corporate Practice of Medicine*

The second barrier to liability is the statutory prohibition on the corporate practice of medicine by HMOs. Specifically, section 58 of the North Carolina General Statutes states that “[a]ny health maintenance organization authorized . . . shall not be deemed to be practicing medicine or dentistry and shall be exempt from the provisions . . . relating to the practice of medicine and dentistry.”²²³

However, the corporate practice of medicine should not preclude any recovery against an HMO for its physicians’ malpractice. Specifically, North Carolina courts must reconcile this statute with the *Blanton*²²⁴ decision, which allowed direct liability for hospitals.²²⁵ Furthermore, other courts have held that ERISA does not preempt medical malpractice claims against HMOs based on apparent agency or other vicarious liability theories.²²⁶ Therefore, statutory prohibitions on the corporate practice of medicine by HMOs can be challenged on both vicarious liability and direct liability theories.

CONCLUSION

From this Comment, it is obvious that North Carolina courts have many legal tools to hold HMOs liable. As managed care organizations continue to grow in this state, North Carolinians will look for protection against substandard patient care. This Comment has pointed out that North Carolina courts have already protected hospital patients from both the malpractice of physicians practicing in hospitals and negligent actions of the hospital itself. Such reasoning

221. *Id.*

222. Pear, *supra* note 174, at A1.

223. N.C.G.S. § 58-67-170(c) (1994).

224. 319 N.C. at 372, 354 S.E.2d at 455.

225. *Id.* at 377, 354 S.E.2d at 459.

226. See, e.g., *Jackson v. Roseman*, 878 F. Supp. 820, 826 (D. Md. 1995) (concluding that vicarious liability claims are not preempted by ERISA and, accordingly, remanding the action to state court); *Dearmas v. Av-Med, Inc.*, 865 F. Supp. 816, 868 (S.D. Fla. 1994) (holding that vicarious liability claim against HMO for malpractice was not “related” to administration of plan and, therefore, not preempted by ERISA).

could be extended towards HMOs. In the end, public policy may demand that such laws be imposed in order to both deter substandard patient care and compensate victims.

JAY JYOTI CHAUDHURI

