

Corporate Liability Imposed on HMOs

by David R. Johnson, Esq.

Managed care organizations are liable for corporate liability where they are "providing health care services rather than merely providing money to pay for services," the Pennsylvania Superior court held October 5, 1998. The concept is not surprising, since earlier case law implied that HMOs were subject to certain aspects of corporate liability. What should be of concern to managed care organizations, however, is the potential scope of their responsibilities.

Shannon v. McNulty, the court held: "When a benefit provider, be it an insurer or a managed care organization, interjects itself into the rendering of medical decisions affecting a subscriber's care it must do so in a medically reasonable manner." No surprise there.

Nor was it remarkable that the court decided that where Health America "provided a phone service for emergent care staffed by triage nurses," it had "a duty to oversee that the dispensing of advice by those nurses would be performed in a medically reasonable manner."

However, *Shannon* indicates that managed care organizations may be liable on much broader terms than previously contemplated. The court held: "We see no reason why the duties applicable to hospitals should not be equally applied to an HMO when that HMO is performing the same or similar functions as a hospital."

"[W]e recognize the central role played by HMOs in the total health care of its subscribers. A great deal of today's healthcare is channeled through HMOs with the subscribers being given little or no say in the stewardship of their care. Specifically, while these providers do not practice medicine, they do involve themselves daily in decisions affecting their subscriber's medical care. These decisions may, among others, limit the length of hospital stays, restrict the use of specialists, prohibit or limit post hospital care, restrict access to therapy, or prevent rendering of emergency room care. While all of these efforts are for the laudatory purpose of containing health costs, when decisions are made to limit a subscriber's



access to treatment, that decision must pass the test of medical reasonableness. To hold otherwise would be to deny the true effect of the provider's actions, namely, dictating and directing the subscriber's medical care."

Mrs. Shannon, an obstetrics patient, called HealthAmerica's emergency phone line and told them that she was having severe irregular abdominal pain, back pain which was worse, at night, and that she thought she may be in pre-term labor. She also told the nurse that she had made prior calls to her doctor and that he felt she was not in labor. The nurse told Mrs. Shannon to call her doctor again.

Mrs. Shannon called HealthAmerica the next day and said her symptoms were getting worse and Dr. McNulty was not responding. She again was told by the triage nurse to call Dr. McNulty. She called him, but he still did not believe that she was in labor.

The next day, with her symptoms increasing, she called HealthAmerica again. This time, she was told to go to the hospital. She delivered a one and one-half pound baby, who survived only two days before dying due to his prematurity.

The Superior Court reversed the trial judge who had dismissed HealthAmerica from the case. The court concluded that the plaintiff was entitled to

have a jury decide whether the nurses had performed negligently. "HealthAmerica provided a medical service in the form of telephonic advice," the court held. "The adequacy of that service and the reasonableness of Mrs. Shannon's use thereof under the circumstances are questions for the jury."

In deciding the case, the judges appeared to accept the premise of plaintiff's expert that the HMO's triage nurses, upon receiving the first call from Mrs. McNulty, should have immediately referred her for a cervical exam and a fetal stress test. The court appeared to base its decision on the expert's testimony that, "they had a duty to follow up Mrs. Shannon's calls by calling Dr. McNulty to insure Mrs. Shannon was actually receiving proper care from him."

Given the involvement of HealthAmerica's triage nurses, there was at least a debatable issue about whether the nurses' responses met the standard of care. Since Mrs. Shannon told the nurses that she had a myriad of symptoms, and that she had been calling her doctor repeatedly and he was not responding, it seems reasonable to expect the nurses to do something more than simply tell the patient to call her doctor again. However, the troubling aspect of the opinion is the suggestion that the nurses had a duty to closely monitor the care being provided, and, perhaps, even to second-guess the patient's doctors. The plaintiff's expert did not just opine that the nurses had a duty to refer the patient to a hospital when the doctor was not responding, the expert said there was a duty to refer Mrs. Shannon "for a cervical exam and fetal stress test." The expert testified that the triage nurse even had a duty to notify the hospital "that this woman was probably in pre-term labor and needed to be handled immediately." The expert said the nurses had an obligation not only to call Dr. McNulty, but, also, to "insure" that "Mrs. Shannon was actually receiving the proper care for him."

There is an old adage that "bad facts make bad law," and this well might be one of those instances. Mrs. Shannon kept calling, either her doctor or the HMO, and none of the calls led to timely care. She appeared to be searching for help and the response, twice, from an HMO nurse was, simply, to call her doctor again. The case, well might have had a different outcome if, in the

first instance, the nurse had told her, "You should go to a hospital immediately to be examined."

Looking ahead, it is vital for managed care organizations to act with an awareness of the developing concept of corporate liability, and to be proactive on two fronts: With the care being provided, and in the courtroom. HMOs must be certain that when their performance and procedures are examined in the face of a bad outcome, they will appear to have been "managing" a patient's medical care in a reasonable manner. If medical advice is given, it is essential that, retrospectively, it not appear to be based at all on economic concerns, because it is certain that a monetarily-driven reason will not be deemed to be reasonable. As in *Shannon*, HMOs will be liable if it appears that their call centers have brushed off patient concerns. On the legal front, it is essential for managed care organizations to do everything possible to make certain that corporate liability does not expand to an unreasonable degree. Claims of corporate liability should be challenged rigorously, and HMOs must articulate and prove that there are important distinctions between the HMOs' role in patient care and the differing function of doctors and hospitals. The obvious point must be pressed that an HMO triage nurse should not be responsible for overseeing and directing doctors who care for patients. The *Shannon* case should concern HMOs. An HMO is a vulnerable defendant, especially if a case can be made that quality health care was withheld because of economic issues. *Shannon* should send a signal that in today's age of close scrutiny, the acts of managed care organizations will be held to high standards. When lawsuits occur, HMOs must muster the best evidence available that their actions were not influenced by financial concerns, that they constituted "reasonable care" and that to expect more would be unreasonable.

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