1-1-1987

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COMMENTS

Contractual Theories of Recovery in the HMO Provider-Subscriber Relationship: Prospective Litigation for Breach of Contract*

I. INTRODUCTION

The delivery of health care services in the United States has historically been bound to the traditional physician-patient relationship. This relationship arises when a patient seeks the services of a physician for the amelioration of discomfort, illness, or disease. Consequently, the services rendered by American physicians have necessarily been treatment oriented, as opposed to preventative in nature. From a legal perspective, this medical emphasis on the treatment of illness has translated into an emphasis on tort actions whenever the physician's duty to the patient is breached and the patient suffers a resultant harm. However, this Comment suggests that if the medical community shifts its emphasis to the prevention of illness, it is logical to translate the legal emphasis to one of contract whenever a breach of the physician-patient relationship occurs. This contractual focus would in turn necessitate a further emphasis on the importance of contractual terms in forming the relationship, and on the resulting expansion of remedial approaches for any breach of the relationship.

Medicine's treatment-prevention distinction was noted by President Richard M. Nixon, who pointed to the irony that the emphasis on treatment has meant that the practitioners of the healing art of medicine receive greater remuneration as the number of their patients (i.e., ill persons) and the subsequent medical services rendered to these patients increase.1 As a result of this financial and philosophical irony, in 1971

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* The author wishes to express his gratitude to Miriam J. Bandes for her insightful guidance in the drafting of this Comment. Sincere thanks are also due to Linda P. Rayter for her diligence in the preparation of the manuscript.

President Nixon endorsed a new method of delivering health services. This novel approach was organizational in nature, provided a comprehensive range of medical services for all of its subscribers in return for a prepaid fixed contract fee, and provided financial incentives to physicians for preventing illness and maintaining health. President Nixon acknowledged that such an organization existed in a variety of forms, but chose to refer to the new entity as a "Health Maintenance Organization" ("HMO").

President Nixon's suggestions were reflective of a larger general concern for the direction and success of federal health care policy. After World War II the federal government took an active role in health care policy, with the expansion of the National Institutes of Health ("NIH") and the funding, construction, and renovation of hospitals. However, subsequent years of mismanagement, unsuccessful policy decisions, and financial excesses gave rise to a perceived need for improved financial management of health care policy in the federal government. Consequently, when the Nixon administration took office in 1969, the priority in health care policy was to create cost-control mechanisms which would be cost-effective and manageable. HMOs are arguably the most visible and illustrative mechanism of this policy.

2. Id. at 4-5.
3. Although Nixon referred to this method of delivering health services as "new," id. at 4, such prepaid medical service plans have in fact existed in the United States since the nineteenth century. These plans were generally unknown to the general public since they were organized around small groups of people, usually around a common group characteristic of employment, religion, or ethnicity. It was not until 1932 that the concept of prepaid health plans was introduced to the American public by a national health committee as a means of providing affordable health care to a public ravaged by the Depression. Luft, Assessing the Evidence on HMO Performance, in HEALTH MAINTENANCE ORGANIZATIONS, supra note 1, at 212.
4. Saward & Greenlick, supra note 1, at 4-5.
7. Id. at 12.
8. For example, such factors as distribution of excess research funds, mismanagement at NIH, construction of underutilized hospitals, failure of financial remedies to cure geographical maldistribution of physicians, and continually rising, but originally underestimated, costs of Medicare and Medicaid, all combined to threaten federal and state finances. Id. at 14.
9. Id. at 15. For a detailed analysis of the federal agenda regarding HMOs, federal policy, and the political maneuvering of all the participants, see id. at 195-275.
Subsequent to the President's endorsement of HMOs, this alternative system of health care delivery received further governmental support and impetus from the Department of Health, Education, and Welfare,10 and the House Committee on Ways and Means.11 This federal initiative, coupled with societal concerns for greater availability of medical services and lower costs,12 led directly to a national health policy, preventative in nature and embodied in the HMO.13 This policy was statutorily expressed in the Federal Health Maintenance Organization Act of 1973 ("HMO Act" or "Act").14 The Act provides for the funding, development, enabling, and regulation of any HMO that becomes certified under the Act.15 Similarly, many states followed suit with their own legislation, since the HMO Act encourages state regulation of HMOs.16 This state initiative is particularly impressive and perhaps even underestimated. An examination of the federal legislative history reveals that an interest in developing HMOs among the states was at least contemporaneous with the federal initiative, and proceeded even in the face of existing state laws that would provide impediments to HMO enabling legislation at the state level.17

As a result of this enabling legislation, and as a function of the concomitant changing societal perceptions of medical services, the HMO is now a medical institution.18 Nonetheless, ambiguity concerning the pre-

10. Saward & Greenlick, supra note 1, at 5-6.
11. Id. at 5.
12. HMOs were originally organized as nonprofit entities concerned primarily with meeting these societal needs. See Stern, The Conversion of Health Maintenance Organizations from Nonprofit to For Profit Status: Background, Methodology, and Problems, 26 ST. LOUIS U.L.J. 711 (1982).
13. Wolinsky, supra note 5, at 248.
15. McNeil & Schlenker, HMOs, Competition, and Government, in HEALTH MAINTENANCE ORGANIZATIONS, supra note 1, at 31, 49.
17. Health Maintenance Organizations — 1973: Hearings on H.R. 51 and H.R. 4871 Before the Subcomm. on Public Health and Environment of the House Comm. on Interstate and Foreign Commerce, 93rd Cong., 1st Sess. 81 (1973) (statement of Hon. Frank Carlucci, Under Secretary, Department of Health, Education, and Welfare). In his testimony, Mr. Carlucci stated that several states were already encouraging HMO use for Medicaid recipients. In addition, he suggested that as early as two years prior, various states had voiced interest in HMOs and had begun to examine the possibility of their own enabling legislation and the necessity of amending currently existing and conflicting state statutes. Although the testimony did not delineate the specific impediments of state law, the surrounding text can be read to indicate that they include issues of insurance and antitrust legislation.
18. As of June 1986, 23.7 million people were enrolled in HMOs. The number of HMOs nationally was 595. This number included HMOs and their regional components (an independent unit of
cise definition of an HMO has persisted, due in large part to the structural differences between HMOs and the types of services they provide. For purposes of this Comment, the operational definition will be:

A Health Maintenance Organization (HMO) is a single entity providing comprehensive health care services for a prepaid fee. An HMO, as both a health insurer and health care provider, contracts with enrolled subscribers to provide a range of health services. Generally, an HMO will provide, at a minimum, physician, laboratory, x-ray, inpatient and outpatient hospital services, and emergency care. Supplemental services, such as dental care, are often included in the plan.

In general, subscribers to an HMO may have to pay a minimal fee (e.g., $2.00) per office visit. However, subscribers contract for unlimited visits and all necessary treatments regardless of cost. The majority, or sometimes all, of the prepaid fees are normally paid by the subscriber's

an HMO operating in a nonadjoining area). Forty-four states, plus Washington, D.C. and Guam, have at least one HMO headquartered within their boundaries. Twenty-six states have 10 or more HMOs and California has the most with 45. California also has the most enrollees with approximately 6.4 million subscribers. New York is the second most populous HMO-enrollee state with 1.7 million subscribers. Other states surpassing the million-subscriber mark include: Michigan (1.2); Illinois (1.1); and Minnesota (1.0). The Individual Practice Association ("IPA") model of HMO, see infra note 19, is the fastest growing type, demonstrating an increased enrollment of 29% in 1985, and a 41% increase in the number of IPA HMOs in the first six months of 1986. In 1985 the average monthly premium charged by HMOs was $206.18 for family contracts and $75.21 for individuals. In 1985 premiums rose an average of 6% for families and 5% for individuals. Employers pay for approximately 77% of the family contracts, and 90% for individual contracts. In 1985, HMOs reported an average utilization of 427 inpatient days per 1,000 enrollees; an average length of stay of 4.7 days per 1,000 enrollees; an average of 7.2 ambulatory visits per 1,000 enrollees over age 65; and an average of 4.1 ambulatory visits per 1,000 enrollees under age 65. Group Health Ass'n of America, Press Release: HMO Fact Sheet (Jan. 1987) [hereinafter HMO Fact Sheet].

19. The HMO Act authorizes three HMO types. Kopit & Klothen, Antitrust Implications of the Activities of Health Maintenance Organizations, 25 ST. LOUIS U.L.J. 247, 249 (1981). However, commentators and medical personnel have described these models somewhat differently, using different names, different descriptive terms, and even by collapsing the three into two. See generally Health Maintenance Organizations, supra note 1 (series of articles discussing various structural formats of HMOs). Therefore, for the sake of clarity, the three types are defined in this Comment as: 1) Traditional HMO (also called Staff), where the HMO entity usually owns the building, provides most of the services on site, and employs the health care providers; 2) Individual Practice Associations ("IPA"), where the HMO contracts with individual physicians to provide services to subscribers, but from the physician's own office (these doctors also maintain their own practice, and are reimbursed by the HMO on a fee-for-service basis for the subscribers they treat); and 3) Group (also called Network when two or more Group HMOs are combined), where a number of providers are united into a group that collectively contracts with the HMO entity to provide services. Services are usually performed at the physician's office, but reimbursement is to the group (based upon a preset fee schedule), which divides the fees among its participants. See Wolinsky, supra note 5, at 257; Note, supra note 16, at 438-39; HMO Fact Sheet, supra note 18.


21. Id. at 438.
employer, insurer, or medical society, based upon a negotiated reimbursement or evaluation system.\textsuperscript{22} Physicians and other medical personnel contract with the HMO to provide medical services, either as a direct employee or as an independent contractor.\textsuperscript{23}

All of these considerations are generally characteristic of HMOs regardless of their structural organization.\textsuperscript{24} In essence then, contrary to the traditional physician-patient relationship where the patient reactively seeks a doctor for treatment of a malady, in the HMO physician-patient relationship the patient prospectively contracts for delivery of medical services. The presence of an insurance component in the contract providing for all future medical needs, unlimited visits, and peripheral medical services, also contributes to the change in the relationship to one emphasizing prospective prevention and wellness.

In theory at least, the administrative medical policy goal and the congressional intent of the HMO Act have been incorporated in the structure and function of HMOs, and in the resultant HMO physician-patient relationship. However, this legislatively induced relationship may have considerable legal implications for the doctor-patient relationship and the duties, obligations, and interactions appertaining thereto. For example, an HMO entity undertakes "a contractual responsibility to provide or assure the delivery of health services to a voluntarily enrolled population . . . ."\textsuperscript{25} Consequently, an HMO may be found liable for breaches of its contractual responsibilities to its subscribers. Further, if these breaches occur in the context of the performance of the physician-patient relationship, then it may follow that traditional causes of action, such as medical malpractice, could sound in contract, instead of a negligence action in tort. This premise has been proposed elsewhere, both in reference to medicine in general,\textsuperscript{26} and to HMOs in particular.\textsuperscript{27}

The HMO is a health care services provider that contracts with enrollees for the delivery of comprehensive health care services in exchange

\begin{itemize}
\item \textsuperscript{22} \textit{Id.}
\item \textsuperscript{23} \textit{Id.} at 438-39.
\item \textsuperscript{24} \textit{See supra} note 19.
\item \textsuperscript{25} Wolinsky, \textit{supra} note 5, at 257 (quoting Luft, \textit{How Do Health Maintenance Organizations Achieve Their Savings? Rhetoric and Evidence, 298 NEW ENG. J. MED., 1336, 1336 (1978)).
\item \textsuperscript{26} Ficarra, \textit{Medical Negligence Based on Bad Faith, Breach of Contract, or Mental Anguish}, in \textit{LEGAL MEDICINE 1980, at 187 (C. Wecht ed. 1980).}
\item \textsuperscript{27} Stern, \textit{Bad Faith Suits: Are They Applicable to Health Maintenance Organizations?}, 85 W. VA. L. REV. 911 (1983). Stern refers to the bad faith breach of contract action against an HMO as a "new tort." \textit{Id.} at 911.
\end{itemize}
for a fixed annual fee from each subscriber. Standing in the position of the doctor in the physician-patient relationship, the HMO is also a party to a written contract delimiting the responsibilities of both parties. Therefore, HMOs may be particularly susceptible to suits alleging breach of contract, even when such a breach may be reflective of what is commonly defined as a negligent breach of duty arising from a physician's treatment of his or her patient.

This Comment will examine the unique nature of the HMO entity, and the subsequent possible increased susceptibility to legal action arising from the HMO provider-subscriber relationship. Specifically, the analysis will focus on the possible emergence of contract actions that may arise in the HMO provider-subscriber relationship. This will be achieved in four sections, the first of which, Section II, will consider the suggestion that the HMO environment is particularly appropriate for contractual actions. Section III will demonstrate advantages to pursuing contractual theories. Section IV will discuss specific contractual theories of recovery. Finally, due to a paucity of actual litigated cases proposing such alternate theories in the provider-subscriber relationship, Section V presents a hypothetical appellate decision in such prospective litigation.

II. GENERAL CONSIDERATIONS SUGGESTING CONTRACTUAL RECOVERIES IN THE HMO PROVIDER-SUBSCRIBER RELATIONSHIP

It is well settled that "[t]he relation of physician and patient arises when the professional service of the physician is accepted by the patient for the purpose of treatment." Although such a relationship may in fact result from an actual contract between the parties, it is not necessary for an express contract to exist before the relationship is created. "The relation of physician and patient is, in its inception, created by contract either express or implied." Indeed, most physician-patient relationships do not arise from an express written instrument, but instead are implied from the consensual acceptance of the relationship between the parties. Whichever the situation, as long as the parties knowingly accept the phy-
sician-patient relationship, a prima facie presumption of a contractual relationship between them is created.\textsuperscript{32}

This presumption has been directly stated in \textit{Henson v. St. Paul Fire & Marine Insurance Co.},\textsuperscript{33} in which a patient sued his doctor’s insurer for the physician’s alleged negligence in injuring the patient during surgery. After the operation the plaintiff had numbness and severe pain on the left side of his face. The surgeon told him that such postoperative pain was normal and would eventually cease. One year later plaintiff consulted another physician, who suggested the condition would improve in six to eight months. Since the condition continued beyond this projected time, the plaintiff eventually sued the surgeon’s insurance company. The trial court held that the applicable statute of limitations was one year, determined either under a general tort theory or under the state’s malpractice laws, and therefore dismissed the plaintiff’s suit.\textsuperscript{34}

The appellate court agreed with the plaintiff that the suit could also be brought as a contract action.\textsuperscript{35} The court stated that “[w]hen a patient goes to a doctor for treatment and the doctor agrees to treat him a contract has been entered into.”\textsuperscript{36} The court reasoned that if a contract was not created, the doctor would have no cause of action against a patient who refused to pay the doctor’s bill for services. In the absence of a strict contractual relationship, the physician’s only other remedy would be to seek a quasi-contract cause of action or one of unjust enrichment, both of which the court found illogical.\textsuperscript{37} Therefore, the court held that the plaintiff had stated a contractual claim within the ten year statute of limitations for contract actions, and reversed and remanded the case to the trial level.\textsuperscript{38} The important point for this Comment is that the physician-patient relationship can be logically interpreted as having its inception in contract. Consequently, the parties to a relationship founded in contract may seek redress in contract.\textsuperscript{39}

The classic illustration of this contention is the famous contract case


\textsuperscript{33} 354 So. 2d 612 (La. Ct. App. 1977), aff’d and remanded, 363 So. 2d 711 (La. 1978).

\textsuperscript{34} 354 So. 2d at 614.

\textsuperscript{35} Id. at 615-16.

\textsuperscript{36} Id. at 615.

\textsuperscript{37} Id.

\textsuperscript{38} Id. at 617.

\textsuperscript{39} See id. at 615-16.
of *Hawkins v. McGee*. In this case a boy suffered a severe burn on his hand from contact with an electric wire. The boy and his father consulted a surgeon who consented to perform an operation on the hand. The operation was intended to both remove scar tissue from the hand and to graft skin from the boy's chest onto the damaged hand. However, the physician also allegedly promised "'I will guarantee to make the hand a hundred per cent perfect hand' or 'a hundred per cent good hand.'" Not only was the operation a failure, but it also resulted in the boy's hand becoming covered with hair.

Although on its facts the case would appear to be one of tortious negligence, the court applied a contractual theory in assessing damages. The measure of damages was based on expectation theory, assessing the damages as the difference in value between the promised condition and the result that actually occurred. Although it may be argued that this measure of damages is insufficient since it ignored the boy's pain and suffering, and left the jury to decide the value of a perfect hand, nonetheless *Hawkins v. McGee* demonstrated that a medical case could be adjudicated in contract terms.

Despite the results in *Hensen* and *Hawkins v. McGee*, most breaches of the physician-patient "contract" have been pursued in tort, through a theory of medical malpractice that is essentially one of negligence. In its basic outline, proof of a tort in medical malpractice must include: (1) the establishment of a standard of care applicable to the provider of such care (e.g., a physician); (2) a breach or violation of such standard by the provider; (3) the suffering of a compensable injury by the patient; and (4) evidence that the injury suffered was caused in fact and proximately caused by the breach.

This preference for tort over contract actions appears to be the result of the majority of courts recognizing the physician-patient relation-
ship as a relational, as opposed to an arm's length, transaction. Similarly, tort theories have been recognized as more appropriate since the situation usually involves issues such as personal injury, battery, or degree of care, all of which are more consonant with tort than contract. By restricting medical malpractice litigation to questions of tort, the courts have also avoided problems of interpreting nebulous or nonexistent contractual terms, discouraged theory shopping, and limited discrepancies in damages and statutes of limitations that may occur in similar fact patterns brought under different theories.

However, even in light of these considerations, because the physician-patient relationship in an HMO arises directly from an express written contract, the HMO patient who suffers a contractual breach in the receipt of medical services should be allowed to seek a remedy of that breach through theories of contract as well as of tort. These contract theories would apply to all aspects of the provider-subscriber relationship, including and especially those of a medical (i.e., physical, relational) nature, and would not be confined to the arm's length aspects of the contract (e.g., raising the cost of office visits to $5.00 from the contractual price of $2.00).

Although the actual services rendered by physicians to their patients in an HMO are no different than those in the independent practice of medicine, patients who independently seek the services of doctors are rarely required to sign a contract delimiting the services to be rendered. The traditional patient will receive medical services as soon as he or she seeks the physician's expertise and initiates the relationship. Conversely, the HMO subscriber must first sign the provider contract after certain eligibility requirements are met. These include, for instance, being an employee of a contracting employer, and, where a choice exists, selecting

47. For example, in Feigelson v. Ryan, 108 Misc. 2d 192, 437 N.Y.S.2d 229 (N.Y. Sup. Ct. 1981), the court denied plaintiffs' breach of contract cause of action, which alleged that the defendant physicians improperly advised the plaintiffs in regard to the risks of pregnancy for women over the age of thirty-five. Id. at 193, 437 N.Y.S.2d at 231. The court held that "the breach alleged is thus tortious in nature," and "the malpractice rather than the breach of contract Statute of Limitations is applicable." Id. at 198, 437 N.Y.S.2d at 234. Plaintiffs' contractual cause of action was dismissed. Id., 437 N.Y.S.2d at 234.
49. Although these latter two discrepancies are a direct result of the theory of the plaintiff's case, and therefore a result permissible by law, they may raise policy issues concerning equal protection of plaintiffs suffering similar injuries. This may be a motivating factor for states that have adopted a special statute of limitations for medical malpractice actions. These statutes may combine considerations and time periods of both negligent tort and contract actions. See infra notes 55 & 58.
one HMO over other HMOs or over a traditional medical insurance plan.\textsuperscript{50} The provider-subscriber relationship is one born out of a written contractual agreement occurring long before the face-to-face confrontation that would normally initiate the traditional consensual physician-patient relationship. Therefore, it would appear that the actual basis of the provider-subscriber relationship is one grounded in contract, suggesting both foundation and remedy in contract.

Similarly, the HMO patient may be said to be "induced" to contract with an HMO. Unlike physicians in individual practice or medical partnerships, HMOs routinely advertise on television and radio, and in magazines and newspapers.\textsuperscript{51} Additionally, they are allowed to present their plan to prospective subscribers at employer sites, such as universities, since employees normally have an annual period to select, or change, their health insurance program.\textsuperscript{52} These inducements to enroll are somewhat analogous to the offer component of traditional contracting. The subscriber is not responding to an immediate physical ailment, but to a contractual offer, indicating that the acceptance is not necessarily creating a relational union but a contractual one. As noted earlier, the subscriber is acting prospectively, bargaining for terms and services, not reactively seeking aid for a specific malady.

Perhaps, then, the HMO entity has in fact altered the traditional personal nature of the doctor-patient relationship into one of independent contracting parties, due in large part to its own behavior in seeking and initiating the relationship. One may argue that a true physician-patient relationship in an HMO does not exist until the subscriber actually receives a medical consultation or treatment. However, one does not have to consume goods before one is considered a party to the contract specifying delivery of those goods.\textsuperscript{53} The parties in an HMO contract are providing for the terms and conditions of that contract in contemplation of the delivery of services in their new relationship as provider-subscriber. This contractual relationship would impose the same duties on

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\item \textsuperscript{50} R. Birnbaum, Health Maintenance Organizations: A Guide to Planning and Development 8 (1976).
\item \textsuperscript{51} "Some HMOs do in fact conduct aggressive enrollment campaigns, including mass advertising; in California, for example, membership has been sold on a door-to-door solicitation basis, a notoriously 'hard sell' style of salesmanship." Curran & Moseley, supra note 45, at 81 (citing Schneider & Stern, Health Maintenance Organizations and the Poor: Problems and Prospects, 70 Nw. U.L. Rev. 90 (1975)).
\item \textsuperscript{52} R. Birnbaum, supra note 50, at 8.
\item \textsuperscript{53} For example, the Uniform Commercial Code provides that "[g]oods which are not both existing and identified are 'future' goods. A purported present sale of future goods or of any interest therein operates as a contract to sell." U.C.C. § 2-105(2) (1978).
\end{itemize}
the parties as would exist under the traditional physician-patient relationship. These duties—and any breach of these duties—would arise from the initiation of the provider-subscriber relationship, whether the relationship arose from a piece of paper or in an operatory. As long as parties knowingly accept the physician-patient relationship, the presumption of a contractual relationship between them is created. A written contract indicates that the parties knowingly accept a physician-patient relationship.

III. WHY PURSUE CONTRACTUAL ACTIONS IN HMO LITIGATION?

The question may be legitimately posed, why should a plaintiff pursue a cause of action in contract, when courts have favored theories of tort? The most honest answer would be that not all such actions should sound in contract, but there may be occasions when contract actions are more appropriate or advantageous. There may also be occasions when either, or both, a contract or tort action is available, or when an alternate theory such as, for example, breach of fiduciary duty is an option.

A. Statute of Limitations

The most obvious advantage of pursuing a cause of action in contract concerns the statute of limitations. Although it is true that most jurisdictions have enacted statutes of limitations that apply directly to health-care providers, and still others have enacted statutes that combine tort considerations with contract considerations, it is still generally true that a pure contractual statute of limitations is longer than that of its counterpart in torts. Consequently, a patient suing a physician under a

54. See infra note 142.
55. "Only seven jurisdictions in the United States have failed to enact limitation statutes directed primarily to malpractice litigation. In these jurisdictions malpractice is governed by the limitations applicable to tort actions generally." 1 D. LOUISELL & H. WILLIAMS, supra note 48, at § 13.02.
56. For a complete summary of federal and state special legislation applicable to medical malpractice and informed consent causes of action, including the corresponding statutes of limitations and coverage of "continuous treatment," "discovery" rules, and "foreign objects," see 2 S. PEGALIS & H. WACHSMAN, supra note 29, at § 6:8 (1981 & Supp. 1986).
57. For example, consider the following comparisons between the applicable malpractice limitation and the state's corresponding general contractual statute of limitations. California, malpractice: An action for injury or death must be brought within "three years after the date of injury or one year after the plaintiff discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first." CAL. CIV. PROC. CODE § 340.5 (West 1982). California, contract: An action upon any contract, obligation or liability founded on a written instrument must be brought within four years. Id. at § 337. Connecticut, malpractice: A cause of action for malpractice causing personal injuries "shall be brought . . . within two years from the date when the injury is first
contract theory will have the advantage of a longer time period to initiate litigation, while the physician will have a longer period of legal liability. It should be noted that this discrepancy and its possible enhancing effect on contractual actions over malpractice claims has not gone unnoticed. Twenty-five jurisdictions have enacted legislation that makes the limitation periods identical for both causes of action. It appears then, that the differences in statutes of limitations have in fact been advantageous for plaintiffs pursuing medical contract claims, and will continue to be so, barring legislative action.

For medical cases, the issue of time and tolling the statute of limitations is extremely important, since the ailment complained of may not be realized by the plaintiff until after the statute of limitations has expired. In malpractice litigation, a jurisdiction will generally employ one of three rules to determine when the cause of action accrues. A contractual theory will allow the plaintiff to choose the longer period, regardless of whether the contractual breach is determined to have occurred at the time of the tortious misconduct, or its discovery.

sustained or discovered or in the exercise of reasonable care should have been discovered, and except that no such action may be brought more than three years from the date of the act or omission complained of . . . ." CONN. GEN. STAT. ANN. § 52-584 (West Supp. 1987). Connecticut, contract: For any action on a simple or implied contract, or on any contract in writing, the limitation is six years. Id. at § 52-576 (West 1960 & Supp. 1987). Minnesota, malpractice: An action for malpractice, whether based on contract or tort, must be commenced within two years. MINN. STAT. ANN. § 541.07 (West 1947 & Supp. 1987). Minnesota, contract: "Upon a contract or other obligation, express or implied, as to which no other limitation is expressly prescribed" the limitation is six years. Id. at § 541.05 (1). Ohio, malpractice: A cause of action for malpractice must be brought within one year after the cause accrued. OHIO REV. CODE ANN. § 2305.11(A) (Anderson 1981 & Supp. 1986). In no event shall any medical claim be brought more than four years after the act occurred. Id. at § 2305.11(B). Ohio, contract: A written contract has a statute of limitations of fifteen years after the cause accrued. Id. at § 2305.06. A contract not in writing, either express or implied, has a limitation of six years after the cause accrued. Id. at § 2305.07. Note the effect of "discovery" of the injury on the tolling of the malpractice statute of limitations. See infra note 59.

58. 1 D. LOUSELL & H. WILLIAMS, supra note 48, at § 13.03; see also supra note 49 and accompanying text.

59. The three rules are: 1) Traditional — The statute of limitations begins to run on the date of the wrongful conduct; 2) Discovery — The limitations period begins when the patient discovers or reasonably should have discovered the harm; and 3) "Hybrid" or combination — A mixture of the two previous rules. The limitation period begins when the plaintiff discovers or reasonably should have discovered the harm. However, after a certain amount of time elapses (e.g., five years) the plaintiff is no longer allowed to bring suit, even if he or she has not yet had the opportunity to discover the harm. 2 S. PEGALIS & H. WACHSMAN, supra note 29, at § 6:7. An action based on contract theory may eliminate some of the concerns over whether a plaintiff should have discovered the injury. As such, the breach itself starts the clock, and the breach constitutes the plaintiff's recognition of the harm.
B. Scope of Injury

A second consideration favoring contractual approaches to litigation in provider-subscriber situations concerns the scope of the injury. Although it is reasonable to conclude that a patient who suffers egregious harm as a result of gross negligence will initiate malpractice litigation, it is also true that most cases do not involve such clear-cut issues. That is, most patients who suffer harm suffer minor harm, which may nonetheless still be a breach of the bargained-for professional standard of care. This is especially true in an HMO where the patient will be exposed to a number of health professionals under the team approach used by HMOs.

Similarly, patients are more likely to suffer a true contractual breach in an HMO than they are to suffer a true tort. However, in both the minor harm and the true contractual situations, the patient is not likely to initiate a malpractice claim in order to seek compensation. Therefore, it is conceivable that wrongs suffered by subscribers in the first situation go unremedied in part due to the subscriber's reluctance to elevate a minor medical claim to one of malpractice, which may escalate into major litigation. Or similarly, in the second situation, where the harm is more contractual than tort-like in nature, litigation may not be pursued due to the subscriber's ignorance of the availability of a contractual path to remediation in a medically related claim.

The suggestion, then, is that the extent and nature of the harms actually suffered in provider-subscriber situations are often most suited to, and equitably remedied in, contract actions. Further, if the harm suffered is indeed egregious, the traditional tort malpractice route should be followed, resorting to a contractual claim only when a tort claim is unavailable.

C. Power of Negotiation

A third reason to seek contractual recovery is to afford the subscriber a voice in the provider-subscriber relationship. Since a health plan is normally provided by the employer, and since only one alternative or only one HMO may be offered, a subscriber often has no real choice in the selection of the plan, no voice in the selection of physicians—often having to abandon his or her own family doctor—and little, if any, power to negotiate for changes in the contract's terms. Consequently, a significant way to effect change, protect individual rights, recoup damages, and increase negotiating power is through actions that sound in contract.

Voicing subscriber complaints to an employer or medical society
which contracts with the provider may be equally ineffective, since the employer is often as powerless as the employee, having little or no choice in accepting the existing plan. Although HMOs were originally intended to provide a competitive alternative to traditional modes of health care, their mercurial growth and comprehensive services have combined to make them a dominant factor in the health care market. As a result, HMOs are recruiting many individual physicians, and are actively hiring new doctors as HMO employees or independent contractors. Similarly, even hospitals and medical groups that once campaigned against HMOs have formed their own HMOs. Further, many HMOs have spread themselves over entire regions by establishing satellite sites in areas outside of their primary coverage. Consequently, HMOs have become so pervasive that there is a general concern that HMOs may be having a general anticompetitive effect on the health care market. An employer's bargaining power against such a formidable party may well be limited. Due to the HMO's control of local market conditions, employers are frequently forced to accept the provider contract on terms most favorable to the HMO. This is especially true in regard to the fringe components of such contracts, since the employer's major concern is with the price it must pay to cover its employees, not necessarily with whether the contract contains such comprehensive components as a prescription plan.

Finally, an employer is likely to continue its ongoing relationship with an HMO as long as employee complaints are not widespread, the payment schedule is reasonable for the employer, and the HMO is not guilty of any egregious behavior. Unlike a singular patient who can choose among scores of physicians in a metropolitan area, an employer can usually choose only among a handful of HMOs in that same area. Therefore, even if an employer contemplated a change, its options are usually limited, or even nonexistent where an area is served by only one HMO.

60. See generally supra notes 1-5 and accompanying text.
61. See supra note 18.
62. See supra note 18; see also Note, supra note 16, at 439-40.
64. Note, supra note 16, at 441.
65. See supra note 18.
66. Note, supra note 16, at 441-48. This appears to be so since independent physicians will find it increasingly difficult to compete against the comprehensive services of HMOs, especially in areas of limited patient populations; existing HMOs will continue to expand and attract a large percentage of the patient population, thereby increasing their control over the provider market.
Voicing a grievance may also be fruitless, since the HMO, as it did in the contract formation phase, will occupy a similarly superior position, often having the final word. Unless a grievance is shared by a large number of subscribers, it would be unlikely that a provider would alter services for one enrollee at the expense of many. Further, if the rest of the industry is used as a standard, the subscriber is at an additional disadvantage. Consequently, preserving a contractual cause of action will not only protect the subscriber's voice in the contract, but may also allow litigation of personal harms that arise out of contractual terms. Without such a voice in the HMO contract, the subscriber would have the irrational alternatives of either dropping his or her health insurance, seeking another plan that may be just as restrictive, or seeking other employment where a different health plan is available.

D. Development of a Revised Standard of Care

A fourth reason to recommend contractual actions is the possibility of the development of a special standard of care applicable to HMOs. In the typical case of negligent medical malpractice, the standard by which a physician's conduct is judged is that of "[t]he reasonably prudent physician or surgeon, acting under the same circumstances." Analogously, the contractual standard may be expressed as the performance or delivery of any terms and conditions for which the parties have contracted. A special standard of care for HMOs would stress that the HMO is a novel entity in the delivery of medical care. In attempting to best meet the medical needs of the public in delivering this care, it is possible that the HMO may be exposed to both the legal problems of the normal practice standards of independent physicians, and those novel ones evolving from the HMO's team-like structure. Consequently, the progress that an HMO may make in preventive medicine may be inhibited by excessive legal liability. Therefore, it may be necessary that separate standards of care, duty, risk, and other factors be established for HMO entities. In the


68. The contractual standard of care expressed here is the author's formulation. A more formal standard may be inferred from the duty component of the classic definition of contract: "[a] contract is a promise, or set of promises, for breach of which the law gives a remedy, or the performance of which the law in some way recognizes as a duty." 1 S. Williston, A Treatise on the Law of Contracts § 1 (3d ed. 1957).

69. Bovbjerg, supra note 5, at 1386-87.
absence of such protection, the HMO may be constantly litigating instead of providing medical care. If governmental funding were to stop for such entities, damage awards could seriously cripple the normal functioning of HMOs and the services they provide, unless they were protected by a different standard of care. Similarly, the cost of services would necessarily increase, endangering their affordability and the subsequent number of subscribers able to continue their membership.

As a result of these circumstances, it has been suggested that the traditional laws and customs dealing with medical malpractice and related litigation be replaced with a standard of care based on HMO custom.\[^{70}\]

It seems desirable to insulate HMOs from having to follow the custom of a very differently organized system of medical care. There is one way to recognize the legitimacy of HMO practices in the absence of independent judicial assessment of each noncustomary practice. The law could accept HMO custom as determinative of due care, to the same extent that insured fee-for-service custom is now accepted, in effect allowing this subgroup of medical practitioners to set its own malpractice standards. Whether or not a particular HMO practice was negligent would thus be judged by the practice of other HMO providers under comparable circumstances.\[^{71}\]

If such a standard of care for HMOs is adopted, it is possible that the HMO will become insulated from liability and litigation. Consequently, the preservation of contract approaches is all the more important for an enrollee who is in an inferior position from the onset. That such a standard of care is contemplated at all indicates the realization that the HMO is susceptible to increased litigation. The fact that such litigation has not yet materialized may be interpreted as indicating that the HMO is an efficient and successful way to practice medicine, or, alternatively, that the HMO is already sufficiently insulated from prospective litigation. Therefore, although an HMO standard of care may be logical and may materialize, it is important that, if it does, the subscriber's right to litigate be preserved.

These rights to litigate are more susceptible to attenuation in tort theories than they are in contract. Consider the suggestion in the quote above that the standard of care be the practice of other HMO providers under comparable conditions. This suggests that only tort theories are available, and that in order to prevail the plaintiff must succeed in showing that the standard of the defendant's industry was breached. Further,

\[^{70}\] See id. at 1408.

\[^{71}\] Id. at 1408-09.
this standard was one that the prospective plaintiff had no voice in creating and usually little voice in accepting. Conversely, if a contractual cause of action is retained, the subscriber always has the ability to litigate whether a tort or a contract breach is suffered. In addition, the criterion for recovery is a breach of a contractual term, not of a standard suggested by a prospective defendant. Consequently, if a legislature acts to make HMO custom determinative of a standard of due care, it would be desirable that both the contractual and malpractice nature of the HMO be considered. In this manner, the advantages to the plaintiff in a contractual action are maintained, and the legislature acts in consonance with the emerging trend of consolidating contractual and tort causes of action in malpractice cases.

E. Effects on Damages

Finally, a brief examination of the comparative effect of contractual and tort recoveries on compensable damages should be noted. In general, "[t]he basic law of damages in tort cases is not changed when applied to malpractice actions." Consequently, compensable damages in malpractice tort litigation may include recovery of pecuniary loss, reimbursement of future medical expenses, recovery for loss of earning capacity, pain and suffering, mental distress, loss of enjoyment of life, cost of drugs, aggravation of a pre-existing condition, and punitive damages.

In contractual actions the plaintiff may receive compensable damages under traditional theories of expectancy, restitution, or reliance. Further, some jurisdictions may equate contractual causes of action with malpractice torts, thereby making it possible that awards associated with traditional tort recoveries may result in contract actions. This would allow a plaintiff to recover damages that are commensurate with the ac-

72. See supra note 57 and accompanying text.
73. See supra notes 56 & 58 and accompanying text.
74. 2 D. LOUISELL & H. WILLIAMS, supra note 48, at § 18.01 (footnote omitted).
75. Id. See RESTATEMENT (SECOND), supra note 45, at §§ 901-910, 917, 924-926.
76. 2 D. LOUISELL & H. WILLIAMS, supra note 48, at § 18.24. For a detailed analysis of how courts may utilize contractual damage awards in medical cases, see Note, supra note 42, at 635-43.
77. In Washington v. Group Hospitalization, Inc., 585 F. Supp. 517 (D.D.C. 1984), the plaintiff brought suit against the defendant health benefit provider for breach of contract and bad faith refusal to pay insurance claims. Id. at 518. The plaintiff sought both compensatory and punitive damages for defendant's failure to investigate her claim and pay her hospital bills while she was covered by an active insurance policy. Id. In considering the appropriateness of punitive damages under plaintiff's contractual theory, the court stated that "[p]unitive damages are not recoverable in the District of Columbia in a breach of contract action even if the breach was willful, wanton, or malicious." Id. at 521 (citing Sere v. Group Hospitalization, Inc., 443 A.2d 33, 37 (D.C. 1982)). "However, if the
tual damages suffered, regardless of what the cause of action is labeled. If one of the purposes of the law is to protect and indemnify an aggrieved party, then such an approach is an equitable one.

In addition, since an HMO is an insurer, a plaintiff who recovers under a contractual action against an HMO may collect damages associated with a breach of an insurance contract. These include recovery of the benefits and services promised, and other injuries: "economic loss, financial damage, and mental distress represent a classification of injuries that should be compensated as damages that arise naturally from breach of the contract."87 The relative similarity of these damage awards across tort and contract causes indicates that a prospective plaintiff would not necessarily be disadvantaged by proceeding in contract.

IV. POSSIBLE CONTRACTUAL THEORIES OF RECOVERY

A. Warranty of a Particular Standard of Care

Contractual recovery in an HMO setting is implied by the fact that "a contractual duty is a prerequisite to a malpractice action in tort."79 Therefore, whether the action is brought in contract or in tort, the relationship between the parties has an element of contractual duty in its formation. Consequently, contractual actions are in fact possible against physicians for breach of an implied or express contract.80 HMOs are not only susceptible to such actions because they require express contracts between themselves and members, but also because of the nature and content of these contracts.

Although there is an express contract between the member patient and the HMO which may not contain specific assurances of high quality care, these terms may usually be implied. The HMO, after all, has agreed to meet the

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breach merges with and assumes the character of a willful tort, such damages may be awarded." Id. (citing Sere, 443 A.2d at 37).

One commentator interprets the case of Sullivan v. O'Connor, 363 Mass. 579, 296 N.E.2d 183 (1973), as an example that "tort remedies may be obtained as a consequence of a contract breach by the use of the reliance theory." Note, supra note 42, at 643. In Sullivan, after three unsuccessful operations on her nose, the plaintiff sued her plastic surgeon for breach of a promised result of enhancing her beauty. 363 Mass. at 580, 296 N.E.2d at 184. The court held that traditional contractual recovery would be inadequate, and allowed plaintiff damages for pain and suffering and for her awareness of her disfigurement. Id. at 588, 296 N.E.2d at 189. The commentator proposes that Sullivan suggests that "[o]nce a duty has been established and breached, courts ought to apply the most meaningful remedy, rather than force their analysis to fit the requirements of a tort or contract label." Note, supra note 42, at 643.

78. Ficarra, supra note 26, at 190.
79. Curran & Moseley, supra note 45, at 75.
80. Id.
The member's every health need up to well defined limitations and to furnish an acceptable physician for these purposes. And, whether that physician is considered an agent of the HMO or the HMO an agent of the physician, it would not be unreasonable for the member to infer a guarantee that high standards of quality will be met. 81

The considerations expressed in the quotation above suggest not only the appropriateness of contractual responsibilities, but also specific theories of contractual recovery. The quotation specifically suggests an express or implied guarantee of a standard of quality care. Although the considerations of express and implied warranty delimited in the Uniform Commercial Code in regard to the sale and exchange of goods are not directly relevant to the HMO contract, the concepts themselves may be applied analogously. This possibility was recognized by Gregory Binford 82 in suggesting various factors to be considered by Group HMOs 83 in constructing subscriber contracts.

One of these factors was the specificity of language needed to assure that the HMO is "not expressly contracting to guarantee or improve the subscriber's health." 84 Binford's concern is that "[r]eferences to quality of health care in the contract may convince judges, who ordinarily would not allow a contract action based on alleged malpractice, to allow a breach of contract claim . . . ." 85 Similar references to quality of services expressed in advertisements and promotional literature may also have evidentiary value regarding services and outcomes warranted. 86 For example, if an HMO member handbook contains a reference to a specific medical procedure, that procedure may be construed as part of the contracted-for services, even if the contract specifically excludes it. This derives from the general judicial practice of interpreting inclusive insurance contract clauses broadly, in favor of coverage, while exclusive clauses are interpreted narrowly. 87

These theoretical concerns were made practical in two California
cases that included causes of action centered around the services "warranted" by HMOs. In Depenbrok v. Kaiser Foundation Health Plan, Inc., a woman who became pregnant after she had undergone a tubal ligation sued for malpractice. She had undergone the operation on advice of two staff physicians of the Kaiser Foundation Health Plan who had assured her that a tubal ligation was "permanent and irreversible." She subsequently became pregnant, had a therapeutic abortion, and then a second tubal ligation. She sued the Health Plan and the physicians on "three theories: medical negligence; lack of informed consent; and breach of warranty." She won at trial, but was reversed at the appellate level, where the court held that the directions given by the trial court misstated the law concerning breach of warranty and were therefore prejudicially erroneous. However, the court did note that a doctor may be held liable on a warranty theory, "or to give the theory its more accurate name, breach of contract," where there is proof of an express contract to effectuate a specific result and the patient granted consent in reliance on that promise.

This in itself is not new law. However, Depenbrok suggests that a physician who works for, or with, an organization having an express written contract delimiting medical services may be susceptible to a finding for a plaintiff based on a theory of breach of warranty. Although not specifically addressing the express components of the written contract, Depenbrok is important since it did have an HMO defendant, the court did allow a breach of warranty theory to be heard against such defendant, and the plaintiff did in fact win at trial. Consequently, oral affirmations made contemporaneously with an existing written contract may give meaning to contractual terms and suggest contractual actions.

Depenbrok also had four judges dissenting who indicated that the doctor did in fact warrant an express outcome, and that the instructions to the jury were not erroneous. Their dissent is important for the

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stant issue because they note that any affirmation or promise of a specific result may be either oral or written; that no particular word or expression is necessary to create an express warranty; nor is it necessary that a defendant use the words "warrant" or "guarantee" or specifically intend to make a warranty.\textsuperscript{95} It would not appear unreasonable to suggest that a particular fact pattern in an HMO could be construed as creating a warranty, especially if the court considers a physician's conduct and speech in conjunction with (or in support of) the HMO subscriber contract.

In \textit{Pulvers v. Kaiser Foundation Health Plan},\textsuperscript{96} the plaintiff brought suit against Kaiser, its related agencies, and a physician for malpractice in the treatment of Bowen's disease. The plaintiff died during the pleading stage and his widow continued the suit with an amended complaint containing additional causes of action, including breach of warranty.\textsuperscript{97} The trial court awarded judgment on the pleadings for the defendants on the breach of warranty cause of action and the court of appeals affirmed. Relying in part on \textit{Depenbrok}, the plaintiffs argued that Kaiser had warranted a standard higher than non-negligence since their literature claimed they would provide "high standards" of medical care.\textsuperscript{98} The court said that plaintiffs' reliance on \textit{Depenbrok} was misplaced, since that case held only that a doctor may be held liable for a breach of contract when he violates a warranty of a specific result. Instead, the court said that the issue in \textit{Pulvers} was that the contractual language relied on by the plaintiff merely constituted "generalized puffing to the effect that the Foundation's doctors would exercise good judgment in their care."\textsuperscript{99} Although the result was not favorable for recovery on plaintiffs' contractual theory, \textit{Pulvers} is significant because it indicates that courts will in fact examine contractual terms to determine if they warrant a degree of care under which physicians and HMOs may be contractually liable in malpractice litigation.\textsuperscript{100}

Although actual litigation may be scarce on the issue of an express or implied standard of care for HMOs and their subscriber contracts, commentators have suggested that a separate standard of care should in

\textsuperscript{95} Id. at 174, 144 Cal. Rptr. at 728.
\textsuperscript{97} Id. at 563-64, 160 Cal. Rptr. at 393. In addition to the wife's suit, her two children, in a separate suit, sued for wrongful death and both actions were consolidated. \textit{Id.} at 564, 160 Cal. Rptr. at 393.
\textsuperscript{98} \textit{Id.}, 160 Cal. Rptr. at 393.
\textsuperscript{99} \textit{Id.} at 565, 160 Cal. Rptr. at 393.
\textsuperscript{100} \textit{Id.} at 567, 160 Cal. Rptr. at 395.
fact be created for HMOs.101 Such a standard would allow HMOs to achieve their societal goals in regard to health care delivery. Issues such as cost and conservativism in ordering diagnostic tests to avoid possible malpractice litigation would be eliminated, and a limitation on theories of litigation, whether in tort or contract, could be expressly defined.

B. Breach of Good Faith and Fair Dealing

A second possible contractual cause of action in HMO malpractice litigation is breach of the duty of good faith and fair dealing. Section 205 of the Restatement of Contracts (Second) provides that “[e]very contract imposes upon each party a duty of good faith and fair dealing in its performance and its enforcement.”102

In every contract there is implied by law a covenant of good faith and fair dealing, a covenant that neither party will do anything to injure the right of the other party to receive the benefits of the contract. To the extent that this covenant is breached, either party can maintain a breach of contract suit against the other, even though there has been no violation of the explicit terms of the contract.103

Bad faith breach of contract in medical litigation is not a novel suggestion, as it has been proposed in malpractice in general,104 and in HMO litigation specifically.105

Under such an approach, any conduct on the part of the HMO-provider that may be characterized as involving bad faith due to a violation of community standards of decency, fairness, or reasonableness,106 may be considered grounds for an action for bad faith breach of contract. For example, an HMO receiving favorable treatment from a local hospital may reward member obstetricians $100 for each baby delivered at that hospital instead of at others that the doctor may normally utilize. However, subscribers may have expressly enrolled in the HMO in order to obtain a specific obstetrician's service at a specific hospital. Consequently, upon contracting for such advertised physicians and sites, any

103. Stern, supra note 27, at 911-12 (footnote omitted). Stern has discussed the bad faith suit under "the tort of bad faith breach of contract." Id. at 911. Stern's analysis has centered on the presumption that such a cause of action is initially a contractual one, but may be sounded in tort to achieve advantages such as greater damages.
104. See Ficarra, supra note 26.
105. See Stern, supra note 27.
106. RESTATEMENT (SECOND), supra note 102, at § 205 comment a.
alteration of such promises may be interpreted as abhorrent to reasonableness, and, consequently, a breach of good faith, especially if the new hospital contains equipment and facilities substandard to the ones for which the subscriber believed she was contracting.

This general concern has been extensively addressed in delimiting bad faith claims in the HMO context.\(^\text{107}\) Whenever economic concerns are a consideration in altering, eliminating, or substituting contracted-for services, the good faith question will become an issue.\(^\text{108}\) The issue is magnified since the subscribers are not equal parties to any changes in personnel or services, meaning that the reasons for such changes may be purely logistical or financial, and therefore solely for the benefit of the HMO and not for the subscribers' health.\(^\text{109}\) Under these circumstances such plaintiff would be foolish not to allege bad faith breach of contract. The HMO contract provides for the delivery, as well as for the reimbursement of health care services, and whenever that delivery is thwarted by explicit policies and improper motives, the good faith covenant implied by law would seem to be violated.\(^\text{110}\)

In addition to the alterations in services consideration, other circumstances that may lead to bad faith breach of contract suits include: ambiguous terms and definitions,\(^\text{111}\) deceptive advertising,\(^\text{112}\) underutilization of services, coordination of benefits across HMOs or with independent physicians and insurers,\(^\text{113}\) and eligibility prerequisites and requirements. Further, HMOs may be subject to a number of bad faith suits due to their status as an insurer.\(^\text{114}\) Since the HMO is both an insurer and a provider, it is susceptible to the consequences of both roles.

C. *Adhesion Contracts*

A third contractual theory is recovery under an adhesion contract. Often the employee has the opportunity to subscribe to a health insurance plan through his or her employer at a significantly reduced cost. However, in order to enjoy the savings brought about by the employer's subsidy, an employee must subscribe to one of the health plans provided

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108. *Id.* at 920-22.
109. *Id.*
110. *Id.* at 921.
111. *Id.* at 922.
112. *Id.* at 925-26.
113. *Id.* at 924.
114. *Id.* at 913-19.
by the employer.\textsuperscript{115} When there is only one option, and that option is an HMO and its concomitant provider contract, the employee has no choice and no bargaining power. He must either accept the contract and its terms, continue to pay for his own plan, or forego coverage altogether. Similarly, even if there is more than one option, when the alternatives reflect standard insurance plans and alternate HMO structures, the HMO structure the employee selects may be the only one offered. For example, if an employee is knowledgeable about HMOs and prefers a staff HMO, but there is only one offered, it is an all or nothing choice. Likewise, if an employee specifically desires Doctor “H” or service “Y,” due to either preference or legitimate medical need, he must also accept all other contractual components attached to that selection.

Further, whichever plan an individual selects, he or she has no input in the contractual terms included in the plan. “[T]he consumer is in an unequal bargaining position, and is offered a standardized form, an agreement approaching a contract of adhesion . . . the enrollee has no choice of terms and no real negotiating power.”\textsuperscript{116} The employer is frequently in a similarly powerless situation to affect terms, and, like her employee, she is at a disadvantage in contracting with an HMO-provider for her employees.\textsuperscript{117}

The contract may also be considered one of adhesion due to its general nature, covering as wide a range of services and subscribers as possible. If an HMO has 100,000 subscribers, all of them receive the same basic contract regardless of their different medical needs. Although this appears to be a rational logistical practice by an HMO, it may mean that a particular problem of an individual could escape coverage.

Similarly, a subscriber to an HMO is usually limited to the services and professionals affiliated with the HMO. Consequently, unless the HMO allows its physicians to prescribe other services, suggest other physicians, or admit its subscribers to non-affiliated hospitals at the provider’s expense, the subscriber is limited to the HMO’s offerings. This

\textsuperscript{115} For example, active employees of the State of New York are allowed to participate in the New York State Health Insurance Program. The Program provides two options. The first, the Empire Plan, is a standard health insurance program and provides for hospital, major medical, surgical, and prescription drug coverage. The second provides for enrollment in an HMO. Employees who are interested in the HMO option are further instructed to contact their personnel office to determine if an HMO provides services in their area. \textit{STATE OF NEW YORK, HEALTH BENEFITS FOR NEW YORK STATE GOVERNMENT EMPLOYEES AND DEPENDENTS} 1-3 (undated) (provided by Personnel Department of the State University of New York at Buffalo, Jan. 15, 1988) (on file at the \textit{Buffalo Law Review}).

\textsuperscript{116} Stem, \textit{supra} note 27, at 915.

\textsuperscript{117} Binford, \textit{supra} note 82, at 341. \textit{See generally supra} notes 61-66 and accompanying text.
may present a problem if an HMO is "weak" in a particular area (e.g., if it has only one radiologist); if a subscriber cannot be reimbursed for continuing to consult her family physician; if a subscriber cannot establish a satisfactory physician-patient relationship with HMO physicians; or if a patient is generally dissatisfied with the HMO physicians or services. Fortunately for the subscriber, since the HMO writes the contract, in all of these prospectively adhesive contractual situations, any ambiguity would be interpreted against the HMO.\textsuperscript{118} In reviewing the adhesive nature of such contracts, it has been noted that courts often conclude that such instruments are to be interpreted with the meaning least favorable to the one who authorized the document.\textsuperscript{119}

In \textit{Madden v. Kaiser Foundation Hospitals},\textsuperscript{120} the Supreme Court of California rejected the plaintiff's contention that the Kaiser contract was one of adhesion.\textsuperscript{121} The State Employees Retirement System negotiated a medical contract with Kaiser for coverage of state employees. The plaintiff sued Kaiser in state court for malpractice. She argued that since she was unaware of the contract's arbitration clause it was an adhesion contract and she could not be bound by it. The court held that the agreement was not an adhesion contract since three factors common to adhesion contracts were absent. First, unlike adhesion contracts where the provision at issue favors the stronger party, here both parties benefitted equally. Second, unlike adhesion contracts where the stronger party writes the contract and the other party has no say, here the subscriber's employer negotiated for its employees with parity of power with Kaiser. Finally, the plaintiff here had the opportunity to choose other plans.\textsuperscript{122} \textit{Madden} is important in that it distinguished between situations where a provider contract is one of adhesion and where it is not. However, it is also limited in its application since it did not distinguish between gradations in the relationship of the subscriber to the party who negotiated the contract for the subscriber. For example, is the contract not one of adhesion if the employee's union negotiates instead of the employee's employer?

In \textit{McLaughlin v. Connecticut General Life Insurance Co.},\textsuperscript{123} dealing in part with the adhesion issue in an insurance contract, the \textit{Madden} principle was upheld as not overruling the California rule that "ambigu-

\textsuperscript{118} See supra note 87 and accompanying text.
\textsuperscript{119} Binford, \textit{supra} note 82, at 341.
\textsuperscript{120} 17 Cal. 3d 699, 552 P.2d 1178, 131 Cal. Rptr. 882 (1976).
\textsuperscript{121} \textit{Id.} at 711, 552 P.2d at 1185-86, 131 Cal. Rptr. at 889-90.
\textsuperscript{122} \textit{Id.} at 710-11, 552 P.2d at 1185-86, 131 Cal. Rptr. at 889-90.
\textsuperscript{123} 565 F. Supp. 434 (N.D. Cal. 1983).
ties in insurance contracts are construed against the insurer." In *McLaughlin* plaintiffs pursued two contractual claims against the defendant-insurer for denial of their claim for expenses incurred in obtaining experimental cancer therapy. *McLaughlin* significantly differs from *Madden* on two grounds regarding the adhesion issue. First, unlike *Madden*, *McLaughlin* involved an arbitration clause that was unfavorable to the plaintiff since it limited the liabilities of the defendant. Consequently, the clause was not beneficial to both parties, but only to the insurer. Second, in *McLaughlin* the plaintiff only had a choice between two plans. Consequently, the court distinguished this case from *Madden*. The plaintiff in *McLaughlin* was awarded a summary judgment for breach of contract and for breach of a covenant of good faith and fair dealing, due to the insurer's general failure to investigate the insured's claim.

D. Unconscionability

Another theory of contractual recovery for prospective HMO litigation concerns unconscionability. The law of contracts suggests that a contract or a specific term that the court deems unconscionable may be denied enforcement in whole or in that part deemed unconscionable. Under a theory of unconscionability, it is possible to examine the specific contractual clauses to determine their relevance to litigation arising from the provider-subscriber relationship. An examination of an actual HMO provider contract reveals the following clause:

No action at law or equity for breach of this Contract shall be brought hereafter against HCP unless commenced within twelve (12) months from the date of the alleged breach. No liability shall be imposed upon HCP other than for the services or other benefits specifically provided herein.

Although the relevant document is a contract, and is labeled on its cover and in the quoted section as a "Contract," this section provides for only a one year statute of limitations. Statutes of limitations in contrac-

124. *Id.* at 448.
125. *Id.*
126. *Id.*
127. *Id.*
128. *Id.* at 453.
129. *Id.* at 454.
130. *Restate ment (Second)*, supra note 102, at § 208.
131. Health Care Plan, Subscriber Contract for Comprehensive Health Service § 12.7 (Ref. #HCP-GA-01) (available from Health Care Plan, Inc., Buffalo, New York). Note the use of the words contract and breach. Note also the attempt to limit liability only to those services and benefits expressly contained in the contract. May this be interpreted as the HMO's recognition of contractual actions? Or as an attempt to limit malpractice litigation? Or both?
tual actions are usually longer than those for malpractice torts. Even a traditional tort action in negligence generally has a statute of limitations of at least two years. Further, the majority of state jurisdictions have created a separate statute of limitations for medical malpractice actions. In addition, some jurisdictions have mandated that a breach of adherence to standards of medical care must sound in malpractice (negligence) and not contract. However, if a cause of action specifically sounds in contract, such as for breach of a specifically warranted result, a contractual statute of limitations is available.

Therefore, for the clause in question, unless it exists in a jurisdiction that specifically precludes contractual actions for malpractice claims, or unless it exists where malpractice and contract statutes of limitations both are one year in duration, it may be arguably unconscionable. Further, since the clause also appears to be directed at all the provisions of the contract, it may be unconscionable in that it attempts to restrict the time limit on bringing legal actions which would ordinarily sound in contract. This would include issues such as conversion privileges, services at subscribers' homes, emergency services, fees for visits, number of visits allowable, and numerous other litigious issues that are provider related and contractual, but not issues of negligence. As such, these issues should be granted the full period provided for under the statute of limitations for contractual claims in the jurisdiction, and should not be unilaterally reduced by an HMO to any shorter period.

The scope of an action for unconscionability is similar to that of good faith and fair dealing. Both apply to a wide range of conduct and both are evaluated in view of the contractual "setting, purpose and effect."

To evaluate whether a contract or clause is unconscionable, the court may consider the comparative status of the parties, contractual capacity, public policy, and even fraud. Consequently, the HMO must be especially careful to draft a fair instrument that does not take excessive advantage of its superior contractual status. If it does, its draftsmanship

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132. See supra note 57; see also Ficarra, supra note 26, at 192.
135. Binford, supra note 82, at 340.
137. RESTATEMENT (SECOND), supra note 102, at § 208 comment a.
138. Id.
may be considered unconscionable for reasons similar to those discussed above in regard to the requirement of good faith and fair dealing, and contracts of adhesion.

V. PROSPECTIVE CONTRACTUAL LITIGATION

An HMO is an entity that is uniquely different from an individual physician, an insurer, and a hospital, while concurrently being very similar to each. Consequently, it has been postulated that the HMO is, and will continue to be, susceptible to a variety of litigation arising under numerous theories of recovery. In addition to the contractual considerations noted previously, these areas of liability have included hospital malpractice, insurer liability, corporate liability, fiduciary responsibility, and negligent selection and retention of personnel (peer review). Considered as a “matrix of liabilities,” these theories and their component parts provide further consideration that breaches of the provider-subscriber relationship can be pursued by theories other than traditional physician-patient negligence actions.

However, even in light of such theoretical considerations in combi-

139. Binford, supra note 82, at 346-49; Curran & Moseley, supra note 45, at 71-75. See generally Janulis & Hornstein, Damned If You Do, Damned If You Don't: Hospitals' Liability for Physicians' Malpractice, 64 Neb. L. Rev. 689 (1985) (exploring various liability problems facing hospitals). In general, although an HMO is not strictly synonymous with a hospital, it is sufficiently similar in function and services provided to suggest the analogy. For example, consider § 4405 of the New York State Public Health Law. Section 4405, in delineating the powers delegated to HMOs, provides that such powers shall include “the furnishing of comprehensive health care services on a prepaid basis through hospitals and other health care providers which are under contract with, otherwise associated with, or employed by the health maintenance organization.” N.Y. Pub. HEALTH LAW § 4405(2) (McKinney 1985). Consequently, even if an HMO does not provide actual hospital services under its own roof, it may contract for its subscribers’ use of actual hospital facilities as part of the HMO plan.

140. Binford, supra note 82, at 341; Kopit & Klothen, supra note 19, at 253-55; Stern, supra note 27, at 913-15.

141. The corporate liability of HMOs is likely to expand as they convert from nonprofit to profit entities. See Stern, supra note 12.

142. Bovbjerg, supra note 5, at 1395-96; Curran & Moseley, supra note 45, at 75-77; Stern, supra note 27, at 919.

143. Binford, supra note 82, at 345-46. In general, the issue of selection and retention of personnel centers around the concern of providing appropriate and quality care. For HMOs, this is accomplished in part by internal peer review to evaluate both physicians and services offered. In addition, HMOs receiving federal monies are subject to evaluation from Professional Standards Review Organizations (PSROs), created by Congress to “monitor the quantity and quality of health care services delivered through certain federally funded programs beginning in 1975.” Curran & Moseley, supra note 45, at 77. Cf. Havighurst & Bovbjerg, Professional Standards Review Organizations and Health Maintenance Organizations: Are They Compatible?, 1975 UTAH L. Rev. 381 (suggesting that PSROs impair HMOs' capacity to innovate and control costs).
nation with actual compatible factual patterns, such "alternate" litigation has, in reality, been relatively infrequent. Consequently, in an effort to illustrate the theoretical postulates discussed in this Comment, the following fictional appellate decision is provided. To the best of the Commentator's knowledge, this particular combination of facts, legal theories, and "judicial reasoning" has not actually occurred.

144. Binford, supra note 82, at 337; Curran & Moseley, supra note 45, at 70-80.
A man who impregnated his wife after having undergone a vasectomy brought a medical malpractice action against a health maintenance organization and the attending physician, on alternate theories of breach of warranty and breach of contract for failure to deliver services contracted for in the provider agreement. The Supreme Court, Erie County, James Tierney, J., entered judgment in favor of plaintiff Robert only, and defendants appealed. Plaintiffs cross-appealed contesting the denial of damages to Mrs. Smith. The Appellate Division, Thomas Knab, J., held that: (1) Plaintiffs' complaint adequately states a cause of action in contract and is therefore not barred by the malpractice statute of limitations; (2) Affirmations made by attending physician in conversation and consultation with plaintiffs constituted a promise for a specific result. Failure to deliver the promised result constitutes a breach of warranty; (3) Cause of action suggesting that contractual clauses in defendant AHM health-provider contract may be interpreted as promising performance of "reasonable and necessary" medical and surgical procedures and family planning services, and that such services were not performed as contracted was left undecided; and (4) Damages awarded should be amended to include Mrs. Smith's lost wages. Since all medical expenses arising from the pregnancy and the delivery were covered by the medical plan they were properly denied. Order should be affirmed in part regarding the judgment and damages for plaintiff Robert. Remand in part to the Supreme Court, County of Erie, for determination of the amount of damages to be awarded to plaintiff Elizabeth, and for consideration of the propriety of awarding further damages for mental distress to both plaintiffs.

Jarvis, J., filed a concurring opinion.
Werner, J., filed a dissenting opinion.

Before KNAB, J.P., JARVIS, WERNER, ABRAMS, and KENNEDY, J.J.
KNAB, Justice Presiding:
American Health Maintenance (AHM) is a non-profit Health Main-
AHM provides its members with a wide range of health services, including physician consultations, hospitalization, laboratory, x-ray, dental, emergency, pharmacy, and general preventive consultation services. As a Staff-HMO most of these services are provided on site by AHM employees. Plaintiffs, Robert and Elizabeth Smith, and their children, are eligible for AHM's services through Robert's employer, who contracted for AHM's health and insurance plan. Services are provided for subscribers in exchange for a prepaid annual fee, paid for in large part by Robert's employer.

The Smiths consulted their AHM family physician, Dr. Robert Burke, in December of 1990. Mrs. Smith had given birth to the couple's fourth child a month earlier, and the Smiths were concerned about their inability to support further growth in their family. However, their religious convictions dissuaded them from the use of contraceptives, and from any consideration of an abortion should Mrs. Smith become pregnant. Consequently, Dr. Burke suggested the Smiths consult with Dr. Alan Willing, an AHM surgeon and urologist, who performs vasectomies for AHM subscribers. Approximately two weeks later the Smiths consulted Dr. Willing, who suggested that Mr. Smith undergo a vasectomy as the cheapest, most painless, and most effective alternative, and also one in consonance with the Smiths' religious convictions.

In addition, in responding to the Smiths' questions and concerns regarding the effectiveness of the vasectomy, Dr. Willing informed them

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1. Dr. Willing also has hospital privileges at a local hospital where he sees patients. However, his primary employment and all of his salary is provided by AHM, where he also serves as an administrator. It is an industry practice for a Staff-HMO to roll-over any external income into an employee-physician's compensation schedule. No separate professional income is allowed an AHM physician.
that such a procedure was "routine, safe, and relatively painless," and "permanent." Doctor Willing did admit that he was aware that there were incidents of vasectomies failing, but that such occurrences were extremely rare and most probably a result of improper procedures. One month later, in January of 1991, Mr. Smith underwent a vasectomy, performed by Dr. Willing at the AHM where Dr. Willing maintains his office. Approximately eight weeks after the operation, a sperm count was performed on a specimen of Mr. Smith's semen, a standard procedure at AHM. The semen specimen was examined by an AHM staff pathologist in order to verify the success of the vasectomy, in conjunction with standard pathological and tissue studies. As required, Dr. Willing also examined the specimen himself, and determined the sample to be sufficiently non-motile to indicate that Mr. Smith was "safe." Dr. Willing then informed the Smiths the vasectomy was successful, and they could resume sexual intercourse. At trial, Mr. Smith testified that he and his wife resumed intercourse the day after they were informed of the vasectomy's success. Mr. Smith further testified that this was the first instance of intercourse since prior to the operation itself. Four months after the operation and two months after resuming intercourse, Mrs. Smith discovered she was pregnant. On December 21, 1991, she gave birth to the Smiths' fifth child.

On January 15, 1994, plaintiffs filed a medical malpractice action against AHM and Dr. Willing. Plaintiffs' complaint alleged a breach of warranty for the result allegedly promised by Dr. Willing, and for breach of contract for nonperformance of services contracted for. Plaintiffs' complaint did not pray for recompense of any personal injuries suffered. Nor did plaintiffs request payment for pain and suffering, or for punitive damages. However, plaintiffs requested compensatory damages for the cost of a second vasectomy that Robert underwent at his own expense from a private (non-AHM) physician. Additionally, they prayed for the subsequent costs related to the pregnancy and delivery of their fifth child, and for subsequent medical expenses for both the infant and the mother. They also requested recovery of lost wages for both Robert and Elizabeth.

Defendants moved for summary judgment on three grounds. First, they contended that the action should be dismissed because the plaintiffs' complaint in reality voiced a standard action in malpractice, and as such it should be dismissed as failing to meet the two years and six months statute of limitations for a malpractice action (CPLR 214-a). Defendants alleged that if any cause of action exists at all, that action should sound
in medical malpractice against the defendants for the misinterpretation of the sperm count by Dr. Willing. They argue, however, that such a claim would be time barred by CPLR 214-a, and consequently, that Mr. Smith's contract claim is merely an attempt to avoid the expired statute of limitations.

Second, defendants alleged that plaintiff Robert suffered no actual physical harm or injury, as evidenced by plaintiffs' allegations of fact in their complaint, and further by plaintiffs' failure to request damages for any pain and suffering. Therefore, defendants claim that plaintiffs' complaint fails to state a cause of action, since the element of plaintiff Robert suffering a compensable injury—necessary to establish grounds for recovery in negligent malpractice—is missing.

Third, defendants claimed that they provided the operation and subsequent services to Robert as contracted for in the provider contract. Beyond this performance, they contend that the contract does not warrant an absolute or higher degree of care or success than is warranted by any other medical provider. They claimed, therefore, that plaintiff Robert received the service that the contract called for, and that they non-negligently met their contractual duty regardless of the operation's outcome.

The Supreme Court, Erie County, denied defendants' motion for summary judgment, and held that plaintiffs' complaint did properly set forth a cause of action in contract, not barred by the statute of limitations. Further, the trial court found for the plaintiffs on both the breach of warranty and the breach of contract causes. The court interpreted Dr. Willing's representations to the Smiths as creating an express warranty of a promised result, and that as a result of these representations, the actual operation received was not the one expressly contracted for in the provider-agreement. The court awarded Robert $150 for the cost of a second vasectomy, and $3,000 for lost wages due to his recovery from the two vasectomies. However, the trial court denied all damages to plaintiff Elizabeth. The court reasoned that all medical expenses of the mother and the child were already covered and paid for by AHM. In addition, Mrs. Smith's request for lost wages arising from the unexpected pregnancy was denied, the court reasoning that Elizabeth was not a party to the operation itself, and therefore any damages she suffered did not directly flow from the defendants' actions.

Defendants bring this appeal arguing that their motion for summary judgment was erroneously dismissed concerning all three allegations expressed in that motion. Plaintiffs cross-appeal, arguing that plaintiff Eliz-
abeth should be allowed compensatory damages since she was a party to the contract. For reasons discussed below, we affirm in part and reverse in part.

I. CAUSE OF ACTION IN CONTRACT

The question presented is whether plaintiffs' complaint adequately states a cause of action in contract. Defendants claim that it does not, since the gravamen of the cause of action is the tort of medical malpractice. Therefore, the nature of the action should be determinative of the appropriate statute of limitations to be applied. If, in fact, the action were to sound in tort, it would be barred by the two years and six months statute of limitations allowed for malpractice actions (CPLR 214-a). Defendants further argue that an appeal to a contractual cause of action amounts to an attempt to skirt the appropriate cause of action and its statute of limitations, indicating blatant theory shopping by plaintiffs. Defendants' contentions would be true (1) if plaintiffs' actions were confined only to tort, or (2) if plaintiffs' complaint did not adequately state a contractual claim. We find neither of these qualifications to exist here.

First, the practice of seeking a contractual recovery in a medical malpractice issue is neither novel nor inappropriate. It is well settled that where a patient-plaintiff successfully demonstrates that a physician-defendant affirmatively promised to achieve a particular result, and that result is not achieved, plaintiff may recover damages on a contractual theory. (Hawkins v. McGee, 84 NH 114.) "[A] doctor and his patient are at liberty to contract for a particular result and, if that result be not attained, a cause of action for breach of contract results which is entirely separate from one for malpractice although both may arise from the same transaction." (Robins v. Finestone, 308 NY 543, 546; see also, Colvin v. Smith, 276 AD 9.) Here, the representations made to the Smiths regarding the probability of the vasectomy's success may have been interpreted by the Smiths as a promise for that result. Consequently, a contractual cause of action is appropriate to determine if such promises constitute a contract, and whether that contract was breached.

In addition, the particular relationship between the Smiths and AHM and Dr. Willing arose out of a written contractual agreement to provide medical and surgical services. HMOs structurally similar to AHM have been sued for medical malpractice under various contractual

2. Under CPLR 213, plaintiff would be allowed six years to commence an action upon a contractual obligation or liability. The two years and six months limitation of a malpractice action would have expired prior to the commencement of the present action on January 15, 1994.

However, in contravention of these considerations, defendants rely on Sala v. Tomlinson (73 AD2d 724). There the court held that the dismissal of a cause of action alleging an agreement to sterilize the plaintiff was properly dismissed as an attempt to "plead as a contract action one which is essentially a malpractice action." (Sala, supra at 725.) In Sala the female plaintiff pleaded eleven causes of action against defendant physicians for an unsuccessful tubal ligation operation, following which she gave birth to a child. Among other claims, plaintiff alleged several malpractice counts, lack of informed consent, breach of an alleged agreement to successfully sterilize her, and breach of warranty of the complete effectiveness of the procedure. The court disallowed all of the contractual causes of action, but plaintiff recovered medical expenses and pain and suffering resulting from the operation, as proper damages from the malpractice claims. (Sala, supra at 725.)

I believe defendants' reliance on Sala is misplaced, since it suggests too narrow an interpretation. The Sala court did deny plaintiff's contractual causes of action. However, in so doing it did not suggest that medical malpractice in general, or unsuccessful sterilization in particular, can never be pursued in contractual actions. To the contrary, the Sala court noted that "[a] cause of action based upon a breach of a particular or special agreement is distinguishable from one in malpractice." (Sala, supra at 725.) The court then noted that it is when damages for personal injury are sought that the action is essentially one of malpractice. Consequently, any allegation of failure to provide adequate medical care in that context is a mere attempt to substitute a contract action for one that is essentially malpractice. (Sala, supra at 725.) Therefore, Sala did not exclude the gravamen of sterilization from contractual causes of action. It merely suggested that the pursuit of personal injury damages arising from inadequate medical care is properly sought in traditional malpractice actions.

This indicates that Sala is not on point in the case at bar, since Mr. Smith did not seek damages for personal injury, pain and suffering, or for punitive damages, as alleged by defendants in their second ground for summary judgment. There they alleged that plaintiff Robert Smith did not claim to suffer a compensable injury, as required for recovery in negligent malpractice. The fact that Mr. Smith did not seek personal injury damages is consonant with a contractual action. Plaintiffs pursued only a
contractual claim, and sought only damages that were compensatory in nature. To suggest that plaintiffs must argue in tort based on *Sala*, and to then highlight the inadequacy of their argument due to its reliance on contractual damages doctrine would be to allow defendants to argue on both sides of the bar. Such a result is inherently distasteful, in that it is reflective of a misinterpretation of *Sala*, and amounts to an attempt to punish plaintiffs for consistency in their pleadings and arguments.

*Sala* is also distinguishable from the case at bar since there was no written contract in *Sala*, the defendants there were individual physicians, not an HMO, and the case also included a cause of action for “wrongful life,” which is not at issue here.

A case with a very similar fact pattern to *Sala* is *Depenbrok*, which also included an unsuccessful tubal ligation. In *Depenbrok*, the operation was performed by HMO physicians who were alleged to have verbally warranted the operation’s success to the plaintiff. Although the plaintiff lost on appeal due to prejudicial directions to the jury (*Depenbrok*, supra at 171), at trial she was allowed to plead her case as one of breach of contract of an express warranty. (*Depenbrok*, supra at 170.) Consequently, to accept defendants’ reading of *Sala* for the instant case would be contrary to what the closer factual pattern of *Depenbrok* (HMO defendant, written contract, verbal assurances) suggests. Namely, that a physician and patient may contract for a specific result, and when that result is not achieved a cause of action in contract exists that may be pursued when properly pleaded. (See *Hawkins v. McGee*, supra.)

Second, interpreted in its entirety, plaintiffs’ complaint does set forth a cause of action in contract. The complaint specifically alleges the defendants’ representations; the specific contractual clauses in issue are the center of the second cause of action; plaintiff alleges no physical injury; and the damages requested are contractual in nature and consonant with the specific claims. Defendants’ reliance on *Liebler v. Our Lady of Victory Hospital* (43 AD2d 898), is misplaced. In that decision, this court dismissed causes of action in contract since there was no allegation that the defendants undertook a special contractual obligation other than to provide adequate medical services. Further, there was no written agreement in *Liebler*, and the action was determined to be one in tort. Conversely, in the case at bar, the representations and the written document make a contractual approach plausible. Therefore, we affirm the court below that the plaintiffs’ complaint appropriately and adequately states a cause of action in contract, and is therefore not barred by the two years
and six months statute of limitations for tortious medical malpractice actions.

II. BREACH OF WARRANTY FOR SPECIFIC RESULT

Although the uncertainty inherent in the science of medicine argues against it, it is possible for a physician and patient to contract for a specific result in medical and surgical services. (See Hawkins v. McGee, supra.) Where it can be shown that a physician warranted a specific result, a contract exists and the physician can be held liable for breach of that contract if the specific result does not occur. In Custodio v. Bauer (251 Cal App 2d 303), the court, in discussing a theory of breach of an express contract that a proposed surgery would result in sterilization of the plaintiff, stated: "[i]t is generally recognized that, where there is proof of an express contract the physician can be held liable for a promise to effect a cure or a certain result." (Custodio, supra at 315.) In Robins, the New York Court of Appeals similarly held that a malpractice action "in contract is based upon a failure to perform a special agreement." (Robins, supra at 546.) In sum, then, if a plaintiff can prove that a physician or a surgeon has "clearly promised a particular result (as distinguished from a mere generalized statement that the result will be good), and that the patient consented to an operation or other procedure in reliance on that promise, there can be recovery on the theory of warranty (or, to give the theory its more accurate name, breach of contract)." (Depenbrok, supra at 170.)

In the instant case the statements made by Dr. Willing prior to the operation are uncontroverted. Dr. Willing contends, however, that such statements were only made to reflect the probabilities of success associated with vasectomies, not to guarantee the success of Mr. Smith's specific vasectomy. However, it is the rule that a defendant need not use specific words or phrases to create an express warranty, nor is it necessary that the defendant possess a specific intent to make a warranty. Instead, it is only necessary that an affirmation of the fact or promise that such operation possess a specific result is made. Such an affirmation creates an express warranty, and if the promise is breached, causing plaintiff injury or damage in relying on that affirmation, plaintiff is entitled to recover from defendant. (Depenbrok, dissenting opinion, supra at 174.)

Therefore, since in seeking defendant's advice in preventing future pregnancies, plaintiff Robert underwent the vasectomy relying on Dr. Willing's assertions regarding the probability of the operation's success, we hold that an express contract was created between Dr. Willing and
Mr. Smith. Further, we hold that Dr. Willing's words could reasonably be interpreted as an express warranty of the vasectomy's success. Since that success was not achieved, Dr. Willing breached his promise to Mr. Smith.

In addition, after examining the semen sample eight weeks after the operation, Dr. Willing proclaimed the operation's success to the Smiths. This proclamation can also be interpreted as an express warranty of success. In fact, it strengthens the argument of express warranty, since Dr. Willing provided such assurances both before and after the actual operation. The latter affirmation can be interpreted as a reinforcement for Mr. Smith of Dr. Willing's earlier contentions as to the effectiveness of a vasectomy. Mr. Smith relied on both affirmations, abstaining from intercourse for eight weeks after the operation, and then resuming intercourse after Dr. Willing confirmed the operation's success. This series of events amounts to a contract (or contracts) with an express warranty (or warranties) of a specific result.

Dr. Willing contends, however, that his postoperative interpretation of the semen specimen was not intended to be understood as a guarantee against any future pregnancy. Instead, he argues that Mr. Smith's sperm count was merely consonant with other postoperative semen results. However, we again hold that Dr. Willing's postoperative words could reasonably be interpreted as an express warranty of the vasectomy's success, and an assurance that future sexual intercourse would not result in an unexpected pregnancy. Therefore, we hold that Dr. Willing breached his promise to Mr. Smith.

Since Mr. Smith suffered no injury and requested no damages for pain and suffering, defendants' contention that the duty owed to Mr. Smith was not breached is also misplaced. The duty owed Mr. Smith was not to not cause pain and suffering, but to achieve the warranted success of the operation. Consequently, failure to breach a duty not in question is no defense to breach of the duty actually owed. Therefore, we affirm the trial court's judgment for Mr. Smith on a theory of breach of warranty.

III. BREACH OF CONTRACT

In the alternative, plaintiffs stated a second contractual cause of action for breach of contract, alleging failure to deliver services contracted for in the HMO provider-agreement. The clauses in question are contained in Article II of the “Enrollee Contract for Comprehensive Health and Emergency Services.” Article II is entitled “Medical, Surgical, and Other Health Services” and provides that “an Enrollee is entitled to re-
Section 2.1(a) of Article II lists Preventive Health Services, including, inter alia, "(6) genetic counseling, family planning services, and services for infertility." Section 2.1(b) of Article II provides for Diagnosis and Treatment and includes: "All services of AHM physicians, AHM referral physicians, AHM referrals to other health professionals, and all other AHM staff when reasonable and necessary for the diagnosis and treatment of disease, injury or other conditions, including surgical procedures, prenatal and postnatal care, and eye, hearing, and dental examinations."

Plaintiffs' somewhat novel argument is that the family planning services of Article II § 2.1(a)(6), and the diagnosis and treatment of other conditions, including surgical procedures, of Article II § 2.1(b), may be read together to include a vasectomy. Defendants do not argue with this contention, and agree that vasectomies are commonly performed at the AHM as part of the covered services.

However, plaintiffs further argue that since a vasectomy entails the excision of a segment of the vas deferens (excretory duct of the testis through which sperm passes), one is not vasectomized unless the excision is "complete." Consequently, since Mr. Smith's operation did not entail a sufficient excision of the vas deferens, plaintiffs argue that Mr. Smith did not become vasectomized and therefore did not receive a vasectomy as provided in the contract. Plaintiffs further argue that the breach of duty resulting in a compensable injury, sounding in tort, proximately caused by Dr. Willing's substandard care, is no different than AHM and Dr. Willing's breach of contract in deviating from the contractually promised vasectomy. Plaintiffs contend that the vasectomy was contracted for in the provider agreement and in the consultations with Dr. Willing. Therefore, they claim that seeking redress under a contractual theory for the same "injury" is merely one possible theory available for recovery. They argue that a vasectomy is particularly conducive to contractual promise, since its success or failure can be subsequently confirmed prior to resumption of intercourse.

Defendants reply that the contract itself promises no specific result, no promise of success, and no higher standard of care (Pulvers, supra at 564). Specifically, defendants contend that the provider contract can only be read as promising quality care from qualified professionals; at most, only an interpretative reading that a generalized promise of good results is appropriate. (Pulvers, supra.) Defendants claim that the surgical procedure Robert "received" was a vasectomy as provided by contractual cov-
verage, and that they performed this procedure professionally as promised, without a contractual promise of outcome. They argue that the operation itself, the pathological and tissue tests, and the semen tests are never conclusive.

The issue, then, is whether the provider contract can be read to indicate “a vasectomy with resultant male sterility,” or should it be read to merely indicate “a vasectomy with attempted excision of the vas deferens.” Or, stated as plaintiffs suggest, does a vasectomy, by its very name, connote successful excision of the vas deferens, so that by including it on a list of services to be provided, it will not be considered provided unless sterility results? If plaintiffs’ argument is accepted, the pregnancy of Mrs. Smith would be proof that Mr. Smith did not receive a vasectomy as contracted for. The court below did not consider this issue, since it interpreted Dr. Willing’s comments as giving specific meaning to the contractual clauses, thereby defining the breach of contract. We disagree with the trial court’s analysis on this issue since the two causes of action were posed as different questions that should be considered separately. However, it is not necessary for us to consider the issue further, as we have affirmed the plaintiffs’ first cause of action. Therefore, we will not issue a holding on the second cause of action. Consequently, we leave the definitional issue of vasectomy to the medical profession, and its contractual interpretation to another day and perhaps another court.

However, the second cause of action does raise legal concerns that warrant discussion. The entire gravamen of this cause of action concerns the precise definition of the contractual term “vasectomy.” If a vasectomy does in fact equate with sterility, and if a vasectomy is valid consideration in a contract, the consideration fails unless sterility is achieved. This would allow the provider contract to be read as promising a vasectomy with guaranteed sterility. However, it is more than likely true that since a vasectomy is a medical procedure, it does not denote or connote sterility in every instance. Medicine is too imprecise to warrant expected results in every medical or surgical procedure. Further, it would be contrary to public policy to suggest that a written provider contract warrants success in all the services it contains. If this were the case, HMOs would be sued for every result not meeting the subscriber’s expectations but listed as a provider service in the contract.

Nonetheless, the lessons for HMOs and all similar providers are clear. The HMO environment transforms the informal physician-patient meeting into a formal one, replete with a written contract providing terms, conditions, and services. Consequently, not only must HMO phy-
Physicians be careful not to promise specific results in their verbal affirmations to patients, but HMO contractors must draft instruments for subscribers that employ medical language denoting commonly agreed upon interpretations wherever possible, and that limit speculative interpretations wherever such agreement is not possible. In addition, HMOs must be aware that even in the face of careful drafting, either specificity or generality in contractual terms dealing with medical services may give rise to unintended interpretations that may suggest contractual liability. This is especially true if a word or procedure, such as vasectomy, does, by itself, suggest a specific outcome. Or further, as the trial court concluded in its analysis, if the language or the behavior of the HMO, its physicians, or other employees, reinforces a specific contractual interpretation, a duty to provide a specific outcome may be created even if a contractual term only presents a general connotation in the written instrument. For example, if in fact plaintiffs' two causes of action here were combined into one, suggesting that defendants imputed meaning to the written contract, plaintiffs would have recovered as the trial court suggested.

Since we have earlier indicated that contractual theories are alternatively available in traditional malpractice situations, it is no stretch of the imagination to suggest that they are appropriately available in contractual malpractice situations. Furthermore, using the instant case as an example, if plaintiffs could successfully prove (perhaps through an expert medical witness) that a vasectomy was "synonomous" with sterility, an intriguing precedent may have been set today. Namely, that the mere inclusion of a medical or surgical service in a provider contract may, without any imputed meaning or behavior, be interpreted as promising a guaranteed outcome.

IV. Damages

The trial court awarded Robert Smith $150 for the cost of a second vasectomy (obtained at his own expense from a private physician) and $3,000 for lost wages. The court denied any damages to Elizabeth Smith, contending that since she was not a party to the vasectomy, she was not a proper plaintiff and therefore not entitled to any damages. The plaintiffs appealed, claiming that Mrs. Smith was in fact a party to the vasectomy, and therefore entitled to damages. We affirm the damage award for Mr. Smith and reverse the decision regarding Mrs. Smith's damage award.

The court below failed to recall that the plaintiffs brought this action in contract, not in tort. Therefore, the Smiths were not suing for any
injury Mr. Smith may have suffered as a result of defendants' tortious conduct, but for financial damages they both suffered as a result of the breach of contract. Both plaintiffs relied on the prediction of the operation's success as a precondition to resume sexual intercourse. In essence, that reliance was to their "detriment" in that an unwanted pregnancy occurred, resulting in financial loss to both plaintiffs.

In addition, the trial court's reasoning that Mrs. Smith was not a proper plaintiff is similarly misplaced. Mrs. Smith is an AHM "subscriber" or "enrollee" to the same, full, extent as is Mr. Smith. Section 1.1 of Article I of the Enrollee Contract defines "Member" as "any Subscriber or any Member of the Family Unit." Section 1.2 of Article I defines "Family Unit" as the Subscriber's spouse, and the Subscriber's unmarried children under eighteen years of age. Consequently, Mrs. Smith is a "Member" entitled to the same contractual services as her husband or any other member. The Smiths brought this action as parties to the contract, not as one person suffering tortious injury. Further, the initial family planning visitation to Dr. Willing was as husband and wife, and Dr. Willing suggested the vasectomy while considering all options for both spouses. Although the actual operation may be interpreted as a contract between Mr. Smith and AHM, Mrs. Smith may be said to have been in privity with her husband, since she was a party in the consultations and relied on Dr. Willing's affirmations. Therefore, the damages suffered as a result of the contractual breach were suffered by Mrs. Smith as well, since she relied on the vasectomy's result as much, if not more, than did her husband.

Mrs. Smith's eligibility for damages may also be demonstrated by analogy. In Weinstein v. Brown (98 AD2d 339), the court held that the wife of a man who underwent an unsuccessful vasectomy had a legally sufficient complaint to plead a cause of action on her own behalf for physical injury and pain and suffering resulting from the unanticipated pregnancy and delivery; emotional suffering; medical expenses; and her husband's loss of consortium. In Weinstein the damages sought logically flowed from the negligent malpractice theory that the plaintiff pursued. In the case at bar, the damages of medical expenses and lost wages logically flow from the contract theory. In both cases, the wife was similarly situated in her relationship with her husband and her reliance on the physician's workmanship. Here, Mrs. Smith's damages are not unreasonable, speculative, or in any way related to the wrongful birth damages that were denied in Weinstein. Therefore, we hold that Mrs. Smith is entitled to recover damages.
The issue of appropriate damages to be awarded to Mrs. Smith is remanded to the trial court for further consideration. Such consideration should include Mrs. Smith’s lost wages during the pregnancy. To the extent that maternity and delivery costs were covered by AHM, these damages were properly denied. The court also orders that the court below consider the propriety of awarding damages for mental distress arising from the unexpected birth to both plaintiffs. Plaintiffs’ original complaint was amended to exclude such damages in order to comply with their contractual claim. However, we suggest that the trial court consider such damages as a matter of equity.

In summary, we affirm the damage award for Mr. Smith and reverse the denial of damages to Mrs. Smith. We remand for proper consideration of the extent of damages to Mrs. Smith in a manner not inconsistent with this opinion, but conclude that any medical expenses incurred by the Smiths and covered by AHM were properly excluded. We order that the court below consider the equity of awarding damages for mental distress to both plaintiffs.

It is so ordered.

JARVIS, Justice, concurring:

I concur in the opinion of the majority that the affirmations of Dr. Willing can be reasonably interpreted as promising the vasectomy’s success. This is especially true since Dr. Willing made two sets of affirmations, one preoperative and the other postoperative. Dr. Willing’s affirmations can also be interpreted as providing meaning to the written provider contract. It is reasonable that the Smiths relied on Dr. Willing’s assurances, and interpreted them as indicating that the operation was routinely successful, and especially so in Mr. Smith’s case. Mr. Smith complied with Dr. Willing’s directive of sexual abstinence until the doctor could confirm the operation’s success. This subsequent affirmation and the failure to achieve the “verified” result constitute a breach of express warranty.

I would also suggest the interpretation that the two sets of affirmations can be perceived as two separate contracts. The first can be construed as completed with the exchange of the operation for the sexual abstinence. The second is created with the postoperative affirmations of success. Together, the two assurances give Mr. Smith more reason to rely on Dr. Willing’s expertise, since the doctor correctly predicted postoperative discomfort. Under this approach, the second contract is the visibly express warranty and the one that was breached. The lesson for physi-
cians and HMOs is that the physician-patient relationship is a fluid one, which may be given contractual meaning as consultations accrue.

Finally, I would go further than the majority and conclude that the particular setting of an HMO contracting to provide services, the presence of a written contract delimiting those services, and the particular two-step procedural nature of a vasectomy, all combine to indicate a contract in which a "vasectomy," by its very name, indicates sterilization. Although I would not go further and allow this interpretation to apply to any other listed service, I believe AHM's policy on vasectomies permits this interpretation. That policy is that the operating surgeon or urologist is responsible himself or herself to verify the vasectomy by analyzing the semen specimen. The operation cannot be proclaimed effective until both the pathologist and the surgeon examine the semen. After such an examination, an affirmation is made to the patient. Since such an affirmation is a component of an AHM vasectomy, a vasectomy by its contractual connotation warrants sterility.

I also agree with the majority that Mrs. Smith was a "Member" and "Subscriber" to the AHM contract, and is therefore entitled to damages arising from a breach of that contract.

WERNER, Justice, dissenting:

I must dissent. Although I will agree with the majority that the plaintiffs' pleadings, arguments, and requested damages are consistently contractual in nature, I nevertheless believe that mere consistency does not transform the real cause of action from one of negligence into one of contract. To this end, I believe that the actual "harm suffered" did not flow from a breach of contract by AHM, but instead may be traced to the negligent performance of the operation, and the negligent interpretation of the semen specimen by Dr. Willing and the staff pathologist. Consequently, the issue should not be whether any promises were made or whether any clauses were breached, but instead whether Dr. Willing's "affirmations" were anything more than mere probabilities of success and whether his performance of the surgical and pathological services was in fact negligent.

Second, I do not believe that the existence of a written provider contract and the setting of an HMO are sufficient to suggest a contractual recovery. The basic physician-patient relationship and the subsequent duties and expectations are not expanded by a written agreement and a corporate entity. The provider contract cannot be interpreted as guaranteeing the success, or patient satisfaction, of every service that is offered. To suggest the opposite would open courtroom doors to every HMO sub-
scriber who perceives a medical-contractual breach, while denying the same access to patients not covered by an HMO plan. The suggestions of my brother Jarvis in his concurring opinion that each such visit to an HMO can be construed as a separate contract carries this misguided reasoning to its illogical denouement. The HMO was formulated to make medical services more readily available to the medically underserved. It was not intended to educate them in theories of legal recovery, nor to suggest that they measure their health in terms of receipt of sufficient contractual consideration.

Assuming, then, that a contractual action is improper, the questions then become what is the actual tort suffered and what are the damages? It is true that Mr. Smith endured the pain and discomfort of a second vasectomy. It is also true that Mrs. Smith endured the unpleasantries of pregnancy and delivery. However, all of the resultant medical expenses were recompensable under their AHM contract. Plaintiffs did not claim damages for pain and suffering, so the question may be asked what damage did they actually suffer? One logical response to this question is that they suffered only the discomfort and expense associated with the birth of a normal, healthy child. As such their suit may be interpreted as an action for wrongful birth, or, more properly, wrongful conception. This state's highest court has held "as a matter of public policy, that the birth of a healthy child does not constitute a cognizable legal harm for which an action in tort will lie." (O'Toole v. Greenberg, 64 NY2d 427, 432.) It is true that such wrongful conception cases have allowed damages for the medical expenses incurred in the pregnancy and delivery. (Sala, supra at 724; Weintraub, supra at 339; Sorkin v. Lee, 78 AD2d 180.) But it is also true that damages for future medical, support, education, and rearing expenses have been uniformly rejected as a matter of public policy. (Sala, supra at 724; Weintraub, supra at 339; Sorkin, supra at 300.) Therefore, since in the case at bar all medical expenses for the pregnancy and birth were covered by AHM, to award any other damages to plaintiffs could be construed as contrary to precedent, and a revocation of the strong public policy against denying a cognizable legal harm and awarding damages for the "wrongful" birth of a normal, healthy child. The taint of any such award in the instant case is so repugnant to this policy, that I would deny all damages to plaintiffs. Further, since a contractual avenue to such an award could be construed as an end run around the wrongful life ban in tort malpractice, I would be adamant in such a denial.

Therefore, on the basis of the above considerations, I would deny
plaintiffs' contractual claims on the grounds that they fail to state a claim and are contrary to public policy.

VI. CONCLUSION

HMOs appear to be the medical wave of the present and of the future. Because they are providers of a total health and medical service, they will encounter their share of medical malpractice litigation. In addition, since they are similar to an insurer, a hospital, and a corporate employer, their vulnerability to litigation may be even broader than that of individual physicians. This litigation may arise through a number of theories, one of them contractual, due in large part to an HMO's status as a contract-provider of medical services. It is possible that such litigation is, in fact, more appropriately sounded in contract than it is in the more traditional tort cause of action.

Not all medical litigation involves issues of major malpractice. Therefore, it may be more appropriate to sound such litigation in contract, or some alternate theory. This is especially true where the issue is minor, or where a prospective plaintiff has no voice or remedy other than litigation. Perhaps this may even result in more appropriate remedies, less malpractice litigation, and the development of separate standards of care and corresponding remedies in HMO litigation.

The fictional appellate decision provided in this Comment is merely suggested as one possible scenario of a contractual malpractice action. The contractual terms were adapted from the present author's actual HMO-subscriber contract. The fictional case is not intended to be reflective or suggestive of any particular HMO, or HMOs in general, and the reader should not make any inferences of that nature. The case is not provided to encourage frivolous or excessive litigation, and is obviously not the final word, since New York's highest court has yet to speak.

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