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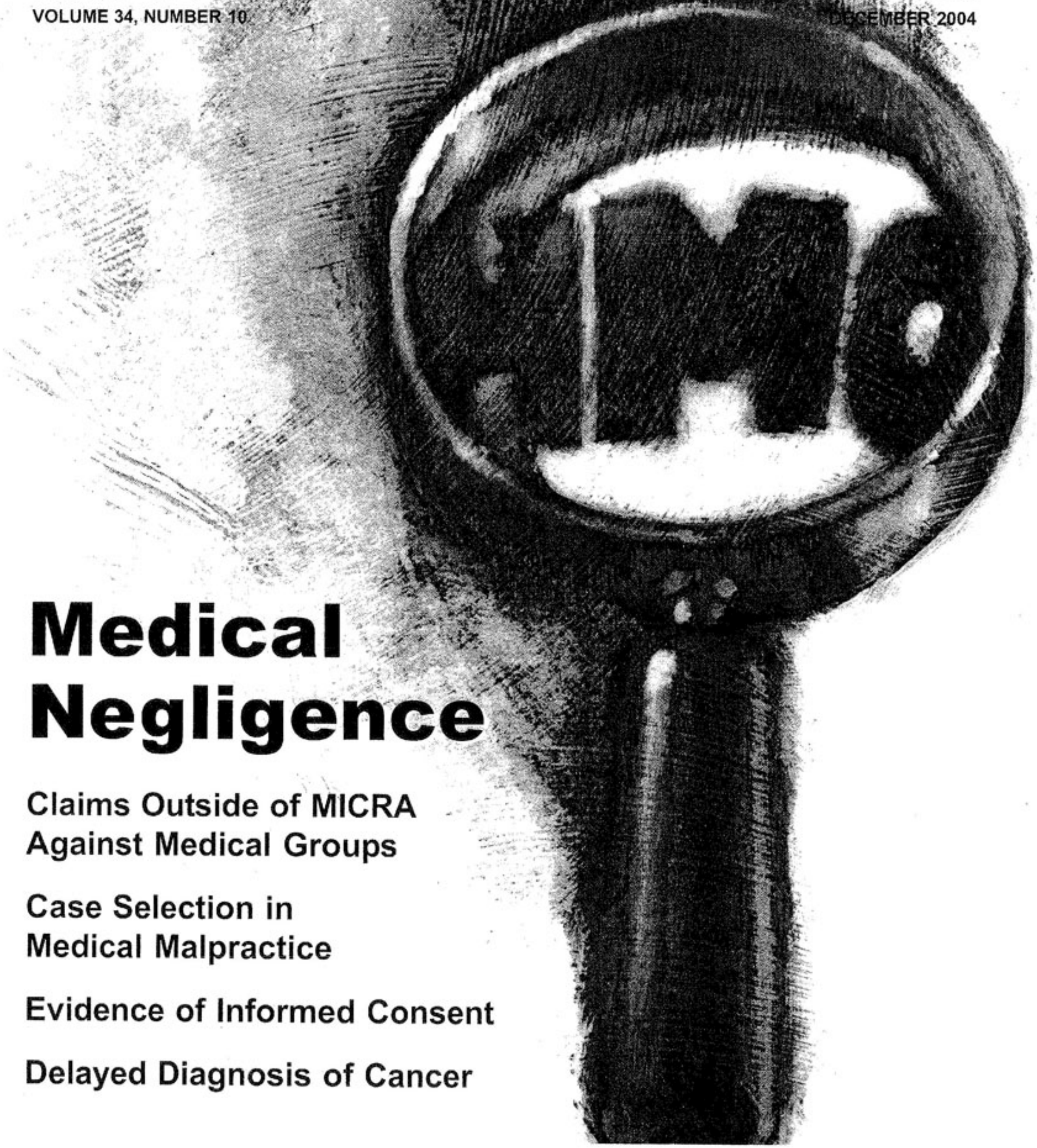

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Claims Outside of MICRA Against Medical Groups in Light of *Lathrop v. Healthcare Partners*

By Russell Balisok, Carol Jimenez, Jeff Haas and Cliff Weingus

Negligence by physicians and other health-care providers sometimes occurs. A physician fails to do a good job during surgery, leaving a sponge or clamp in an abdomen, inadvertently nicks a femoral artery during surgery, or mis-diagnoses a skin lesion or other serious medical condition. Such occurrences naturally give rise to a suit based on breach of the standard of care. The breach may be simply negligent. However if the physician was repeatedly intoxicated at the time, or was burdened by a long history of similar error, the breach may be culpable; it may provide a basis for an intentional tort, or provide a basis for allegations that it was in conscious disregard of the probability of injury.

Whatever the nature of the physician's culpability, there are times when plaintiff's counsel should explore the liability of the medical group to which the physician belongs. And, while it may appear that the physician is protected by MICRA and other protections including C.C.P. § 425.13, the medical group might not benefit from such protections simply because it is not a health care provider.

Lathrop v. Healthcare Partners (Jan. 21, 2004) 114 Cal.App.4th 1412 demonstrates that a medical group may not be a "licensed health care provider." However, in order to reach the medical group without MICRA's limitations, the plaintiff must present a case of *direct* (not vicarious) liability against the group. *Lathrop* establishes that if the medical group's liability is based solely on its status as an employer (or principal) of the physician, the medical group will still be entitled to the defenses available to its agent/employee physician. Obviously, one such defense is MICRA's cap on general damages, still set (after 29 years) at $250,000.

When a case of direct liability against a medical group can be established, the group is not entitled to MICRA's protections, and a plaintiff's general damages claim against the medical group is free of MICRA, including its onerous MICRA cap, and also free of other protections afforded health care providers, such as C.C.P. § 425.13.

Lathrop's Analysis of Health Care Provider Status Is Limited to the Question of Licensure

In October 2001, Jeff Haas and Cliff Weingus tried *Lathrop v. Healthcare Partners Medical Group* in San Francisco Superior Court. *Lathrop* arose out of a failure to diagnose breast cancer. Terry Lathrop and her husband sued Healthcare Partners and three of its physicians as well as a radiology group and an independent surgeon.

Pre-trial, Healthcare Partners stipulated that its three physicians were acting in the course and scope of their employment for Healthcare Partners and the physicians were then dismissed. The jury returned a verdict against all defendants in favor of Terry Lathrop, including $600,000 for past non-economic damages and $1.5 million in future non-economic damages. Fifth-eight percent of the liability was apportioned to Healthcare Partners.

Post verdict, all defendants moved to have the non-economic damages reduced based on the MICRA cap. Plaintiffs opposed the motion by Healthcare Partners only, arguing that it had failed to establish that, as a medical group, it was a licensed health care provider. Plaintiffs further argued that Healthcare Partners was a managed care entity and not a health care provider and therefore not subject to MICRA protections. Plaintiffs argued that there was sufficient evidence in the record to establish a basis for direct liability on the part of Healthcare Partners and also argued that the licensed health care provider status of Healthcare Partners' employee physicians should not inure to the benefit of Healthcare Partners. The trial court denied Healthcare Partners' motion and refused to reduce the non-economic

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damages verdict against it. Healthcare Partners appealed.

The Court of Appeal for the First Appellate District, Division 5, agreed that Healthcare Partners was not a licensed health care provider and therefore not covered by MICRA. Nevertheless it reduced the non-economic damages verdict to $145,000, finding that the sole basis of Healthcare Partners' liability was vicarious, and rejected plaintiff's claims that there was a basis for direct liability against Healthcare Partners.

Lathrop, clearly and simply, held that because the group had no license it could not quality for MICRA protection. Since the medical group did not claim it operated a licensed facility, the court's analysis addressed only whether it was a licensed health care practitioner. The court explained:

> In any event, the definition of "health care provider" extends only to a "person *licensed*" under the Business and Professions Code. The Business and Professions Code sets out the licensing provisions pertaining to medicine in the Medical Practice Act (Bus. & Prof. Code, § 2000 et seq.), and that act is quite explicit that "only natural persons shall be licensed" to practice medicine. (Bus. & Prof. Code, § 2032.) Indeed, licenses are issued to physicians who meet certain educational requirements. (Bus. & Prof. Code, §§ 2050, 2089-2096.) Only a natural person can complete medical training. Furthermore, the license authorizes a physician to "use drugs or devices in or upon human beings and to sever or penetrate the tissues of human beings and to use any and all other methods in the treatment of diseases, injuries, deformities, and other physical and mental conditions." (Bus. & Prof. Code, § 2051.) Only a natural person can perform such acts. The concept of medical licensing would be nullified if such practices could be performed by a legal entity using agents of its own choosing. The Medical Practices Act clearly intends only individual persons to be licensed to practice medicine....
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> ... [H]aving authority to conduct business as an artificial entity is not the same as having a license to practice medicine. Again, only natural persons are *licensed* to practice medicine. (Bus. & Prof. Code, §§ 2032.) Because HealthCare Partners is not itself a medically licensed person, it does not qualify as a "health care provider."

The second question in *Lathrop* was whether the medical group, as the employer of the physician, would be protected by the MICRA limits under common law rules that a principal cannot be subject to greater liability than its agent when sued merely as the principal. On this second question, *Lathrop* held that the employer medical group in effect benefitted from the physician's MICRA protection.

Lathrop's Conflict with *Palmer v. Superior Court* (or Medical Malpractice Meets Managed Care)

Lathrop's approach to the question of a medical group's status as a health care provider provides for certainty. A very limited factual question needs to be decided, i.e., whether the medical group itself has a license in order to determine whether the medical group is MICRA-protected. In contrast to *Lathrop*, the court in *Palmer v. Superior Court* (2002) 103 Cal.App.4th 953, 966, looked beyond the fact that the medical group had no license, and instead examined factual questions regarding the role the medical group played in the transaction in which the plaintiff was injured. *Palmer* concluded that the medical group's performance of utilization review functions delegated to it by its contracting HMO was "more like the 'provider' definition of Health and Safety Code section 1345, subdivision (i) (delivering or furnishing services) than it is like the 'health care service plan' definition of Health and Safety Code section 1345, subdivision (f) (arranging for or paying for services)."

In other words, *Palmer* accorded the medical group status as a "health care provider" because it was acting more like a provider (see Health & Saf. Code § 1345(i)) than a "managed care entity" arranging for health care for enrollees for a fixed or periodic fee (see Health & Saf. Code § 1345(f)) in the performance of utilization review functions delegated to it by an HMO.

There are two problems with *Palmer's* analysis, aside from the fact that, like Healthcare Partners in *Lathrop*, it had no license. First, any entity performing utilization review as the delegee of an HMO is performing the function and the role of a managed care entity. "Utilization review" is a managed care function imposed by California licensing law on the HMO. (See Health & Saf. Code §§ 1363.5(a), 1367.18, 1370.) Second, a medical group, like the defendant in *Palmer*, who contracts with an HMO, as a business practice, agrees to receive a fixed or periodic fee for its service in performing delegated utilization review functions for its contracting HMO, and therefore itself clearly qualifies as a "managed care entity" under Health & Safety Code § 1345(f). As such, Civil Code § 3428(c), which denies MICRA protection to managed care entities, applies to the medical group, as well as the HMO.

Instead of the flawed analysis of *Palmer*, the issues the court should have reached are: (1) Who has legal responsibility and authority to conduct utilization review? and (2) Was the medical group involved in the care of the plaintiff pursuant to a contract with the HMO for a periodic or fixed fee?

As to the first question, in a managed care context, it is the HMO itself which has the responsibility to conduct utilization review to ensure that resources are properly and efficiently used to deliver the care which enrollee/patients reasonably need. (Health & Saf. Code §§ 1363.5(a), 1367.18, 1370.) An HMO that delegates this responsibility still remains legally liable for it. (See *California Association of Health Facilities v. California Department of Health Services* (1997) 16 Cal.4th 284, 329 [revising rule of non-delegable duty of licensee responsibilities].)

In *Palmer*, the medical group performed utilization review as the delegee of an HMO. The medical group's utilization review activity was in the capacity of its delegor, and its activity is subject to the same rules applicable to HMOs. Since HMOs are not health care providers entitled to the benefits of MICRA (Civ. Code § 3428(c)) and have no standing as "a health care provider," neither should the medical group in *Palmer*.

In addition, if the medical group received a periodic or fixed fee to provide care, it would itself be a "managed care

entity" under Health & Safety Code § 1345(f), and, regardless of the nature of activities or whether it discharged them through physicians, it is not a "health care provider" entitled to the protections of MICRA.

Courts Should Avoid Detailed Factual Analysis When Determining "Health Care Provider" Status

Should courts look further than *Lathrop* looked to ascertain whether a particular defendant is entitled to MICRA type protections? Should there be a factual inquiry into the role a particular "medical" defendant played in a particular case in order to apply MICRA or C.C.P. § 425.13 as *Palmer* did? These questions are important because the question of a defendant's status as a health care provider, and hence whether it is protected by MICRA (or entitled to the protections of C.C.P. § 425.13), typically arise first at the pleading stage. The following examples, which may arise in a pure negligence claim,[1] serve to illustrate the problems that result if a court must conduct a *Palmer*-type analysis to determine the status of a defendant at the pleading stage:

- Defendant moves to compel arbitration in response to a complaint, and the plaintiff asserts that the defendant's arbitration agreement does not comply with the mandatory requirements of MICRA's C.C.P. § 1295. If the defendant is not a "health care provider" under MICRA, § 1295 ought not to apply.
- Defendant files a demurrer based on the MICRA statute of limitations at C.C.P. § 340.5. If the defendant is not a "health care provider" under MICRA, the statute of limitations would be C.C.P. § 335.1 (two years) and subject to general tolling under C.C.P. § 352.
- Defendant moves to strike punitive damages based on the plaintiff's asserted failure to comply with C.C.P. § 425.13 which, like MICRA, protects "health care providers." If the defendant is not a "health care provider," § 425.13 would not apply.

If *Palmer's* approach is correct, each of these scenarios presents the court with complex factual issues which must be decided prior to ruling on what would otherwise be garden variety law-and-motion issues. It's easy to foresee extensive discovery proceedings into the facts of the case, *before* the court could rule on these crucial issues. However, if a medical group had no license, the issue would be summarily determined under *Lathrop*. Likewise, if a defendant with a license to act as a "health care provider" nonetheless entered into an agreement to perform HMO delegated functions, or if its agreement to provide care prescribed a "fixed or periodic fee," its conduct within the scope of that agreement would nevertheless not be protected by MICRA, since its conduct would fall within Health & Safety Code § 1345(f) and Civil Code § 3428(c).

Since affirmative defenses such as MICRA protections must be pleaded and proved by the defendant, you must be careful not to gratuitously allege that the defendant was licensed. If the defendant is understood to be licensed, you should be

careful to affirmatively allege (a) that the defendant medical group was performing an HMO's duties which had been delegated to it, and/or (b) that the medical group was paid a fixed or periodic fee to provide care. Either allegation should provide a basis for invoking Civil Code § 3428(c)'s provision that the defendant is not entitled to MICRA protections, even if there is a license.

Finding Direct Liability Against a Medical Group or Vicarious Liability for an Intentional Tort

Before discussing direct liability theories of a medical group, you must remember that *MICRA doesn't apply to intentional torts.* Therefore, where a physician commits an intentional tort within the course and scope of employment or agency, the medical group, as principal, is liable. (See *Lisa M. v. Henry Mayo Newhall Memorial Hospital* (1995) 12 Cal.4th 291, 296.) Except for MICRA's arbitration provision at C.C.P. § 1295, which applies to intentional torts as well as negligence, MICRA does not apply to intentional torts. (See, e.g., *Barris v. County of Los Angeles* (1999) 20 Cal.4th 101.)

Turning to negligence claims, does the medical group have a duty of ordinary care to the patient-member and, if so, did its breach lead to injury? A "secondary defendant" such as a medical group may be nothing more than an organization to facilitate the practice of medicine, similar to a law partnership. With the prevalence of managed care, however, the medical group probably does far more:

- The group enters into managed care agreements with HMOs to provide "physician services" to the HMO's enrollees and, in doing so, the medical group undertakes to provide care to enrollees.
- The group may, in turn, enter into agreements with physicians (who may or may not be shareholders in the group) who actually provide care.
- The group may undertake utilization review or other administrative functions by delegation from the HMO and in such capacity may deny care, even care ordered by the enrollee's physician. Such denial is usually done under the rubric that the care is "not medically necessary."
- The group may enter into agreements with a hospital to share in the hospital's profit, conditioned on achieving established targets for patient-bed-days. The existence of such financial incentives colors the group's failure to authorize admission to the hospital, the physician's reluctance to order admission, or the physician's early discharge order.
- The group may discourage its participating physicians, as well as ancillary health care providers such as nursing homes or home health agencies, from requesting authorization for medically necessary treatment or care, including hospitalization.

These arrangements give rise to affirmative duties to patients, because the medical group promised to provide care to the patient (and then delegated that duty to the physician), because of the special relationships between the group and the physician or patient, or because the relationship between the group and the physician created a peril that medically necessary care and treatment will be denied or deferred, for example through financial incentives to physicians or medical groups. (See 6 Witkin, Summary of California Law, Torts § 858, et seq. [special relationship doctrine, or duty to act after creating peril to patient].)

Breach of such duty by medical groups and physicians in this context usually causes injury from the denial or deferment of medically necessary care, with accompanying disease, emotional distress and/or death. Such denial may occur when the physician fails to consider optional treatment, or fails to inform the patient of the potential efficacy of such treatment. Such denial may be more apparent, as when the physician orders medically necessary care or treatment, but the medical group, in the "guise" of utilization review, denies the request for authorization for such treatment because of "policy" or expense. Or the "denial" may be hidden by economic pressure on the physician or other treater not to seek authorization for treatment, so that no official written notice of denial need issue to the patient. The duty of ordinary care may be breached negligently, but considering financial incentives on motivation, the breach may be intentional. This distinction is key when suing "secondary defendants" and analyzing the application of MICRA.

In addition, a duty to disclose conflicts of interest arises from the financial interest of the physician or medical group to cheat patients of medically necessary care. (See *McCall v. PacifiCare* (2001) 25 Cal.4th 412, 426 [all providers including an HMO have a duty to disclose financial conflicts of interest].)

Some advance planning and review of the marketing materials issued by the medical group (and also the HMO) should assist you in ascertaining whether the group (or some other secondary defendant) is directly liable for the client's injury. The result of doing so may be a substantial action, unrestricted by MICRA or C.C.P. § 425.13, that provides full compensation for the client's injuries. Instead of a simple case of negligence against the physician, the inferences to be drawn by the jury are that the physician failures were the product of medical group action or influence, that the breach of the medical group's own duty to the patient caused injury, and that the conduct was intentional or malicious. What seems like a simple MICRA-limited negligence claim against a physician, in a managed care setting may actually be a legitimate case of direct liability against the medical group, including claims of malice, fraud or oppression, warranting imposition of punitive damages.

The effort by a medical group to challenge a complaint based on its claim of "health care provider" status should be anticipated by allegations that the medical group's liability stems from duties delegated to it by its contracting HMO and that it receives a fixed or periodic payment for providing services. In addition, the challenge to the complaint should be evaluated on the question of whether there is a qualifying license, as in *Lathrop*, and any attempt to inject factual issues like those examined in *Palmer*, at least at the pleading stage, should be rebuffed. ■

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[1] If the cause of action is for intentional tort, or a statutory tort not consistent with negligence, MICRA's provisions would not apply, with the sole exception of C.C.P. § 1295, which applies to negligence and intentional tort alike. (See *Barris v. County of Los Angeles* (1999) 20 Cal.4th 101; *Herrera v. Superior Court* (1984) 158 Cal.App.3d 255.)