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APPLICATION OF THE CORPORATE NEGLIGENCE DOCTRINE TO MANAGED CARE ORGANIZATIONS: SOUND PUBLIC POLICY OR JUDICIAL OVERKILL?

Emmanuel O. Ihekwumere*

INTRODUCTION

In the past, physicians, in their sole discretion, usually determined courses of treatment for their patients and insurance companies paid the charges.¹ However, with the emergence of the health maintenance organization (HMO) as part of the managed care organization (MCO) system, which is not only a force to be reckoned with but also the dominant system in health care delivery,² the physician's role has been

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* Eaton & McClellan, Philadelphia, Pennsylvania. B.A., summa cum laude, Clarion University of Pennsylvania; J.D., Temple University School of Law. I dedicate this article to my siblings, Emeka, Prince, Ugochi and Chioma, and to my children, Emmanuel, Jr., Jane, and Marshall. I express my sincere gratitude to Prof. Frank M. McClellan of Temple Law School, and Allen T. Eaton for giving me a better appreciation for medical malpractice and products liability litigation. I also thank all my colleagues at Eaton & McClellan, both in the Philadelphia and Washington, D.C. offices. I am grateful to my dear friend Prof. Philip Aka of Chicago State University, and Craig L. Thorpe, Esquire for reviewing the earlier draft. Lastly, I am greatly indebted to the editorial staff of this journal, particularly Richard Weinblatt, for their superb editorial assistance.


2. Domenick C. DiCicco, Jr., Symposium: Pursuing Health in an Era of Change: Emerging Legal Issues in Managed Care: HMO Liability for the Medical Negligence of Member Physicians, 43 VILL. L. REV. 499 (1998). There appear to be three models of HMOs. These include the staff, independent practice association (IPA) and group models. Under the staff model the HMO employs physicians and other health care providers such as nurses and technicians on a salary basis, provides the facilities where care is rendered and furnishes the necessary equipment. Under the IPA model, the HMO contracts with independent physicians who own their own offices and provides the facilities and equipment needed for administering treatment. In return for their services to the HMO subscribers, the HMO pays the IPA physicians a predetermined amount, called a capitation fee, per month for each subscriber who selects the IPA as his or
largely relegated to recommending a course of treatment. This transition ultimately leaves to MCOs, through their utilization review process (UR), \(^3\) the ultimate decision of whether or not a treatment should be rendered. \(^4\) In light of the power and influence of MCOs in medical decision making, courts have imposed vicarious liability upon MCOs when their conduct has been deemed negligent and has resulted in harm to patients. \(^5\) Some courts have gone as far as allowing claims of MCO corporate negligence that are based on negligent selection and retention \(^6\) and negligent implementation of cost containment procedures to proceed. \(^7\) Other courts have endorsed, although not applied, the corporate negligence doctrine to MCOs. \(^8\) In 1998, the Pennsylvania Superior Court, in Shannon v. Healthamerica, \(^9\) expressly applied the

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3. See, e.g., James Bartimus & Christopher A. Wright, HMO Liability: From Corporate Negligence Claims for Negligent Credentialing and Utilization Review to Bad Faith, 66 UMKC L. REV. 763, 770 (1998) (defining utilization review as the “process by which an HMO determines if medical services requested or proscribed by a primary care physician are appropriate and necessary”).

4. See Vandall, supra note 1, at 298.

5. See, e.g., Shannon v. Healthamerica, 718 A.2d 828 (Pa. Super. Ct. 1998) (holding that an HMO may be vicariously liable for the negligent conduct of its triage nurses who provided improper medical advice to a subscriber over the telephone and failed to timely refer her for needed care); Petrovich v. Share Health Plan of Ill., 696 N.E.2d 356 (Ill. App. 1998), appeal granted, 705 N.E.2d 448 (Ill. 1998) (holding that an HMO may be held vicariously liable for the conduct of its participating physicians where its representations leads the subscriber to look up to it as the provider of medical care and injury results, citing Boyd v. Albert Einstein Med. Ctr., 547 A.2d 1229 (Pa. Super. Ct. 1988)).


Corporate negligence doctrine to an HMO for negligent medical advice offered by the HMO's triage nurses to a subscriber over the telephone. This article will analyze Shannon and other recent rulings that show a willingness to impose direct liability upon MCOs for negligent medical care. This article will examine whether an extension of the corporate negligence doctrine to MCOs, in view of the job MCOs have done in reducing the rampaging cost of health care, constitutes sound public policy or merely judicial overkill. This article concludes that sound public policy requires the extension of the corporate negligence doctrine to MCOs. Such an extension will ensure that MCOs will act reasonably in their dealings with patient-subscribers, who have already lost substantial control over the amount and quality of care they receive.

I. THE ERA OF MEDICAL CAVEAT EMPTOR: CHARITABLE AND SOVEREIGN IMMUNITY FOR HOSPITALS

Imagine this scenario. On September 14, 1960, a patient goes to her local community teaching hospital for treatment. While at the hospital a student nurse negligently injects her with a medication, resulting in paralysis of her left leg and toe, attended by severe pain and suffering. Seeking justice in the form of monetary compensation for her injury, the patient, now a plaintiff, sues the hospital for the negligence of the student nurse. In response, the hospital files a motion for summary judgment, claiming the defense of charitable immunity. Undaunted by the motion, the injured patient places her hope on the trial judge to do justice. To her surprise, the trial judge grants the motion. Certainly, the trial judge was mistaken in his interpretation of the law, plaintiff surmises. On appeal plaintiff receives another shock: the trial judge was right. The defense of charitable immunity shields the hospital from responsibility for the negligent conduct of the student nurse.

Most people would react viscerally to the above scenario without an explication of the charitable immunity doctrine that until recently shielded hospitals from tort liability for the negligent conduct of their agents and/or ostensible agents. Beginning with the seminal case of

10. See infra note 52.

11. Caveat emptor is a Latin term which summarizes the maxim that the purchaser of goods must judge for himself and buy at his own risk. BLACK'S LAW DICTIONARY, 22 (6th ed. 1997). In the medical context, the term meant that the patient received treatment from an institution enjoying either charitable or sovereign immunity at his or her own risk.

McDonald v. Massachusetts General Hospital, the doctrine of charitable immunity descended on the common law of the United States. The charitable immunity doctrine considered hospitals to be charitable institutions, and accordingly exempted them from the general rule holding a corporation liable for the negligent conduct of its servants, employees and/or agents. Hospitals not protected by charitable immunity were generally protected from liability under sovereign immunity, a relic from the English common law, which states employed to insulate their agencies from tort liability.

With the protection of charitable and sovereign immunities, hospitals had no real incentives to ensure patient safety. Courts adopted legal fictions such as the borrowed servant doctrine to afford patients a modicum of protection from the negligent conduct of hospital employees and agents. Under the borrowed servant doctrine, a surgeon was deemed to have borrowed the hospital's nurses and other support staff during surgery, and was held responsible for their negligent conduct. The borrowed servant doctrine later gave rise to the captain of the ship doctrine. Under the captain of the ship doctrine, the surgeon was held vicariously liable for the conduct of others in the operating room where the surgeon is the individual with the highest authority. During the era

13. 120 Mass. 432 (1876).
14. See, e.g., Garlington v. Kingsley, 289 So. 2d 88, 90-92 (La. 1974) (overruling several intermediate appellate court holdings which had upheld the charitable immunity doctrine in Louisiana, and harshly criticizing the rationale behind the doctrine).
15. See Roger N. Braden & Jennifer L. Lawrence, Medical Malpractice: Understanding the Evolution-Rebuking the Revolution, 25 N. Ky. L. Rev. 675, 678 (1998); see also Ellen Wertheimer, Calabresi's Razor: A Short Cut to Responsibility, 28 Stetson L. Rev. 105, 122 (1998) (observing that the basic premise of tort law is that everyone should be responsible for his or her negligent conduct).
16. See Braden & Lawrence, supra note 15, at 678.
17. See, e.g., C.E. Jacobs, The Eleventh Amendment and Sovereign Immunity 5 (1972) (observing that the sovereign immunity doctrine emanated from the English rule that the king can do no wrong).
19. Id.
20. Id.
21. See, e.g., Monk v. Darner, 403 F.2d 580, 583 (D.C. Cir. 1968) (declaring that the fact that the nurse is under the doctor's supervision and acts under his orders as to some matters does not make her his agent for all purposes. On the other hand, his supervision of specific conduct of the nurse can make her his agent at the same time that she is the agent of the hospital (emphasis added).); Szabo v.
of unbridled charitable and sovereign immunities, an injured patient's only recourse was against the treating physician individually. However, if the physician was not insured and had no personal assets that a prevailing injured party could reach upon securing a judgment, the injured party and his or her lawyers were left without a remedy.

Courts began to abrogate the doctrines beginning with the Rhode Island case of *Glavin v. Rhode Island Hospital*, and extending from the 1940s through the 1970s, due to the horror stories accompanying application of the charitable and sovereign immunity doctrines. By 1971, all but three states, Maine, New Mexico and South Carolina, had repudiated the doctrine of charitable immunity completely.

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22. 12 R.I. 411 (1879).

23. See, e.g., President & Dir. of Georgetown Coll. v. Hughes, 130 F.2d 810 (D.C. Cir. 1942).


26. See *Brown*, 234 S.E.2d at 875 (quoting Prosser & Keaton, *PROSSER & KEETON ON THE LAW OF TORTS*, § 133 (4th ed. 1971)). This statement should not be taken to mean that the doctrine of charitable immunity is dead. On the contrary, the doctrine still retains some viability in one form or another in some jurisdictions. See, e.g., Schultz v. The Roman Catholic Archdiocese of Newark, 472 A.2d 531 (N.J. 1984); Harrell v. Total Health Care, Inc., 781 S.W.2d 58 (Mo. 1989).
II. THE RISE OF MCOs

In 1927, in the small town of Elk City, Oklahoma, an enterprising physician established a medical cooperative for about 6000 farm workers. This medical cooperative planted the seed for the present system of MCOs by developing the concept of a prepaid health plan.27 By the 1930s, the concept had gathered momentum, leading to the establishment of the modern MCO by the Kaiser industries for the benefit of its large construction workforce.28 Apparently perceiving the MCO as a threat to the ability of physicians to charge what they pleased and to practice medicine as they saw fit, the American Medical Association (AMA) waged a pitched battle against the growth of MCOs in the 1930s by labeling the concept as socialized medicine or communism,29 fully aware of the hostility such labeling would invite during the peak of the Cold War. The AMA did not stop at mere labeling, but undertook a vigorous campaign to stop this “corporate practice of medicine”30 and to ensure that hospitals denied privileges to physicians affiliated with or employed by MCOs.31 For example, a local medical association stripped membership from a physician employed by the Sears Roebuck employees' health care plan.32 The medical association, taking its cues from the AMA, contended that the physician's reduced rate on services to employees' family members was unethical and conflicted with the practice of fellow physicians in private practice.33 The AMA's campaign against one such MCO, the Group Health Association (GHA), a prepaid cooperative association of government employees in Washington, D.C., drew the attention of the Department of Justice (DOJ).34 The DOJ

27. See, e.g., DiCiccio, supra note 2, at 500.
29. Id. at 20.
31. Id. at 161.
32. Id. at 159-60. Battaglia observed that “[t]he medical profession viewed company controlled medicine with suspicion and viciously attacked the entrepreneurial physicians who were creating cooperatives or entering into prepaid agreements with employee groups or employers.” Id. at 159.
33. Id. at 159-60.
34. Apparently, the AMA “carried out a course of conduct intended to
brought indictments against the AMA and others for antitrust violations, predicated on restraints of trade and commerce in the District of Columbia. \(^{35}\) The indictments ultimately resulted in convictions. \(^{36}\) The convictions, however, did not stop AMA opposition to MCOs.

Notwithstanding the AMA's hostility to the early MCOs, the concept continued to grow in the 1940s and the 1950s, resulting in the formation of MCOs such as the Group Health Cooperative of Puget Sound and the Health Insurance Plan of Greater New York. \(^{37}\) Despite MCOs' attempts to grow in the face of AMA opposition and restrictive state statutes, HMOs numbered less than forty by 1972, with about three million enrollees. \(^{38}\)

In 1973, in reaction to increases in the cost of health care, Congress provided great impetus to the growth of MCOs by passing the Health Maintenance Organization Act of 1973 (HMO Act). \(^{39}\) The HMO Act not only provided grants for the development of HMOs, but also subsidized their initial operating losses. \(^{40}\) The result was impressive. By 1988, the number of MCOs had risen to about 648, and enrollment had climbed to approximately thirty-one million. \(^{41}\) The cost of health care had reached an astounding twelve percent of all consumer spending by 1990 \(^{42}\) and an alarming fourteen percent of the gross domestic product (GDP) by 1992 while approximately thirty-five million people still remained without health insurance. \(^{43}\) As a result of this dramatic increase in health care costs, MCO enrollment climbed to about fifty-six million in 1995 \(^{44}\) and to an estimated enrollment of sixty \(^{45}\) to seventy-seven million by 1997. \(^{46}\)

prevent GHA from securing and retaining the services of qualified physicians or using hospital facilities in the District of Columbia." \(^{47}\) Id. at 161.

\(^{35}\) Id.

\(^{36}\) Id.

\(^{37}\) DiCicco, supra note 2, at 501.

\(^{38}\) Id. at 502-03.


\(^{40}\) Id.

\(^{41}\) Randall, supra note 28, at 21.

\(^{42}\) See Vandall, supra note 1, at 294.

\(^{43}\) Id. at 296; see also Perez v. Wyeth Lab., Inc., 1999 N.J. LEXIS 1000 (N.J. Aug. 9, 1999) (observing that health care is the single largest business in the United States, representing 14% of the gross domestic product, and consuming the single largest amount of non-governmental spending). In addition, Perez noted that Americans spent more than $1 trillion on health care products and services in 1996 alone. Id.

\(^{44}\) See Bartimus & Wright, supra note 4, at 763.

\(^{45}\) Id.
MCO enrollment continues to grow and had been projected to reach well over one hundred million by the year 2000.\(^4\)

MCOs not only increased enrollment at impressive rates over the years, but also parlayed their newfound power and influence into provider contracts with more than seventy-five percent of practicing physicians.\(^4\) MCOs are not merely insurers, but are also providers of health care.\(^4\)

When several studies in the 1980s questioned the propriety of certain medical procedures that involve substantial expense,\(^4\) MCOs bypassed the traditional insurance industry's deference to the judgment of the physician\(^4\) and established the UR system. MCOs employ the UR to

46. See Braden & Lawrence, supra note 16, at 686.
47. See, e.g., DiCicco, supra note 2, at 500; Bartimus & Wright, supra note 4, at 763 (noting that “several estimates place HMO enrollment by the year 2000 at over 100 million members”). Although this projection may be off by a small margin due to recent decreases in HMO enrollment, there is reason to believe that enrollment in HMOs will continue to increase over the next several years. See HMO enrollment declines, MEDICAL MARKETING & MEDIA (Aug. 1, 2000) (reporting results of a study showing that for the first time total enrollment in HMOs have fallen, resulting in a total enrollment of 80.1 million as of July 1, 1999). But see Employers See 100% M+C Premium Hikes; HMOs Still a Deal; But at Breaking Point, MANAGED CARE & MEDICAID (Aug. 7, 2000) (noting likely increases in health care insurance premiums, but observing that employers are still likely to keep pushing employees into HMOs due to escalating prescription drug costs).
48. See, e.g., Elizabeth C. Price, The Evolution of Health Care Decision-Making: the Political Paradigm and Beyond, 65 TENN. L. REV. 619, 621 (1998) (observing that by 1996 “over eighty percent of doctors had signed contracts with managed care organizations”); Braden & Lawrence, supra note 16, at 686 (noting “[b]y 1993, the number of physicians participating in or affiliated with HMOs had increased to 75%”).
49. See Vandall, supra note 1, at 296 (describing an HMO as “a large group of consumers who are now able to buy large volumes of medical care for less” and noting that the reason for the HMO’s influence is its ability to pull together all the diverse financial interests of its members into a viable economic bargaining power “with the monopolistic health care industry”). See also, DiCicco, supra note 2 and accompanying text for additional definitions of an HMO.
50. See, e.g., Mark A. Hall & Gerard Anderson, Health Insurers' Assessment of Medical Necessity, 140 U. PA. L. REV. 1637, 1652-53 (1992) (describing studies questioning the appropriateness of several medical procedures routinely ordered by physicians and other studies finding a wide variation in hospital admission rates across geographic areas which could not be explained by either demography, health or economic status or other relevant factors).
51. See, e.g., Vandall, supra note 1, at 298; Margaret Gilhooley, Broken Back: A Patient’s Reflections on the Process of Medical Necessity Determinations, 40
determine whether a particular medical procedure recommended by the treating physician is medically necessary. The UR typically involves a prospective review, which includes precertification, concurrent review of length of hospitalization, second opinion requirements for surgical procedures and management of expensive procedures. The UR also includes retrospective review, which includes analysis of data on hospital admissions, patterns of treatment and utilization of certain procedures to identify instances of overutilization. During the precertification stage, MCO employees or agents screen a requested admission to a medical facility to assess the necessity of admission. Concurrent review involves

VILL. L. REV. 153, 161-62 (1995) (observing that due to the differences of medical opinions on the need for a particular medical procedure, insurers traditionally deferred to the opinion of the treating physician, even when the procedure was expensive).

52. Bartimus & Wright, supra note 4, at 770 (defining utilization review). Medical necessity, which is the benchmark of HMO UR, is normally described in the typical HMO contract as follows: "[T]he service is (a) ordered by a doctor. (b) is commonly and customarily recognized throughout the doctor's profession as appropriate in the treatment of the sickness or injury. (c) is neither educational nor experimental in nature nor provided primarily for research purposes." Hall & Anderson, supra note 50 (citing Dozsa v. Crum & Forster Ins. Co., 716 F. Supp. 131, 134 (D.N.J. 1989)). See Mark A. Hall & Teresa Rust Smith, et al., Symposium on Consumer Protection in Managed Care: Mechanics of Consumer Protection-the Marketplace and Regulation: Judicial Protection of Managed Care Consumers: An Empirical Study of Insurance Coverage Disputes, 26 SETON HALL L. REV. 1055, 1055-56 (1996) (noting that both private and public insurance, such as Medicare and Medicaid, typically describe medical necessity as medically appropriate). "It excludes experimental care, nonstandard treatments, treatment without any known benefit, and treatment such as cosmetic surgery not intended to correct or relieve a medical condition." Id.

53. Hall & Anderson, supra note 50, at 1653.
54. Randall, supra note 28, at 27.
55. See Hall & Anderson, supra note 50, at 1654. The authors described a typical precertification UR as follows:

The insurance contract requires the subscriber or physician, except in emergencies, to obtain permission before entering the hospital or undergoing certain expensive outpatient procedures. The treatment request is usually reviewed initially by a computer algorithm that flags certain requests for further clinical review. Then a nurse, applying fairly rudimentary screening criteria, reviews these cases to determine which ones require further physician review. Physician reviewers, who rely on published studies of medical effectiveness as well as their own clinical experience, then apply their independent judgment of medical appropriateness, usually after consulting with the treating physician in
the MCO's determination of the necessity of the patient's continued hospital stay. 56

UR accomplished the MCO's health care reduction goal 57 by cutting costs substantially over the years. 58 Abuses of the process accompanied the success of the UR system. In some instances, MCO reviewers became obsessed with costs to the detriment of the patient, failing to accord proper respect to the opinions of treating physicians. 59 The age-old tension between MCOs and physicians reappeared with UR, which overly focused on the profit motive. Glaring instances of negligent URs resulting in injuries to patients 60 prompted judicial, legislative and

cases of disagreement. In most such cases, the two doctors reach some accord.

*Id.*


57. See, e.g., Vandall, *supra* note 1, at 310 (observing that "[t]he historical basis of the HMOs and the key to their success is cost containment. HMOs exist because they brought the explosive escalation of medical expenses to a halt."); David Kline, *Affairs of State: HMOs Are Losing the Battle of Public Opinion*, CAPITOL NEWS SERVICE, at 9 (Jan. 13, 1998) ("HMOs were designed to cut costs, pure and simple. They are able to do so by purchasing in volume and by tightening control to combat doctors' urges to order unnecessary tests or pills").

*Id.*

58. See, e.g., Christine C. Dodd, *Note, The Exclusion of Non-Physician Health Care Providers from Integrated Delivery Systems: Group Boycott or Legitimate Business Practice?*, 64 U. CIN. L. REV. 983, 986 (1996) (observing that UR allows HMOs to reduce costs over conventional plans by ten to forty percent); Vandall, *supra* note 1, at 294, n.9 (observing that it has been predicted that HMOs will save Americans up to $383 billion this decade alone).

59. See, e.g., Dukes v. U.S. Health Care, Inc., 57 F.3d 350 (3d Cir. 1995) (providers, acting on MCO UR guidelines, failed to perform necessary and relatively inexpensive blood tests ordered by patient's primary care physician, resulting in clearly avoidable death of patient); Corcoran v. United Health Care, Inc., 965 F.2d 1321 (5th Cir. 1992) (MCO failed to honor obstetrician's recommendation that patient with high risk pregnancy be hospitalized, and instead, assigned a day nurse to be with patient 10 hours a day. During assigned nurse's off duty baby went into fetal distress and died); Wickline v. State of California, 239 Cal. Rptr. 810 (1986) (MCO's refusal to approve an eight-day extension requested by attending physician for hospitalized patient led to a chain of events resulting in the avoidable amputation of the patient's leg).

60. See infra note 62; see also Alex Rodriguez, *Council panel hears HMO horror stories; Proposed law would impose reforms within city*, CHIC. SUN-TIMES, Apr. 9, 1997, at 24 (reciting a patient's ordeal with her MCO, and an attempt by the City of Chicago City Council to pass an ordinance regulating the conduct of HMOs operating within the City); *NOT BOTH WAYS; HMOs cannot direct care*
scholarly re-examination of whether and how MCOs should be held liable for their negligent conduct.61

III. EXEMPTION OF MCOs FROM LIABILITY – SELECTED CASES

With the abrogation or modification of charitable immunity, many jurisdictions began holding hospitals accountable in tort for the negligent conduct of their employees, agents, or ostensible agents on theories of vicarious liability62 and corporate liability.63 In the landmark case of Bing v. Thunig,64 the New York Court of Appeals made a poignant statement

yet refuse responsibility, HOUSTON CHRON., Nov. 26, 1996, at A18 (outlining disturbing practices by HMOs, which include, among others, requiring the performance of mastectomies on an outpatient basis, and contractually imposing gag rules which limit the ability of physicians to discuss treatment alternatives with patients); Jane Nelson, HMO allegations show why reforms are needed, THE FORT WORTH STAR-TELEGRAM, Apr. 26, 1997, at 15 (recounting HMO horror stories which convinced the writer, a Republican State Senator, to introduce a bill regulating the conduct of HMOs in Texas); Tom Kelly, HMO Excesses Have Spurred Backlash, Regulation, FORT LAUDERDALE SUN-SENTINEL, Nov. 29, 1996, at A27 (observing that in 1996 alone more than one thousand pieces of legislation were introduced to regulate or curb the conduct of HMOs, resulting in the passage of fifty-six new laws in thirty-five states).

61. See, e.g., Dukes v. U.S. Health Care, Inc., 57 F.3d 350 (3d Cir. 1995); McClellan v. HMO PA, Inc., 604 A.2d 1053 (Pa. Super. Ct. 1992); Raglin v. HMO Ill., 595 N.E.2d 153 (Ill. App. 1992); Corcoran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir. 1992); TEX. INS. CODE ANN. art. 20A.14 (1997); Vandall, supra note 1; DiCicco, supra note 2; Battaglia, supra note 34. The concern about MCO practices has even convinced the House of Representatives to pass a measure dubbed the Patients' Bill of Rights in October 1999, which would give patients the right to sue MCOs, particularly HMOs, when their actions negligently result in injury.

62. See supra notes 24-26 and 28; see also Capan v. Divine Providence Hosp., 287 Pa. Super. 364, 430 A.2d 647 (1980) (noting that it would be unfair to require an injured patient to be familiar with the law of respondeat superior and to inquire of each person who treated him or her whether the individual is employed by the hospital). In addition, Capan held that a hospital may be held vicariously liable for the negligent conduct of an independent contractor physician if the facts show that the injured patient looked to the hospital rather than the individual physician for care, and that the hospital held out the physician as its employee such as 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 649.

63. See Darling v. Charleston Cmty. Mem. Hosp., 211 N.E.2d 253 (Ill. 1965); see also cases cited infra note 71.

64. 143 N.E.2d 3 (N.Y. 1957).
about the duty of courts to protect the innocent patient who seeks
treatment from a hospital. The court stated that "the conception that the
hospital does not undertake to treat the patient, does not undertake to act
through its doctors and nurses, but undertakes instead simply to procure
them to act upon their own responsibility, no longer reflects the fact."
Seizing on this idea, in \textit{Darling v. Charleston Community Memorial
Hospital},\textsuperscript{6} the Illinois Supreme Court became the first appellate court to
impose corporate liability upon a hospital for its negligent failure to
ensure the safety of the patient while in the hospital.\textsuperscript{67} Soon the doctrine
became an emerging trend when several jurisdictions adopted it.\textsuperscript{68} In
\textit{Thompson v. Nason Hospital},\textsuperscript{69} the Pennsylvania Supreme Court traced
the origin of the corporate negligence doctrine, set forth explicit and well-
reasoned rationales for application of the doctrine to hospitals and laid
down the most concise and definitive description of a hospital’s duties to a
patient under the doctrine.\textsuperscript{70}

Coincidently, although most courts were imposing liability upon

\textsuperscript{65.} Id. at 8.

\textsuperscript{66.} See \textit{Darling}, 211 N.E.2d at 253.

\textsuperscript{67.} See, e.g., \textit{Bost v. Riley}, 262 S.E. 2d 391, 396 (N.C. App. 1980) (noting
"[t]he proposition that a hospital may be found liable to a patient under the
discipline of corporate negligence appears to have its genesis in the leading case of
\textit{Darling v. Hospital}"); \textit{Bartimus and Wright, supra} note 4, at 765 (observing "[t]he
discipline of corporate negligence was first imposed against hospitals in the
landmark case of \textit{Darling v. Charleston Community Memorial Hospital}").

\textsuperscript{68.} See, e.g., \textit{Purcell v. Zimbelman}, 500 P. 2d 335 (Ariz. Ct. App. 1972); \textit{Bost},
262 S.E.2d at 396; \textit{Insinga v. Labella}, 543 So. 2d 209 (Fla. 1989); \textit{Thompson v.

\textsuperscript{69.} 591 A.2d 703 (Pa. 1991).

\textsuperscript{70.} \textit{Thompson v. Nason Hospital} first adopted the corporate negligence
discipline in Pennsylvania holding that the hospital is liable under corporate
negligence if it fails to uphold the proper standard of care owed the patient, which
is to ensure the patient’s safety and well-being while at the hospital. This theory
of liability creates a non-delegable duty that the hospital owes directly to the
patient. Therefore, the injured party does not have to establish the negligence of
a third party.

Further, \textit{Thompson} set forth four distinct duties of hospitals with regard to patient
care as follows:

(1) a duty to use reasonable care in the maintenance of safe and adequate
facilities and equipment; (2) a duty to select and retain only competent
physicians; (3) a duty to oversee all persons who practice medicine within
its walls as to patient care; and (4) a duty to formulate, adopt and enforce
adequate rules and policies to ensure quality care for the patients.

\textit{Thompson}, 591 A.2d at 707 (citations omitted).
hospitals under both vicarious and corporate liability theories, horror stories of the negligent conduct of MCOs began to catch the attention of the public. Even though MCOs participate in patient’s health care decisions and actively intervene between the doctor and the patient, the early decisions on MCOs exempted them from liability. In two of those cases, the California Court of Appeals and the Fifth Circuit Court of Appeals handed down opinions that absolved MCOs of liability for negligence in overruling the medical judgments of patients’ treating physicians.

In Wickline v. California, a California appellate court absolved an MCO of liability, holding that the patient’s treating physician was solely responsible for the harm that she had suffered. There, Lois J. Wickline, a medical assistance recipient, went to her primary care physician (PCP), Dr. Stanley Z. Daniels, a general family practitioner, with complaints of back and leg pains. Dr. Daniels put Mrs. Wickline through a physical therapy regimen. When her condition did not improve, Dr. Daniels had her admitted to Van Nuys Community Hospital for treatment. Subsequent to her admission, Dr. Daniels brought into the case Dr. Gerald E. Polonsky, a surgeon specializing in peripheral vascular surgery. Dr. Polonsky examined the plaintiff and diagnosed her condition as Leriche’s Syndrome.

Given the advanced stage of Mrs. Wickline’s illness, Dr. Polonsky performed a major surgical operation, involving the removal of a part of her artery and the insertion of a teflon graft in its place. Later, on the same day, Mrs. Wickline developed a clot on the graft, necessitating a second surgery to remove the clot. The second surgery took place within hours of the initial surgery. Her post-operative recovery was described as

71. See cases cited supra note 61.
72. See, e.g., Lawrence J. Rose & Katherine S. Somervell, Claims Against Managed Care Organizations, HEALTH L. LITIG. REP. (Oct. 1999); see also Pegram v. Herdrich, 530 U.S. 211 (2000) (emphasizing “the physicians through whom HMOs act make just the sorts of decisions made by licensed medical practitioners millions of times every day, in every possible medical setting”).
73. See, e.g., Joshua Michael Kaye, Closing the Lid on Pandora’s Box: ERISA Preemption of Tort Actions Against Managed Care Organizations in State Courts, 54 U. MIAMI L. REV. 373, 376 (Jan. 2000).
74. See, e.g., Ellen Wertheimer, Calabresi’s Razor: a Short Cut to Responsibility, 28 STETSON L. REV. 105, 106 (Summer 1998) (observing that “the law applicable to HMOs began not with the extension of liability to HMOs, but with an exemption from liability”).
75. 192 Cal. App. 3d 1630 (1986).
"stormy," with incidents of severe spasms and hallucinations. Due to the intensity of the spasms, Dr. Polonsky performed a third surgical procedure, known as a lumber sympathectomy, which involved the surgical removal of a chain of nerves lying on each side of the spinal column. The chief of surgery at the hospital, Dr. Leonard Kovner, assisted Dr. Polonsky with all three surgeries.

Mrs. Wickline was scheduled to be discharged five days following the last surgery. However, the day before her scheduled discharge, Dr. Polonsky and other physicians determined that it was medically necessary to keep her in the hospital for an additional eight days, citing the risks of infection and/or clotting. Hospital personnel subsequently filed the necessary request for extension with the MCO, Medi-Cal, owned by the state of California.

Upon receiving the request for extension, a Medi-Cal “on-site nurse,” with the authority to wholly, but not partially, approve the request, determined that eight additional days were unnecessary. Consistent with the UR procedure in place, she contacted a Medi-Cal board-certified general surgeon, Dr. William S. Glassman. Dr. Glassman had no specialization in peripheral vascular surgery. Apparently, without examining any of the available documentary information about Mrs. Wickline, Dr. Glassman denied the eight-day extension request, but did grant four additional days. Further, Dr. Glassman did not discuss Mrs. Wickline’s case with either the PCP or the attending surgeon nor did he consider the determinative signs and symptoms in arriving at his decision.

Compounding the cycle of patient neglect, neither the PCP nor the surgeons pressed the issue of the full extension of hospitalization. Mrs. Wickline was discharged at the end of the additional four days, over her personal protest. The surgeons’ fears materialized when she developed severe infections and clotting on the graft of the operated leg that were so serious that they resulted in her emergency admission nine days later. Attempts to save her leg proved futile, resulting in an amputation initially below the knee, and then above the knee.

Mrs. Wickline and her husband brought suit against Medi-Cal, charging that its refusal to grant the full extension was the proximate cause of her injury. The plaintiffs prevailed at the trial court level. On appeal, the court appropriately observed that the risks associated with the

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76. Id. at 1635.
77. Id.
78. Id. at 1638. The basis for this conclusion is that Dr. Glassman testified he had no recollection of reviewing any information on Mrs. Wickline’s case. Id.
79. Id. at 1633.
prospective UR were much higher than those associated with the retrospective UR, because the former puts increased pressure on practitioners to sometimes withhold necessary medical treatment while the latter may only result in denial of payment for services rendered.\footnote{80}{Id. at 1634.} The court then considered the then existing California Civil Code § 1714, which provided for liability on each tortfeasor for its negligent conduct.\footnote{81}{Id. at 1643.} The court reversed the judgment, holding that the MCO "did not override the medical judgment of Wickline’s treating physicians at the time of her discharge."\footnote{82}{Id. at 1646.}

Disregarding its own statement that "[t]hird 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,"\footnote{83}{Id. at 1645.} the court took comfort in its finding that the treating physicians did not protest the halving of the extension request, thus placing sole responsibility for the plaintiffs' injuries on the physicians.\footnote{84}{Id.}

The problem with the court's reasoning was its classification of the MCO as a mere third party payor.\footnote{85}{See id.} MCOs, as previously indicated, are more than third party payors.\footnote{86}{Vandall, supra note 1, at 296.} MCOs involve themselves in the medical treatment of their subscribers and actively intervene between patients and doctors.\footnote{87}{Rose & Somervell, supra note 72; Kaye, supra note 76, at 376.} The Medi-Cal MCO was no different. It reviewed the treating physicians' medical decisions and determined the appropriate hospitalization stay under the circumstances. It did not merely decide
issues of payment, as would a mere third-party payor.88

In the wake of Wickline, the Fifth Circuit decided Corcoran v. United Healthcare, Inc.89 According to the court, the facts in this case were undisputed.90 Plaintiff Florence Corcoran became pregnant with her second child. Her obstetrician considered her pregnancy high risk, based on the documented history of fetal distress that accompanied her first pregnancy (a view shared by a second-opinion obstetrician retained by Bell).91 Therefore, he recommended and sought precertification for her hospitalization from United Healthcare, the MCO charged with administering the UR aspect of her employer’s self-funded welfare benefit plan.

Despite the recommendation of the treating physician, and the apparent concurrence of the independent obstetrician retained by the employer,92 United Healthcare denied authorization for hospitalization. Instead, it authorized ten hours of home nursing care per day. When no nurse was on duty, the fetus experienced distress and died.93 Mr. and Mrs. Corcoran filed a wrongful death action in Louisiana state court against United Healthcare and Blue Cross, which was also involved in the administration of the plan. The lawsuit alleged that United Healthcare’s decision that Mrs. Corcoran “did not require hospitalization during the last month of her pregnancy,” was an erroneous medical decision.94 The defendants removed the action to the federal court on the grounds of alleged ERISA preemption and complete diversity of citizenship. Subsequently, the defendants filed motions for summary judgment, alleging that the plaintiffs’ action was really a claim for damages for “improper handling of a claim from two entities whose responsibilities were simply to administer benefits under an ERISA-governed plan.”95

The court granted summary judgment. The court appears to have

88. Rose & Somervell, supra note 72 (observing that traditionally, third party payors such as insurance companies “simply issued reimbursement checks on proof that medical bills have been incurred by an insured”).
89. 965 F.2d 1321 (5th Cir. 1992).
90. Id. at 1322.
91. See id.
92. See id.
93. Id. at 1324.
94. Id. at 1330. The Corcoran’s argued that “they are not advancing a claim for improper processing of benefits. Rather, they say, they seek to recover solely for United’s erroneous medical decision that Mrs. Corcoran did not require hospitalization during the last month of her pregnancy.” Id.
95. Corcoran, 965 F.2d at 1325.
agreed with the defendants' contentions and subscribed to an overly expansive reading of the ERISA preemption clause.\textsuperscript{96} It held that since an ERISA plan was the source of the relationship between the defendants and the plaintiffs, the claim was related to ERISA, and was therefore preempted.\textsuperscript{97} On appeal, the plaintiffs only pursued United Healthcare.\textsuperscript{98}

Observing that the potential liability of MCOs was only in its infancy, the court conceded that Louisiana law was unclear on the viability of plaintiffs' theory of recovery.\textsuperscript{99} Although the court agreed that United's decision on benefits due under the applicable plan involved a medical determination,\textsuperscript{100} it concluded that the language of ERISA was broad enough to preempt the plaintiffs' cause of action.\textsuperscript{101} Notwithstanding its recognition that "imposing liability on United might have the salutary effect of deterring poor quality medical decisions,"\textsuperscript{102} the court declared itself hamstrung by what it considered the significant risk that "state liability rules would be applied differently to the conduct of utilization review companies in different states," resulting in increased costs associated with maintaining UR programs.\textsuperscript{103}

The court concluded that ERISA compelled a result that deprived the plaintiffs of a remedy under federal and state tort law for what the court

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\textsuperscript{96} The statutory ERISA preemption clause relied upon by the defendants and the District Court, Section 514(a), contained in 29 U.S.C. § 1144(a) (2001), provides in relevant part:

Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) [29 U.S.C. § 1003(a)] and not exempt under section 4(b) [29 U.S.C. § 1003(b)].

\textsuperscript{97} Corcoran, 965 F.2d at 1325.

\textsuperscript{98} Id. at 1326.

It is evident that the Corcorans no longer pursue any theory of recovery against Blue Cross. Although they mention in their appellate brief the fact that they asserted a claim against Blue Cross, they challenge only the district court's conclusion that ERISA pre-empts their state law cause of action against United.

\textsuperscript{Id.}

\textsuperscript{99} Id. at 1328.

\textsuperscript{100} Id. at 1332. "In our view, United makes medical decisions as part and parcel of its mandate to decide what benefits are available under the Bell plan."

\textsuperscript{Id.}

\textsuperscript{101} Id.

\textsuperscript{102} Id. at 1333.

\textsuperscript{103} Id.
considered a potentially serious medical mistake. The court's conclusion can be ascribed to its overriding concern for uniformity and for the potential increase in cost to MCOs in the event of non-application of preemption.

Corcoran assumed that Congress was so concerned with ensuring the survival of plan funds that it overlooked the traditional role of states in the regulation of professional malpractice in enacting section 514 of ERISA. The problem with the court's approach is that section 514 of ERISA is silent on any Congressional intent to preempt the role of states in the regulation of the quality of medical care. Notwithstanding the court's assertion that its holding was consistent with the expressed

104. Id. at 1338. "The result ERISA compels us to reach means that the Corcorans have no remedy, state or federal, for what may have been a serious mistake." Id.

105. Id. at 1333 (emphasizing "although imposing liability on United might have the salutary effect of deterring poor quality medical decisions, there is a significant risk that state liability rules would be applied differently to the conduct of utilization review companies in different states") (emphasis added, internal citation omitted). The court's position was indeed ironic since it acknowledged that ERISA has the purpose of "safeguarding the interest of employees." Id. at 1338. It is therefore difficult to comprehend why the concern for uniformity was allowed to trump any considerations of the employee's interests. Certainly, plan beneficiaries have an interest in receiving quality care, whether in the form of actual medical treatment or advice, which is deserving of substantial consideration in the preemption analysis, especially where the care provider hides behind the preemption argument to escape liability for its arguably negligent conduct.

106. Id. at 1333 (emphasizing "[t]he cost of complying with varying substantive standards would increase the cost of providing utilization review services, thereby increasing the cost to health benefit plans of including cost containment features such as the Quality Care Program").

107. Id. "[I]t is foreseeable that state courts, exercising their common law powers, might develop different substantive standards applicable to the same employer conduct, requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction. Such an outcome is fundamentally at odds with the goal of uniformity that Congress sought to implement." Id. (emphasis added).

108. See, e.g., Dukes v. U.S. Health Care, 57 F.3d 350, 357 (3d Cir. 1995) (noting that "[q]uality control of benefits, such as the health care benefits provided here, is a field traditionally occupied by state regulation and we interpret the silence of Congress as reflecting an intent that it remain such"); see also Pegram, 530 U.S. 211 (noting that "in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose," citing New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 654-55 (1995)).
intention of Congress when it enacted ERISA,\textsuperscript{109} nothing in the statutory preemption clause of ERISA, section 514(a), or in the civil enforcement provision of ERISA, section 502,\textsuperscript{110} makes clear that state tort actions premised on the negligent medical decisions of a plan administrator are preempted.

One may wonder why ERISA preemption is so significant. The answer is that the remedies available under ERISA are woefully inadequate to address the compensatory needs of a patient injured through negligent medical care. The civil enforcement provision of ERISA, section 502(a), only provides a plan beneficiary with three remedies: A civil action to (1) recover benefits due to him under the terms of his plan; (2) enforce his rights under the terms of the plan; or (3) clarify his rights to future benefits under the terms of the plan. The civil enforcement provision fails to mention the negligent provision of medical care either directly or indirectly.\textsuperscript{111} In the face of preemption, an injured party's only recourse would be to file suit to recover benefits due him or her under the plan, such as the right to medical treatment. However, what benefit would such recovery have, since the party is already injured on account of medical negligence? Such a recovery will not compensate for losses on account of the negligent care, i.e., pain and suffering and lost income. Alternatively, a plan beneficiary could bring a legal action to compel the plan administrator to continue authorizing benefits under the plan or to reimburse for costs incurred, or an equitable action such as a declaratory judgment action or injunction to clarify his or her rights for future benefits under the applicable plan. However, as mentioned before, such actions would not address the compensatory needs of the injured party.

\textsuperscript{109} See Corcoran, 965 F.2d at 1339 (observing, "we acknowledge our role today by interpreting ERISA in a manner consistent with the expressed intentions of its creators").

\textsuperscript{110} The civil enforcement provision of ERISA, section 502(a), provides in pertinent part that a participant or beneficiary of an employee benefit plan may bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132 (2000).

\textsuperscript{111} See, e.g., Dukes, 57 F.3d at 357.

[A] claim about the quality of a benefit received is not a claim under § 502 (a)(1)(B) to "recover benefits due ... under the terms of [the] plan". ... [A] suit "to recover benefits due under the terms of [the] plan" is concerned exclusively with whether or not the benefits due under the plan were actually provided. The statute simply says nothing about the quality of benefits received.

\textit{Id.}
Attorneys for MCOs, who were fully aware of the limited remedy available under the enforcement provisions of ERISA in comparison to what may be obtained under a state tort action, advise:

It should be the goal of every defense attorney in a health coverage matter to persuade the court that the plaintiff’s state law claims are preempted by ERISA. The benefits of this strategy are clear: claims under ERISA are limited to reimbursement for medical care received or other equitable relief (no compensatory damages, no punitives), and there is no jury trial.\textsuperscript{112}

Perhaps cognizant of this fact, and unwilling to give section 514(a) the sweeping preemptory effect Corcoran adopted, some federal and state cases decided subsequent to Corcoran have disagreed with that court’s approach and have repudiated Corcoran’s holding and rationale.\textsuperscript{113}

\begin{itemize}
\item[112.] Rose & Somervell, \emph{supra} note 72, at 18.
\item[113.] See, e.g., Blaine v. Community Health Plan, 687 N.Y.S.2d 854 (N.Y. Sup. Ct. 1998) (tort action alleging that HMO’s employees negligently failed to timely diagnose and properly treat patient’s back problem, resulting in a discectomy not preempted under ERISA); \textit{Dukes}, 57 F.3d at 357 (finding the absence of preemption under ERISA where state tort action alleged negligent provision of medical care). “We find nothing in the legislative history suggesting that Section 502 was intended as a part of a federal scheme to control the quality of the benefits received by plan participants.” \textit{Id}. In addition, \textit{Dukes} stressed “[q]uality control of benefits, such as the health care benefits provided here, is a field traditionally occupied by state regulation and we interpret the silence of Congress as reflecting an intent that it remain such.” Also, see the following cases holding that the companion federal Act, the Medicare Act, does not preempt state tort actions where the claims are based on the quality of care rendered: McCall v. Pacificare of Cal., 87 Cal. Rptr. 2d 784 (Cal. App. 4th Dist. 1999) (tort action premised on HMO and primary care physician’s unreasonable delay in making a referral to a specialist for the treatment of progressive lung disease, resulting in the worsening of patient’s condition, not preempted under the Medicare Act); Plocica v. Nylcare of Tex., 43 F. Supp. 2d 658, 664 (N.D. Tex. 1999) (claim based on HMO’s unreasonable interference with and/or termination of psychiatric care of patient, leading to patient committing suicide, not preempted under the Medicare Act); Ardary v. Aetna Health Plans of Cal., Inc., 98 F.3d 496, 501 (9th Cir. 1996) (state wrongful death action against private Medicare provider not seeking recovery of Medicare benefits, but seeking compensatory and punitive damages for the provider’s alleged negligent denial of emergency medical services and misrepresentation not preempted under Medicare Act). Justifying its holding, \textit{Ardary} noted that the “removal of the right to sue the private Medicare provider for its torts would result in an inequitable and substantial dilution of the rights of patients.” 98 F.3d at 501.
\end{itemize}
IV. APPLICATION OF VICARIOUS AND DIRECT LIABILITY ON MCOs
– SELECTED CASES

Wickline, Corcoran and other cases114 have declined to hold MCOs liable for their negligent medical decisions resulting in injuries to patients. However, opinions from the California court that decided Wickline115 and courts in Indiana,116 Illinois,117 New Jersey,118 Pennsylvania119 and Ohio120 have held MCOs liable under various tort theories.

In McClellan v. HMO PA, Inc.,121 for example, the Pennsylvania

114. See also Williams v. Good Health Plus, 743 S.W.2d 373 (Tex. App. 1987) (sustaining the grant of summary judgment to the defendant HMO on the ground that HMO could not practice medicine, and was thus not liable for negligence of member physician resulting in surgical removal of patient's thumbnail).


117. Petrovich v. Share Health Plan of Ill., 696 N.E.2d 356 (Ill. App. Ct. 1998) (reversing summary judgment and holding that a triable issue of fact existed as to whether plaintiff-patient's treating physicians were the apparent agents of the defendant HMO); Raglin v. HMO Ill., Inc., 595 N.E.2d 153, 156 (Ill. App. Ct. 1992) (holding that an HMO may be held liable under ostensible agency, respondeat superior, and corporate negligence).

118. Dunn v. Health Care Plan of N.J., 656 A.2d 413 (N.J. 1995) (affirming judgment against HMO defendant on respondeat superior grounds and emphasizing that an HMO may be held liable under the corporate negligence theory for negligent selection and negligent UR, and additionally, that liability may be based on breach of contract or warranty).


121. 604 A.2d 1053 (Pa. Super. Ct. 1992). Four years prior to McClellan the
Superior Court confronted the issues of ostensible agency, corporate negligence, breach of contract, breach of warranty and intentional misrepresentation or fraud. After acknowledging that the managed care system indirectly provides diminished compensation to physicians who deem additional medical care necessary or desirable, the court declared itself precluded by constitutional mandate from deciding whether such a system violated public policy. It opined that such a determination was within the purview of the legislature. The plaintiff’s primary factual allegation was that the primary care physician removed a suspicious looking mole from the back of the decedent and discarded it instead of submitting the mole for a biopsy or other histological examination as the standard of care required. The plaintiff alleged that the failure to submit the mole for testing prevented a timely diagnosis of the decedent’s cancer, resulting in metastasis and death.

The court reversed the trial court’s grant of defendants’ preliminary objections, and held that sufficient facts existed regarding the liability of the defendant HMO under the ostensible agency theory of negligence by its participating primary care physician. In addition, the court held that the facts pleaded in the complaint were sufficient to withstand demurrers to plaintiff’s allegations of misrepresentation based on representations by the HMO and breach of contract. On the question of corporate negligence, the court held “it would appear unnecessary . . . to extend the theory of corporate negligence to IPA model HMOs in order to find that such HMOs have a non-delegable duty to select and retain only competent primary care physicians.” Significantly, this was one of the duties that Thompson v. Nason placed on hospitals under the corporate negligence doctrine. Unwilling to expressly extend the Thompson v. Nason doctrine of corporate negligence to HMOs in this opinion, the McClellan Court relied on the Restatement (Second) of Torts section 323 same court became the first court to extend the ostensible agency doctrine from the hospital setting to the MCO setting. Boyd, 547 A.2d at 1229. See Joshua Michael Kaye, Comment, Closing the Lid on Pandora’s Box: ERISA Preemption of Tort Actions Against Managed Care Organizations in State Courts, 54 U. MIAMI L. REV. 373, n.170 (Jan. 2000).
122. 604 A.2d at 1056.
123. Id.
124. Id. n.6.
125. Id. at 1058.
126. Id. at 1060-61.
127. Id. at 1059.
in holding that the HMO had a duty to select and retain only competent physicians. 129

In *Jones v. Chicago HMO*, 130 the Illinois Appellate Court considered issues of first impression under Illinois medical malpractice jurisprudence. These included whether an HMO may be held liable under the corporate negligence doctrine and breach of contract. 131 On January 18, 1991, plaintiff's three month old daughter developed a loss of appetite, abnormal sleep patterns, fever, constipation and became prone to excessive crying. In response plaintiff called her HMO PCP, Dr. Robert Jordan. Unable to reach him, plaintiff related her daughter's symptoms to the nurse in Dr. Jordan's office. The nurse advised the plaintiff to give the infant some castor oil. Later, Dr. Jordan returned the plaintiff's call and echoed the nurse's castor oil recommendation. 132 The infant's condition did not improve, prompting the plaintiff's visit to the emergency room with her daughter the next day. At the ER the infant was admitted, and later diagnosed with bacterial meningitis. The infant suffered permanent brain damage as a result of the meningitis. 133

The plaintiff then filed suit against the HMO seeking to hold the HMO liable under corporate negligence, vicarious liability and breach of

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129. *McClellan*, 604 A.2d at 1059. The court emphasized:
We find that the allegations of the complaint are sufficient to state a cause of action for negligence in the selection, retention, and/or evaluation of the primary care physician. Since Section 323 of the Restatement (Second) of Torts has long been part of the law of this Commonwealth, we need not now consider or decide whether the theory of corporate negligence is applicable to IPA model HMOs. *Id.* (citations omitted). Restatement (Second) of Torts Section 323 provides in pertinent part:

One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of the other's person or things, is subject to liability to the other for physical harm resulting from his failure to exercise reasonable care to perform his undertaking, if

(a) his failure to exercise such care increases the risk of such harm, or
(b) the harm is suffered because of the other's reliance upon the undertaking. *Id.*


131. *Id.* at 504. "Until now, no Illinois medical malpractice case has dealt with claims of HMO independent corporate negligence and breach of contract with covered patients." *Id.*

132. *Id.* at 507.

133. *See id.*
contract. Deposition testimony revealed that the HMO, which both sides conceded was an IPA model HMO, assigned the PCP to the plaintiff and specifically referred to subscriber PCPs as "your Chicago HMO personal doctor," in its handbook. Deposition testimony also showed that the HMO had the right to review the PCP's medical decisions and to terminate his contract if his practices did not comport with the HMO's guidelines. At the end of discovery, the trial court granted the HMO's motion for summary judgment on all three theories of liability. On appeal, the appellate court observed that "[n]o Illinois case has held an HMO can be liable for an injury to the plan's patient on a theory of independent corporate negligence." The court also noted that "Petrovich and Raglin make passing reference to the viability of such a theory, but they did not decide the issue." It also cited two cases from other jurisdictions, McClellan and Harrel v. Total Health Care, Inc. Those cases held that an HMO may be held liable under the corporate negligence doctrine for negligent UR and/or failure to conduct reasonable investigation of the qualifications into its participating physicians.

Observing that HMO liability based on corporate negligence was "new ground . . . fraught with considerations of public interest, matters that courts are ill-equipped to determine," the Jones Court affirmed summary judgment on corporate negligence and breach of contract. However, it reversed on vicarious liability, holding that a question of fact existed regarding the ostensible agency liability of the HMO for any proven negligence of the PCP, based on the HMO's aggressive marketing and representations to the plaintiff. The Illinois Supreme Court then reversed the grant of summary judgment in favor of the HMO with respect to the corporate negligence claim. The court's decision was based on the conclusion that public policy militated against allowing HMOs to assign more patients to a primary care physician than the physician is capable of handling, when it is reasonably foreseeable that such excessive

134. For a description of the different HMO models, see supra note 3.
135. See Jones, 703 N.E.2d at 507.
136. Id. at 508.
137. Id.
138. 781 S.W.2d 58 (Mo. 1989).
139. Ironically, Harrel v. Total Health Care, Inc. essentially affirmed the grant of immunity to an MCO for the negligent conduct of a participating physician, based on a state statutory provision allegedly exempting non-profit MCOs from liability for the negligence of independent licensed physicians. Id. at 61.
140. Jones, 703 N.E.2d at 509.
141. Id. at 511.
assignment could result in injury to the patients.\textsuperscript{142}

Finally, in \textit{Shannon v. Healthamerica},\textsuperscript{143} Pennsylvania became the first jurisdiction to hold a managed care plan directly liable for its own independent corporate negligence. The evidence in \textit{Shannon} showed that Mrs. Shannon, a subscriber of the HMO, Healthamerica, selected Dr. Larry P. McNulty as her obstetrician/gynecologist during her first pregnancy from a list supplied by Healthamerica.\textsuperscript{144} The HMO membership card supplied to Mrs. Shannon advised her to call either her physician or the HMO medical hotline, which was staffed by registered nurses, if she had any medical questions or in the event of an emergency. Consistent with this advice, she called Dr. McNulty on October 2, 1992 with complaints of abdominal pain, and scheduled an appointment with him for October 5, 1992.\textsuperscript{145} On the day of the appointment, Dr. McNulty examined her for five minutes and decided that her abdominal pain was due to a fibroid uterus.\textsuperscript{146} He prescribed bed rest and took her off work for one week. Dr. McNulty did not order any diagnostic tests to confirm his diagnosis, nor did he advise Mrs. Shannon of the symptoms of preterm labor.\textsuperscript{147}

In the next four days, Mrs. Shannon called Dr. McNulty at least four more times with complaints of continuing abdominal pains and explained to him that she had also developed back pains, constipation and difficulty sleeping. She inquired whether she was in preterm labor, since her symptoms were similar to ones described in a reference book she had on labor.\textsuperscript{148} During each call, Dr. McNulty assured her that she was not in

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\item \textsuperscript{142} See Jones, 703 N.E.2d. at 1134. The Jones court asserted: we hold that Chicago HMO had a duty to its enrollees to refrain from assigning an excessive number of patients to Dr. Jordan. HMOs contract with primary care physicians in order to provide and arrange for medical care for their enrollees. It is thus reasonably foreseeable that assigning an excessive number of patients to a primary care physician could result in injury, as that care may not be provided.

\item \textsuperscript{143} Id. The court continued, “Public policy would not be well served by allowing HMOs to assign an excessive number of patients to a primary care physician and then ‘wash their hands’ of the matter. The central consequence of placing this burden on HMOs is HMO accountability for their own actions.” \textit{Id.} (emphasis deleted).

\item \textsuperscript{144} 718 A.2d 828 (Pa. Super. Ct. 1998).

\item \textsuperscript{145} \textit{Id.} at 831.

\item \textsuperscript{146} \textit{Id.} at 832.

\item \textsuperscript{147} \textit{Id.}

\item \textsuperscript{148} \textit{Id.}
\end{itemize}
preterm labor and increasingly became impatient and irritated with her calls. Unable to obtain relief from Dr. McNulty, and sensing his impatience, she called the HMO hotline and related her symptoms and the various calls to Dr. McNulty. In response, the HMO's triage nurse advised her to call Dr. McNulty again. When she called Dr. McNulty again and indicated that her symptoms were getting worse, he did not change his medical advice. On October 11, 1992, Mrs. Shannon called the HMO triage nurse again and related Dr. McNulty's failure to respond to her complaints. Again, the HMO nurse advised her to call Dr. McNulty. Once more she called Dr. McNulty and related that her condition had worsened. In addition, she informed him that her legs were beginning to go numb. Dr. McNulty continued to respond with impatience and angrily asserted that she was not in preterm labor.

Frustrated with Dr. McNulty's non-responsiveness, Mrs. Shannon called the HMO's medical hotline on October 12, 1992 and related her ordeals with worsening symptoms and with Dr. McNulty. In response, one of the HMO's in-house orthopedic physicians spoke with her on the phone and directed her to go for a back examination at West Penn Hospital, located about one hour away from her house. Mrs. Shannon passed several hospitals on her way to West Penn. At West Penn she was initially processed for a back examination, based on the instructions from the HMO's in-house physician, but was admitted to the obstetrical wing as a formality based on the stage of her pregnancy. The same day, she delivered a baby who died two days later due to severe prematurity.

The Shannons brought suit against the HMO, asserting claims of vicarious and direct liability under the corporate negligence doctrine. Plaintiffs alleged that the HMO, through its triage nurses, deviated from the standard of care by not referring Mrs. Shannon to a hospital for a pelvic examination and a fetal stress test on October 10 and 11, 1992. In addition, the Shannons' expert testified that the HMO, through its nurses and orthopedic physician, deviated from the standard of care on October 12, 1992 by not arranging for immediate hospitalization and examination

149. Id. at 832.
150. Id.
151. Id.
152. Id.
153. See id.
154. Id.
155. Id.
156. Id.
157. See id.
of the patient. These acts and omissions, in the expert's opinion, increased the risk of harm to the baby.\textsuperscript{158}

At the close of plaintiffs' evidence, the trial court granted a compulsory nonsuit to defendants on both the vicarious and direct liability theories.\textsuperscript{159} On appeal, the Superior Court examined the duties set forth under the corporate negligence doctrine in \textit{Thompson v. Nason},\textsuperscript{160} and held that the third duty required by the holding in that case, the overseeing of all persons who practice medicine within an institution's walls as to patient care, was applicable. Accordingly, the court reversed and remanded for a new trial. The court emphasized that like the \textit{Thompson} court's recognition of "the corporate hospital's role in the total health care of its patients," it too was recognizing the "central role played by HMOs in the total health care of its subscribers."\textsuperscript{161}

The court pointed out the various roles HMOs play in the provision of care, stressed the helplessness of subscribers in the stewardship of their care, and noted that while HMOs may not be practicing medicine, "they do involve themselves daily in decisions affecting their subscriber's medical care."\textsuperscript{162} More importantly, \textit{Shannon} held that when an MCO makes a decision to limit a subscriber's access to treatment, "that decision

\textsuperscript{158} See \textit{id.} at 834. For analysis of the increased risk of harm, see, e.g., Hamil v. Bashline, 392 A.2d 1280 (Pa. 1978), holding in pertinent part:

Once a plaintiff has introduced evidence that a defendant's negligent act or omission increased the risk of harm to a person in plaintiff's position, and that the harm was in fact sustained, it becomes a question for the jury as to whether or not that increased risk was a substantial factor in producing harm.

\textit{Id.} at 1286. See also \textit{RESTATEMENT (SECOND) OF TORTS}, § 323(a), which provides:

One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of the other person or things, is subject to liability to the other for physical harm resulting from his failure to exercise reasonable care to perform his undertaking, if (a) his failure to exercise such care increases the risk of such harm[.]

\textsuperscript{159} A compulsory nonsuit is a ruling against the party with the cause of action, usually at the close of that party's presentation of evidence, which indicates that the party has failed to prove the elements of the controverted action. Under Pennsylvania law a nonsuit may be voluntary, whereby the plaintiff voluntarily terminates the action, or compulsory, when the court determines that the plaintiff has failed to establish a right to relief. See Pa. R. Civ. P. 230 & 230.1. See also Fed. R. Civ. P. 41 for the companion federal rule.

\textsuperscript{160} 591 A.2d 703 (Pa. 1991).

\textsuperscript{161} \textit{Shannon}, 718 A.2d at 835.

\textsuperscript{162} \textit{Id.}
must pass the test of medical reasonableness." It also stressed that "when a benefits provider, be it an insurer or a managed care organization, interjects itself into the rendering of medical decisions affecting a subscriber's care it must do so in a medically reasonable manner." In addition, the court held that once Healthamerica provided a phone service for emergent care staffed by triage nurses, it was under a duty to ensure that the medical advice dispensed was medically reasonable. Finally, regarding corporate liability, the court stressed "we now make explicit that which was implicit in McClellan and find that HMOs may, under the right circumstances, be held corporately liable for a breach of any of the Thompson duties which causes harm to its subscribers."

V. APPLICATION OF CORPORATE LIABILITY ON MCOs: SOUND PUBLIC POLICY OR JUDICIAL OVERKILL?

As discussed above, the Shannon Court was willing to hold managed care organizations corporately liable. The Illinois Appellate Court in Jones admonished that courts are ill-equipped to deal with the issue of managed care organization corporate liability. Given these cases, the issue arises as to whether judicial imposition of corporate liability on managed care organizations comports with sound public policy or constitutes judicial overkill.

Direct liability may be imposed on hospitals under the corporate negligence doctrine for negligent failure to: (a) maintain safe and adequate facilities and equipment for patients; (b) select and retain only competent physicians; (c) oversee all persons who practice medicine within their walls as to patient care; and (d) formulate, adopt, and enforce adequate rules and policies to ensure quality care for patients. The decision to impose liability on these theories emanated from the recognition that hospitals wield substantial influence over their employee physicians and nurses, and also over those non-employee physicians who have admitting privileges at hospitals. That decision also recognizes that when patients go to a hospital, they normally look to the hospital to ensure their safety and well-being while at the hospital. The hospital in

163. Id. at 835-36.
164. Id.
165. Id. at 836.
166. 703 N.E.2d at 509.
turn acts through its employee physicians and nurses, and others granted privileges at the hospital, to respond to the reasonable expectations of the patients. The rationale justifying application of corporate negligence to hospitals is equally applicable to MCOs.

Individuals normally enroll in an MCO with a reputation for qualified and reputable health care providers, reasonable premiums, and adequate and timely provisions of care. In the case of staff model MCOs, which directly employ physicians and other health care providers to care for their enrollees, it is clearly reasonable to assume that the enrollees expect the MCOs to ensure their safety and well-being while receiving care from those retained by the MCOs. Accordingly, MCOs have the same obligations as hospitals to select and retain on their enrollment lists only competent health care providers. They also have the obligation to maintain safe and adequate facilities and equipment for enrollees when the MCOs decide to provide direct medical care. Further, the duty to oversee all who practice under their influence and control should fall on MCOs, as well as the obligation to formulate, adopt, enforce and insist on their enrolled providers' formulation, adoption and enforcement of adequate rules to ensure quality care for enrollees.

Imposition of corporate negligence upon MCOs when supported by facts is also strongly supported by the widely-accepted premise of tort law – that everyone must accept responsibility for his or her conduct. For the average patient who suffers an injury as a result of medical negligence, public policy militates in favor of compensation and restitution, and against immunity for the responsible MCO. Any assumption that a corporate entity will act appropriately under the circumstances without


169. See, e.g., David Algeo, Managed care options improve HMOs respond to customers' demand for access, choice, THE DENVER POST, Mar. 15, 1998, Business Section, at 25.

170. See supra note 3.

171. See Wertheimer, supra note 77, at 122 (asserting that the basic premise of tort law is that all members of society should be responsible for compensating those they injure). It is also instructive to note that a system which allows managed care organizations to escape liability for their negligent infliction of injury on subscribers runs the risk of frustrating the noble purposes of tort law. For the purposes of tort law see, e.g., RESTATEMENT (SECOND) OF TORTS § 901 (1977) providing in relevant part that the purposes for which actions in tort are maintainable include: “a) to give compensation, indemnity or restitution for harms; (b) to determine rights; (c) to punish wrongdoers and deter wrongful conduct; and (d) to vindicate parties and deter retaliation or violent and unlawful self-help.”
the threat of tort liability is an illusion. Managed care organizations deserve commendation for their efforts to rein in the spiraling cost of health care. MCOs, as their records demonstrate, are essential to reining in the skyrocketing cost of health care. However, their remarkable effort in achieving cost containment should not excuse them from liability when facts show that their medically-related decision imperiled the life or safety of a patient. Although recent rulings reflect a developing trend toward disallowing an ERISA preemption defense when the quality of care provided by an MCO is at issue, courts need to do

172. Id. at 122-23 (stressing that “HMOs like all other entities, need the incentive of tort liability to encourage them to act reasonably,” and observing that “[p]roviding such an incentive to all participants in society is, indeed, one of the moving forces behind the adoption of a negligence standard in the first place”); Vandall, supra note 1, at 297 (observing that because HMOs are usually for profit, their primary obligation may be to represent their shareholders’ interest in the quest for profit).

173. See Vandall, supra note 1, at 294, n.9 (observing that HMOs are predicted to save Americans about $383 billion in health care costs by end of the last decade (1999) alone).


175. See, e.g., Pappas v. United Healthcare, 724 A.2d 889, 894 (Pa. 1997), vacated and remanded by United States Healthcare Sys. of Pa., Inc. v. Pennsylvania Hosp. Ins. Co., 120 S. Ct. 2686 (2000) (allegation that MCO unreasonably interfered with medical decision regarding which medical facility was best suited for plaintiff’s neurological emergency condition and then unreasonably delayed authorization for the transfer of plaintiff, resulting in permanent quadriplegia, not preempted under ERISA, because negligence laws have “only a tenuous, remote, or peripheral connection with [ERISA] covered plans, as in the cases with many laws of general applicability,” (quoting New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co, 514 U.S. 645, 661 (1995)). Although the U.S. Supreme Court vacated and remanded Pappas without an opinion, in light of its ruling in Pegram v. Herdrich, 530 U.S. 211 (2000), the U.S. Supreme Court’s action neither compels a reversal of, nor vitiates the holding of Pappas by the Pennsylvania Supreme Court. Pegram neither disavowed the Court’s own rationale in Travellers, Inc., relied on by Pappas, nor questioned what appears to be the well-settled rule that regulation of health care is traditionally a matter of state interest, not subject to ERISA preemption without clear congressional intent. See Pegram, 120 S. Ct. at 2158 (emphasizing “in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose”). Further, Pegram, unlike Pappas, was concerned with the issue of whether “treatment decisions made by a health maintenance organization, acting through its physician employees, are fiduciary acts within the meaning of ERISA,” 120 S. Ct. at 2147. The question raised in Pappas was whether ERISA preempts a
more to deter negligent decision making influenced by excessive emphasis on the bottom line.

Although legislatures play important roles in holding MCOs directly liable for their negligent acts and omissions, the judiciary has an obligation to protect the interests of patients. Unlike MCOs and the medical profession, patients do not have the ability to strenuously oppose any legislation adverse to their interests. Patients need the protection of the courts to ensure that MCOs do not escape liability either through the invocation of an alleged ERISA preemption clause, or by arguing that they do not practice medicine when their decisions put patients' health or life in jeopardy. In addition to holding MCOs vicariously liable for the negligent conduct of their employees, agents and ostensible agents, courts have an obligation to hold them directly liable under the corporate liability principle when their negligent actions or omissions harm patients.

When MCOs provide health care services or interject themselves into medical decisions resulting in injuries to patients, sound public policy calls for the imposition of tort liability to ensure the safety and protection of patients. Likewise for the corporate hospital, common sense and logic require the imposition of a non-delegable duty upon MCOs to select and retain only competent physicians, maintain safe and adequate facilities and equipment for patient care, oversee all who practice medicine under their direction, and formulate, adopt and enforce adequate rules and standards.

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176. See, e.g., Frank M. McClellan, Is Managed Care Good for What Ails You? Ruminations on Race, Age and Class, 44 VILL. L. REV. 227, 249 (1999) (stressing that when the impersonal managed care system diminishes the incentive to deliver care, the legal community must rely on the tort system to protect the interest of the consumer-patient); see also Bivens v. Six Unknown Named Agents of Federal Bureau of Narcotics, 403 U.S. 388, 407 (1971) (Harlan, J., concurring) (emphasizing the equal role of the judiciary, along with the legislature, in protecting the welfare of the people).

177. See DiCicco, supra note 2, at 511 (asserting accurately that “[i]n the interest of encouraging high standards of health care it behooves the Courts to hold HMOs liable for the conduct of their participating physicians, when the facts so merit”).
policies to ensure quality care for patients. No reasonable basis exists for allowing MCOs to escape liability to patients when their actions imperil patients on the grounds of alleged preemption under ERISA, the Medicare Act, or considerations of the effect of added litigation expense on cost containment. The same standard of reasonableness applied to hospitals by courts under the corporate negligence doctrine should be applied to the conduct of MCOs. Otherwise, the tort system runs the risk of undermining its purpose of providing compensation, indemnity or restitution for harms, and deterring wrongful conduct. Such a system also runs the risk of compounding the obligation of hospitals and physicians in the provision of care to patients. In other words, a hospital or physician which terminates treatment to a patient based on an MCO’s prospective UR that indicates that further treatment was unwarranted, risks liability if the denied treatment was medically necessary. However, the MCO would escape liability by arguing that it did not practice medicine, and that it was shielded by preemption under ERISA or the Medicare Act.

Although the costs and burdens of litigation are legitimate factors to consider, such considerations should not overshadow the need to ensure that MCOs act reasonably in their delivery of health care. Common sense and experience indicate that less litigation would result in the long run if the threat of tort liability compelled MCOs to act reasonably in medically related decisions. Attention to reasonable UR, and a dedication to ensuring the safety and well-being of patients would likely lead to better care for patients. This would in turn result in less litigation about alleged

178. See, e.g., RESTATEMENT (SECOND) OF TORTS § 901 (1977), discussed supra note 171.


180. See, e.g., Corcoran, 965 F.2d at 1331.

181. See the following cases for the defendants’ arguments for preemption under the Medicare Act: McCall v. Pacificare of Cal., 87 Cal. Rptr. 2d 784, 789 (Cal. App. 4th Dist. 1999); Plocica v. Nylcare of Tex., 43 F. Supp. 2d 658, 663 (N.D. Tex. 1999); Herdrich v. Pegram, 154 F.3d 362, 365 (7th Cir. 1998), rev’d, 530 U.S. 211 (2000); Ardary v. Aetna Health Plans of Cal., Inc., 98 F.3d 496, 501 (9th Cir. 1996). In addition, see the rationales advanced by Judges Easterbrook, Posner, Flum, and Wood in their dissenting opinion in Herdrich v. Pegram, 170 F.3d 683 (7th Cir. 1999), rev’d, 530 U.S. 211 (2000).

182. See Wertheimer, supra note 74, at 127 (observing that the threat of liability engendered by litigation has resulted in enormous increases in product safety, especially during the 1990s). There is no reason why the threat of liability would not encourage MCOs to provide better and safer medical care to their
substandard care emanating especially from negligent UR. Although proper UR is absolutely essential to contain the escalating cost of health care occasioned by new technologies, the aging baby boomers and increases in life expectancy, UR should not involve only the bottom line. Patient care should be paramount, or at least enjoy equal consideration with cost containment in the UR analysis, especially considering the imbalance between the subscriber and the MCO in the contractual relationship for the provision of health care. When there is doubt whether treatment should be denied, MCOs must err on the side of approving the treatment. This requirement is especially important since doctors are better qualified than MCO executives to determine the best course of treatment for patients.

Courts also have an obligation to use their equity powers to void unconscionable provisions in MCO contracts such as gag rules that may have the effect of preventing physicians from providing patients with information regarding alternative options to those approved by the MCOs. Further, contrary to the laissez-faire approach advocated by some, courts have the obligation to impose liability where the acts or omissions of corporate entities such as MCOs imperil the welfare of patients, who are already in an inferior position in the management of subscribers.

183. See, e.g., McEvoy v. Group Health Coop. of Eau Claire, 570 N.W.2d 397 (Wis. 1997) (upholding application of the tort of bad faith, traditionally applied to insurance companies, to HMO which breached its contractual obligation to pay up to the subscriber’s policy limit for psychological inpatient care without a reasonable basis, on the ground, that because “HMO subscribers are in an inferior position for enforcing their contractual health care rights, application of the tort of bad faith is an additional means of ensuring that HMOs do not give cost containment and utilization review such significant weight so as to disregard the legitimate medical needs of subscribers”).

184. Herdrich, 154 F.3d at 377 (appropriately emphasizing that trained physicians, with inputs from their patients, are best qualified to chart courses of treatment, and not insurance executives).


186. For a detailed analysis of the requirements of the informed consent doctrine, see Emmanuel O. Ihekwumere, HIV-Positive Medical Practitioners: Legal and Ethical Obligations to Disclose, 71 St. John’s L. Rev. 715 (1997).


their health care.

CONCLUSION

The MCO system has changed dramatically the way health care is delivered in the present age. It has also made commendable inroads on the fight against escalating health care costs mainly through UR procedures. Notwithstanding the success of the MCO UR in attacking health care costs, abuses associated with UR have arisen to such an extent that several states have passed measures to curb managed care excesses. However, MCOs continue to hide behind arguments premised on alleged ERISA or Medicare Act preemptions and the alleged non-practice of medicine when escaping liability for their negligent conduct.

Courts have an obligation to extend the corporate negligence doctrine, imposed upon hospitals by many of the states, on MCOs to ensure their compliance with the requirements of reasonable conduct, and thus protect patients from substandard care and resulting injuries.

(countering argument that the legislature was in a better position to alter the learned intermediary doctrine when a prescription drug manufacturer markets directly to the patient with the observation that “[d]efining the scope of tort liability has traditionally been accepted as the responsibility of the courts”). For a discussion of the learned intermediary doctrine see Emmanuel O. Iheukwumere, Prescription Drugs Liability in Pennsylvania: Is Strict Liability Dead?, 70 PA. B. ASS'N Q. 135 (1999).