Loyola University Chicago Law Journal

Volume 20
Issue 3 *Spring 1989 Health Care Law Symposium*

Article 8

1989

Evolving Theories of Malpractice Liability for HMOs

Michael Kanute

Comments

Evolving Theories of Malpractice Liability for HMOs

I. INTRODUCTION

Traditional health care providers, such as hospitals, have been subjected to liability on a number of different theories, including *respondeat superior*, ostensible agency, and corporate negligence. The recent growth in the popularity of health maintenance organizations ("HMOs") raises questions regarding the scope of their liability. HMOs differ from hospitals in several respects; thus, courts will face the question of whether these new alternative systems of health care delivery should be subject to the same liability risks that hospitals face.

This Comment will recount the traditional bases on which hospitals have been held liable and will examine whether HMOs should be subject to the same liability.

II. BACKGROUND

A. Definition and Structure of HMOs

An HMO is defined as an alternative system of health care delivery,[1] whereby health care providers, namely physicians, nurses, and other medical personnel, enter into contracts with or are employed by a health care entity to provide comprehensive health care to voluntarily enrolled patients.[2] The most distinguishing characteristic of membership in an HMO is that an enrolled patient pays a prepaid, fixed fee for medical services.[3] This payment

1. The term "alternative health care delivery system" is used to describe HMOs, Preferred Provider Organizations ("PPOs"), or any other system of health care delivery that differs from the traditional "fee-for-services" system of health care. Fee-for-services, as the name indicates, refers to the typical relationship between a physician and patient in which the patient pays a separate fee for each service rendered by the independent physician, as opposed to one fixed, prepaid fee. Bovbjerg, *The Medical Malpractice Standard of Care: HMOs and Customary Practice*, 1975 DUKE L.J. 1375, 1376-77 (1975).

2. *See* Walsh v. Women's Health Center, 376 So. 2d 250, 251 (Fla. Dist. Ct. App. 1979) (includes a detailed description of the characteristics of an HMO). The patients enrolled in an HMO will hereinafter be referred to collectively as "membership."

3. *See* Ludlam, *Health Maintenance Organizations HMOs: Do They Really Work?*, 10 FORUM 405, 406 (1974) ("an individual . . . contracts in advance with . . . an HMO for

scheme differs from the traditional fee-for-services[4] structure that most general practitioners employ in that the patient pays a one-time charge for subsequent complete health care services.[5] The prepaid, fixed fee is paid without regard to the actual amount of services provided to the enrolled patients.[6]

There are three traditional models of HMOs: staff, group, and individual practice association ("IPA").[7] The models are characterized or distinguished by the relationship that the HMO's administrative body maintains with its physicians.[8] Not every HMO fits neatly into one of these model structures; rather, each type simply illustrates typical relationships between an HMO and its affiliated physicians.

The staff model HMO is the simplest model. In the staff model, the HMO's administrative body directly employs physicians and compensates them through salaries.[9] The employed physicians who provide treatment to the enrolled patients are considered HMO staff. The staff physicians usually work in a facility or health center that is owned or operated by the HMO's administrative body.[10] HMO physicians devote most of their time to serving the needs of the organization and its membership.[11] Consequently,

---

substantially all of his and his family's health care needs"). The prepaid characteristic sets the HMO apart from traditional health care delivery systems in several other respects, including assumption of financial risk. Bovbjerg, *supra* note 1, at 1376-77. Because HMOs must provide a program of comprehensive care to their members from an inelastic pool of funds, they are well motivated to scrutinize the effectiveness of every risk-reducing measure available. *Id.* at 1376. Fee-for-service providers, on the other hand, have little or no financial incentive to weigh costs in evaluating possible risk-reducing measures because neither they nor their patients may apply insurance proceeds saved in one area to other, more productive uses. For a complete discussion of the risk aspects of HMOs, see *id.*

4. For an explanation of the traditional fee-for-services structure, see *supra* note 1.

5. The complete health care plan that an HMO provides is set forth through a specifically enumerated list of medical services in the HMO agreement or application, which typically includes general services, emergency services, inpatient hospital and physician care, and outpatient preventive medical services. *See generally* Sloan v. Metropolitan Health Council, 516 N.E.2d 1104, 1105 (Ind. Ct. App. 1987); Huff v. St. Joseph's Mercy Hosp., 261 N.W.2d 695, 698 (Iowa 1978); Ludlam, *supra* note 3, at 406.

6. In addition to the fixed, prepaid amount, an HMO may require an extra charge for certain special or unnecessary treatments (*i.e.*, cosmetic surgery). Such treatments usually are set forth in the HMO agreement or application. Bovbjerg, *supra* note 1, at 1378 n.2.

7. Binford, *Malpractice and the Prepaid Health Care Organization*, 3 WHITTIER L. REV. 337, 338 (1981).

8. *See generally* J. MICHAELS, LEGAL ISSUES IN THE FEE-FOR-SERVICES/PREPAID MEDICAL GROUP (1982).

9. J. MICHAELS, *supra* note 8, at vi; Binford, *supra* note 7, at 338 n.2.

10. J. MICHAELS, *supra* note 8, at vi; Binford, *supra* note 7, at 338 n.2.

11. Lemkin, *Alternative Forms of Health Care Delivery Systems: HMOs, IPAs and*

the private practice of these physicians is limited.[12] In short, these physicians are employees of the HMO, involved in a typical employer-employee relationship.[13]

The second and most popular type of HMO is the group model.[14] The group model has many of the same characteristics as the staff model. For instance, the physician group usually uses facilities owned or operated by the HMO's administrative body.[15] In the group model HMO, however, the HMO's administrative body contracts with or employs a medical group, rather than individual physicians, to provide health care services to the HMO membership.[16] This medical group is usually a multi-specialty group practice which adds a prepaid component to its fee-for-services practice.[17] Consequently, unlike the staff HMO, this group may or may not devote a majority of its time to serving the needs of the HMO.[18] Because the HMO's administrative body contracts with a group of physicians, the membership has a limited choice of physicians within the group.[19]

The IPA model is the third type of HMO model. With this model, the HMO's administrative body contracts with an IPA, which is usually a partnership or corporation of physicians, to provide health care services to the HMO membership.[20] The IPA, in turn, contracts directly with its physicians, who then serve the IPA.[21] The IPA model differs significantly from either the staff or group models. Although the IPA maintains contact with the

---

PPOs, in R. McNair, *The New Health Care Economy: Legal Responses to New Economic Forces*, A4-4103 Practicing Law Institute, 97, 108 (1985).

12. J. MICHAELS, *supra* note 8, at vi.

13. J. MICHAELS, *supra* note 8, at vi; Binford, *supra* note 7, at 338 n.2. Whether an employer-employee relationship exists becomes important in the context of *respondeat superior*, discussed *infra* at notes 43-95 and accompanying text.

14. Lemkin, *supra* note 11, at 108.

15. J. MICHAELS, *supra* note 8, at vi. Often the medical facilities are owned by the physician group itself. This is true in the situation where a medical group has been operating out of its own facility for a long period of time, and decides to affiliate itself with an HMO. *Id.*

16. J. MICHAELS, *supra* note 8, at v; Binford, *supra* note 7, at 339; Meyer, *Group Prepaid Health Plan Liability When a Physician Provider Malpractices*, 6 N.M.L. REV. 79, 80 (1975).

17. J. MICHAELS, *supra* note 8, at v. These medical groups are usually multi-specialty in nature so that they can provide a comprehensive health care plan, which is one of the attractive features of HMOs. *See* Meyer, *supra* note 16, at 82.

18. Binford, *supra* note 7, at 339; Lemkin, *supra* note 11, at 108.

19. Binford, *supra* note 7, at 339; Meyer, *supra* note 16, at 80.

20. J. MICHAELS, *supra* note 8, at vi; Oakley & Kelley, *HMO Liability for Malpractice of Member Physicians: The Case of IPA Model HMOs*, 23 TORT AND INS. L.J. 624 (1988).

21. J. MICHAELS, *supra* note 8, at vi; Oakley & Kelley, *supra* note 20, at 624.

HMO's administrative body, its physicians usually work in their own offices or facilities, use their own equipment, and keep their own records.[22] The HMO pays the IPA a specified amount, known as a "capitation,"[23] and the IPA, in turn, pays the treating physicians on a fee-for-services basis.[24] Hence, the IPA model HMO combines, in a single program, features of the staff and group model HMOs. An IPA model HMO provides the comprehensive benefit package of a staff model HMO and care in the office of one of a group of privately practicing physicians who is not directly employed by the HMO's administrative body.[25]

Although the discussion above outlines the three major types of HMOs, it is necessary to look past the HMO label when examining and evaluating an HMO for its liability. Some HMOs have characteristics of all three models, making them difficult to categorize.[26] The various models serve only as guides in determining how certain characteristics and attributes of the HMO will affect its potential liability.

B. HMO Legislation

Although this Comment examines common law theories of liability, it is necessary to mention that most states have enacted legislation that is directed toward the organization and operation of HMOs.[27] Most of the laws are "enabling" statutes, which are laws

22. J. MICHAELS, *supra* note 8, at vi; Lemkin, *supra* note 11, at 109; Oakley & Kelley, *supra* note 20, at 624.

23. Capitation is an actuarially determined amount prepaid by an HMO to the primary physician for each patient who has chosen that physician. Boyd v. Albert Einstein Medical Center, 547 A.2d 1229, 1234 (Pa. Super. 1988).

24. J. MICHAELS, *supra* note 8, at vi; Binford, *supra* note 7, at 338 n.3.

25. Oakley & Kelley, *supra* note 20, at 624. *See also* J. MICHAELS, *supra* note 8, at vi; Binford, *supra* note 7, at 338 n.3.

26. Binford, *supra* note 7, at 338-39, sets forth the following caveat:

> It should be recognized that while all three terms are commonly bandied about in HMO parlance, the labels do not always carry the same definitions. Within the extremes of the three basic models exist all forms of HMOs exhibiting characteristics of one or all three models. The application of this analysis to these 'hybrid' models will require care, depending upon the degree of similarity between the model in question and forms discussed here . . . . [T]he informed reader should be careful to look beyond the 'label' of the HMO with which he or she may be dealing in order to ensure correct application of the principles presented.

Id.

27. There is also federal legislation regarding HMOs, commonly known as the Federal HMO Act of 1973, 42 U.S.C. § 300e (1982). This statute was enacted, among other reasons, to provide funds in assisting the establishment and growth of HMOs. Epstein, *Federal and State Definitions of HMOs*, 23 DRAKE L. REV. 782 (1974). Thus, an issue

specifically designed to authorize the establishment and regulation of prepaid health plans.[28] The enabling statutes may establish the relationship between HMOs and other state statutes,[29] the requirements for information to be distributed to enrollees,[30] the requirements for financial reserves,[31] or the formal complaint procedure for members.[32] Thus, by recognizing the service nature of HMOs, such legislation usually creates a beneficial legal environment for establishing and operating an HMO.[33]

A few statutes attempt to shield HMOs from liability for the medical malpractice or negligence of their agents or physicians.[34] The New Jersey statute (the "Statute")[35] is perhaps the most explicit in this regard. The Statute provides in part:

> c. Any health maintenance organization authorized under this act shall not be deemed to be practicing medicine and shall be exempt from the provision . . . relating to the practice of medicine.
>
> d. No person participating in the arrangements of a health maintenance organization other than the actual provider of health care services or supplies directly to enrollees and their families shall be liable for negligence, misfeasance, nonfeasance or malpractice in connection with the furnishings of such services and supplies.[36]

Most states, however, have avoided extending such extreme protection from liability to HMOs.

The Texas Health Maintenance Organization Act (the "Act")[37] serves as an example of a more typical statute. In setting forth the relationship between an HMO, a physician, and a patient, the Act provides that it shall not be construed to:

---

confronting a developing HMO is whether to seek federal qualification status. J. MICHAELS, *supra* note 8, at 17.

28. J. MICHAELS, *supra* note 8, at 7.

29. *See, e.g.*, KY. REV. STAT. ANN. § 304.38-200 (Michie/Bobbs-Merrill 1981); N.H. REV. STAT. ANN. § 420-B:20 (1983).

30. *See, e.g.*, MINN. STAT. ANN. § 62D.09 (West 1986); TEX. INS. CODE ANN. § 20A.11 (Vernon 1981).

31. *See, e.g.*, MINN. STAT. ANN. § 62D.041(2) (West 1986); N.J. STAT. ANN. § 26:2J-14 (West 1987).

32. *See, e.g.*, GA. CODE ANN. § 56-3610 (Harrison 1988); ME. REV. STAT. ANN. tit. 24-A, § 4211 (1988).

33. *See* J. MICHAELS, *supra* note 8, at 7-8. These statutes also often limit the impact of a state's insurance laws on HMO operations. *Id.*

34. Due to the absence of litigation involving the liability of HMOs, it is difficult to judge the effectiveness of these provisions.

35. N.J. STAT. ANN. §§ 26:2J-25(c)-(d) (West 1987).

36. *Id.*

37. TEX. INS. CODE ANN. § 20A.29 (Vernon 1981).

a. authorize any person, other than a duly licensed physician or practitioner of the healing arts, acting within the scope of his or her license, to engage, directly or indirectly in the practice of medicine or any healing art, or
b. authorize any person to regulate, interfere, or intervene in any manner in the practice of medicine or any healing art.[38]

Statutes like the Act attempt to shield an HMO from liability by providing that the HMO entity (*i.e.*, a corporation) is not statutorily authorized to practice medicine and, therefore, is not subject to medical malpractice liability.[39] In addition, many state statutes completely fail to mention liability as to HMOs.[40]

III. TRADITIONAL THEORIES OF LIABILITY

Since the emergence of HMOs as a popular alternative health care delivery system, there has been sparse litigation regarding the liability of an HMO for the malpractice or negligence of its physicians. Yet, with the recent growth in the number of HMOs and expectations of continued growth and popularity, liability issues concerning HMOs have surfaced.[41] Therefore, it is necessary to consider possible common law theories of liability applicable to HMOs by reviewing traditional theories of liability to which health care providers have been subject, and comparing these traditional theories to the few cases dealing with HMO liability.[42]

---

38. *Id.*

39. *See, e.g.*, Williams v. Good Health Plus-HealthAmerica, 743 S.W.2d 373 (Tex. Ct. App. 1987) (discussed *infra* at notes 123-35 and accompanying text).

40. *See, e.g.*, GA. CODE ANN. § 56-3601 ff. (Harrison 1988); IND. CODE ANN. § 27-8-7-1 ff. (West 1978); IOWA CODE ANN. § 514B.1 ff. (West 1988).

41. *See, e.g.*, Pulvers v. Kaiser Found. Health Plan, 99 Cal. App. 3d 560, 160 Cal. Rptr. 392 (1979) (breach of warranty action against an HMO); Sloan v. Metropolitan Health Council, 516 N.E.2d 1104 (Ind. Ct. App. 1987) (attempt to hold an HMO liable for the malpractice of its physician on a respondeat superior basis); Harrell v. Total Health Care, No. WD 39809, slip op. (Mo. Ct. App. Apr. 25, 1989) (attempt to hold an HMO liable for the malpractice of its physician based on a corporate negligence theory); Williams v. Health Am., No. 13088, slip op. (Ohio Ct. App. Oct. 7, 1987) (action against an HMO for bad faith in handling patient's claim); Boyd v. Albert Einstein Medical Center, 547 A.2d 1229 (Pa. Super. 1988) (attempt to hold an HMO vicariously liable for the malpractice of its physician based on an ostensible agency theory); Williams v. Good Health Plus-HealthAmerica, 743 S.W.2d 373 (Tex. Ct. App. 1987) (attempt to hold an HMO vicariously liable for the malpractice of its physician based on an ostensible agency theory).

42. The traditional common law theories of liability discussed in this Comment are *respondeat superior*, ostensible agency, and corporate negligence. In addition to these bases of liability, an HMO may be liable for the negligence or malpractice of one of its physicians on the grounds of bad faith, breach of warranty, or breach of contract. Breach of contract and breach of warranty are non-tort theories of liability, and are raised infrequently in actions against hospitals due to the inability to obtain damages for pain and

A. Respondeat Superior

Under the doctrine of *respondeat superior*, a master may be liable for the wrongful acts of his servant.[43] *Respondeat superior* is invoked most often in the employment setting when an employee acts within the scope of his or her employment.[44] Because *respondeat superior* depends on a master/servant relationship, it does not apply to independent contractors.[45] Prior to the 1950s, courts perceived physicians and nurses as independent contractors because of their professional skill and decision-making autonomy.[46] Courts, therefore, refused to find hospitals liable for the negligent acts of their doctors and nurses.[47] Judge Cardozo first enunciated the *respondeat superior* principle in *Schloendorff v. Society of New York Hospital*.[48] Cardozo discussed the relationship between hospitals and physicians associated with the hospital:

It is said that this relation is not one of master and servant, but

---

suffering. Curran & Moseley, *The Malpractice Experience of Health Maintenance Organizations*, 70 NW. U.L. REV. 69, 75 (1975). A few plaintiffs have attempted to hold HMOs liable for the malpractice or negligence of their physicians based on bad faith, breach of warranty, or breach of contract. *See* Williams v. Health Am., No. 13088, slip op. (Ohio Ct. App. Oct. 7, 1987) (court reversed a grant of summary judgment which was in favor of the HMO, holding that material questions of fact existed as to whether the plaintiff's claim was handled in good faith); Pulvers v. Kaiser Found. Health Plan, 99 Cal. App. 3d 560, 160 Cal. Rptr. 392 (1979) (court rejected plaintiff's breach of warranty cause of action against an HMO, holding that the theory should be applied only in cases where the physician has clearly and unequivocally warranted a particular result through his chosen course of action); Oakley & Kelley, *supra* note 20, at 634 (breach of contract cause of action may exist between a patient and an HMO because there is usually an express contract between the two parties).

43. BLACK'S LAW DICTIONARY 1179 (5th ed. 1979); PROSSER & KEATON ON TORTS § 69 (5th ed. 1984).

44. PROSSER & KEATON ON TORTS § 69 (5th ed. 1984).

45. *Id.*

46. Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 105 N.E. 92 (1914), *overruled*, Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957).

47. *Id.*

48. *Id.* In *Schloendorff*, the plaintiff suffered permanent injuries due to the negligence of a hospital physician. *Id.* at 126, 105 N.E. at 93. The physician performed surgery on the plaintiff to remove a fibroid tumor. *Id.* Following this procedure, gangrene developed in the plaintiff's arm and several of her fingers had to be amputated. *Id.* This case involved a charitable hospital, and Judge Cardozo based the hospital's immunity from liability on two grounds: first, one who accepts the benefit of a charity impliedly waives any claim for injury occurring as a result of the negligence of the charity's servants; and second, the relationship between a hospital and the physicians who serve it is not that of master and servant because the physicians are independent contractors. *Id.* This language may embrace private as well as charitable institutions, and later New York decisions are not in agreement as to whether Judge Cardozo intended his remarks to apply to private as well as charitable institutions. *See* Annotation, *Liability of Hospital or Sanitorium for Negligence of Physicians or Surgeons*, 69 A.L.R. 2D 305, 307 n.3 (1960) [hereinafter *Liability of Hospital*].

> that the physician occupies the position, so to speak, of an independent contractor, following a separate calling, liable, of course, for his own wrongs to the patient whom he undertakes to serve, but involving the hospital in no liability, if due care has been taken in his selection.[49]

Because physicians and nurses were considered independent contractors at the time of *Schloendorff*, hospitals could not be liable on the basis of a *respondeat superior* theory.[50]

Over the next fifty years, the character of major hospitals changed significantly.[51] The court in *Bing v. Thunig*[52] addressed the problems created by the change in hospitals, the difficulties in applying *Schloendorff*, and the growing trend toward imposing liability on hospitals for their physicians' malpractice.[53] The court in *Bing* noted the inconsistency in holding employers liable for the acts of their employees in every context except that of physicians and hospitals.[54] Physicians and nurses, though deemed to be independent contractors, were often, in fact, salaried employees and should be recognized as such.[55] By mid-century, the public had come to expect a great deal from treatment in a hospital facility.[56] The *Bing* court responded accordingly and expressed its view regarding the burden that hospitals should bear:

> Hospitals should, in short, shoulder the responsibilities borne by everyone else. There is no reason to continue their exemption from the universal rule of respondeat superior. The test should be, for these institutions, whether charitable or profit-making, as it is for every other employer, was the person who committed the negligent injury-producing act one of its employees and, if he

---

49. *Schloendorff*, 211 N.Y. at 126, 105 N.E. at 93.

50. *Id.* Cardozo did state that a hospital could be vicariously liable for negligence on a *respondeat superior* theory in performing "administrative" acts, but not "medical" acts; thus, he created a confusing dichotomy which came under constant attack in subsequent years. *Id. See Liability of Hospital, supra* note 48, at 317.

51. In Ybarra v. Spangard, 25 Cal. 2d 486, 154 P.2d 687 (1944), the court noted that a hospital today conducts a highly integrated system of activities, with many persons contributing to its efforts, including nurses and interns who are employees of the hospital, and doctors and surgeons who may or may not be hospital employees. *Id.* at 491, 154 P.2d at 690. Thus, because a patient is quite likely to come under the care of a number of persons in different types of contractual and other relationships with each other, the court felt that it was time to reexamine the legal theories on which a plaintiff may recover. *Id.*

52. 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957).

53. *See id.* For a synopsis of the evolution of the law in this area, see *Liability of Hospital, supra* note 48, at 305.

54. *Bing*, 2 N.Y.2d at 663-64, 143 N.E.2d at 6-7, 163 N.Y.S.2d at 8-9.

55. *Id.*

56. *Id.* at 666, 143 N.E.2d at 8, 163 N.Y.S.2d at 10-11. The person who availed himself of hospital facilities expected that the hospital would attempt to cure him, not that the nurses and other employees would act on their own responsibility. *Id.*

was, was he acting within the scope of his employment.[57]

Thus, *Bing* opined that hospitals are employers and should no longer be accorded special treatment.[58] Rather, hospitals should be subject to vicarious liability under the theory of *respondeat superior* as would any other employer.[59]

Since the *Bing* decision, hospitals' potential for incurring liability for the acts of their physicians has expanded greatly.[60] Recently, courts have used a "control" test to determine whether there is an employment relationship between a hospital and its physicians that will provide a basis for holding hospitals liable under a *respondeat superior* theory.[61] In *Mduba v. Benedictine Hospital*,[62] a New York court held that an emergency room physician who contracted with a hospital was an employee of the hospital despite express contractual language to the contrary.[63] The court based this determination on the fact that the physician was required to operate the emergency room in accordance with the

57. *Id.* at 666-67, 143 N.E.2d at 8, 163 N.Y.S.2d at 11.

58. *Id.* at 666, 143 N.E.2d at 8, 163 N.Y.S.2d at 11.

59. *Id.* at 666-67, 143 N.E.2d at 8, 163 N.Y.S.2d at 11.

60. Jackson v. Power, 743 P.2d 1376 (Alaska 1986), discussed *infra* at notes 112-19 and accompanying text; Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966), discussed *infra* at notes 155-64 and accompanying text; Adamski v. Tacoma Gen. Hosp., 20 Wash. App. 98, 579 P.2d 970 (1978), discussed *infra* at notes 67-71 and accompanying text; Johnson v. Misericordia Community Hosp., 99 Wis. 2d 708, 301 N.W.2d 156 (1981), discussed *infra* at notes 176-82 and accompanying text.

61. Beeck v. Tucson Gen. Hosp., 18 Ariz. App. 165, 500 P.2d 1153 (1972) (hospital held vicariously liable when it had the right to control standards of performance of a physician employed by the hospital in order to perform an inherent and essential function for the hospital); Kitto v. Gilbert, 39 Colo. App. 374, 570 P.2d 544 (1977) (operating surgeon who assumed control in operating room was liable for acts of hospital employees assisting in the operation, but both the surgeon and the hospital could not be held liable under a theory of vicarious liability); Foster v. Englewood Hosp. Ass'n, 19 Ill. App. 3d 1055, 313 N.E.2d 255 (1st Dist. 1974) (hospital held vicariously liable when an employee of hospital assisted a physician who retained some degree of control over the assisting employee, and the employee remained within the bounds of her employment); Adamski v. Tacoma Gen. Hosp., 20 Wash. App. 98, 579 P.2d 970 (1978) (the mere existence of hospital regulations and procedures was insufficient to establish control for purposes of imposing vicarious liability on the hospital since the governing body of the hospital never actually controlled a physician's medical decisions or treatment).

62. 52 A.D.2d 450, 384 N.Y.S.2d 527 (1976). Mduba was a wrongful death action against the defendant hospital to recover for the negligence of the hospital's emergency room personnel for failing to obtain a blood sample and transfuse with blood after the decedent's automobile accident. *Id.* at 451, 384 N.Y.S.2d at 528. As a result, the plaintiff's decedent died shortly afterward from irreversible shock. *Id.* The theory presented by the plaintiff was that the doctor's negligence could have caused or contributed to the death of the decedent. *Id.*

63. *Id.* at 452, 384 N.Y.S.2d at 528.

hospital's rules and regulations.[64] The court reasoned that the hospital, through its regulations, controlled how the doctor operated the emergency room.[65] This control created an employer-employee situation, and the hospital could, therefore, be held vicariously liable for the doctor's negligence under the theory of *respondeat superior*.[66]

In *Adamski v. Tacoma General Hospital*,[67] a Washington appellate court attempted to clarify the "control" test in holding a hospital liable for the malpractice of its emergency room physicians.[68] The court stated that the mere existence of hospital regulations and procedures was insufficient to establish control for purposes of imposing vicarious liability on a hospital because the governing body of a hospital never actually controlled a physician's medical decisions or treatment.[69] Proposing a different approach for imposing vicarious liability, the *Adamski* court reasoned that the doctrine of *respondeat superior* ought to be applied to a hospital-physician relationship when: (1) the patient sought treatment primarily from the hospital; and (2) the hospital paid the doctor a salary.[70] The *Adamski* court preferred this test because it defined some of the elements that courts should consider when determining whether a hospital should be held liable for the negligence of its physicians and, therefore, was a better test for finding an employer-employee relationship.[71]

Under the theory of *respondeat superior*, a hospital's liability for acts of its physicians has increased significantly throughout the

64. *Id.* at 452, 384 N.Y.S.2d at 529.

65. *Id.*

66. *Id.*

67. 20 Wash. App. 98, 579 P.2d 970 (1978).

68. *Id.* The plaintiff in *Adamski* broke his finger while playing basketball. *Id.* at 99, 579 P.2d at 971. The plaintiff forced the bone back into position, applied a crude splint and bandage, and went to the defendant's emergency room later that evening. *Id.* The doctor on duty cleansed and treated the wound and told the plaintiff to consult his personal physician in five to six days. *Id.* After experiencing swelling and pain, the plaintiff was referred to a new doctor, who diagnosed an infection in the plaintiff's hand. Treatment of this infection required surgery. *Id.* The plaintiff subsequently brought action against the hospital, alleging that the original emergency room physician was negligent in his diagnosis and treatment, and that he was acting as the hospital's agent. *Id.* at 101-02, 579 P.2d at 972.

69. *Id.* at 107, 579 P.2d at 975.

70. *Id.* (relying on Brown v. La Societe Francaise de Bienfaisance Mutuelle, 138 Cal. 475, 71 P. 516 (1903)).

71. Other courts have looked simply at all the facts and circumstances of the physician-hospital relationship before concluding that a *respondeat superior* theory should apply. *See, e.g.*, Beeck v. Tucson Gen. Hosp., 18 Ariz. App. 165, 500 P.2d 1153 (1972); Kober v. Stewart, 148 Mont. 117, 417 P.2d 476 (1966).

course of the past few decades.[72] The evolution in this area of law indicates a willingness on the part of the judiciary to treat health care facilities as business entities. Hospitals are no longer exempt from liability based on notions of a doctor's or nurse's skill or independence.[73] Instead, hospitals must take responsibility for the control that they exert over their employee-physicians and nurses.[74]

Whether the doctrine of *respondeat superior* will be applied in the same manner to HMOs is questionable. The liability of a staff model HMO under the theory of *respondeat superior* was considered in *Sloan v. Metropolitan Health Council of Indianapolis*.[75] In *Sloan*, the plaintiffs brought suit against Metropolitan Health Council of Indianapolis ("Metro") for negligent failure to diagnose.[76] Metro argued that its physicians were independent contractors and, therefore, were not subject to control by the HMO.[77]

Metro resembled a staff model HMO. The HMO's administrative body contracted with its member physicians and paid them a fixed annual salary, regardless of what services they rendered.[78] Through an agreement, Metro offered its subscribers specifically enumerated services.[79] Metro, not the physicians, billed the patients.[80] Metro employed a medical director whose duties included determining medical policy matters relating to the health care services.[81] Although the medical director's judgment as to policy matters was final, the practicing physician was responsible for the administration and supervision of the health services.[82] Metro's bylaws provided for periodic review of medical care rendered and for audits of the medical program by outside authorities.[83]

In granting summary judgment for the HMO, the trial court relied on *Iterman v. Baker*.[84] *Iterman* made clear that a corporation

72. Oakley & Kelley, *supra* note 20, at 627.

73. Bing v. Thunig, 2 N.Y.2d 656, 664-65, 143 N.E.2d 3, 7, 163 N.Y.S.2d 3, 9-10 (1957), discussed *supra* at notes 52-59 and accompanying text.

74. *Id.* at 666-67, 143 N.E.2d at 8, 163 N.Y.S.2d at 11.

75. 516 N.E.2d 1104 (Ind. Ct. App. 1987).

76. *Id.* at 1106.

77. *Id.*

78. *Id.* at 1105.

79. *Id.*

80. *Id.* Metro also had one office, one phone number, and one medical record for each patient. *Id.*

81. *Id.* The medical director's main duty was to see that medical services pursuant to contracts between the HMO and its subscribers were carried out. *Id.*

82. *Id.*

83. *Id.*

84. 214 Ind. 308, 15 N.E.2d 365 (1938). The plaintiff in the *Iterman* case brought

in Indiana, by statute, cannot practice medicine and, therefore, cannot be vicariously liable on a *respondeat superior* basis for the malpractice of its physicians.[85] The *Sloan* court reasoned that:

> The entire rationale for the holding in *Iterman* is based upon the conclusion reached by the court that, since no Indiana statute existed at that time which permitted a corporation to practice medicine, a public policy existed prohibiting a corporation to practice medicine; thus the doctrine of respondeat superior was inapplicable.[86]

In *Sloan*, however, the court of appeals rejected the trial court's rationale, noting that the Professional Corporation Act of 1983 (the "Act")[87] abolished the public policy underlying the *Iterman* decision.[88] The Act sets forth the services that a professional corporation may perform and provides for liability through rendered services:

> A corporation whose employees perform professional services within the scope of their employment or of their apparent authority to act for the corporation is liable to the same extent as its employees.[89]

In addition, the Act provides that:

> The relationship between a professional corporation performing professional services and the client or patient is the same as between the client or patient and the individual performing the services.[90]

The *Sloan* court, in relying on precedent, stated that it is a *non sequitur* to conclude that because a hospital cannot practice medicine or psychiatry, it cannot be liable for the actions of its employed agents and servants who may be so licensed.[91] The

---

suit against the incorporated New Castle Clinic and several physicians, alleging negligence in failing to diagnose several fractures. *Id.* at 310, 15 N.E.2d at 368. The clinic operated as a hospital. *Id.* at 311-12, 15 N.E.2d at 368-69. In denying the plaintiff recovery, the Supreme Court of Indiana held that a corporation was not able to engage in the practice of medicine and, therefore, was not estopped from denying liability for malpractice of one of its physicians. *Id.* at 316-17, 15 N.E.2d at 369-70. Such physicians were independent contractors, precluding the clinic from liability. *Id.* at 318-19, 15 N.E.2d at 370.

85. *Id.* at 314, 15 N.E.2d at 369-70.

86. *Sloan*, 516 N.E.2d at 1107.

87. IND. CODE ANN. §§ 23-1.5-1-1 to 23-1.5-2 (West 1988).

88. *Sloan*, 516 N.E.2d at 1108-09.

89. IND. CODE ANN. § 23-1.5-2-6(c) (West 1988).

90. IND. CODE ANN. § 23-1.5-2-7(b) (West 1988).

91. *Sloan*, 516 N.E.2d at 1108. The court in Mathes v. Ireland, 419 N.E.2d 782 (Ind. Ct. App. 1981) analogized that:

> Similar logic would dictate that a city cannot be liable for the negligence of its employees in driving automobiles since the city cannot hold a driver's license or

Sloan court concluded that Metro's medical director controlled its staff physicians and that an employer-employee relationship existed between the physician and Metro.[92] Absent a statutory scheme in Indiana precluding the application of *respondeat superior* to medical corporations, the court may hold an HMO vicariously liable for the malpractice of its staff.[93] Thus, the *Iterman* public policy argument was no longer valid, and the court held that it was possible that Metro could be held vicariously liable through the doctrine of *respondeat superior*.[94] *Sloan* is the only case to date that deals specifically with the doctrine of *respondeat superior* as it applies to HMOs.[95]

B. Ostensible Agency

Ostensible agency, also known as apparent agency, is another basis for vicarious liability for health care providers.[96] Ostensible agency is defined as the relationship that arises when a principal represents or creates the appearance that a person is his agent, and a third party reasonably relies on that representation.[97] An employer may be held vicariously liable under the theory of ostensible agency when the employer holds out the employee as his agent, even if an employee is an independent contractor.[98] The two fac-

---

that a corporation cannot be liable for the misactions of its house counsel since it could not [sic] hold a license to practice law.

Id. at 786. *See also* Birt v. St. Mary Mercy Hosp., 175 Ind. App. 32, 370 N.E.2d 379 (1977) (includes dicta which further illustrates a change in public policy).

92. *Sloan*, 516 N.E.2d at 1109. The medical director "controlled" the staff physicians in that he "policed" their services and performance. *Id.*

93. *Id.*

94. *Id.* Although Metro was not incorporated under the Act, the court held that the Act stood as a pronouncement of public policy concerning a corporation's vicarious liability for the acts of its employee-physicians and, therefore, Metro could not avoid liability through the simple act of not incorporating. *Id.*

95. *Sloan* is scheduled for trial in early 1989 and, therefore, the application of *respondeat superior* to HMOs in Indiana may be determined at that time.

96. Phoenix & Schlueter, *Hospital Liability for the Acts of Independent Contractors: The Ostensible Agency Doctrine*, 30 ST. LOUIS U.L.J. 875 (1986). For a list of some of the jurisdictions that have applied the ostensible agency theory to hospitals, see *infra* note 100.

97. *See* RESTATEMENT (SECOND) OF TORTS § 429 (1984):

> 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. See also RESTATEMENT (SECOND) OF AGENCY § 267 (1984).

98. RESTATEMENT (SECOND) OF TORTS § 429 (1984). The ostensible agency theory

tors that indicate a finding of ostensible agency are: (1) whether the principal, through its acts, created the appearance that an agency relationship existed between the principal and the negligent agent; and (2) whether the third party reasonably relied upon that appearance to his detriment or injury.[99]

The ostensible agency theory of vicarious liability is often applied in the health care context to the relationship between emergency room physicians and hospitals.[100] In the typical situation, the patient attempts to hold the hospital vicariously liable for the malpractice or negligence of the hospital's emergency room personnel on the basis that the hospital represented or held out the physicians as employees of the hospital.[101] A "holding out" or representation may arise when the hospital acts or fails to act in some way that leads the patient to reasonably believe that he is being treated by the hospital through one of its employees.[102]

The doctrine of ostensible agency as a ground for hospital liability was recognized as early as 1942.[103] Within the last decade, ap-

---

is also commonly known as the "holding out" theory. This term arises from the fact that the principal "holds out" a person as his agent or represents to the whole world that an agency relationship exists, even if it in fact does not. *Id.*

99. Phoenix & Schlueter, *supra* note 96, at 879 (*citing* RESTATEMENT (SECOND) OF AGENCY § 267 (1984)).

100. Hardy v. Brantley, 471 So. 2d 358, 370 (Miss. 1985), discussed *infra* at notes 105-11 and accompanying text. The basic rationale of ostensible agency cases in the health care context is that unless a patient believes that the treating physician in a hospital is an independent contractor, it is natural for him to assume that he can rely upon the reputation of the hospital and not the reputation of the particular doctors in the hospital. *Id.* Other jurisdictions show a strong trend toward imposing liability on hospitals that permit or encourage patients to believe that independent contractor-physicians are, in fact, authorized agents of these hospitals. *See, e.g.*, Porubiansky v. Emory Univ., 156 Ga. App. 602, 275 S.E.2d 163 (1981); Paintsville Hosp. v. Rose, 683 S.W.2d 255 (Ky. 1985); Mehlman v. Powell, 281 Md. 269, 378 A.2d 1121 (Md. 1977); Grewe v. Mt. Clemens Gen. Hosp., 404 Mich. 240, 273 N.W.2d 429 (1978); Arthur v. St. Peters Hosp., 169 N.J. Super. 575, 405 A.2d 443 (1979); Weldon v. Seminole Mun. Hosp., 709 P.2d 1058 (Okla. 1985); Themins v. Emanuel Lutheran Charity Bd., 54 Or. App. 901, 637 P.2d 155 (1982); Adamski v. Tacoma Gen. Hosp., 20 Wash. App. 98, 579 P.2d 970 (1978).

101. The RESTATEMENT (SECOND) OF AGENCY § 267 (1984) provides: "The [ostensible agency] rule normally applies where the plaintiff has submitted himself to the care or protection of an apparent servant in response to an invitation from the defendant to enter into such relations with such servant." *Id.*

102. *See* Adamski v. Tacoma Gen. Hosp., 20 Wash. App. 98, 108, 579 P.2d 970, 979 (1978), discussed *infra* at note 119; Phoenix & Schlueter, *supra* note 96, at 879.

103. Stanhope v. Los Angeles College of Chiropractic, 54 Cal. App. 2d 141, 128 P.2d 705 (1942). In *Stanhope*, the plaintiff sued the defendant corporation for alleged malpractice of the defendant physicians in examining and treating him after he had sustained a broken back in an accident. *Id.* at 142-43, 128 P.2d at 708. The court held the defendant corporation liable on the basis of ostensible agency because the physicians performed all treatment on the patient, creating the appearance of an employment relationship between the defendant corporation and the physicians. *Id.*

plication of the ostensible agency theory has increased substantially.[104] *Hardy v. Brantley*[105] represents a typical example of such application. *Hardy* involved a patient who died after arriving in the defendant hospital's emergency room with severe abdominal pain.[106] The patient's estate brought suit against the hospital for the treating physician's negligent diagnosis of a perforated duodenal ulcer.[107] The Supreme Court of Mississippi, apparently applying the doctrine of ostensible agency,[108] held the hospital liable for the doctor's negligent diagnosis.[109] The court specifically noted that the hospital held itself out to the general public as a provider of quality health care through advertising and other forms of solicitation.[110] Furthermore, the court stated:

> It goes without saying that hospitals such as [the defendant hospital] are corporate entities capable of acting only through human beings whose services the hospital engages . . . . If they do their job well, the hospital succeeds in its chosen mission, profiting financially and otherwise from the quality of emergency care so delivered . . . . [A]n anomaly would attend the hospital's escape from liability.[111]

In holding the hospital liable, the court rejected the traditional rationale that doctors, rather than hospitals, practice medicine, and thereby recognized the ostensible agency theory of vicarious liability in the health care context.

In *Jackson v. Power*,[112] the Supreme Court of Alaska recognized and applied a holding out theory of liability.[113] The *Jackson* court noted that all of the facts and circumstances surrounding the pa-

104. For a list of jurisdictions that have applied ostensible agency to hospitals, see *supra* note 100. The decision in Greene v. Rogers, 147 Ill. App. 3d 1009, 498 N.E.2d 867 (3d Dist. 1986) provides the exception to the widespread application of the ostensible agency doctrine. The *Greene* court expressly declined to adopt the ostensible agency doctrine, holding that the absence of power to control the decision-making of emergency room physicians demands that the independent relationship between hospital and emergency room physicians be recognized. *Id.* at 1015, 498 N.E.2d at 871. Illinois' obstinacy has been criticized by subsequent decisions in other states. *See, e.g.*, Jackson v. Power, 743 P.2d 1376, 1380 (Alaska 1987) ("[w]e view *Greene* as an aberration dependent upon reasoning which is not particularly persuasive").

105. 471 So. 2d 358 (Miss. 1985).

106. *Id.* at 360.

107. *Id.* at 361-62.

108. *Id.* at 369-73. The court spoke of *respondeat superior*, ostensible agency, and agency by estoppel often as if the terms were synonymous or interchangeable. *Id.*

109. *Id.* at 371.

110. *Id.*

111. *Id.*

112. 743 P.2d 1376 (Alaska 1986).

113. *Id.* at 1377. In *Jackson*, a young patient suffered severe injuries when he fell from a cliff. *Id.* The doctor's examination failed to ascertain whether there had been

tient's admission to the emergency room could have led one to believe that the hospital employed the emergency room physicians.[114] In determining the application of the ostensible agency doctrine, the court enumerated two relevant factors. First, the patient must look to the institution rather than the individual for care.[115] Second, the hospital must "hold out" the physician as its employee.[116] The ostensible agency theory does not require any affirmative misrepresentation by a hospital.[117] Rather, the hospital in *Jackson* simply failed to clarify that it did not employ its emergency room personnel, leading the patient reasonably to believe that he was being treated by hospital employees.[118] Because a jury could conclude that the hospital held itself out as providing such emergency care services to the public, the hospital could be vicariously liable for the physician's malpractice based on an ostensible agency theory.[119]

The doctrine of ostensible agency protects a patient's expectations based on the hospital's conduct.[120] Most jurisdictions apply the ostensible agency theory of liability because the services which

---

damage to the patient's kidneys. *Id.* The plaintiff subsequently underwent the surgical removal of both kidneys due to damage sustained in the fall. *Id.*

114. *Id.* at 1381. The circumstances included the fact that the hospital was the only such facility in the area, no signs or notices indicated anything out of the ordinary regarding the emergency room services, and the hospital made no attempt to distinguish the emergency room employees from other hospital personnel. *Id.*

115. *Id.* at 1380.

116. *Id.*

117. *Id.*

118. *Id.* at 1382.

119. *See also* Adamski v. Tacoma General Hospital, 20 Wash. App. 98, 579 P.2d 970 (1978), in which the court found that the hospital was not entitled to summary judgment, and may be liable on an ostensible agency theory for the acts of its emergency room personnel based on the following:

> A jury could find that plaintiff reasonably believed [that the treating physician] *was employed by the Hospital to deliver that emergency room service.* It appears plaintiff was not advised to the contrary and, in fact, he believed he was being treated by the Hospital's agent; in addition, the written instructions provided him after surgery could reasonably be interpreted as an invitation to return for further treatment if plaintiff could not contact his personal physician. The form bearing this instruction also carried the title 'Tacoma General Hospital Emergency Care.'

Id. at 115, 579 P.2d at 979 (emphasis added).

Other facts which might give rise to apparent agency include emergency room personnel wearing garments with hospital insignia, consent forms which do not indicate the employment arrangement with emergency room personnel, equipment which is owned by the hospital, and no effort by the hospital to inform the public that the emergency room physicians are not employees of the hospital. *See* Greene v. Rogers, 147 Ill. App. 3d 1009, 498 N.E.2d 867 (3d Dist. 1986), discussed *supra* at note 104.

120. Phoenix & Schlueter, *supra* note 96, at 881-82.

a hospital provides have expanded, and the hospitals' methods of providing those services has also changed.[121] The resulting difficulty in distinguishing between employees of the hospital and independent contractors has led the courts to focus on the patient's expectations as a result of the hospital's acts.[122] When a hospital fails to make clear the independent status of its physicians, the court may hold the hospital vicariously liable under the doctrine of ostensible agency, regardless of the actual status of its physicians.

The doctrine of ostensible agency was first considered in a claim against an HMO in *Williams v. Good Health Plus-HealthAmerica*.[123] In *Williams*, the plaintiff sought damages for injuries caused by a physician's alleged negligent treatment of her thumb based on a holding out theory.[124] After examination by the treating physician, the plaintiff's right thumbnail became infected and subsequently was surgically removed.[125] Good Health Plus was an IPA model HMO;[126] therefore, it contracted with an IPA to render medical services to HMO subscribers.[127] The court noted that the individual physicians that formed the IPA were not employees of the HMO because their only contract was with the IPA.[128]

The trial court entered summary judgment for the defendant HMO.[129] The plaintiff appealed, claiming that an issue of fact existed as to whether the HMO represented that its physicians were employees, creating an ostensible agency relationship.[130]

The plaintiff raised the holding out theory of ostensible agency as a possible basis for recovery.[131] Addressing the substantive as-

121. *Id.* at 886. For example, hospitals commonly contract with outside organizations to provide emergency room services. *See, e.g.*, Jackson v. Power, 743 P.2d 1376 (Alaska 1987); Mehlman v. Powell, 281 Md. 269, 378 A.2d 1121 (1977). Also, a hospital may contract with independent physicians or groups to provide minor surgical procedures through a freestanding surgery center. Phoenix & Schlueter, *supra* note 96, at 881-82.

122. Phoenix & Schlueter, *supra* note 96, at 881-82.

123. 743 S.W.2d 373 (Tex. Ct. App. 1987).

124. *Id.* at 374-75.

125. *Id.* at 374.

126. For a discussion of the structure and characteristics of an IPA model HMO, see *supra* notes 20-25 and accompanying text.

127. *Williams*, 743 S.W.2d at 376.

128. *Id.*

129. *Id.* at 373.

130. *Id.* at 378. The plaintiff also sought recovery under the theory that the HMO itself was the provider of the medical care. *Id.* at 375. The defendant argued that as a matter of law, the HMO could not practice medicine and, therefore, was not subject to liability. *Id.* at 375-76. The court held for the defendant on this issue because the state's HMO enabling statute absolved Good Health Plus from liability. *Id.* at 378.

131. *Id.* The "holding out" theory was set forth by the plaintiff in a late-filed motion

pects of the issue, the court firmly rejected the plaintiff's argument.[132] Finding for the HMO, the court noted that all notes and memoranda were on forms and stationery bearing the name of the IPA rather than the name of the HMO.[133] The court also relied on the fact that Mrs. Williams signed a consent form which identified the treating physician and the IPA by name, but did not refer to the HMO in any way.[134] Furthermore, the plaintiff presented no evidence to establish that the HMO held itself out as the employer of the treating physician.[135] Because the plaintiff failed to file a response to the defendant's motion for summary judgment, it is difficult to determine whether the court would have applied the doctrine of ostensible agency to the defendant HMO in the absence of the plaintiff's procedural errors.

The holding out theory of ostensible agency was again raised with reference to an HMO in *Boyd v. Albert Einstein Medical Center*.[136] In *Boyd*, a Pennsylvania court reversed a grant of summary judgment awarded in favor of an HMO.[137] In contrast to the *Williams* decision, the *Boyd* court held the HMO vicariously liable under the theory of ostensible agency.[138]

In *Boyd*, the plaintiff's deceased wife (the "patient") contacted her primary care physician regarding a lump in her breast.[139] After an examination, the patient's physician referred her to Dr. Cohen, another participating HMO physician.[140] In performing a biopsy, Dr. Cohen improperly perforated the decedent's chest wall with a biopsy needle.[141] Following Dr. Cohen's treatment, the patient's condition worsened, requiring a two-day hospitalization.[142] In the following weeks, after suffering further problems, the patient contacted Dr. Rosenthal, who administered more tests and sent the

for continuance after the plaintiff failed to file a response to the defendant's motion for summary judgment. *Id.* On the day of the hearing for the defendant's motion, the plaintiff filed a motion for continuance, which contained unsigned and unsworn affidavits, yet which plaintiff's counsel argued would defeat the motion for summary judgment. *Id.*

132. *Id.* at 378-79. The court rejected the holding out theory argument because the issue was never raised in either the first amended complaint or in the plaintiff's answers to interrogatories served by the HMO. *Id.*

133. *Id.* at 378.

134. *Id.* at 378-79.

135. *Id.* at 379.

136. 547 A.2d 1229 (Pa. Super. 1988).

137. *Id.*

138. *Id.* at 1235.

139. *Id.* at 1230.

140. *Id.*

141. *Id.*

142. *Id.*

patient home to rest where she died soon thereafter.[143]

The patient's husband brought suit against the HMO, alleging that the treating physicians were the ostensible agents of the HMO, and that the HMO was therefore vicariously liable.[144] The trial court granted the HMO's motion for summary judgment, finding that the plaintiff failed to establish ostensible agency.[145]

In reversing the trial court, the court relied on *Capan v. Divine Providence Hospital*,[146] which established that under Pennsylvania law, hospitals may be liable under an ostensible agency theory.[147] The *Boyd* court rejected the HMO's assertion that ostensible agency should only be applied to hospitals.[148] Although the hospital precedent was factually distinguishable, the *Boyd* court reasoned that the delineation of the ostensible agency theory in that precedent was pertinent when applied to the present case.[149] The court noted that the plaintiff paid his doctor's fees to the HMO rather than the individual physicians, selected his primary care physician from a list provided by the HMO, and relied on the screening and practice regulations that the HMO imposed on those physicians.[150] Based on these facts, the court held that there was a genuine issue of material fact as to whether the primary care physicians were the ostensible agents of the HMO.[151] Thus, based on

143. *Id.*

144. *Id.* at 1231.

145. *Id.*

146. 287 Pa. Super. 364, 430 A.2d 647 (1980).

147. *Boyd*, 547 A.2d at 1231-32. *Capan* involved a wrongful death action against the defendant hospital in which the court recognized that several jurisdictions had applied the doctrine of ostensible agency in holding a hospital vicariously liable for the negligence or malpractice of independent contractor physicians. For a list of some of these jurisdictions, see *supra* note 100. The court based its application of the doctrine on two factors: first, the evolving role of the hospital and the fact that patients look to the institutions and not individual physicians for treatment; and second, the traditional element of holding out. *Capan*, 287 Pa. Super. at 366-67, 430 A.2d at 649. The *Capan* opinion cited the *Adamski* case, noting that a holding out occurs when the hospital acts or omits to act in some way which leads the patient to a *reasonable* belief he is being treated by the hospital or one of its employees. *Id.* at 367, 430 A.2d at 649 (citing *Adamski*, 20 Wash. App. at 115, 579 P.2d at 979).

148. *Boyd*, 547 A.2d at 1234.

149. *Id.* at 1234-35.

150. *Id.* at 1235. For example, a physician applying for membership in the HMO must undergo a four- to six-month review process which includes interviews, screenings, background checks, and visits to the facilities. *Id.*

151. *Id.* The court stated that:

> [B]ecause [the patient] was required to follow the mandates of HMO and did not directly seek the attention of the specialist, there is an inference that [the patient] looked to the institution for care and not solely to the physicians; conversely, that [the patient] submitted herself to the care of the participating physicians in response to an invitation from HMO.

Boyd, the theory of ostensible agency may be a valid basis for holding an HMO vicariously liable for the negligent acts of its physicians.

C. Corporate Negligence

In addition to the theories of *respondeat superior* and ostensible agency, the third traditional theory upon which hospitals are held liable for the negligence or malpractice of their physicians is the theory of corporate negligence. The doctrine of corporate negligence provides that a hospital owes an independent, non-delegable duty to its patients to exercise reasonable care in insuring that the physicians selected as members of the hospital staff are competent.[152] This doctrine, like those discussed above, was adopted as courts recognized that hospitals should play a greater role in controlling the quality of the health care which they provide.[153] Hospitals must monitor the quality of the health care which they provide by both ensuring that their medical staffs are qualified and evaluating and reviewing the care that is provided.[154]

The doctrine of corporate negligence was first introduced in *Darling v. Charleston Community Memorial Hospital*.[155] The plaintiff in *Darling* broke his leg in a college football game.[156] The defendant emergency room doctor placed the leg in a plaster cast.[157] Soon afterward, the plaintiff experienced great pain in his leg and his toes became swollen and discolored.[158] Three days later the defendant physician removed the cast from Darling's infected leg.[159] The plaintiff was subsequently transferred to another hospital and after several futile attempts by another physician to save the plaintiff's leg, the limb ultimately had to be amputated eight

---

Id.

152. *See* Tucson Medical Center v. Misevch, 113 Ariz. 34, 545 P.2d 958 (1976), discussed *infra* at notes 166-69 and accompanying text; Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965); Pedroza v. Bryant, 101 Wash. 2d 226, 677 P.2d 166 (1984), discussed *infra* at notes 170-75 and accompanying text.

153. Janulis & Hornstein, *Damned If You Do, Damned If You Don't: Hospitals' Liability for Physician Malpractice*, 64 NEB. L. REV. 689, 690-92 (1985); Perdue, *Direct Corporate Liability of Hospitals: A Modern Day Legal Concept of Liability for Injury Occurring in the Modern Day Hospital*, 24 S. TEX. L.J. 773, 774-75 (1983).

154. Johnson v. Misericordia Community Hosp., 99 Wis. 2d 708, 719, 301 N.W.2d 156, 165 (1981), discussed *infra* at notes 176-82 and accompanying text.

155. 33 Ill. 2d 326, 211 N.E.2d 253 (1965).

156. *Id.* at 328, 211 N.E.2d at 255.

157. *Id.*

158. *Id.*

159. *Id.*

inches below the knee.[160] The Illinois Supreme Court held the defendant hospital liable for breaching its duty to review the treatment and procedures of its independent contractor physicians.[161]

Darling was the first case to recognize that hospitals are responsible for a wide range of factors affecting the quality of care which they offered.[162] Hospitals were forced to acknowledge that they had a direct legal responsibility to their patients for the quality of care rendered on their premises.[163] *Darling* was a landmark case because it authoritatively set forth the duties that a hospital owes its patients.[164]

Other jurisdictions followed *Darling* and applied the corporate negligence theory to hospitals.[165] For example, in *Tucson Medical Center v. Misevch*,[166] the Supreme Court of Arizona recognized the overall policy considerations and changing role of hospitals when it held the defendant hospital liable for wrongful death under the theory of corporate negligence.[167] The court stated that a hospital assumes certain responsibilities for the care of its patients and, therefore, it must meet the standards of responsibility commensurate with this trust.[168] If a medical staff is negligent in supervising its members or in failing to recommend action by the hospital's governing body prior to the case in issue, then the hospital is negligent and should be liable.[169]

In *Pedroza v. Bryant*,[170] the Supreme Court of Washington expressly adopted the corporate negligence theory as applied to hospitals. The *Pedroza* court noted the widespread application of the corporate negligence doctrine in other jurisdictions and reiterated that the public recognized hospitals as providers of a wide range of

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

161. *Id.* at 333-34, 211 N.E.2d at 258.

162. *Id.* at 333, 211 N.E.2d at 258. Some of the factors for which the defendant was held liable included failure to have a sufficient number of trained nurses for bedside care of all patients at all times capable of recognizing the progressive gangrenous condition of the plaintiff's leg, failure to require consultation with or examination by members of the hospital surgical staff skilled in such treatment, and failure to review the treatment rendered to the plaintiff. *Id.*

163. Janulis & Hornstein, *supra* note 153, at 704.

164. *Darling*, 33 Ill. 2d at 330-34, 211 N.E.2d at 256-58; Janulis & Hornstein, *supra* note 153, at 703.

165. For examples of cases that have applied the corporate negligence theory to hospitals, see *infra* notes 166-82 and accompanying text.

166. 113 Ariz. 34, 545 P.2d 958 (1976).

167. *Id.* at 36, 545 P.2d at 960.

168. *Id.*

169. *Id.*

170. 101 Wash. 2d 226, 677 P.2d 166 (1984).

health care services.[171] The court concluded that the increased public reliance upon hospitals favored adopting the corporate negligence theory.[172] Additionally, the court reasoned that hospitals are in a superior position to monitor and control physician performance.[173] The *Pedroza* court, however, limited its application of the doctrine to cases where the plaintiff was a patient within the hospital.[174] Under *Pedroza*, individuals harmed from treatment in a physician's private office could not recover even though the physician might be a hospital staff member.[175]

Johnson v. Misericordia Community Hospital[176] is a landmark case involving the doctrine of corporate negligence in the hospital context. The plaintiff, Johnson, was permanently injured when a physician negligently removed a pin fragment from his hip.[177] The plaintiff contended that the hospital was liable for negligence in failing to investigate the attending physician's background and abilities when the hospital knew or should have known that the physician lacked the proper credentials.[178]

In a detailed opinion examining the history of the corporate negligence doctrine, the Supreme Court of Wisconsin held that the promotion of quality care and treatment of patients requires hospitals to perform a thorough evaluation of medical staff applicants.[179] Such an evaluation should inquire into areas of professional competence, ethics, and established reputation.[180] The court further held that hospitals are required periodically to review the qualifications of their staffs through a peer review or medical audit mechanism.[181] The court also emphasized that the patient's welfare is the primary concern of hospitals requiring them to establish basic procedures to prevent subjecting patients to harm and injury by physicians who fail to possess an adequate level of technical skill,

171. *Id.* at 230-31, 677 P.2d at 169.

172. *Id.*

173. *Id.*

174. *Id.* at 237, 677 P.2d at 171-72.

175. *Id.*

176. 99 Wis. 2d 708, 301 N.W.2d 156 (1981).

177. *Id.* at 710, 301 N.W.2d at 158. The jury found that the doctor was negligent. *Id.* This finding was based on undisputed expert testimony regarding the inadequacy of the procedure performed and it was not challenged on appeal. *Id.*

178. *Id.* The evidence established that the hospital did not investigate the doctor's application before appointing him to the staff and that the hospital should not have granted the doctor orthopedic privileges. *Id.* at 715, 301 N.W.2d at 163.

179. *Id.* at 722-23, 301 N.W.2d at 169.

180. *Id.* at 723, 301 N.W.2d at 169.

181. *Id.* at 734-35, 301 N.W.2d at 169-70.

competence, and ethical principles.[182] Thus, the *Johnson* court emphasized that the theory of corporate negligence is necessary in the health care context in order to assure quality health care.

Despite ever-expanding corporate liability, the doctrine of corporate negligence has not been successfully applied to HMOs. *Harrell v. Total Health Care*[183] represents an unsuccessful attempt to hold an HMO liable for its negligent review and control of a physician. In *Harrell*, the plaintiff, Mrs. Harrell, consulted her primary care physician regarding a urinary tract problem.[184] Mrs. Harrell was referred to Dr. Witt, who performed urological surgery on the plaintiff.[185] In the medical malpractice case that was severed for trial, the court found that the surgery was negligently performed.[186] Mrs. Harrell then attempted to sue the HMO for failure to investigate Witt's credentials and reputation, which would have disclosed the large number of medical malpractice suits then currently pending against Dr. Witt.[187] The court never addressed the issue of corporate negligence. Instead, the court focused on a Missouri statute which immunizes health services corporations from liability.[188] Total Health Care was found to be a health services corporation and, therefore, was immune from liability.[189] Thus, the applicability of corporate negligence to an HMO is unresolved.

IV. ANALYSIS

Traditional theories of liability are applicable to hospitals and their physicians. Courts recognize an expanded basis of liability for hospitals, which forces these institutions to play a greater role in the monitoring of the quality of their health care. HMOs, however, are different health care entities, and the stance that courts will advocate regarding these alternative delivery systems is still unclear.

A. Respondeat Superior

Cases involving the *respondeat superior* theory of liability (for both hospitals and HMOs) focus directly on the aspect of con-

182. *Id.* at 735, 301 N.W.2d at 170.
183. No. WD 39809, slip op. (Mo. Ct. App. Apr. 25, 1989).
184. *Id.* at 3.
185. *Id.*
186. *Id.*
187. *Id.* at 5.
188. *See* MO. ANN. STAT. § 354.010(4) (Vernon 1978).
189. *Harrell*, No. WD 39809, slip op. at 9.

trol.[190] The employer, the hospital or HMO, is liable if it exerts control over the practicing physician who commits malpractice or negligence.[191] The vast differences among the various types of HMOs may preclude the application of *respondeat superior* in certain situations.[192] The *respondeat superior* theory of liability will apply most readily to the group and staff model HMOs, as those HMOs typically exercise some control over their physicians.[193] The group and staff model HMOs exert such control by contracting directly with the physician, utilizing some type of review procedure to measure the quality of care and owning the facilities and equipment which the physicians use.[194] Thus, when an employer-employee relationship exists in the typical staff and group model HMOs, the theory of *respondeat superior* should apply.

On the other hand, IPA model HMOs are less likely to be vicariously liable based on the theory of *respondeat superior*.[195] The physicians in a pure IPA model HMO essentially run their own practice — they use their own facilities and equipment, keep their own records, and administratively deal directly with the patients rather than through the HMO.[196] The IPA model HMOs exert no control over their physicians, and the physicians cannot be characterized as employees.[197] Consequently, the theory of *respondeat superior* should not apply to IPA model HMOs.

In determining the actual relationship between an HMO and a physician, a court should consider the following factors: method of payment, ownership of facilities, and control.[198] Physician payment by means of a salary is indicative of an employer-employee situation.[199] In addition, if a physician practices in his own office, rather than an HMO facility, the HMO will generally exert less control over that physician. Finally, the HMO's ability to assign

190. Oakley & Kelley, *supra* note 20, at 627.

191. *Id.*

192. *Id.* at 626. "Courts will review both the contract between the HMO and the physician and the actual day-to-day relationship between the physician and the HMO." *Id.*

193. For descriptions of these models, see *supra* notes 9-19 and accompanying text.

194. Sloan v. Metropolitan Health Council, 516 N.E.2d 1104 (Ind. Ct. App. 1987). For a description of a review procedure, see *supra* notes 81-83 and accompanying text.

195. Binford, *supra* note 7, at 338 n.3.

196. For a description of IPA model HMOs, see *supra* notes 20-25 and accompanying text.

197. J. MICHAELS, *supra* note 8, at vi; Oakley & Kelley, *supra* note 20, at 625.

198. Oakley & Kelley, *supra* note 20, at 627-29.

199. On the other hand, "[i]f the payment arrangement [between the HMO and the physician] is invisible to other parties it may facilitate an inference by those other parties that an independent relationship does not exist." *Id.* at 628.

physicians to subscribers or to coordinate the scheduling of physicians is evidence of control over these physicians by the HMO, and will strengthen the argument in favor of establishing an employer-employee relationship.

The advent of HMOs as an alternative health care delivery system should not change the policy established in *Bing v. Thunig*.[200] *Sloan v. Metropolitan Health Council of Indianapolis*[201] established that the theory of *respondeat superior* can be applied to HMOs in the same way that it is applied to hospitals and other health care providers.[202] In *Sloan*, the court looked beyond public policy which precluded health care providers from vicarious liability.[203] Instead, the court emphasized substance over form — no matter what label was applied to the physicians, the court determined that the physicians were actual employees of the HMO.[204] This application of *respondeat superior* is consistent with the court's policy toward hospitals. In contrast, when the physicians associated with an HMO are independent contractors, as with a pure IPA model HMO, then the HMO will be shielded from vicarious liability under *respondeat superior*.[205]

B. Ostensible Agency

Even when the physician is an independent contractor, however, a plaintiff may still recover for the physician's malpractice from a health care entity based on the theory of ostensible agency.[206] When the appearance that an agency relationship exists between a hospital and its physicians, the hospital will be liable for that physician's negligence, in the event that the patient reasonably relied on that appearance to his detriment or injury.[207]

The theory of ostensible agency will apply to all three HMO models because the actual relationship between the physician and

200. 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957) (one of the first cases to expand the liability of hospitals under the theory of *respondeat superior*). For a discussion of the *Bing* case, see *supra* notes 52-59 and accompanying text.

201. 516 N.E.2d 1104 (Ind. Ct. App. 1987), discussed *supra* at notes 75-95 and accompanying text.

202. *Id.* at 1109.

203. *Id.* at 1107.

204. *Id.* at 1108.

205. *See* Williams v. Good Health Plus-HealthAmerica, 743 S.W.2d 373 (Tex. Ct. App. 1987) (*respondeat superior* did not apply to an HMO which was a pure IPA model HMO and which retained very little control over its physicians). For a discussion of the *Williams* case, see *supra* notes 123-35 and accompanying text.

206. Oakley & Kelley, *supra* note 20, at 630.

207. *Id.* at 629.

the HMO is irrelevant. Unless otherwise indicated, the public assumes that contracting physicians are employed by the HMO. Thus, the HMO bears responsibility for its physicians, unless it expressly enumerates that its physicians are independent contractors. In *Williams v. Good Health Plus-HealthAmerica*,[208] the HMO went to great lengths to inform its subscribers that the member physicians were independent contractors.[209] Even the details, such as the letterhead on the physicians' memoranda, served to support the independent contractor status.[210] The subscribers knew or should have known that the HMO exerted very little, if any, control over these physicians.[211] An HMO that goes to such lengths to disclose to its members the actual HMO-physician relationship should be free from any liability based on ostensible agency.

Boyd v. Albert Einstein Medical Center[212] is significant to the ostensible agency theory because it suggests that the theory is applicable to HMOs. The case sets forth some of the factors which a court considers in determining whether an ostensible agency relationship exists between a physician and an HMO. For example, such things as name tags, insignias on garments, signs, and the fact that the HMO may assign a physician or provide a list of physicians to its subscribers may be influential in an argument supporting ostensible agency.[213] Such factors serve to "hold the physicians out" as employees of the HMO.[214] In addition, statements such as "he's our [HMO's] best man" may lead a patient to believe that the physician was an employee of the hospital or HMO.[215]

Possibly the most important factor that could lead to establish-

208. 743 S.W.2d 373 (Tex. Ct. App. 1987).

209. *Id.* at 378.

210. *Id.*

211. *Id.* at 379.

212. 547 A.2d 1229 (Pa. Super. 1988), discussed *supra* at notes 136-51.

213. *Id.* at 1235. *See also* Porter v. Sisters of St. Mary, 756 F.2d 669, 673 (8th Cir. 1985).

214. For cases that involve the holding out theory as it applies to hospitals, see Jackson v. Power, 743 P.2d 1376 (Alaska 1987), discussed *supra* at notes 112-19 and accompanying text; Beeck v. Tucson Gen. Hosp., 18 Ariz. App. 165, 500 P.2d 1153 (1972); Vanaman v. Milford Memorial Hosp., 272 A.2d 718 (Del. 1970); Irving v. Doctors Hosp., Inc. 415 So. 2d 55 (Fla. App. 1982); Williams v. St. Claire Medical Center, 657 S.W.2d 590 (Ky. App. 1983); Mehlman v. Powell, 281 Md. 269, 378 A.2d 1121 (1977); Howard v. Park, 37 Mich. App. 496, 195 N.W.2d 39 (1972); Rucker v. High Point Memorial Hosp., 20 N.C. App. 650, 202 S.E.2d 610 (1974); Hannola v. Lakewood, 68 Ohio App. 61, 426 N.E.2d 1187 (1980); Themins v. Emmanuel Lutheran Charity Bd., 54 Or. App. 901, 637 P.2d 155 (1981); Capan v. Divine Providence Hosp., 287 Pa. Super. 364, 430 A.2d 647 (1980), discussed *supra* at note 147.

215. *But see* Porter v. Sisters of St. Mary, 756 F.2d 669 (8th Cir. 1985) (such a statement alone failed to supply the proof necessary to establish ostensible agency).

ing an ostensible agency relationship is advertising.[216] As commentators have noted, "[h]ospital advertisements often fail to communicate clearly to the consumer that independent contractors, and not hospital employees, provide the alternative health services."[217] This will be especially applicable to HMOs, which are often dependent upon advertising. For example, in order to attract the greatest number of subscribers, HMOs often emphasize their "comprehensive" health care package and the qualifications of their physicians.[218] Prospective patients may rely on these representations and an HMO, like a hospital, may be liable on a holding out theory if it fails to live up to the patient's reasonable expectations.[219] Thus, due to the increasingly large amounts of advertising in the health care industry, the ostensible agency doctrine may be applied more frequently to HMOs until these health care providers begin clearly delineating the actual relationship between themselves and their physicians.

C. Corporate Negligence

In *Darling v. Charleston Community Memorial Hospital*,[220] the corporate negligence theory was applied specifically to hospitals. *Darling* established that hospitals have a duty to choose their physicians with care and to review the medical care provided by the physicians.[221] Even though application of the doctrine of corporate negligence to hospitals is often qualified or restricted,[222] "the trend is toward broadening corporate liability."[223] Society has an obvious interest in maximizing the quality of health care which is provided, and:

> [S]ince it is estimated that seventy-five to eighty percent of all medical malpractice claims arise in hospitals, the institution is the logical starting place for addressing problems of professional

---

216. *See generally* Phoenix & Schlueter, *supra* note 96, at 886 (hospitals advertise to remain competitive in the market).

217. *Id.* at 887.

218. *See* Boyd v. Albert Einstein Medical Center, 547 A.2d 1229, 1232 (Pa. Super. 1988), discussed *supra* at notes 136-51 and accompanying text.

219. Phoenix & Schlueter, *supra* note 96, at 887.

220. 33 Ill. 2d 362, 211 N.E.2d 253 (1965), discussed *supra* notes 155-64 and accompanying text.

221. *Id.* at 369, 211 N.E.2d at 258.

222. *See, e.g.*, Pickle v. Curns, 106 Ill. App. 3d 734, 435 N.E.2d 877 (2d Dist. 1982) (hospital liable only if it knew or should have known that the physician would provide negligent treatment); Fiorentio v. Wenger, 19 N.Y.2d 407, 227 N.E.2d 296, 280 N.Y.S.2d 373 (1967) (hospital will not be held responsible unless it had reason to know that it should have acted within its duty, yet failed to act).

223. Janulis & Hornstein, *supra* note 153, at 705.

> incompetence. Furthermore, the hospital is in a position superior to that of state licensing boards, professional organizations, and [review organizations] to monitor and control physicians' medical performance.[224]

The independent contractor status of the physician is irrelevant in the application of the corporate negligence theory.[225] This theory has yet to be applied to HMOs.

As with hospitals, an HMO should be liable if it negligently selects a physician for membership in the HMO. This is especially true with staff and group model HMOs, in which the subscribers choice of physicians is limited to a small group that the HMO selected. If the HMO negligently selects an incompetent physician, liability should be imposed.[226]

HMOs should have a duty to monitor the selection of their physicians, as hospitals do. In addition, a periodic review procedure[227] would insure the quality of health care that HMOs provide. Such surveillance procedures, however, might increase an HMO's operating costs and limit its accessibility to people of lower incomes. On the other hand, the review procedure would ensure a greater efficiency of services, thereby reducing the patient's costs. Thus, the role of HMOs in providing quality medical care will be altered by future decisions regarding the duties which an HMO has in selecting and monitoring its physicians.

The plaintiff in *Harrell v. Total Health Care*[228] attempted to hold the HMO liable under a corporate negligence theory.[229] Even if the HMO had not been immune from liability,[230] the corporate negligence theory would have shielded the HMO against liability because the HMO served mainly an administrative function and played no role in the assignment or supervision of the physicians.[231]

---

224. Koehn, *Hospital Corporate Liability: An Effective Solution to Controlling Private Physician Incompetence?*, 32 RUTGERS L. REV. 342, 376 (1979).

225. Oakley & Kelley, *supra* note 20, at 632.

226. *Id.* at 633.

227. Such a procedure could be implemented through a medical director or a committee which periodically reviewed a physician's methods and records. *See supra* notes 81-83 and accompanying text.

228. No. WD 39809, slip op. (Mo. Ct. App. Apr. 25, 1989), discussed *supra* at notes 183-89 and accompanying text.

229. *Id.* at 2.

230. The HMO was immune from liability based on a non-liability statute. *See supra* note 188.

231. *Harrell*, No. WD 39809, slip op. at 8. The HMO in this case was mainly responsible for billing and reimbursement of subscribers for their expenses. *Id.* It did nothing to assist in the rendering of health care services. *Id.*

Group and staff model HMOs might be subject to greater liability under the corporate negligence doctrine than IPA model HMOs. The group and staff HMOs exercise control over their physicians, reflecting an employer-employee relationship. Due to this control, the recruitment and the selection of the physicians becomes important. The theory of corporate negligence dictates that the HMO is liable for negligent selection of its physicians. The doctrine is not amenable to application to IPA model HMOs because three acts of negligence would have to be established: negligent selection of the IPA by the HMO, negligent selection of the physicians by the IPA, and negligence of the physician who provided the care.[232] In the absence of any authority, however, it is not certain that courts will apply this doctrine to HMOs in the same way that they apply it to hospitals.

Given the trend towards broadening the liability of providers of health care, HMOs will be held liable for the malpractice and negligence of their physicians. When disputes arise, courts will be forced to make decisions concerning the role of the HMO. Courts will face a vital decision of who ought to bear responsibility for the physician's negligence. State legislatures and the judiciary responded when the character of the hospital was changing, increasing the duties and responsibilities of the hospital in maintaining the quality of care which it provided to the general public.[233] The same policy considerations should apply in determining the potential liability of HMOs.

V. IMPACT

If HMOs face the same expanded liability that hospitals currently encounter, the nature and role of HMOs in society could be altered dramatically. An increased basis of liability could multiply the number of controls which the legislature and judiciary will impose on alternative health care delivery systems. Possible controls include prescribed procedures regarding physician selection, physician review, control of facilities, and more rigid subscriber application requirements. If greater controls are imposed, increases in HMO operating costs and subscriber enrollment fees will follow. Increased costs might eliminate one of the most attractive and unique aspects of the present day HMO — affordability. By increasing the bases of liability, courts and legislatures will doom

232. Binford, *supra* note 7, at 346. These three acts of negligence are necessary because the IPA selects the physician and the HMO selects the IPA.

233. *See supra* notes 155-64 and accompanying text.

HMOs to the same fate which plagues other systems of health care delivery, namely, high costs. On the other hand, the increased operating costs might be counterbalanced by greater efficiency resulting from the legislatively and judicially imposed control. At issue is the necessity of balancing the benefits that an HMO offers through affordable costs with the quality of care that an HMO must ensure.

Hospital liability has increased under several theories, forcing these institutions to monitor their employees and their employees' practices. Similar trends will probably occur regarding the liability of HMOs. Inevitably, HMOs will face vicarious liability for the malpractice and negligence of their physicians based on the traditional theory of *respondeat superior*. This doctrine was originally inapplicable to hospitals, but as hospitals changed their methods of operation, the courts felt that hospitals should be treated like other employers.[234] There is no rational justification for courts to treat HMOs any differently than hospitals. Courts should not create an exception to the application of *respondeat superior* by exempting HMOs from liability. This would result in a reversion to the philosophy espoused by *Schloendorff v. Society of New York Hospital*.[235] In determining whether to impose liability, the courts look directly to the relationship between the hospital and the physician.[236] If a plaintiff can establish an employer-employee relationship, then the court will hold the hospital liable for its physician's malpractice and negligence based on *respondeat superior*.[237]

The doctrine of *respondeat superior* does not normally apply to IPA model HMOs because there is no employer-employee relationship between the hospital and the physician.[238] In an effort to avoid liability under *respondeat superior*, an HMO might label itself as an IPA model HMO. These circumstances call for a strict

234. *See* Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957), discussed *supra* at notes 52-59 and accompanying text.

235. 211 N.Y. 125, 105 N.E. 92 (1914), *overruled*, Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957), discussed *supra* at notes 48-50 and accompanying text.

236. *See, e.g.*, Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957), discussed *supra* at notes 52-59 and accompanying text.

237. *See, e.g.*, Beeck v. Tucson General Hosp., 18 Ariz. App. 165, 500 P.2d 1153 (1972); Kober v. Stewart, 148 Mont. 117, 417 P.2d 476 (1966); Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957), discussed *supra* at notes 52-59 and accompanying text; Mduba v. Benedictine Hosp., 52 A.D.2d 450, 384 N.Y.S.2d 527 (1976), discussed *supra* at notes 62-66 and accompanying text; Adamski v. Tacoma Gen. Hosp., 20 Wash. App. 98, 579 P.2d 970 (1978), discussed *supra* at notes 67-71 and accompanying text.

238. For a description of IPA model HMOs, see *supra* notes 20-25 and accompanying text.

scrutiny of the actual relationship between the physician and the HMO. Courts should be careful to distinguish between form and substance in these situations.

Even if an HMO is an IPA model HMO, thus precluding vicarious liability of the HMO under *respondeat superior*, the plaintiff is not left without a remedy. The IPA itself should bear the burden of compensating the plaintiff for injuries due to the physician's negligence or malpractice. This involves a proper application of the *respondeat superior* theory to the IPA rather than the HMO because there will usually be an employer-employee relationship between the IPA and the physician.

The ostensible agency doctrine is a basis of liability against HMOs.[239] The relationship between an HMO and its physicians is often unclear and, in the absence of any indication to the contrary, the public generally assumes that the physicians are employed by the HMO. An HMO that effectively discloses to its members the HMO-physician relationship should be free from any liability based on the theory of ostensible agency. Conversely, when the relationship between the physician and HMO is unclear and the HMO holds out the physician as its employee, the HMO should be liable for the malpractice of its physicians. Imposing liability would be consistent with the evolution of ostensible agency as applied to hospitals.[240]

To avoid liability, the best defense for all three HMO models is a systematic approach to public relations that involves informing the patient of the medical facts and the procedural facts.[241] The procedural facts include disclosing the identity of the health care provider, describing the relationship between the provider and the HMO, and noting the HMO's role in the patient treatment plan.[242] Such a detailed disclosure to patients should absolve an HMO from vicarious liability under ostensible agency.[243]

239. For a discussion of the ostensible agency theory of vicarious liability, see *supra* notes 96-151 and accompanying text.

240. For a description of the application of the ostensible agency doctrine to hospitals, see *supra* notes 100-22 and accompanying text.

241. Phoenix & Schlueter, *supra* note 96, at 890.

242. *Id.* The actual relationships between the HMO and the physician within the three models are not important in establishing ostensible agency because an agency relationship is deemed to exist even if, in fact, it does not. RESTATEMENT (SECOND) OF TORTS § 429 (1984).

243. Oakley & Kelley, *supra* note 20, at 630. It is important to note that disclaimers declaring the parties independent contractor status are not always sufficient because under the doctrine of ostensible agency, the courts focus on the overall appearance of an agency relationship. Disclaimers, however, will likely aid in avoiding false impressions, especially when communicated to third parties. *Id.*

Additionally, HMOs should be careful in advertisements, as this is an increasingly popularly device that HMOs use to "hold themselves out" to the public. For an HMO to avoid liability, its advertisements should indicate the independent contractor status of the HMO physicians and that the HMO itself is not responsible for providing the health care services.[244] Some HMOs may not choose to make such disclosures, instead utilizing a riskier strategy of maximizing its name recognition and market share.

The development of HMO liability under the corporate negligence doctrine will probably parallel the evolution of the doctrine in its application to hospitals.[245] The application of the doctrine to these health care entities is based on the notion that the provider must attempt to ensure that health care is of a certain quality. This is logical because the HMO is in the best position to monitor the practices and background of its physicians. In the group and staff model HMOs, the HMO's administrative body recruits or selects the individual physicians. Thus, the HMO should bear the responsibility if it negligently selects the physicians and should be subject to liability under the corporate negligence doctrine.

VI. CONCLUSION

The emergence of HMOs as a popular health care delivery systems raises questions regarding their liability. Due to the lack of litigation regarding HMOs, it is difficult to draw firm conclusions regarding the extent of their liability for the acts of their physicians. Hospitals traditionally have been held liable for the malpractice of their physicians based on the theories of *respondeat superior*, ostensible agency, and corporate negligence. The hospital cases are informative in that they show a trend toward expanding liability for health care providers. Even though HMOs are a relatively new system of health care delivery that differ in a number of ways from hospitals, HMOs will probably be subject to similar expanding liability. The few cases reported demonstrate that courts will look beyond the labels attached to HMOs to determine the actual relationship between the physician and the HMO to decide whether or not to impose liability. Consequently, as HMOs con-

244. *See generally* Phoenix & Schlueter, *supra* note 96, at 890. HMOs cannot avoid liability completely by making such statements if they do not indicate the actual relationship between the HMO and the physician. As previously stated, courts will probably look to substance over form in these situations. *See supra* note 243. Also, such misstatements may render the HMO liable for a breach of warranty.

245. For a discussion of the evolution of the corporate negligence doctrine as it applies to hospitals, see *supra* notes 152-82 and accompanying text.

tinue to become more popular, they will almost certainly be subject to an increased number of malpractice claims. The viability of HMOs may depend upon their ability and willingness to protect themselves adequately against malpractice claims.

MICHAEL KANUTE