# On Entry into Phase Two in Family Practice Development

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January 1977 marks a new beginning of importance in the continued growth and development of family practice as a specialty in the United States. Ten years have now passed since the publication of the three major national reports which had much to do with the genesis of family practice – the Millis, Willard, and Folsom reports. It has been eight years since the formation of the American Board of Family Practice. It is useful at this point to reflect briefly on what has been accomplished and what remains to be done.

If the first decade is viewed as Phase One, the initial development of this specialty can be considered to have been completed successfully. Departments or divisions of family practice have been started in a majority of the nation's medical schools, almost 300 approved family practice residencies are in operation, and medical students in large numbers have shown a sustained interest in this field. The initial difficulties with faculty recruitment have been sufficiently overcome so that enough new faculty have become involved in teaching programs to have allowed this progress to be made. Public and legislative support for family practice remains at a high level, and the medical profession has to a large extent now recognized family practice as a major component within the new emphasis on primary care.

Impressive as this progress is, we are now entering an even more challenging, exciting, and difficult stage in family practice development. Phase Two, in my view, must deal with more fundamental issues involving the better definition of the academic discipline and the development of the research base in the field. Therein lies the life blood required to assure the continued development of family practice as a specialty.

The decline of general practice during the last 30 years involved two basic failures: (1) the failure to develop an academic base in medical schools and medical education, and (2) the failure to define itself in anything more than derivative terms (ie, as portions of knowledge and skills derived from other disciplines within medicine).

In 1966, McWhinney noted the absolute importance of the development of the academic discipline for any specialty to survive. He suggested four criteria which must be fulfilled by a subject claiming to be a discipline: (1) a unique field of action; (2) a defined body of knowledge; (3) an active area of research; and (4) a training which is intellectually rigorous.[1] The pressing task during Phase One has been to establish educational programs in family practice at both undergraduate and graduate levels. It has not been possible to address all of these criteria, particularly that involving research, with equal vigor. The development and continued evolution of the academic discipline of family medicine, including an active emphasis upon research, is the major task of Phase Two, now that many of the initial organizational and logistic aspects of program development have been successfully completed.

January 1977 is also a significant landmark for *The Journal of Family Practice.* This issue marks the start of the fourth year of publication and the increase to monthly from bimonthly publication. The Editorial Office has been moved to the University of Washington School of Medicine.

The initial development and progress of *The Journal* are particularly important in several respects. A forum has been created to encourage and share original work in clinical, educational, and research areas of the field. Family physicians, family practice residents, and others involved in the developing specialty have become increasingly involved in creative efforts that have resulted in the publication of original work reflecting the family physician's perspective and experience. This is an important step beyond the usual kind of literature in the field, which tends to be derivative in nature from other clinical disciplines (usually in the form of review articles) from the viewpoint and experience of specialists in other fields.

We are now at a critical point in the development of family practice. There is no time for complacency because of the successful aspects of Phase One. The urgent task of Phase Two is to develop and articulate the academic and research base of the specialty. This can lead to improvements in patient care and in teaching programs, and will require the active participation of family practice faculty, practicing family physicians, and related disciplines.

**Reference**

1. McWhinney IR: General practice as an academic discipline. Lancet 1:419-423, 1966

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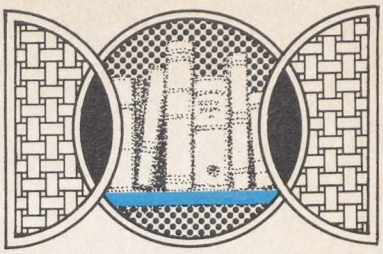
# Book Reviews



**Screening in General Practice.** *Edited by C. R. Hart. Longman Inc., New York, 1975, 338 pp., $16.00.*

This is an up-to-date, comprehensive review of the effectiveness of various screening programs instituted within the United Kingdom. The work should be of reference value to medical students, family practitioners, and administrators of Home Health Agencies interested in detecting treatable, asymptomatic illnesses.

The central problem of screening lies in deciding which disease to screen for, and whether recognition of the disease in the symptomless individual will bring mutual benefit to the patient and the doctor. Accordingly, the authors argue that screening is best carried out by the general or family practitioner because of his or her more intimate relationship with and understanding of the patient.

The experience of the authors reveals that the benefits derived from many screening programs carried out in England are questionable. Cost, confining screening to the high-risk group, and follow-up care were considered important parameters in the series studied by the authors.

The investigations adhered to Wilson's Criteria:

1. The condition sought should be an important problem.
2. There should be an accepted treatment for patients with recognized disease.
3. Facilities for diagnosis and treatment should be available.
4. There should be a recognized latent or early symptomatic stage.
5. There should be a suitable test or examination.
6. The test or examination should be acceptable to the population.
7. The natural history of the condition, including its development from latent to declared disease, should be adequately understood.
8. There should be an agreed upon policy as to whom we should treat as patients.
9. The cost of case finding (including diagnosis and subsequent treatment) should be economically feasible.
10. Case-finding should be a continuing process and not a "once for all" project.

Using the above criteria and by means of the age-sex register organized by the British National Health Service, the following groups and specific diseases were screened and evaluated by the authors: (1) the newborn, (2) the pre-school child, (3) the school child, (4) the prenatal clinic, (5) women in middle years, (6) geriatric screening, (7) psycho-geriatric screening, (8) urinary infections, (9) diabetes mellitus, (10) obesity, (11) hypertension, (12) ischemic heart disease, (13) glaucoma, (14) anemia, (15) carcinoma of the breast, and (16) mental illness.

A well-organized, readable presentation has been accomplished, and much information contrary to our general medical knowledge has been uncovered. This text should be well worth an interested physician's time.

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**Medical Care of the Adolescent (3rd Edition).** *Edited by J. Roswell Gallagher, Felix P. Heald and Dale C. Garell. Appleton-Century-Crofts, New York, 1976, 774 pp., $17.40.*

Review of this text presents basic problems since the assumptions around which it was organized and written are not ones with which I agree. The central rationale for the effort which is stated in the Introduction is one which reads like a tongue-in-cheek advertisement for family practice: "[Adolescent] medical care has inevitably fallen between

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Spironolactone has been shown to be a tumorigen in chronic toxicity studies in rats. In one study using 25, 75 and 250 times the usual daily human dose (2 mg./kg.) there was a statistically significant dose-related increase in benign adenomas of the thyroid and testes. In female rats there was a statistically significant increase in malignant mammary tumors at the mid-dose only. In male rats there was a dose-related increase in proliferative changes in the liver. At the highest dosage level (500 mg./kg.) the range of effects included hepatocytomegaly, hyperplastic nodules and hepatocellular carcinoma; the last was not statistically significant.

**Precautions:** Patients should be carefully evaluated for possible disturbances of fluid and electrolyte balance. Hyperkalemia may occur in patients with impaired renal function or excessive potassium intake and can cause cardiac irregularities which may be fatal. Hypokalemia may develop as a result of profound diuresis, particularly when Aldactazide is used concomitantly with loop diuretics, glucocorticoids or ACTH. Transient elevation of BUN may occur. Dilutional hyponatremia or rarely low-salt syndrome may develop. Gynecomastia may develop and in rare instances some breast enlargement may persist.

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*Associated with thiazides:* Gastrointestinal symptoms (anorexia, nausea, vomiting, diarrhea, abdominal cramps), purpura, thrombocytopenia, leukopenia, agranulocytosis, dermatologic symptoms (cutaneous eruptions, pruritus, erythema multiforme), paresthesia, acute pancreatitis, jaundice, dizziness, vertigo, headache, xanthopsia, photosensitivity, necrotizing angiitis, aplastic anemia, orthostatic hypotension, muscle spasm, weakness and restlessness.

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the two stools of internal medicine and pediatrics." The proposed corrective for this neglect is to urge the specialization of physicians in the area of adolescent medicine and the establishment of clinics for the care and study of adolescents. Once having decided that the cure for a symptomatic expression of specialization is subspecialization, the stage is set for the organization that follows.

The book is divided into 20 parts representing general organ systems or topics, and 69 chapters, mostly dealing with specific disease entities. It reproduces, then, much of what would be available in traditional texts of medicine, pediatrics or surgery, attempting to stress those areas with particular relevance to adolescence. This creates an occasional awkwardness such as that found in the chapter on nocturnal enuresis, when the rationalization for writing about childhood enuresis is said to be that " . . . the best way to treat adolescent bedwetting is to treat it early in childhood . . . " The text is well-written with adequate graphics where needed. There is an excellent section on the legal status of adolescents with a state-by-state breakdown of relevant statutes and an addendum that attempts to update the information to the time of publication.

The book suffers from the usual, perhaps unavoidable, problem of a text authored by multiple writers in that much is repetitive and some is contradictory. For example, in Chapter 5, "The Psychology of Adolescence," anorexia nervosa is attributed to displacement of pleasure-seeking from sex to food, while in Chapter 25 it is ascribed to disturbance in body image and perception. Certainly alternative viewpoints deserve to be voiced, but there is no acknowledgment that such a difference exists elsewhere in the text. The area of most concern to this reviewer, however, is the absence of the "family medicine"[1] perspective generally. To a disturbing extent, the adolescent patient is seen from an intrapsychic orientation with minimal attention to the family's role in a systems or contextual way. Thus, problems of asthma, diabetes mellitus, and anorexia nervosa have chapters devoted to their discussion without reference to the important work of the Philadelphia Child Guidance Clinic.[2,3,4] In these studies, the origin and treatment of these diseases is related to the family structure and dynamics in a manner that suggests vital significance to the practicing family physician.

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**Principles of Genetic Counseling.** *Edmond A. Murphy and Gary A. Chase. Year Book Medical Publishers, Chicago, 1975, 391 pp., $22.95.*

This volume seeks to serve as a source of thorough and readily accessible information on genetic counseling. It is, in general, tightly written and well organized, although there is inevitable recourse, in the more technical chapters, to mathematical formulae whose formats are sufficiently forbidding as to discourage the average practitioner from further encounters. Explanatory charts and diagrams are clear and well laid out.

The authors have provided in the first 100 pages a very logical and clear development of the elements of good genetic counseling, as well as the basic genetic principles and probability theory which underly this process. This section of the book, taken alone, should prove to be of substantial assistance to the practitioner seeking to refresh his prior knowledge of genetics and counseling strategies.

Overall, the text tends to emphasize the more technical considerations in genetic counseling. As a result, it would appear to be of relatively little utility as a day-to-day reference volume for the practicing physician.

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# Book Excerpts

The following article has been selected by the Publisher from its forthcoming book, *Legal Medicine 1976,* edited by Cyril H. Wecht, in the hope that it will have immediate usefulness to our readers who otherwise might not have had access to it.

## Group Prepaid Health Plan Liability when a Physician Provider Malpractices*

Robert N. Meyer, JD

### Introduction

In government and the health-care field, group prepaid health plans are being heralded as a possible solution to many of this country's health-care delivery problems.[1] Concurrently, there is a growing interest among plaintiffs in holding a health care institution liable when a physician malpractices within its structure.[2] But little has been written about the possible bases for Group Prepaid Health Plan liability when such a physician provider malpractices.[3] This article will analyze Group Prepaid Health Plans which might be relevant to the inquiry, and which might indicate the Plan's liability when a physician provider has malpracticed.

First, this article examines what Group Prepaid Health Plans[4] (hereinafter GPHP) actually are and what they represent themselves to be. Second, three legal theories that might apply to GPHPs are reviewed. Finally, structural functional, economic and policy factors potentially influencing GPHP liability are analyzed.

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### *The Model*

A GPHP has three essential components which may be combined into one or two functional units or kept separate.[5] First, there is the plan itself. This, at a minimum, consists of the administrative, marketing, and quality control units. When GPHP liability is discussed, it is this component which is addressed as being potentially liable.

Second, there is the inpatient hospital unit. The hospital may be owned by the plan or merely have a contractual relationship with it.

Third, there is the medical group. This group of doctors may be directly employed by the plan and treat only plan patients; it may be a separate corporation under contract with the plan; or it may be a hybrid of these extremes. This medical group, however related to the plan, is a closed panel of physicians. "Closed panel" means a limited number of physicians, each of whom is chosen either directly or indirectly by the plan. The consumer has some choice among physicians within the closed panel, but most choose only from the panel.

The model to be discussed here is a nonprofit, closed panel GPHP that may employ some of its physicians but does not employ the particular physician who has malpracticed. The hospital is owned and operated by the GPHP, but the medical group which employs the malpracticing physician is a separate corporation under contract to the GPHP.

This structure, which lies between the centralized GPHP which employs all of its physicians and the decentralized Foundation for Medical Care, is chosen because it is as yet unclear whether this model will be held liable for physician provider malpractice. Models under which the plan employs the malpracticing physician provider are excluded here because the question of liability is not considered close. Providers in general, and GPHPs specifically, are usually vicarious liable when one of their physician employees malpractices, by operation of the doctrine of *respondeat superior.*[6] At the other end of the GPHP spectrum, Foundations for Medical Care (FMC) are excluded because they are a radically different type of organization which may not be a medical care provider at all. Even when FMCs are providers, they are unlikely to be held liable under most of the theories that may apply to GPHPs.[7] FMCs retain: fee-for-service private physician practice, physician employment solely by the individual patient, and total freedom of choice on the part of both physician and patient.[8]

While only the GPHP model that does not employ all of its physician providers will be directly discussed,[9] many of the theories and factors influencing liability which are presented here will be applicable to other Health Maintenance Organizations (HMO).

### The GPHP Role

A GPHP is fundamentally different from a Blue Cross/Blue Shield insurance carrier.

> An HMO in operation admittedly resembles an insurance company: its members or subscribers make periodic prepayments of dues or "premiums" which will be used by the HMO to protect the member against the unpredictable risk of future illness. The difference is that the insurance company essentially saves up the premiums it receives in order to be able to pay cash to the member for the health-care services he has to purchase when he becomes ill, while the HMO immediately invests the premiums in facilities, equipment, and personnel which together will make available the health-care services needed by the member.[10]

GPHPs, then, are not just selling a financing arrangement. They are, rather, selling and providing actual health care,[11] as does a modern hospital.[12] This similarity has been recognized by insurance carriers who, in determining insurability, coverage and rates for GPHPs, tend to treat them like hospitals.[13]

A GPHP's function, however, is much broader than that of a hospital. GPHPs actively market themselves as offering consumers " . . . a 'single portal of entry' to all necessary resources of a comprehensive health-care delivery system."[14] In contrast to fee-for-service patients in hospitals, a GPHP consumer need not locate and select physicians or other necessary medical services if the services required are named in the GPHP contracted package of benefits.[15] Because of this function and their promotion of it, GPHPs have a duty to provide high quality medical services.[16]

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Unlike nearly every other type of health care provider, the HMO cannot apologize that it does not have the facility, equipment, personnel or expertise required to treat a member's medical problems and attempt to pass him on to some other provider of health care. The level of medical care quality offered by the HMO always must be as high as is necessary to deal optimally with the member's problem.[17]

Complementing the high quality single source comprehensive care function of the GPHP is its stated objective to concentrate on preventive health care[18] at a lower cost to the consumer.[19] In theory, the need for inpatient hospital services is to be lowered by emphasizing good health maintenance and preventive care. Under the GPHP prepayment system, the consumer's costs will not go up if he or she seeks medical care before serious illness or the need for expensive inpatient hospital care arises.

The consumer purchases the GPHP's services under a capitation contract which provides for the prepayment by the consumer of a fixed sum per year[20] regardless of the quantity of services used. The closed panel GPHP is also characterized by the selection and organization of all the physician providers by the plan itself, through a committee of the GPHP's physicians and administrators.

Given the GPHP's assumed role as the complete medical care provider, it is proper to inquire into the GPHP's liability when a physician provider malpractices. Should malpractice be considered a breach of the consumer/-GPHP contract? Should the courts, given malpractice by a physician, inquire whether there was also negligence by the GPHP in the selection or in the control of the physician? Or, should GPHPs be exempt from such liability?

## GPHP Liability Theories

### *Breach of Conract Liability*

While breach of contract liability for physician malpractice is unusual, it may more appropriately be allowed against GPHPs than against other health-care providers.

When a doctor treats a patient, a contract is implied if one has not been agreed to expressly.[21] But without an express special contract for a specific result most courts have held that allegations of breach of a contract to provide reasonably skillful medical care sound in tort.[22] While this is still the position of a majority of jurisdictions, it is by no means the only, nor, perhaps, the soundest standard. The Wisconsin Supreme Court has recently held that a patient can successfully bring a breach of contract action against a physician based on his failure to exercise the proper skill or care in treatment.[23]

If a breach of contract action is maintainable against an individual physician, such an action should have even more likelihood of success against a GPHP. Physicians and hospitals often have no more than implied, ill-defined contracts with their patients. GPHPs, however, have express contracts describing what they are contracting to provide the patient. Usually, more than a contract to provide reasonably good medical care is involved, at least by implication from the contract and GPHP's promotional literature. More extensive expectations might also be created by the term "Health Maintenance Organization" itself.

Even given these expectations and the stated purpose of a GPHP to be a health care provider,[24] the major problem facing a breach of contract action against a GPHP will be proving that the GPHP contracted to provide medical care itself.[25] Therefore, an inquiry into the contractual relationship between patient and GPHP must also delve into the relationship between GPHP and physician. If and only if there is a sufficiently strong GPHP/physician relationship will there be a GPHP/patient relationship strong enough for a court to hold that the GPHP itself has contracted as a medical care provider.

### *Negligent Selection of Physician Liability*

A health-care institution's liability for negligently selecting the malpracticing physician is a more conventional, yet not much more commonly applied theory than breach of contract. Even though negligent selection liability has long been recognized,[26] it is infrequently successful because of the problems inherent in the theory.

The problem of remoteness between the negligent act (selection by the institution of the physician) and the injury and resulting damages causes difficulties. As in all negligence theories, the plaintiff must show that the action, here the selection of the physician, proximately caused the injury to the patient.[27] Among other problems, this usually necessitates proof of two different negligent actions: the physician was negligent, and the hospital was negligent in selecting him.[28]

Proving that the hospital was negligent in selecting the physician involves showing that the institution knew or should have known that the physician should not have been selected. To do this, it must first be shown what selection steps ought to have been taken, and second, that the institution did not take all those steps. The first requirement necessitates expert testimony,[29] the second requires evidence and testimony which is often difficult to obtain.[30]

Furthermore, any physical or organizational remoteness of the physician from the institution makes it far easier for the institution to establish that the physician is an independent contractor and not a servant of the institution. While it is certainly possible to find an institution liable for the negligent selection of an independent contractor, such findings are as yet even more uncommon and difficult to prove than findings of liability when the physician is the institution's servant.[31]

These remoteness problems are especially relevant to GPHPs because there is usually a hospital or medical group structurally between the GPHP and the physician. To show proximate cause the plaintiff may have to show three acts of negligence: negligent selection of the hospital or medical group by the GPHP, negligent selection of the physician by the hospital or medical group, and negligence by the physician. However, the GPHP's close relationship with the patient should imply a close enough GPHP/physician relationship to impose a direct duty on the GPHP itself to ensure that the physician is carefully selected.[32] The GPHP's interposition of itself as a medical care provider between the patient and physician should impose upon the GPHP this duty of physician selec-

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tion.[33] Because the GPHP chooses the physician, and, more importantly, because the patient in reliance upon the GPHP's expert selection has allowed the GPHP to restrict his right to choose, the GPHP should be held to a nondelegable duty of selection.[34] Joiner v Mitchell County Hospital Authority[35] adopts a parallel rule. A hospital sought to absolve itself from negligent selection liability by alleging it left selection of nonemployee physicians to its medical staff. The Joiner court held this attempt to delegate its duty not a defense because the medical staff were agents of the hospital. A GPHP has a duty to select a physician, and if the GPHP employs a hospital or medical group to screen physicians, the GPHP must remain responsible for negligent selection of the staff.[36]

Finally, GPHPs might allege that the physician is an independent contractor and that, therefore, the GPHP has a lesser duty in selection because of his extraordinary skill and judgment; that the GPHP contracted only to finance the medical care. This core allegation, a response common to all GPHP liability theories, has already been touched on briefly and will be extensively discussed below.[37]

### *Negligent Control of Physician Liability*

Institutional liability for negligent control of a physician provider's actions within the institution's structure addresses more directly than any other relevant theory the institution's role in health care delivery.[38] Unless it is found that the GPHP (or other institution) is or should be the actual health-care provider, closely related to its physicians, there obviously can be no duty to control those physicians.

Partially because this theory most directly faces the issue of the GPHP's role in health-care delivery, negligent control of physician liability probably has the most potential for use. Just as Darling v Charleston Community Memorial Hospital[39] revolutionized hospital institutional liability, a similar GPHP negligent control of physician case will most likely open an era of GPHP institutional liability and focus needed attention on this issue and its consequences.[40]

The history of negligent control liability in the United States might be said to have begun a century ago, when the dominant health-care institution was the private nonprofit hospital. The hospital was then only a structure that housed the facilities physicians needed to provide medical care.[41] In 1876 these "doctors' workshops" were granted immunity from institutional tort liability in McDonald v Massachusetts General Hospital.[42]

A fundamental argument advanced to support this charitable immunity doctrine is that doctors and nurses, the actual medical care providers, should be regarded as independent contractors even when they are employed by a health-care institution. It is contended that because of their specialized skills, doctors and nurses cannot be controlled by the institution.[43] This same argument can be made when arguing the issue of GPHP liability for negligent control of physicians. Therefore, the development and decline of hospital charitable immunity may foreshadow the future of GPHP negligent control liability.

Sometime after the introduction of the immunity rule some courts began to recognize the inequity of a total ban on recovery against a charitable hospital, recognizing that a hospital can control many, though not all, acts of a physician working in that hospital. Therefore, a judicial compromise between institutional liability and total immunity for charitable institutions led to the differentiation between "medical" and "administrative" acts in determining whether physicians' negligent acts were under the hospital's control. If the act was "administrative," the salaried physician was considered an employee, and the hospital was vicariously liable. If the act was "medical," the salaried physician was regarded as an independent contractor, and no hospital liability attached.[44]

Charitable immunity was further eroded by other courts. Some held that the immunity rule would only apply to vicarious liability and not to negligence committed by the hospital corporation itself. This was justified on the ground that a breach of a duty owed the patient directly by the hospital was an administrative action of the hospital, not of the physician, and involved no question of control over an independent contractor physician.[45]

Other limitiations, exceptions and distinctions turned on whether the victim was a beneficiary of the charity (no recovery); the victim was a servant or stranger (recovery possible); the patient knew the hospital was charitable (no recovery); the patient paid for the charity's services (recovery possible); the negligent act was part of a noncharitable activity of the hospital (recovery possible); or the breach was of a statutory duty (recovery possible).[46]

Recognizing that the various exceptions and redefinitions were inconsistent and often inequitable, courts began to reexamine the original bases for immunity. In 1957 the Court of Appeals of New York made such an examination and concluded that the charitable immunity doctrine should be abandoned and the hospitals should bear the same liability as do other institutions.[47]

The Court rejected the argument that hospitals' inability to control employee physicians and nurses required that these salaried employees be regarded as independent contractors. Judge Fuld pointed out that this reasoning ". . . is inconsistent with what salaried professional personnel have been held to be in every other context. . . ."[48] He added that the special skill of professionals, the reason given for the hospital's inability to control them, had never been the basis for denying the application of respondeat superior when airline pilots, locomotive engineers, chemists, or any other employees with special skills were involved.[49]

The control of physicians that hospital liability recognizes does not require lay administrators to practice clinical medicine. But it places ". . . an ultimate duty on the hospital to control professional standards of medical practice by staff physicians. . . "[50]

While vestigal remnants of charitable immunity still remain, there is a strong and growing tendency to impose liability on the institution for negligent medical acts of professionals,". . .working or performing services in or near the hospital's 'walls.' Liability, like medical practice, has been institutionalized."[51]

While the medical/administrative dichotomy had its origin in the erosion

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of the largely discredited charitable immunity doctrine, it has retained a diminished vitality, sometimes under different labels.[52] This is because it addresses an issue that is almost as old as medicine[53] but which remains current: lay control of a physician's practice of medicine.[54]

The medical/administrative dichotomy ought not be allowed to arise in GPHP liability. The dichotomy is inconsistent with both the function and purpose of the GPHP. As Professor Southwick has pointed out, the dichotomy may interfere with the institution's delivery of medical care because it misconceives the correct allocation of roles and responsibilities between doctor and institution and might injuriously aggravate relations between institution and doctor.[55] The resulting conflicts within the institution[56] might lead to increased exposure to liability in spite of the dichotomy's presumed effect of reducing liability.[57]

The medical/administrative dichotomy is also inconsistent with the institution's organizational structure. The board of directors is responsible for the standards of patient care. The board delegates to the medical staff responsibility for staff appointments, review and discipline. There is no dichotomy in the corporate purpose: the board of directors is ultimately responsible for the functions it delegates, both administrative and medical.[58]

This expectation of unitary function is not found solely in the eyes of the law. The public and much of the medical profession itself sees the health-care institution as more than a doctor's workshop. They, too, picture the institution as medical care provider as well as administrative agency.[59]

Recognizing these factors, courts have rejected the medical/administrative act dichotomy and have held hospitals liable for the malpractice of salaried and unsalaried physicians,[60] but no reported case has extended the negligent control doctrine to a GPHP.

In a decision that is forcing institutional responsibility and control over the medical care delivered within a hospital's structure, the Illinois Supreme Court in Darling v Charleston Community Memorial Hospital[61] held a hospital liable for failing to review a patient's treatment and to require necessary consultations. In Darling the plaintiff was brought to the hospital's emergency room after he had fractured a leg in a college football game. The institution selected for him and contacted a nonemployee staff physician on emergency call duty. The physician put a cast on the patient's leg and admitted him to the hospital. From this point a series of glaringly negligent acts and omissions ended in the patient's being taken to another hospital, where another physician was forced to amputate the leg. The hospital was held negligent for failing to require the physician to consult with specialists and for failing to have a sufficient number of nurses on duty to recognize what the physician had not: progressive deterioration of the plaintiff's leg.

The decision was not based on respondeat superior. The physician was not an employee, and the negligence of the doctor was never established at at trial. Clearly, the hospital was held liable for breaching its own duties to the patient.[62]

It is no coincidence that this first case to hold a health-care institution liable for negligent control of a nonemployee physician quoted Bing v Thunig,[63] a portentious decision which abolished as defenses charitable immunity and the medical/administrative dichotomy:

> The conception that the hospital does 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. Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. They regularly employ on a salary basis a large staff of physicians, nurses and interns as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such services, if necessary, by legal action. Certainly, the person who avails himself of "hospital facilities" expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility.[64]

This description applies at least as well to GPHPs as it does to hospitals. It is clear that a health-care institution's corporate duty to control its nonemployee staff physicians requires more of the institution than did previous theories. There is a refinement in both the directness of the duty and in the degree of control required. "Corporate negligence is the failure of those entrusted with the task of providing accommodations and facilities necessary to carry out the charitable purpose of the corporation to follow in a given situation the established standard of conduct to which the corporation should conform."[65] "Those who are entrusted with this task" are the officers and board of directors of the charitable GPHP or hospital corporation.[66] The important charitable purpose here is fostering and controlling high standards of medical care.[67] This purpose does not mean that the corporation is an insuror of patient safety or a guarantor of a cure, but that the institution will be ultimately liable under one of a number of theories for a physician's deviation from ordinary professional standard.[68] As Jay Hedgepath, general counsel for the American Hospital Association, has asserted, Darling did not establish vicarious liability for all negligence of a nonemployee staff physician.[69] While it has been suggested by others that vicarious liability for health-care institutions should be extended to cover negligence of nonemployee staff physicians or that strict liability should be applied,[70] Darling certainly retains a requirement that the institution itself be found negligent.

While Darling has led the way toward hospital liability for negligent control of physicians, there is no such guiding precedent for GPHP liability. Darling recognized that hospitals should control their physicians, based on the institutionalization of hospital medical care provision and its concommitant close hospital/physician relationship. Because GPHPs for the most part are a new entity, their roles and purposes still in flux, no court has found that a GPHP should control its physicians. Such a holding would depend upon what society decides the GPHP/consumer relationship, and therefore the GPHP/physician relationship, should be. A common law of GPHP liability for failure to control its physicians would recognize that if the GPHP is to be an institutionalized health-care provider, then by necessity, the GPHP must control its physi-

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cians, or accept liability for its failure to do so.

### Indicia Influencing GPHP Liability

#### *Structure and Function of the GPHP*

This article proposes that as the care a patient receives moves from the older individual doctor oriented non-system of delivery to an integrated and comprehensive delivery system, the system assumes a duty of care concurrent with its delivery function. "The fundamental trends in the law of hospital liability clearly show that the institutionalization of medical care results in the institutionalization of liability."[71]

*Comprehensive Facilities and Services.* Part of what is behind the policy to impose a duty of care on a delivery system as it becomes more institutionalized is the belief that comprehensive and organized health-care delivery should result in higher quality care delivered by the instititon as an entity. This is a common theory in hospital liability judgments.[72]

Judge Fuld in Bing v Thunig considered the following factors in holding a hospital liable for physician negligence: the employment of large numbers of people including doctors, the billing of patients for medical care directly by the institution, collecting if necessary by legal action, and the necessary operation of the plant in a business-like fashion.[73] All of these factors are elements of a GPHP's comprehensive services and facilities package.

In a 1951 GPHP case, not involving liability as an issue, the Supreme Court of Washington pointed out that the increased comprehensiveness and organization inherent in GPHP was expected to allow the rendition of better service than that offered by private physicians. The Court summarized a number of specific advantages listed by the chief of the cooperative's professional staff and set out in the contract between the cooperative and the staff:

> Increased opportunities for, and convenience in effectuating referral of patients to other doctors to take advantage of various specialties; access to more and better equipment and laboratory facilities; improved quality of service because of constant surveillance by other members of the staff; opportunities for consultation, staff conferences, refresher courses and post graduate studies; better organization of time as, for example, the rotation of emergency night call service; greater incentive to give patients proper treatment; security of professional income regardless of daily patient load; and disassociation of the business aspects of the service, so that the doctors may devote themselves entirely to professional matters.[74]

Unitary medical records, unique to GPHPs in their comprehensiveness, is another, more recently developed procedure. By creating a greater continuity in GPHP care provision than is possible in a hospital, unitary medical records are intended to favorably influence the quality of care provided by the coordinated structure.[75]

It is clear that a GPHP is the next logical step after hospitals in the institutionalization of health care. "Previously, a sick person, even with Blue Cross/Blue Shield health insurance, had to seek out a physician on his own initiative. . . . The GPHP gathers all these personnel, services and resources under a single organizational roof and makes implicit, if not explicit, assurances of their quality and competence. . . . The GPHP is a highly organized delivery system."[76]

*Institutional Treatment of the Consumer.* Through coordinated and continuous care provision the GPHP assumes the role of providing consumer care. Even when a GPHP allows the patient to pick a staff physician as the patient's primary doctor, that doctor will and must integrate others into the patient's treatment program through consultations, referrals to specialists, laboratory testing, therapists, walk-in clinics, and long-term treatment facilities. Because a GPHP is complex, it is likely that several persons (inevitably some of whom are employees) and entities will be, at least indirectly, involved in patient treatment and resulting malpractice. When this occurs, institutional liability may follow.[77]

This complex of facilities and personnel treating the consumer mandates institutional liability not only because of its function as a monolithic care delivery system, but also because it tends to break down the traditionally close doctor/patient relationship. Because the care is still coming from the same general provider using the same facilities and personnel, it is easier for the consumer to switch from one doctor to another within a GPHP than between independent private practitioners.

Although GPHPs may try to have each consumer establish a steady relationship with one physician, they are often unsuccessful. Many consumers regularly make unannounced visits to the GPHP emergency room or walk-in clinic, rather than setting appointments with a regular physician. This disrupts any close physician/patient relationship. An often repeated explanation by GPHP officials for increased incidence of malpractice claims against GPHPs is a breakdown in the traditional relationship between physician and patient.[78]

*Institutional Control of Care.* This fragmentation of care delivery within the structure is a creature of GPHPs exercising their power to control the patient's care and the physician's work. Equivalent hospital liability cases make it clear that the corporate board of directors holds the power to control care,[79] and Shapiro v Health Insurance Plan[80] used language that might be used to imply that a GPHP board has this power. Because this power of control is crucial to finding GPHP liability, it is important to explore who has it, when, and why.[81]

Certain control factors have been noted in cases and by commentators, but the list varies with the situation and is never exclusive. A checklist of court-recognized factors made to determine control of physicians by hospitals but also applicable to GPHPs includes whether the hospital provides compensation to the physician or the drugs and supplies used in treating patients. The extent to which the physician practices exclusively at the hospital or has regular "on call" duties is also relevant, as is the degree to which the hospital can control duty hours or other conditions of employment or has the power to select or discharge the physician.[82]

While not all GPHPs meet all of these criteria, virtually every GPHP has another major control factor arising in hospital liability law – medical audit and/or peer review units.[83] In these units the quality of a physician's care is reviewed by other physicians, who report their findings to the institution.

GPHP control of care is also indicated if any or all of its physicians are salaried. This is relevant even if the

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malpracticing physician is not employed by the GPHP because it indicates not only the capacity to control but also that salaried physicians may control the nonsalaried physician while the salaried physician is acting as an agent of the board. For example, a salaried medical director has insititutional responsibilities to control the care GPHP consumers receive from nonsalaried physicians under contract with the GPHP.[84]

GPHPs may be somewhat more likely than hospitals to be held liable for physician malpractice because GPHPs tend to become more "intimately involved" in providing medical services, especially when the GPHP owns the facility in which the malpractice occurred.[85] And the existence of a contract promising services by the GPHP, a contract often not explicit with hospitals, may require that the GPHP become more intimately involved in patient care than does a hospital. One study has disclosed only one GPHP, H. I. P. of New York, which might argue in attempting to avoid direct liability that its medical groups are independent contractors.[86]

This institutional control of care is highly visible in GPHP quality control programs. Curran and Moseley listed 44 quality control procedures in use.

> The 12 HMOs visited employ a variety of quality control procedures which appears to include essentially every such control device known to the American medical community. About half the HMOs utilize some form of genuine peer review of individual cases, a proportion which likely is higher than that for hospitals or private group practices. Another frequently mentioned device is the phenomenon of "doctors looking over each other's shoulders," a sort of informal peer review which is more acceptable in the HMO setting than in a typical hospital medical staff composed of independent physicians. Another important factor is the various attributes of different HMO medical records systems, which can be "unitary" or "problem oriented" or "computerized" or all three.[87]

Their report also indicated that many physicians resist certain quality control procedures, such as continuing education programs. Many doctors will not voluntarily participate in such programs. GPHP liability for failure to control care quality might encourage GPHPs to require their doctors, through specific contractual provisions, to participate regularly in such programs.[88]

This public policy was cited in Darling as a basis for imposing institutional control of care liability. In Darling, the hospital had medical staff bylaws and accreditation standards which required staff physicians to follow certain quality control procedures. Dr. Alexander had not complied with these regulations, and the hospital had not taken action to force compliance. The Illinois Court of Appeals said:

> It is obvious that hospital staff rules must be adopted to protect patients in major operations from unethical or unskilled practitioners, even though they are licensed physicians. Anybody may be forced to undertake a major operation. The rule in controversy is fundamentally a provision for the public safety and the public welfare.[89]

In affirming, the Illinois Supreme Court held that the duties of a hospital are to be determined by national or regional standards of care based partially upon the institution's own quality control regulations and such regulations common to like institutions across the country.[90]

Because GPHPs are medical care providers which ought to control their physicians through quality procedures in the same way hospitals do, and because the public policy supporting Darling applies equality to GPHPs, the Darling institutional duty of care in control of physicians should apply to GPHPs as it does to hospitals.

*Apparent Agency.* This same issue of institutional control of care and of physicians gives rise to another method of finding institutional liability, apparent or ostensible agency. Technically a respondeat superior theory, apparent or ostensible agency can be used to hold an institution liable for the negligence of a physician without showing actual employment of the physician or independent negligence by the institution.

In Seneris v Haas, a leading hospital apparent agency case, the court outlined the theory:

> An agency is ostensible when the principal intentionally, or by want of ordinary care, causes a third person to believe another to be his agent who is not really employed by him" § 2300, Civ. Code. In this connection it is urged by appellant that "before a recovery can be had against a principal for the alleged acts of an ostensible agent, three

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**Novafed® A Capsules**
Decongestant Plus Antihistamine
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ACTIONS: NOVAFED A combines the action of a nasal decongestant, pseudoephedrine hydrochloride, and an antihistamine, chlorpheniramine maleate. These ingredients are combined to provide prompt and sustained nasal and upper respiratory decongestant and antihistaminic action.

Pseudoephedrine hydrochloride is an orally effective nasal decongestant. Pseudoephedrine is a sympathomimetic amine with peripheral effects similar to epinephrine and central effects similar to, but less intense than, amphetamines. It has, therefore, the potential for excitatory side effects. At the recommended oral dosage, pseudoephedrine has little or no pressor effect in normotensive adults. Patients taking pseudoephedrine orally have not been reported to experience the rebound congestion sometimes experienced with frequent, repeated use of topical decongestants.

Chlorpheniramine maleate is an anithistaminic drug which possesses anticholinergic and sedative effects. It is considered one of the most effective and least toxic of the histamine antagonists. Chlorpheniramine antagonizes many of the pharmacologic actions of histamine. It prevents released histamine from dilating capillaries and causing edema of the respiratory mucosa.

INDICATIONS: NOVAFED A is indicated for the relief of nasal congestion and eustachian tube congestion associated with the common cold, sinusitis and acute upper respiratory infections. It is also indicated for perennial and seasonal allergic rhinitis, vasomotor rhinitis, allergic conjunctivitis due to inhalant allergens and foods and for mild, uncomplicated allergic skin manifestations of urticaria and angioedema. Decongestants in combination with antihistamines have been used for many years to relieve eustachian tube congestion associated with acute eustachian salpingitis, aerotitis media, acute otitis media and serous otitis media. NOVAFED A may be given concurrently, when indicated, with analgesics and antibiotics.

CONTRAINDICATIONS: Sympathomimetic amines are contraindicated in patients with severe hypertension, severe coronary artery disease, hyperthyroidism, and in patients on MAO inhibitor therapy. Antihistamines are contraindicated in patients with narrow-angle glaucoma, urinary retention, peptic ulcer, during an asthmatic attack, and in patients receiving MAO inhibitors.

Children under 12: NOVAFED A controlled-release capsules should not be used in children less than 12 years of age.

Nursing Mothers: Pseudoephedrine is contraindicated in nursing mothers because of the higher than usual risk for infants from sympathomimetic amines.

Hypersensitivity: This drug is contraindicated in patients with hypersensitivity or idiosyncrasy to sympathomimetic amines or antihistamines. Patient idiosyncrasy to adrenergic agents may be manifested by insomnia, dizziness, weakness, tremor or arrhythmias.

WARNINGS: Sympathomimetic amines should be used judiciously and sparingly in patients with hypertension, diabetes mellitus, ischemic heart disease, increased intraocular pressure, or prostatic hypertrophy. See, however, Contraindications. Sympathomimetics may produce central nervous system stimulation and convulsions or cardiovascular collapse with accompanying hypotension.

Antihistamines may impair mental and physical abilities required for the performance of potentially hazardous tasks, such as driving a vehicle or operating machinery, and mental alertness in children. Chlorpheniramine maleate has an atropine-like action and should be used with caution in patients with increased intraocular pressure, cardiovascular disease, hypertension or in patients with a history of bronchial asthma. See, however, Contraindications.

Do not exceed recommended dosage.

**Use in Pregnancy:** The safety of pseudoephedrine for use during pregnancy has not been established.

**Use in Elderly:** The elderly (60 years and older) are more likely to have adverse reactions to sympathomimetics. Overdosage of sympathomimetics in this age group may cause hallucinations, convulsions, CNS depression, and death. Therefore, safe use of a short-acting sympathomimetic should be demonstrated in the individual elderly patient before considering the use of a sustained-action formulation.

PRECAUTIONS: This drug should be used with caution in patients with diabetes, hypertension, cardiovascular disease and hyperreactivity to ephedrine. The antihistaminic may cause drowsiness and ambulatory patients who operate machinery or motor vehicles should be cautioned accordingly.

ADVERSE REACTIONS: Hyperreactive individuals may display ephedrine-like reactions such as tachycardia, palpitations, headache, dizziness, or nausea. Patients sensitive to antihistamines may experience mild sedation.

Sympathomimetic drugs have been associated with certain untoward reactions including fear, anxiety, tenseness, restlessness, tremor, weakness, pallor, respiratory difficulty, dysuria, insomnia, hallucinations, convulsions, CNS depression, and rhythmias, and cardiovascular collapse with hypotension.

Possible side effects of antihistamines are drowsiness, restlessness, dizziness, weakness, dry mouth, anorexia, nausea, headache and nervousness, blurring of vision, heartburn, dysuria and very rarely, dermatitis.

DRUG INTERACTIONS: MAO inhibitors and beta adrenergic blockers increase the effect of sympathomimetics. Sympathomimetics may reduce the antihypertensive effects of methyldopa, mecamylamine, reserpine and veratrum alkaloids. Concomitant use of antihistamines with alcohol, tricyclic antidepressants, barbiturates and other central nervous system depressants may have an additive effect.

DOSAGE AND ADMINISTRATION: One capsule every 12 hours. Do not give to children under 12 years of age.

CAUTION: Federal law prohibits dispensing without prescription.

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things must be proved, to wit" (quoting from Hill v. Citizens Nat. Tr. & Sav. Bank, 9 Cal.2d 172, 176, 69 P.2d 853, 855): "(First) The person dealing with the agent must do so with belief in the agent's authority and this belief must be a reasonable one; (second) such belief must be generated by some act or neglect of the principal sought to be charged; (third) and the third person in relying on the agent's apparent authority must not be guilty of negligence.[91]

In Seneris the court found it a jury question whether the malpracticing physician was an agent of the defendant hospital given these facts: he was one of six anesthetists on the hospital's staff; he was an anesthetist at defendant hospital only; he had rotating "on call" duty at the hospital; he was not chosen by the patient; all facilities, equipment and drugs were owned and supplied by the hospital; and the patient had not been on notice that the anesthetist was not an employee of the hospital.

The key issue, whether the institution leads the patient to believe that the physician is in its employment, seems ripe for application to GPHPs. GPHPs ". . . purport to offer members a 'single portal of entry' to all necessary resources of a comprehensive health care delivery system."[92] In fact, "[the] health plan itself is the agent of the physicians partnership and the hospital corporation, or at least is so integrally tied with their operations that it should be responsible."[93]

Factors that courts have looked to in determining hospital apparent agency have potential application to GPHPs. Retention of the physician is an important indicator. If the patient did not select the physician, if the patient had little or no choice of physicians, if the patient asked the institution to choose the physician, if the institution chose the physician, or if the patient requested the institution, and not a particular physician, for treatment, there is strong evidence of apparent agency.[94] This directly applies to GPHPs: patients infrequently select their own physicians;[95] consumers often have no preference among physicians and ask the plan, which complies, to choose the physician. Finally, the patient seldom contracts with any particular physician, but expects the GPHP generally to provide the best possible treatment.[96]

Strongly related to choice of physician factors are other factors that probably reinforce consumer expectations[97] that the physician is an employee of the GPHP. The following indicia have been cited by court as relevant to this issue when the defendant was a hospital: the building where the physician treated the patient had the institution's name on it; the building, facilities, equipment and/or supplies used by the physician to treat the patient were owned by the institution; the personnel assisting the physician in treating the patient were employees of the institution; the patient was billed by the institution and not by the physician; the patient was not told the physician was an independent contractor and not an employee, or worse, the institution or its personnel explicitly or implicitly represented the physician as an employee of the institution.[98]

Other factors cited in hospital apparent agency cases that would lead a consumer to expect the physician to be employed by the GPHP include: the services performed for the patient by the physician were an essential function of a health-care institution; the institution controlled the physician's work hours and/or the physician had regular on call duty at the hospital; other physicians at the institution performing the same service as the malpracticing physician performed for the patient were employees of the institution; all of the type of services performed by the physician for the plaintiff that are performed at the institution are performed solely by that physician or his corporation; and the physician has no private practice and /or does not provide the service in question at any other institution.[99]

Certain other factors that courts have recognized as relevant to the theory of apparent agency and which often apply to GPHPs include: the physician is under a contract *for* services to be provided at the institution in contrast to a contract *of* service; the physician is paid by the institution a percentage of the gross receipts of the department in which the physician works; the institution sued and the corporation that actually employs the physician have the same ownership; and the institution has a right to control the physician's standards of performance.[100]

A patient entering the GPHPs "sin-

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**HALOG® CREAM** (Halcinonide Cream 0.1%)

Each gram of Halog Cream (Halcinonide Cream 0.1%) contains 1 mg. halcinonide (0.1%) in a cream base.

**INDICATIONS:** This product is intended for topical application for adjunctive therapy and symptomatic relief of inflammatory manifestations of acute and chronic corticosteroid responsive dermatoses.

**CONTRAINDICATIONS:** Topical steroids are contraindicated in vaccinia, varicella, and in those patients with a history of hypersensitivity to any of the components of the preparation. This preparation is not for ophthalmic use.

**PRECAUTIONS:** *General*—If local infection exists, suitable concomitant antimicrobial or antifungal therapy should be administered. If a favorable response does not occur promptly, application of the corticosteroid should be discontinued until the infection is adequately controlled. Although systemic side effects associated with absorption of topical corticosteroid preparations are rare, their possible occurrence must be kept in mind when these preparations are used over large areas or for an extended period of time. If irritation or sensitization develops, the preparation should be discontinued and appropriate therapy instituted. Although topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use during pregnancy has not been absolutely established; therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

*Occlusive Dressing Technique*—The use of occlusive dressing increases the percutaneous absorption of corticosteroids; their extensive use increases the possibility of systemic effects. For patients with extensive lesions it may be preferable to use a sequential approach, occluding one portion of the body at a time. The patient should be kept under close observation if treated with the occlusive technique over large areas and over a considerable period of time. Occasionally, a patient who has been on prolonged therapy, especially occlusive therapy, may develop symptoms of steroid withdrawal when the medication is stopped. Thermal homeostasis may be impaired if large areas of the body are covered. Use of the occlusive dressing should be discontinued if elevation of the body temperature occurs. Occasionally, a patient may develop a sensitivity reaction to a particular occlusive dressing material or adhesive and a substitute material may be necessary. If infection develops, discontinue the use of the occlusive dressing and institute appropriate antimicrobial therapy.

**ADVERSE REACTIONS:** The following local adverse reactions have been reported with topical corticosteroids: burning, itching, irritation, striae, skin atrophy, secondary infection, dryness, folliculitis, hypertrichosis, acneform eruptions, and hypopigmentation. The following may occur more frequently with occlusive dressings: maceration of the skin, secondary infection, skin atrophy, striae, and miliaria. Contact sensitivity to a particular dressing material or adhesive may occur occasionally (see PRECAUTIONS).

For full prescribing information, consult package insert.

**HOW SUPPLIED:** In tubes of 15 and 60 g. and in jars of 240 g. (8 oz.).

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**TEDRAL® /TEDRAL® Elixir**

**Description.** Tedral: each tablet contains 130 mg theophylline, 24 mg ephedrine hydrochloride, and 8 mg phenobarbital.

Tedral Elixir: each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine hydrochloride, and 2 mg phenobarbital; the alcohol content is 15%.

**Indications.** Tedral, Tedral Elixir are indicated for the symptomatic relief of bronchial asthma, asthmatic bronchitis, and other bronchospastic disorders. They may also be used prophylactically to abort or minimize asthmatic attacks and are of value in managing occasional, seasonal or perennial asthma.

These Tedral formulations are adjuncts in the total management of the asthmatic patient. Acute or severe asthmatic attacks may necessitate supplemental therapy with other drugs by inhalation or other parenteral routes.

**Contraindications.** Sensitivity to any of the ingredients; porphyria.

**Warnings.** Drowsiness may occur. PHENOBARBITAL MAY BE HABIT-FORMING.

**Precautions.** Use with caution in the presence of cardiovascular disease, severe hypertension, hyperthyroidism, prostatic hypertrophy, or glaucoma.

**Adverse Reactions.** Mild epigastric distress, palpitation, tremulousness, insomnia, difficulty of micturition, and CNS stimulation have been reported.

**Dosage.** Tedral: Adults—(average prophylactic or therapeutic dosage)—one or two tablets every 4 hours. With the one-tablet dose, an additional tablet may be taken at onset of symptoms, but dosage should not exceed two tablets in any 4-hour period.

*Children over 60 lb*—one-half the adult dose.

Tedral Elixir: Children—(for frequent attacks or for prophylactic therapy)—one to two 5 ml teaspoonfuls per 60 lb body weight, 4 times a day. For an occasional attack—one teaspoonful per 60 lb body weight, as needed.

*Children under 60 lb*—use only as directed by physician. Should be given to children under 2 years of age only with extreme caution.

Adults—4 to 8 teaspoonfuls every 4 hours.

Reduce dosage if drowsiness, nervousness, restlessness or sleeplessness occurs.

**Supplied.** Tedral: White, uncoated scored tablets in bottles of 24 (N 0047-0230-24), 100 (N 0047-0230-51) and 1000 (N 0047-0230-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0230-11).

Tedral Elixir: Dark red and cherry-flavored in 474 ml (16 fl oz) bottles (N 0047-0242-16).

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gle portal of entry" to comprehensive care seldom knows which physicians are GPHP employees and which are independent contractors, and the GPHP seldom points them out. "[GPHPs] in an attempt to reduce malpractice claims, strive to create a feeling of belonging and closeness and informality in the member's attitude toward the [GPHP] as an organizational entity."[101] Notice that some unspecified number of the GPHP's physicians are independent contractors and not GPHP employees may appear in the written contract between the patient and the GPHP. A patient who is a GPHP member through her employer, however, may never see this contract but only sign a membership card. Even if the patient does sign a form indicating that some physicians are not employees, apparent agency may still exist. In the Beeck case the patient had signed a "Conditions of Admissions" form which specifically stated that the physician who later malpracticed on her was not an employee. The Beeck court held that this acknowledgement had no legal effect as notice, partly because of the unequal bargaining power of the parties and the language barrier faced by the patient.[102]

*Contract Between Plan and Consumer*

This section will concentrate on factors influencing GPHP liability arising from the plan/consumer relationship. The thesis here is that if that relationship is or should be close enough for the GPHP to be the consumer's health-care provider, the GPHP must accept a duty of care in the performance of that role.

*Consumer Expectations.* At various points this paper has mentioned that GPHPs have set high medical care goals for themselves, such as higher quality services and facilities, lower cost, better consumer health and more comprehensive services. These goals differ only in degree from those of a charitable hospital. Public reliance on hospitals as centers of the highest quality medical practice has been argued to be a basis for hospital institutional liability,[103] and the equivalent should be true for GPHPs. This is another area affecting institutional liability in which the argument is far stronger when applied to GPHPs than when applied to hospitals.

The very name of the HMO – "health maintenance organization" – suggests a certain degree of medical infallibility. . . . What is further unique about HMO-delivered health care is that, one way or another, it is being actively "marketed" or "promoted." Traditionally, doctors opened private offices and waited passively for the patients to come. When they did come, the doctor tried to practice good medicine and hoped that somehow the word would get around. The role of the hospitals has been equally passive.[104]

Curran and Moseley have written the following somewhat hyperbolic summary of what is happening with GPHPs:

> This, then is the picture. There is developing in this country a method of health care delivery which seems to be so systematic and efficient in its organization, so thorough and comprehensive in its services, that patients can easily believe that it is the repository of the highest possible quality care and that no human ailment is beyond its ability to cover. And, if this blind faith on the part of patients were not sufficient, the new mode of delivery seems to be consciously promoting such an image of itself.[105]

Furthermore, ". . . an official of a California HMO noted that state law allowed door-to-door selling of HMO memberships, that some HMOs were using this marketing method and were paying their salesmen commissions, and that some of them appeared to have been misrepresenting the benefits of membership in an HMO. Unfulfilled expectations were a direct outcome."[106] Similar unfulfillable expectations arise from statements in GPHP promotional literature.[107]

In addition to the policy argument that liability is necessary to counteract excessive or deceptive promotion, GPHPs, even ones that have not deceived their consumers, should not be allowed to minimize their responsibility in the courtroom in an attempt to avoid liability while publicly posturing themselves as the complete medical care provider.[108]

*The Plan/Consumer Contract.* The written plan/consumer contract raises a number of questions relevant to plan liability when a physician provider has malpracticed. These questions include: whether the plan has contracted to provide medical services, and therefore assumed a duty of care in providing such services; whether once that duty is assumed, the plan can subcontract that duty away to an independent contractor; whether the courts and

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legislatures will sustain a clause in the contract disclaiming plan liability for negligence to the consumer; and whether the courts and legislatures will recognize a breach of contract action against the plan when a plan physician malpractices on a consumer.[109]

The consumer/plan contract may by itself be sufficient evidence to hold the plan to a duty of care in providing medical services. If the plan's contract is a direct service contract promising medical services and not just an indemnity or services arrangement contract, a finder of fact could reasonably conclude that the plan has assumed such a duty of care. A simple statement at the beginning that the plan is merely "arranging" care should not be determinative. A contract which specifies numerous integrated services which the GPHP will provide for the consumer or states that the plan will regulate care quality should be sufficient to find such a duty.[110] Of course, even if the contract's terms alone are insufficient to impose a duty of care, such contractual provisions remain relevant together with other evidence of the plan's role and duty of care.[111]

GPHP claims that, even if the plan has a duty of care in treatment, it may and has delegated that duty to an independent contractor, ie, the hospital, medical group, or physician, meet with three objections founded in sound public policy.

One court has noted that the generally accepted principle that the employer of an independent contractor is not liable for the torts of such a contractor or his servants does not apply

> . . . when one has undertaken to do a certain thing or to do it in a particular manner, [because] he cannot, by employing an independent contractor, avoid liability for injury resulting from a non-performance of duties assumed by the independent contractor under his agreement.[112]

Moreover, an employer remains liable for the negligence of an independent contractor if the work to be performed is "inherently dangerous" or is peculiarly dangerous "unless special precautions are taken to prevent them." Additionally, certain duties are "non-delegable" where the responsibility undertaken is so important to society that the employer should not be permitted to transfer it to an independent contractor.[113]

Each of these three rules is applicable to GPHPs as the rules have been interpreted by the courts. In Shagrin v Wilmington Medical Center, Inc.[114] a hospital had undertaken to run an emergency room for the emergency care of its patients. The court implied that the hospital might be liable for the negligence of an independent contractor emergency room physician. In Giusti v C. H. Weston Co.[115] a hospital association had contracted with a high school to provide medical services for its football team. The association was held liable for the malpractice of one of its physicians because it had contracted to perform services and therefore could not delegate away the duty of care to the physician. A GPHP undertakes to provide medical care under conditions strikingly similar to those in Shagrin. The GPHP contracts to render medical services just as had the corporation in Giusti. And the Giusti court held ". . . that one bound to performance of a duty by contract cannot absolve himself from such obligation by devolution of performance upon a stranger to it."[116]

Additionally, a GPHP's function, providing medical care, may be characterized as dangerous unless special precautions are taken. It has been held that a hospital is created for purposes which could not be accomplished without the exercise of extraordinary care and skill.[117] There are few situations that are as continuously and pervasively hazardous as being a patient in a medical care institution. Unless medical care providers are especially cautious as to diagnoses, prognoses, and treatments, most GPHP patients would agree that they would be in a peculiarly dangerous position.

Concurrently, a GPHP carries a high responsibility to the community: to provide quality medical care that will not negligently injure patients. It is a responsibility that, once assumed, by contract or otherwise, society should make "nondelegable."

Defenses based upon contract clauses disclaiming liability are usually unavailing. These are two important reasons for the invalidity of such disclaimer clauses: the public interest in imposing a duty of care upon health-care providers and unequal knowledge and bargaining power between GPHP and consumer. The pub-

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# Private Practice Management

It is important that the business and financial aspects of family practice be built on the same scholarly foundations as the rest of our material. We hope that this column, and those to follow in future issues, will provide a substantial, thought-provoking basis for dealing creatively with what might otherwise appear to be obstacles to family care. The articles will be prepared by R. J. Vargo, Ph.D., Director of Graduate Studies, and R. E. McGillivray, Ph.D., CPA, from the College of Business Administration, The University of Texas at Arlington.

## 63 Questions to Ask About Computer Data Processing

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This article will not try to convince you that computerization of your medical financial records is good or bad for your office. You have to make that decision. But, at any given moment, a fair percentage of physicians and office staffs are evaluating the services offered by various computer vendors. To aid in this important evaluation process, some overall framework of investigation is helpful. It is too late to ask questions after the contract has been signed. Presented below are 63 questions designed to assist physicians, their office staffs, and their accountant/business advisors in evaluating computer data processing services. The questions relate to the vendor's background, conversion techniques employed, input required by the system, output furnished, and cost. The list is not exhaustive; other questions will develop as the evaluation proceeds.

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