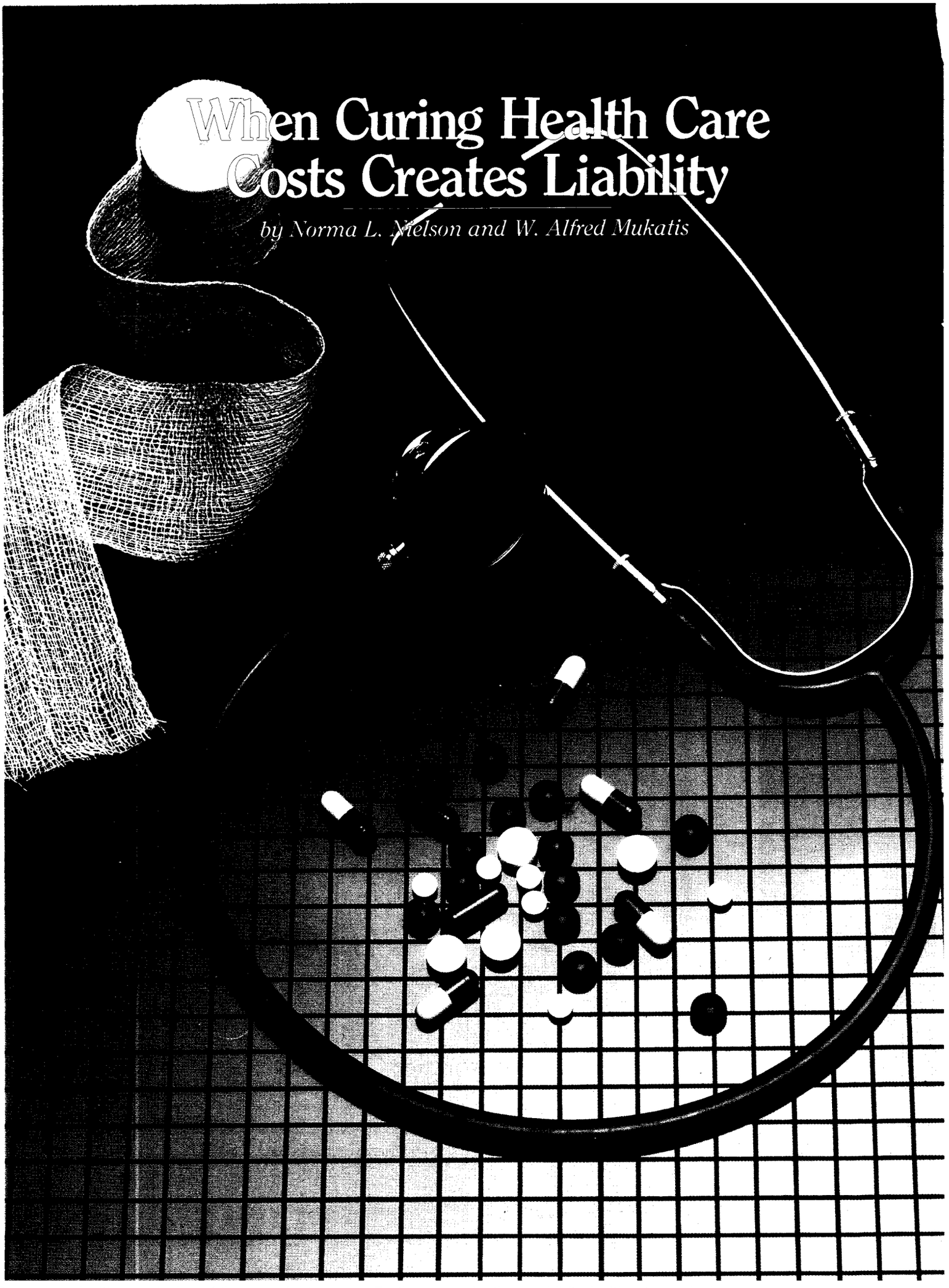
When Curing Health Care Costs Creates Liability

by Norma L. Nielson and W. Alfred Mukatis



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RM GENERAL

Highlights of the 1985 Cost of Risk Survey, James D. Blinn, Michael R. Levin. January, p. 22.

The fourth Cost of Risk Survey conducted by RIMS and Tillinghast Towers, Perrin, Forster, and Crosby designed to measure the effectiveness of risk cost controls.

Proof Is In The Process, Rita Epstein. January, p. 46.

This Asia Pacific Conference session overviews the risk management process through the perspectives of a risk manager, broker and underwriter.

A New Understanding of Risk Management, Alexander Berlonghi and Jurg W. Mattman. April, p. 54.

Recognizing that risk managers provide an invaluable internal link within a corporation, the article maintains that risk managers must be well-versed in a variety of subjects and also be able to analyze the impetus that makes upper management act.

The New Breed of Risk Managers: Learning to Adapt in a Turbulent Market, William B. Mather. April, p. 92.

A review of the challenges and changing priorities and problems facing risk managers.

RIMS Pittsburgh Chapter Calls for a Return to Solid Underwriting Skills, Tom Johnson. April, p. 96.

Advocates a "back to basics" approach to underwriting skills and ethics during the insurance recovery period.

Putting the Liability Insurance Crisis in Perspective, John Harkavy. April, p. 104.

Reviews the problems facing the liability insurance market, the need for tort reform and the significance of the growth in alternative risk financing mechanisms.

The Risk Manager's Role in Preventing Product Liability Claims, Darwin B. Close. May, p. 36.

Discusses the results of a survey conducted by the author which asked risk managers where in manufacturing and marketing activities did they think their involvement should be increased. The data indicates that few risk managers want to expand their duties in the product liability area.

Who is Responsible for Managing the Information Flow? Jim Loeb. May, p. 44.

Details the necessary steps to take when establishing a risk management information system including identification, evaluation, treatment and monitoring of information.

A New Opportunity to Control Claims Information, Alan B. Cantor. May, p. 48.

Explains how risk managers can produce reasonable projections of expected losses as well as present value costs under different tax analyses by using personal computers.

Using Behavioral Research to Uncover Hidden Jury Bias, Donald E. Vinson. June, p. 44.

Describes how behavioral research statistics can be used to make informed decisions concerning the most effective way to proceed with a trial and select juries.

Risk Management...By Many Other Names, Felix Kloman. June, p. 56.

Discusses how risk managers must broaden their definition of risk management and develop systematic approaches for dealing with the insurance market.

PRIMA Soars Through Its Eighth Annual Conference, Ken Weinstein. July, p. 50.

Provides an overview of the issues effecting public risk managers as discussed at the 1987 annual Public Risk and Insurance Management Association (PRIMA) conference.

Avoiding the Ivory Tower Syndrome, Bruce McEwan. August, p. 34.

Risk managers should analyze their job functions to see if they are balancing their work between "administrative tasks," and "operational tasks."

RIMSNET: Riding the Information Wave, Brynell Somerville. August, p. 40.

Describes the features subscribers to the electronic news and information network receive, including electronic mail, a risk management index and the Standard and Poor's Insurance Rating Service.

The Making of a Risk Manager—Part One, Robert M. Bieber. September, p. 23.

Explains why risk managers and their departments must master many skills to minimize company losses in the least expensive way.

Commentary: Professionalism and the Risk Manager, Suzanne H. Crager. September, p. 58.

Exhorts risk managers to take a more active role in their profession and criticizes the lack of response to the Cost of Risk Survey as an illustration of risk managers' lack of involvement.

Emerging Issues in Risk Management: The Responsibilities and the Opportunities are Changing, Richard C. Heydinger. September, p. 60.

Discusses new developments occurring in the legal, political and insurance fields that will affect risk managers and how they perform their jobs.

The Making of a Risk Manager—Part Two, Robert M. Bieber. October, p. 48.

This second of two articles discusses that it is important to first understand the management side of the risk management process in order to make the process work.

Duke University to Launch Workers' Compensation Chair, Tom Johnson. November, p. 91.

Discusses the formation and funding of a chair at Duke University devoted to the study and arbitration of workers' compensation issues.

RM APPLICATIONS

Burgeoning Business, Rita Epstein. January, p. 48.

Discusses some of the ramifications of doing business in the People's Republic of China.

Project CARE—A Grass Roots Solution to the Excess Liability Crisis, Tom Johnson. January, p. 58.

Discusses Corporate America's Risk Exchange or CARE—a newly formed excess liability insurance company devoted to providing insurance at cost.

Promoting Risk Management in Developing Countries, Harold D. Skipper, Jr.. June, p. 18.

Referring to a report published by Georgia State University's Center for Risk Management and Insurance Research for the United Nations Conference on Trade and Development, the article discusses which government and business entities should be involved in promoting risk management in developing countries.

The New Frontier: Integrating Human Resources and Risk Management, Henry V. S. Hall. October, p. 28.

Describes how a company integrated the two departments and effectively controlled risks and significantly cut losses.

The Mattman Model: The Risks of Special Events, Jurg W. Mattman and Alexander E. Berlonghi. October, p. 60.

Presents the model that attempts to guide the risk manager in assessing risks of special events, maintaining that assessment of risk and fact are different and communication between the risk manager and the organizer of the event is vital.

Keeping Boiler Operation Costs at a Simmer, David V. Carlson. November, p. 62.

Discusses the new techniques involved in

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inspecting a steam boiler and the techniques that can be used to minimize risk such as pre-emergency plans, training programs and maintenance logs.

LOSS CONTROL

Profit, Loss and Risks. Rita Epstein. January. p. 48.
Focuses on the specific requirements that facilities must meet if they are deemed to be highly protected risks.

Financial Responsibilities in An Insurer Insolvency: Widespread Misconceptions. Corbette S. Doyle, Michael J. Ammean, James V. Davis. April. p. 22.
Cites such industry sources as Best Ratings, NAIC Early Warning Tests and SEC Loss Reserve Disclosure as ways to assess the financial strength of insurers.

Management Considerations for Emergency Plan Development. Michael Krikorian. April. p. 38.
Article helps companies find out if an emergency plan is needed through a risk evaluation that can identify workplace hazards, determine exposures, and quantify and assess risks.

How One Utility Used Accountability and Loss Prevention to Cut Liability Costs. Phil Zinkewicz. April. p. 45.
Relates how Brooklyn Union Gas changed its direction by focusing on potential loss areas instead of existing ones and lowered its projected expenditures for legal and claims-related costs from 19 percent to under four percent.

A Glimpse at the Phoenix of CAP Policies. Russell A. Drake, Jr.. April. p. 64.
Discusses the rise and fall of corporate asset protection policies and touches upon a new concept which could be called a claims paid insurance policy tailored to cover corporations only for claims paid, not for what has occurred.

Assessing Insurer Insolvency: An In-House Method. Eric P. Hein. May. p. 18.
Offers a number of signs that a risk manager should look for in order to detect a potential insolvency.

New Ways to Look at Loss Control. Susan Hurley. May. p. 76.
Speakers discuss different methods risk managers can use to train and educate management and employees to lower a company's loss exposure.

The Balance Sheet Effects of Insuring Property at Book Value. Bob A. Hedges. July. p. 54.
Discusses how limiting property insurance coverage to the book value of property can have an adverse effect on financial recovery and net cash flow in case of loss.

Managing Earthquake Exposures. Russell C. Opferkuch and Douglas O. Frazier. August. p. 16.
Recommendations for properly assessing seismic loss potential by analyzing buildings individually and the effect adjoining buildings will have on each other during an earthquake.

Loss Cost Allocation: Don't Carry That Weight. Oakley E. Van Slyke. September. p. 34.
Explains why proper loss allocation is important and discusses several different methods for allocating loss costs among company divisions.

A Successful Equation for Protecting Computers. Kenneth E. Berg. September. p. 52.
Examines different methods for protecting computer centers from fire water smoke damage.

Truth and Consequences: The European Directive on Product Liability. Edward J. Hester. October. p. 38.
Discusses the impact of the European Commission's adoption of the trend to put product liability burden of proof on the manufacturer into law.

Pre-Placement Screening: Survival of the Fittest. Charles K. Anderson. November. p. 44.
Explains how pre-placement screening can be an effective way to control workplace injuries.

Defining Policy Terms: The Critical Path to Loss Control. Donald B. McDougall. November. p. 56.
Discusses how risk managers and brokers should agree on the concepts and definitions of "value" and what value definition could arise in loss situations.

EMPLOYEE BENEFITS/ HEALTH CARE DELIVERY

Getting to Know COBRA. Craig W. Plumhoff. January. p. 16.
Overviews COBRA specifics including such provisions as broadening employer responsibility to terminated employees, protecting dependents who lose their medical coverage due to divorce or death of an employee and protecting children whose coverage ends due to age or marital status.

Why Be Concerned with Chronic Pain Treatment?. Richard L. Stieg. January. p. 28.
Discusses how Chronic Pain Syndrome (CPS), a condition in which chronic pain tied to pathological causes, is one of the most expensive health problems in the U.S.

Future of Employee Benefits Sets Conference Agenda. Tom Johnson and Howard Greene. January. p. 54.
Authors report on the International Foundation of Employee Benefit Plans annual conference, including pertinent issues that faced the 100th Congress.

Medic First Aid: A Risk Management Tool. Jerry L. Hedrix. February. p. 48.
Discusses the fusion of CPR and first aid into Medic First Aid—an innovative system of life saving in an easy to understand format.

Mandated Employee Benefits: Something To Look Forward To?. Ken Weinstein. February. p. 60.
Discusses upcoming legislation, the major issues surrounding these benefits and offers 1987 predictions.

Controlling Benefit Costs: The Flexible Option. L. Brian Rush. April. p. 30.
Discusses how employers and employees need to come to an understanding on how to share the expense of a benefit program in order to control costs.

The Employee Benefits Mandate—Direct Action to Fill the Void. Tom Johnson. May. p. 66.
Panelists at RIMS annual conference discuss the pros and cons of mandating employee benefits at both state and national levels.

David Levinson's Pledge of Allegiance to Good Health. Tom Johnson. May. p. 68.
Interview probes Mr. Levinson's healthcare philosophy of providing incentives that would motivate people into making healthy lifestyle choices.

Employee Benefits At Large: A Conversation With Phyllis Borzi. Tom Johnson. May. p. 69.
Conversation details Ms. Borzi's views on a variety of employee benefits issues including prefunding mechanisms for retiree welfare benefits, the effect on the business community of catastrophic medical insurance, and the passage of parental leave proposals in Congress.

An Apple a Day Won't Reduce Doctor's Charges. Tom Johnson. May. p. 70.
Seminar coverage details the expensive problem of successfully managing doctor's charges.

Coping with AIDS on the Job. Thomas J. Naglieri. June. p. 36.
Suggests guidelines employers can use to develop effective corporate policies that deal with the AIDS epidemic including formulating policy checklists and keeping abreast of medical developments.

Understanding the Demographics of Aging. Tom Johnson. June. p. 78.
Panelists at RIMS annual conference divide the American populace into different age sub-groups and discuss the particular healthcare benefit funding problems that apply to each.

MedFacts: An Intelligent Way to Choose Health Care. Joseph G. Charles. November. p. 28.
Describes the Medical Information Service developed at Ryder Systems, Inc. to provide employees with a database of healthcare information.

RISK RETENTION

An Overview of the Risk Retention Act. Michael J. Mullen. January. p. 36.
Discusses how the Risk Retention Act was passed by Congress in 1986 to help special risk retention groups purchase insurance and how it benefits risk managers by eliminating certain provisions contained in state insurance laws that impose conflicting requirements on group self-insurance programs.

The Risk Retention Act of 1986: The Options Increase. Jon Harkavy. March. p. 22.
Provides an in-depth analysis of the Act, focusing on how it provides more options for scarce liability insurance coverage.

The Risk Retention Act—More Than Meets the Eye!, Robert H. Myers, Jr., March, p. 36.
Article explores how the Risk Retention Act of 1986 has been updated and improved and now offers expanded insurance capabilities for risk retention groups and more insurance lines that purchasing groups can buy.

Opportunity Knocks: The Risk Retention Act of 1986. James T. McIntyre, Jr., March, p. 42.
States the potential positive benefits of the Risk Retention Act of 1986 including the ability to decrease insurance costs and increase coverage.

The Risk Retention Dilemma, Ken Weinstein, May, p. 75.
Discusses the pros and cons of risk retention and risk purchasing groups and offers an insight into people's fears and anxieties about the Act.

INSURANCE MARKET

Helpful Hints for Mastering the New CGL Policy, Elliot E. Cohen, January, p. 42.
Provides a tip sheet of helpful procedures designed to master the new CGL Policy maze.

A Simple Model for Detecting Financial Distress in P C Users. Ran Bar-Niv and Michael L. Smith, February, p. 38.
Discusses the need for an industry-wide standard for assessing financial distress in an insurer and provides a method of how one may overcome this problem.

Spreading the Blame for the Liability Insurance Crisis. Fikry S. Gahin, March, p. 48.
Article argues that everyone must accept a share of responsibility in causing the liability insurance crisis including the property and casualty industry, the legal profession, insurance commissioners and U.S. society in general.

Tort Reform, Public Relations Will Top Insurers' Agenda in 1987, Elizabeth Hook, March, p. 64.
Report of the annual meeting of the Insurance Services Office and Insurance Information Institute which stressed the problems the insurance industry faces due to misperception by the public and the industry's efforts to counteract the problem.

Is the Insurance Industry Doomed to Follow the Eternal Cycle?, Elizabeth Hook, May, p. 71.
A distinguished panel at the RIMS Conference debate whether or not this last hard market signalled the end of the insurance industry cycle forever.

Daring to Go Bare: Is It a New Alternative?, Elizabeth Hook, June, p. 76.
Report of a RIMS Conference seminar that focused on how a no-insurance program can be made to work even when the market is soft.

Explaining the Mechanics of the Alternative Market, Elizabeth Hook, May, p. 81.
Panelists at a RIMS Conference seminar describe the operation of alternative market vehicles—such as ACE and XL—spawned by the insurance market crisis.

Is There Life in the Umbrella Market?, Elizabeth Hook, May, p. 84.
Since the soft market of the late '70s changed the perception and use of such coverages as umbrella and excess and surplus, panelists at a RIMS Conference seminar analyzed the real purpose and most effective use of these coverages.

New Players in the Insurance Market Game. Elizabeth Hook, June, p. 79.
Interviews with risk management and insurance industry leaders at the RIMS Conference reveals that some of the traditional roles in the industry have permanently changed.

Have We Weathered the Liability Storm?, Elizabeth Hook, December, p. 62.
Panelists at the 4th AEAI RIMS International Forum discuss the emergence of the insurance industry from the liability crisis and the potential effects of the EEC Product Liability Directive.

Risk Managers: The World Is Your Oyster. Elizabeth Hook, December, p. 64.
What lessons were learned from the last hard market and what the softening market means to the future of the industry were analyzed by a Lloyds' broker and an American reinsurer at the 4th AEAI RIMS International Forum.

CGL: The Rumors of Its Demise Are Premature, Elizabeth Hook, December, p. 67.
During a seminar at the 4th AEAI RIMS International Forum, a U.S. broker and Lloyds Peter Wilson give an overview of the CGL policy and the niche it has found in the current insurance market.

Soft Cycle Finds Underwriters in Compromising Position, Ken Weinstein, December, p. 74.
Offers a London underwriter's perspective on the emerging soft cycle and what steps will be taken to avoid making the same mistakes this time around.

LEGAL

Viewpoint: The Creeping Side Effects of Civil Justice Abuse. Warren Anderson, February, p. 52.
Mr. Anderson argues that four particular reforms of the current liability system are vital: revising joint and several liability; capping pain and suffering awards; revising collateral rule; and establishing a state-of-the-art defense system for manufacturers.

Punitive Damages: The Real Story, Stephen Daniels, March, p. 55.
Article details the preliminary results of the American Bar Foundation's study on punitive damages to show that large rewards are not routine.

Avoiding Legal Pitfalls in Claims Made Contracts. Tom Johnson, March, p. 74.
Discusses the viability of providing a legal analytical framework for dealing with the ambiguities of claims made forms.

What Risk Managers Should Know About Medical Testimony, Eric H. Marcus, April, p. 70.
Provides a tip sheet on information to consider when professional medical opinions in court testimony are involved including, recognizing large gaps that exist in the fabric of medical science, and understanding that doctors are human beings and therefore fallible.

The Debate Over The McCarran-Ferguson Act Continues. Ken Weinstein, May, p. 72.
The potential repercussions of either modification or repeal of the Act are revealed by major players in and around the industry.

Tort Reform: Don't Blame the Underwriter. Ken Weinstein, May, p. 73.
Provides an inside view of an insurer's perspective on the need for tort reform.

Pension Legislation on the Move in Canada. Tom Johnson, May p. 99.
Article points to changes in Canadian benefits legislation that have led to a widespread reassessment of corporate benefits strategies in that country—particularly those that concern pension plans.

ADR: Shaking Hands Instead of Shackling Them, Kathleen M. Cullen, June, p. 28.
Discusses alternative dispute resolution with its forums of mediation, arbitration and the mini-trial as a viable alternative to the civil justice system.

What's Up Doc?—The Patient and the Malpractice Suit. Edward E. Bartlett, August, p. 26.
Discusses how communication failures are probably responsible for the vast majority of medical malpractice claims and suggests four ways for those involved in the medical industry to reduce the risk of lawsuits.

Controlling Litigation Can Mean Increased Savings. Steven G. Schumaier, September, p. 44.
Discusses how risk managers can control litigation costs by becoming familiar with litigation concepts and being able to recognize settlement opportunities.

The New Wave of Asbestos Litigation, George A. Peters, November, p. 38.
Predicts a second wave of asbestos litigation will take place in the near future and recommends that risk managers become more informed about asbestos regulations and risks.

1987 RIMS Canadian Conference—"A Risk Management Exposition." Tom Johnson, November, p. 70.
Includes general remarks on the current state of the risk management profession as well as the need for Canadian tort reform and the nature of risks associated with insuring the 1988 Winter Olympics in Calgary.

RIMS West Coast Conference Makes Members' Day! Tom Johnson, November, p. 71.
Discusses the step-by-step process of pushing revised Colorado captive legislation through the state senate and house of representatives.

ADR: A New Tool for Employment Relationships. John E. Sands, December p. 22.
Explains several different ways in which alternative dispute resolution can be used by employers to diffuse conflicts between employees and reduce employers' chances of financial loss.

CAPTIVES

Life for Offshore Captives under the New Tax Law, William L. Burke and John J. Sarchio. February. p. 20.
Shows how the Tax Reform Act of 1986 will effect offshore captive insurers by discussing discount loss reserves based on mid-term rate rather than a deduction of the full value of the reserves.

Risk Transfer Can be Profitable, R.S. Johnson. February. p. 28.
Discusses how the Risk Exchange Association of Bermuda was designed by risk managers for risk managers to economically transfer parental risk via subsidiary captives to other captives.

On-Shore or Off-Shore: Where To Take Your Captive, Ken Weinstein. May. p. 100.
Notes that risk retention groups are growing, but there are no one-minute solutions and provides guidelines in making the decision to move on-shore or stay off.

ENVIRONMENTAL IMPAIRMENT

The Danger All Around Us, Susan Hurley. June. p. 77.
Speakers discuss the problems risk managers have in coping with carcinogenic exposures present in the workplace.

A 1987 Superfund Primer, G.S. Peter Bergen. July. p. 20
Reviews the creation of the Superfund cleanup fund and the Superfund Amendments and Reauthorization Act of 1986.

Perspectives on Environmental Liability: The Boeing Story, Scott K. Lange. July. p. 28.
Discusses how Boeing became involuntarily involved in the cleanup of a waste recycling operation site when the company's financially troubled waste hauler was listed on a government clean up list.

Environmental Risk Insurance: Don't Count on It, Donald V. Jernberg and Mark C. Furse. July. p. 42.
Discusses how companies can follow several untraditional approaches to obtain environmental risk protection.

Environmental Risk Insurance: You Can Count On It, Eugene R. Anderson and Maxa Luppi. October. p. 68.
A rebuttal to Donald V. Jernberg and Mark C. Furse's article in July, it claims that, in fact, CGL policies do cover hazardous waste claims costs and recommends that risk managers and policy-holders' lawyers seek pollution damages' coverage under any liability policy they have, no matter how old.

Squaring-Off Successfully Against Toxic Waste Risks, Wayne Tusa. November. p. 50.
Suggests ten guidelines to help risk managers reduce the costs associated with the cleanup of hazardous waste sites.

RIMS/INDUSTRY LIAISON

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Looking to the Past to Secure a Better Future, Richard M. Inserra. April. p. 12.

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Meeting the Special Needs of Special Clients, Russel Thomas. November. p. 80.

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RIMS Helps Charm COBRA, December. p. 7.

Every business faces numerous sources of legal liability each day. Liability can arise based on tort, contract, agency and statutory law. In a recent case, said to be the first of its kind, employers were afforded a glance of the potential exposure to liability which they may have brought upon themselves in their quest to contain health care costs. In *Wickline v. State of California* (1986)[1] a California jury held a third-party payor, the State of California through its system for medical welfare, liable and awarded $500,000 to a patient whose leg required amputation after being discharged four days earlier than her physician initially recommended. A Medi-Cal consultant employed by the California Department of Health in its Los Angeles office approved only four days in the hospital when the patient's surgeon had initially stated that eight days was appropriate. While the surgeon could have appealed the shorter preauthorized stay, he chose not to do so and discharged the patient.

The trial court's decision was reversed on appeal, but the appellate court warned that the injured patient should be allowed to recover from all those responsible for the lack of care, including third party payors, and that "third party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms such as when requests for medical care are arbitrarily ignored or unreasonably rejected." This statement is important not only because of its broad sweep but also because the decision arose in California, a state whose precedents often spread to other jurisdictions.

Employers have a right to be concerned about the potential for liability as a result of someone else's actions, especially medical personnel, hospitals, preferred provider organizations (PPOs) and health maintenance organizations (HMOs). Allegations of such liability—referred to in legalese as vicarious liability[2]—would force an employer to incur the costs of defending a lawsuit (even if the defense is ultimately successful) and loss of such a case would find the employer participating in the damages awarded for medical malpractice.

For decades, common law has held an employer responsible for negligence (and sometimes intentional and strict liability) torts committed by employees and other agents in the course and scope of their employment. Therefore, a key element in assessing potential vicarious liability is determining whether medical care givers will be considered legally to be 1) your agents and/or employees or 2) independent contractors. Vicarious liability is imputed to the employer without its breaching a legal duty. Societal concerns for compensating victims form the basis for holding the employer responsible for the person or entity, such as doctor, nurse, hospital, PPO or HMO, who violated a duty. For example when Goodyear Tire & Rubber Company opened a plant in Lawton, Oklahoma in 1984 it attempted to control costs by contracting with local doctors and hospitals to provide medical attention to its employees. Unable to obtain satisfactory agreements, Goodyear built its own medical clinic on the plant site and hired its own doctors, pharmacists, and X-ray technicians.[3] In doing so Goodyear (and any other private employer who hires its own doctors) exposes itself to greater potential liability than if its employees had free choice of physicians who would be viewed legally as independent contractors. Nurses and medical technicians who exercise less discretion are more likely than doctors to be held to be employees or servants rather than independent contractors. However, any of the above medical personnel may be held to be either under appropriate circumstances. Where the medical personnel is held to be an employee or servant, the private employer may be held liable for the negligence and malpractice of the particular individual-care provider under vicarious liability principles in addition to its liability for its own negligent selection and/or retention of generally incompetent individuals.

Where existence of the agency is established, the private employer may be vicariously liable for any medically inappropriate decision that results from a defect in the design or implementation of a cost control mechanism. For example, this legal argument could easily be applied where a private employer or a third-party insurer requires pre-authorization of medical treatment decisions and the request is unreason-

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1. 228 Cal. Rptr. 661 (Cal. App. 1986).
2. Note that the employer may also incur liability for its own negligent selection and/or retention of incompetent medical personnel. Vicarious liability is separate from the liability associated with the negligent selection and/or retention of an incompetent individual and can occur in addition to that negligence liability.
3. M. R. Greene & H. A. Laskey, *The Health Care Cost Containment Effort–How Successful?,* Benefits Quarterly 9, 14 (1st quarter 1985).

ably ignored or arbitrarily rejected. It could conceivably be applied to any cost containment measure of the employer which is subsequently held to be defectively designed or implemented and which when carried out by an agent or employee results in injury to the employee or dependent who is a beneficiary (employee-beneficiary) of the company health care plan.

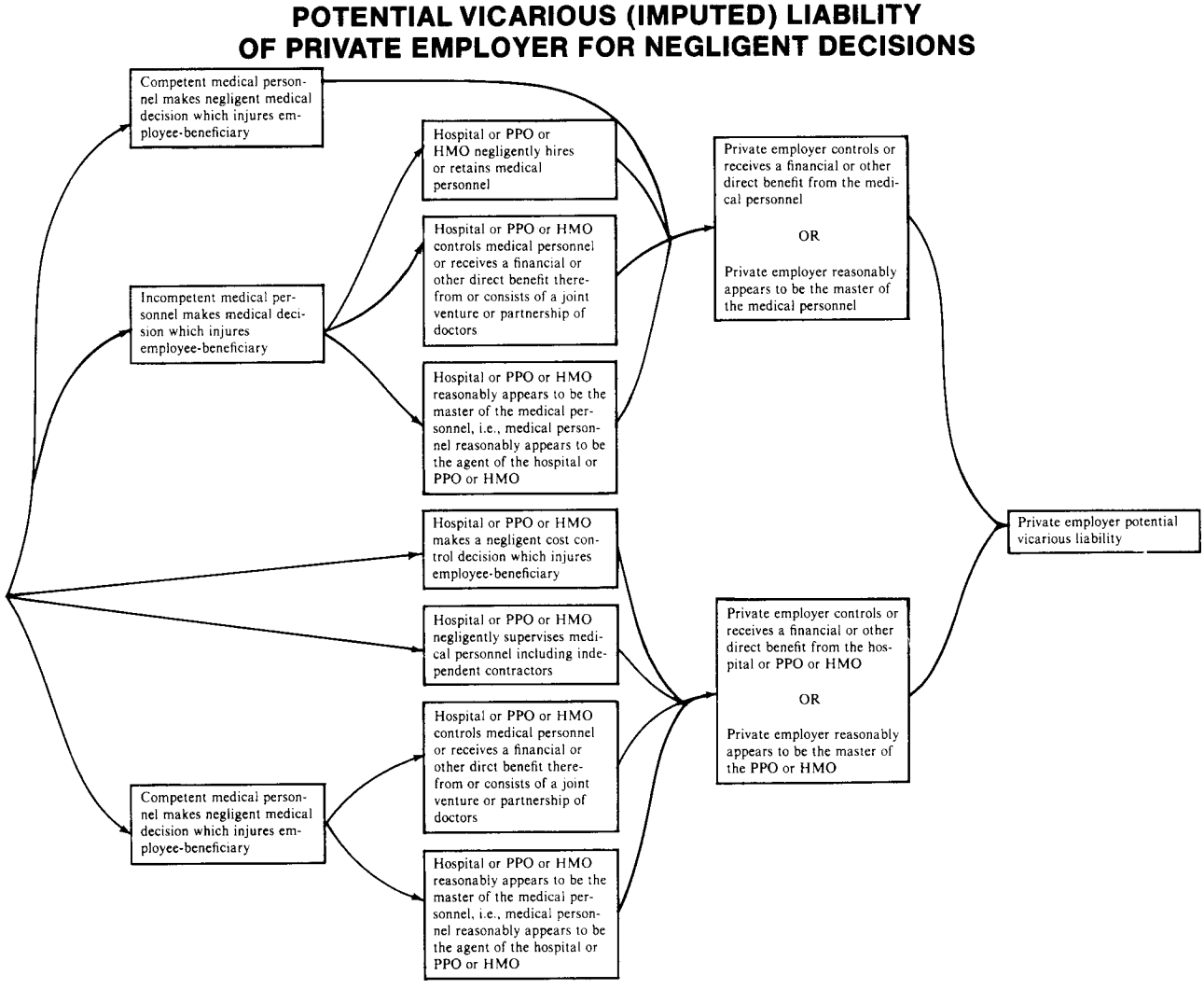
Determining Whether An Agency Exists

The traditional test to establish the master-servant relationship and hence vicarious liability of the master is whether the former controls or has the right to control the conduct of the latter. Where an employee-beneficiary alleges vicarious liability for the acts of a doctor, the employer will attempt to argue that because the doctor's decisions relating to medical care are not controlled by the employer, there can be no master-servant relationship. This argument has failed in a number of situations. In *Willoughby v. Wilkins* (1983), the plaintiff sued an emergency room doctor who had treated her, the hospital and the county which operated the hospital. The physician testified that he was an independent contractor, and that he exercised his own judgment in respect to treatment of patients and the trial court found in favor of the hospital and county on a directed verdict. But on appeal the court found that the hospital exercised significant control over the doctor's method of performing his duties under the physician-hospital contract. It held that he may have been an agent and reversed and remanded for trial on that issue.[4]

In *Miami v. Oates,* a hospital was held liable for

4. 65 N.C. App. 626, 310 S.E.2d 90.

Figure 1



the malpractice of an intern whom the Florida Supreme Court characterized as an employee rather than an independent contractor. The city of Miami which operated the hospital in its corporate capacity was also held liable.[5]

When vicarious liability of the private employer is based on the employer having a right to control the doctor's conduct as it would other employees, the plaintiff need not establish that the doctor-patient relationship normally required for a successful malpractice action existed. In *Jones v. Tri-State Tel. & Tel. Co.,* a private employer hired a doctor for its own purposes to examine an employee who had been injured on the job. Normally when a company hires a doctor to examine an employee for its own purposes, no doctor-patient relationship is created. Yet the appellate court held that the doctor was the agent of the employer and the latter could be sued the same as if a manager or other employee had caused the injury to the plaintiff.[6] This same result has been reached in the case of a prospective employee where as a precondition to employment, the candidate was examined by a doctor hired by the employer.[7]

Where the private employer hires its own medical personnel, a master-servant relationship will often be easier to establish with respect to the medical technician, nurse or other supporting personnel than for the doctor because these supporting personnel usually have less discretion to act independently than the doctor. The most common means of establishing the master-servant relationship is control by the employer. However, where a doctor is the alleged agent, the courts have fashioned reasons in addition to control which create agency. Courts have held a private employer liable for the malpractice and negligence of a physician or surgeon hired by the employer where the employer for profit or gain supplies his employees with medical or surgical treatment based on wage deductions. For instance, in *Ulbrich v. Boone County Coal Corp.,* an employee-patient sued his employer after being injured by the negligence of a physician employed by the employer to treat all workers needing medical care. The employee claimed that the required deductions from wages for the services of the physician were more than sufficient to pay the physician and medical expenses leaving a profit that the employer kept. The court rejected the company claim that the physician was an independent contractor and stated that the company was in a position similar to one holding himself out to offer medical treatment for gain, and was thereby in a master-servant relationship and liable for the malpractice of the physician.[8]

5. 152 Fla. 21, 10 So.2d 721 (1942).
6. 118 Minn. 217, 218, 136 N.W. 741, 741 (1912).
7. *Mrachek v. Sunshine Biscuit, Inc.,* 308 N.Y. 116, 121-22, 123 N.E.2d 801, 804-05 (1954).

Vicarious Liability

Traditional vicarious liability of an employer did not extend to the acts of independent contractors. While the private employer was generally held vicariously liable for negligence of its agents and employees, it was not liable for negligence of persons (including doctors) held to be independent contractors. However, as the cases described in the previous section illustrate, the line dividing employees and other agents from independent contractors is not always clear—especially where the alleged agent has a great degree of autonomy and discretion as in the case of doctors and other professionals. In addition, even where an employer-independent contractor relationship is established, exceptions exist that might result in employer liability.[9] Figure 1 diagrams a number of possibilities for private employer vicarious liability where errors in medical care decisions are made by medical personnel who arguably might be independent contractors.

Vicarious Liability and Cost Containment

A private employer that hires a physician or surgeon for purposes of controlling costs may be incurring a profit or gain sufficient to establish the master-servant relationship. In *McGuigan v. Southern Pacific Company,* an action was brought under the Federal Employer's Liability Act by the decedent's administratrix against the decedent's employer. The decedent, who worked as a herder for the railroad, had been given three months' sick leave because of a heart condition. Before the end of the period he was returned to work and suffered a fatal heart attack. The jury found the railroad liable for the employee being sent back to work. The court on appeal stated that:

> .... where the medical services are furnished under circumstances that a direct benefit to the employer results, the employer is liable for the negligence of the doctors .... [and] according to some authorities, if an employer derives some pecuniary benefit from a hospital which he maintains for his employees ... to treat them when ill or injured, he is liable for the malpractice of a physician or surgeon whom he employs, notwithstanding he exercises due care in the selection of

8. 16 Pa. D & C 315 (1931).
9. For example, certain duties are not delegable to independent contractors. If an employer could delegate all duties to independent contractors it conceivably could avoid all responsibility and the law does not allow this.

such person.[10]

In *Phillips v. St. Louis & S. F. R. Co.,* a patient of an association hospital was run over and killed by a streetcar shortly after the chief surgeon let him leave the hospital, unattended and without notifying his family, knowing he was mentally unsound and in need of further treatment and that he would have to find his way home in a large city. The association hospital was established as a separate nonprofit organization to treat the employees of the defendant railroad. However, the hospital was supported by compulsory wage deductions of the employees and an annual company contribution. Furthermore, the railroad employer issued rules and regulations which governed the admission and free treatment of sick and injured employees and also required the giving of notice of injuries to the railroad's general claim agent. The railroad also stipulated that the doctors were railroad employees. The trial court held the employer not liable, but the appellate court reversed and concluded that the hospital and doctors were all agents of the railroad. The court stated that the railroad benefited as much or more than the employees in this situation.[11]

"Sometimes an injury occurs in medical care and no one is at fault"

No reported court decision has yet determined whether negotiation of discounts from normal charges, as occurs in many PPO arrangements and in negotiated provider agreements (NPA), constitutes a sufficient benefit to assign liability. Any future malpractice occurring in the Goodyear situation could well provide one of the first modern test cases on this issue of employer benefit from cost containment. If cost containment were to be held a sufficient financial or other direct benefit to Goodyear, the company could be held liable for the negligence and malpractice of the doctors and other medical personnel at the hospital. A court could find a master-servant relationship and hold the employer vicariously liable on either of two bases: that the lower employer costs are a sufficient benefit to the employer or that limitation of employees to the company-hired doctors and hospital is sufficient control by the employer. This probable result would be even more certain if the employee is required to pay for part of the services through wage deductions.

On the other hand, Flexible Spending Accounts offer a modern example of expense funds administered by the employer without gain and without serious exposure to the kind of liability we are discussing here. Employee expenses are paid out of employer funds to gain an employee tax advantage. No benefit or profit accrues to the employer and no vicarious liability is likely.

Liability and Alternate Delivery Systems

The introduction of a variety of alternate delivery systems tends to somewhat insulate the private employer by placing one more barrier between the party injured by inadequate medical care and the private employer. But liability of an intermediary health care provider may in some circumstances still be imputed to the private employer using vicarious liability principles.

Before we examine the question of the employer's liability under such systems, some understanding is needed of the liability of the operators and of alternate delivery systems themselves. One applicable liability could result if the PPO or HMO negligently selected, retained, or supervised the doctor who injured the employee-beneficiary. In a number of cases the legal connection between a hospital, as opposed to a PPO or HMO,[12] has been established where the hospital is held liable for the negligent selection, retention, or even supervision of a doctor. It can probably be said that in the absence of charitable immunity, this is a general rule even where the doctor is an independent contractor. The extension of this principle to hospital-based PPOs is clear and, in many cases, it could be applied to other organizational forms of PPOs and HMOs.

A second possible legal liability can occur where the PPO or HMO receives a sufficient financial or other direct benefit from one of its doctors or exerts enough control over the doctor's activities that a master-servant relationship exists. A number of cases have held a hospital liable for the negligence of staff doctors based on a master-servant relationship. For instance in *Miami v. Oates,* the hospital was held vicariously liable for the negligence of a staff doctor practicing in the hospital. If a PPO or HMO exerted enough control over a doctor or derived a benefit from the arrangement, the PPO or HMO might be held vicariously liable for the negligence of the doctor. Many PPOs and some HMOs are hospital-based and these alternative delivery systems certainly are subject to the same connections. The hiring of staff doctors and the payment of wages are definite links in the case

10. 129 Cal. App. 2d. 482, 277 P.2d 444, (1954).
11. 211 Mo. 419, 111 S.W. 109, (1908).
12. Some HMOs are hospital based and the same argument should apply to them.

of group practice HMOs.

The contractual nature of individual practice association HMO changes the legal position of the parties from that of a group practice HMO. A contract in which the physician agrees to provide care in exchange for a fixed sum of money would appear to create an employer-independent contractor relationship without any substantial control over the physician's treatment discretion. The inclusion of bonuses for the physician from the HMO in exchange for cost savings strengthens the legal link between the HMO and provider. The more control the HMO or PPO exercises over the primary medical care provider, the more likely the PPO or HMO will be held vicariously liable for the negligence of that primary provider even where the actual relationship would have been employer-independent contractor under a more traditional agency test. Also where the organization receives a pecuniary or other direct benefit from the primary provider a master-servant relation may be established.

A third possible legal liability could occur where the PPO or HMO was negligent in some other critical part in the medical decision making chain such as where one of their cost containment mechanisms was defective and resulted in injury to the employee-beneficiary. Examples include an arbitrary denial or unreasonable rejection of a request for medical care. The appellate court in *Wickline* made it abundantly clear that a patient who is injured when appropriate care is not provided should recover for the injuries from all parties responsible for the deprivation of care. Any harm to the employee-beneficiary that results from defects in the design or implementation of cost containment mechanisms of a PPO or HMO may result in liability against the organization.

A fourth possible legal liability may be established for *any* duty the PPO or HMO as an entity owes to its patients directly. In a 1982 Illinois case, *Magana v. Elie,* the plaintiff sued a hospital claiming her injuries were proximately caused by her physician's failure to warn her of risks involved in proposed surgical procedures. The trial court dismissed the action, but on appeal the court held that a hospital has a duty to its patients to "conform to the legal standard of reasonable conduct in the light of apparent risk." The appellate court remanded for the jury to decide whether that standard requires the hospital to monitor informed consents. This duty of the hospital to the patient extends to supervising a treating physician who is an independent contractor.[13] PPOs and HMOs could incur the same liability.

13. 108 Ill. App. 3d 1028, 439 N.E.2d 1319.

A fifth legal liability could occur where the doctors in a hospital, PPO, or HMO are considered partners or in a joint enterprise. The organization's liability would for all practical purposes be the same as where the doctor is held to be the employee of the organization, that is, the partnership and each other doctor is jointly and severally liable with the negligent doctor.[14]

"When the private employer hires medical personnel directly, potential liability is greatest"

A sixth possible legal liability may occur where it *reasonably appears* to the employee-beneficiary that the doctor is a servant (agent) of the PPO or HMO. This is referred to as apparent or ostensible agency or agency by estoppel. In *Grewe v. Mt. Clemens General Hospital* (1978), the plaintiff went to the hospital for treatment of a dislocated shoulder. He was admitted and was treated by several doctors with staff privileges (but not on the staff) and by one of the residents who was paid a salary by the hospital. The result was further damage to the plaintiff's arm which had to be repaired in a separate operation. He sued the hospital and its "agents and servants" and one of the treating doctors who was not on the staff but had staff privileges. After a trial, a reversal on appeal, and a second trial, the judgment was in favor of the treating doctor but against the hospital. The appellate court affirmed the trial court decision based on the rationale of "apparent agency," that is, even though the other doctors who attempted to correct the dislocation were not agents or servants of the hospital, they *appeared* to be agents to the plaintiff. The plaintiff had gone to the hospital expecting treatment from the hospital staff and not knowing any of the doctors who treated him had the right to assume they were on the hospital staff.[15] Another court expressed the public policy behind the apparent agency theory as follows:

> "[A] patient today frequently enters the hospital seeking a wide range of services rather than personal treatment by a particular physician. It would be absurd to require such a patient to be familiar with the law of . . . [vicarious liability] . . . and so to inquire of each person who treated [him or her] whether he is an employee of the hospital or an independent contractor. Similarly, it would be unfair to allow "secret limitations" on liability

14. *Malpractice Alert,* Oregon Medical Association, (October 3, 1986), 2.
15. 404 Mich. at 246, 273 N.W.2d at 431.

contained in a doctor's contract with the hospital to bind the unknowing patient.[16]

Consequently, even for a PPO or an individual practice HMO it is possible that the negligent doctor could be held to be the apparent agent (apparent servant) of the PPO or HMO.

Establishing liability of a PPO or HMO or other health care organization is a critical link in the liability chain from the injured patient to the private employer. It means that the employer cannot necessarily shield itself from liability by the establishment of some intervening organization to provide medical care.

In summary, there are at least six possibilities for establishing liability of a hospital, PPO, or HMO that could then be transferred to a private employer using vicarious liability principles. First, at least in some circumstances, hospitals and presumably PPOs and HMOs will be liable for the negligent selection and retention of incompetent doctors under the plan. Second, where a hospital and presumably a PPO or HMO exerts enough control over a doctor or receives a financial or other direct benefit from the arrangement, a master-servant link may be established. Third, hospitals and probably also PPOs and HMOs may be liable for defects in their own cost containment plan. Fourth, hospitals, and probably PPOs, and HMOs, have a general duty to "conform to the legal standard in light of apparent risk and can be liable for the negligent supervision of staff and independent contractor physicians who commit malpractice."[17] Fifth, PPOs and HMOs will probably be liable where the doctors in the organization are partners or in a joint enterprise, and one commits malpractice or is incompetent and injures an employee-beneficiary. Sixth, even where no true master-servant relationship exists but where it reasonably appears to exist to an employee-beneficiary, the hospital, PPO, or HMO may be held vicariously liable for any injury caused.

Strict Liability or Implied Warranty Breach

Sometimes an injury occurs in medical care and, no one is at fault. If the caregiver is held responsible for the injury regardless of fault that is an example of strict liability. One area of the law where strict liability occurs is under the Food, Drug and Cosmetic Act. A manufacturer responsible for the adulterated or misbranded food, drug, or cosmetic entering interstate commerce is strictly liable for a crime. And if an individual is injured by consuming or using an adulterated or misbranded food, drug, or cosmetic the manufacturer is usually strictly liable for damages in a private tort action.

For an example in medicine consider the first cases of acquired immune deficiency syndrome (AIDS) transmitted through blood transfusions. Some cases occurred before a causative agent was suspected and others after the agent was discovered but before an economically feasible identifying test was developed. Should the medical personnel who performed these transfusions or the hospitals where they were performed be held liable? If so this could establish the first of two links in the liability chain connecting an injured party with a private employer. Even if this first link is established should a private employer too closely associated with the medical care decision making or reaping a pecuniary or other direct benefit be held vicariously liable thus establishing the second link?

"An employee sued after being injured by a physician employed by the employer"

In areas other than medical care the principle of 1) absolute or strict liability or 2) liability for a breach of an implied warranty that a product or service was not defective has been used to confer liability on a party not at fault. The public policy behind these decisions is that it is better to place liability on whoever furnishes the defective product or service as a cost of doing business instead of refusing to compensate the innocent victim.

In most cases involving medical services courts have rejected causes of action against a hospital or its employees on the basis of strict liability in tort or breach of implied warranty. The general rule was stated in *Hoven v. Kelble*.[18] The court while acknowledging that some cases extended the doctrine of strict liability in tort beyond situations involving damages in the sale of a defective and unreasonably dangerous product pointed out that with respect to medical services the cases uniformly required a showing of negligence. Thus the first link in the liability chain between the injured employee-beneficiary and the private employer will probably not be formed. This would probably be true in our earlier example for a PPO or HMO that employed the individual tranfusing the blood or controlled the hospital where the transfusion occurred prior to the availability of an economical test.

16. *Capan v. Divine Providence Hospital,* 287 Pa. Super. 364, 369, 430 A.2d 647, 649 (1980).
17. *Magana v. Elie,* 108 Ill. App. 3d 1028, 439 N.E.2d 1319.
18. 79 Wis. 2d 444, 256 N.W.2d 379 (1977).

However, even here, exceptions may exist. In *Cunningham v. MacNeal Memorial Hospital,* the Illinois Supreme Court rejected the hospital's contention that it could not be held strictly liable for transfusing blood containing the hepatitis virus and remanded for a trial on the issue.[19] Similarly, in *Hoffman v. Misericordia Hospital of Philadelphia,* the trial judge dismissed a complaint for the alleged transfusion of impure blood based on the implied warranties of merchantability and fitness for a particular purpose, but the appellate court reversed and remanded holding that recovery on those theories may be possible.[20] In these rare cases, the courts have not ruled that liability exists in the first step of the chain, only that there was a legitimate legal cause of action that still needed to be proved in the trial court.

Liability of Employers Sponsoring an ADS

The questions that courts will examine separately for each individual case and that will likely determine the outcome of suits alleging vicarious liability for employers sponsoring medical care through an alternate delivery system are 1) the degree of control the employer has over medical decisions and/or 2) the benefit derived. Establishing a case against the employer providing medical care through an HMO or PPO would first involve establishing an appropriate legal liability (usually tort negligence) against the PPO or HMO. Once liability of the provider organization is established, a second legal connection would have to be forged between the private employer on the one hand and the hospital, PPO or HMO on the other hand in order to hold the employer vicariously liable.

"Common law has held employers responsible for negligence torts committed by employees"

For instance, even if Goodyear had chosen to retain a PPO or HMO which in turn hired doctors to provide medical services, Goodyear could be found vicariously liable for the negligence of the doctors and other medical personnel.

With the PPO or HMO interposed, the legal distance between the private employer and the doctor is increased and may at first glance appear too tenuous to support a successful claim against the former, but each case will likely be examined first to ascertain the type of relationship between the injured individual and the health care organization, and second the organization and the employer. Liability remains a possibility. The second link may be established particularly where the private employer exerts significant control over the provider organization, receives a financial or other direct benefit from the operation of the PPO or HMO, or even where an apparent association exists.

In the narrower area of warranty or absolute duty, decisions in most states have not imposed such a strict standard for medical services on the medical personnel involved or the hospital, and by analogy, would probably not for a PPO or HMO. These precedents make employer tort liability without negligence unlikely. However, in states that recognize the principle of strict liability or breach of implied warranty in medical decision making situations the employer may, in these situations, be held vicariously liable.

The private employer that wants to minimize the risk of being held vicariously liable for the negligence of medical personnel, hospitals, PPOs and HMOs should distance itself from those individuals and associations. In other words, the employer should not hire doctors nor other medical personnel[21] nor contract with or establish hospitals, PPOs or HMOs where the employer exerts any significant management or control over any of those individuals or organizations or receives a financial or other direct benefit therefrom, nor even give the appearance of such a relationship.

In situations where the private employer is closely associated with the medical decision making process, it may be impossible to maintain sufficient distance to avoid liability while attempting to control costs. Clearly, where the private employer hires doctors and other medical personnel directly, the potential liability is greatest. Even where there is no direct hiring of medical personnel, courts may hold either 1) that cost control is a benefit sufficient to establish a master-servant relationship between the employer and a hospital, PPO, or HMO or 2) that employee perceptions of the employer as being closely associated with the medical decision making process warrant finding of liability under the theory of apparent authority. Perhaps the use of a trust to select the medical care would insulate the employer from liability for medical care decisions. But the trust would have to be independent of the employer. Even if the employer receives a pecuniary or other direct benefit from the trust a slim possibility for vicarious liability exists. **RM**

19. 47 Ill. 2d 443, 447, 266 N.E.2d 897, 899 (1970).
20. 439 Pa. 501, 503, 267 A.2d 867, 868 (1970).
21. The case where an employer hires a doctor and other medical personnel to be at a company site for immediate treatment of on-the-job illnesses and injuries is not addressed directly. This discussion is more concerned with the broader plan for coverage of employee's needs for medical treatment not arising out of or in the scope of the employment.