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PHYSICIAN IMMUNITY UNDER THE
MASSACHUSETTS TORT CLAIMS ACT:
A TEST WITHOUT DIRECTION

TERRI SKLADANY*

INTRODUCTION

The Massachusetts Tort Claims Act (MTCA) provides immunity to physicians working as “public employees” by transferring liability for their negligent or wrongful acts to the employer.¹ Many physicians work exclusively as either “public employees” or private practitioners and, therefore, clearly are included within or excluded from the MTCA grant of personal immunity. Some physicians, however, fall within a “gray area,” exhibiting characteristics of both public and private practitioner. In Kelley v. Rossi² and Smith v. Steinberg,³ the

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² 395 Mass. 659, 481 N.E.2d 1340 (1985). In Kelley, the parents of a deceased boy brought a negligence action against Dr. Rossi and Boston City Hospital after the physician failed to diagnose the boy's fatal condition. At the time of the alleged malpractice, Dr. Rossi was participating in Boston University School of Medicine's residency program. The program included a rotating work schedule whereby the residents would serve in a number of area hospitals according to a schedule that Boston City Hospital established. On the night of the alleged malpractice, Dr. Rossi was working at Kennedy Memorial Hospital (a private institution). Id. at 660, 481 N.E.2d at 1341. Doctor Rossi claimed immunity under the MTCA. The Supreme Judicial Court of Massachusetts reversed a superior court order granting summary judgment in favor of the physician, stating that there was a question of material fact as to whether the physician was a “public employee” at the time of the alleged negligence. Thus, there was a question as to the applicability of the MTCA. Id. at 665, 481 N.E.2d at 1344. See infra text and notes beginning at note 30 for an extended discussion of Kelley.

³ 395 Mass. 666, 481 N.E.2d 1344 (1985). In this case, Dr. Steinberg was an associate professor of orthopedic surgery and a member of a group practice plan that is available to instructors at the University of Massachusetts Medical School. Physicians who work in the group practice plan are paid by the plan for their services, but set their own hours and choose their own patients. At the time of the alleged malpractice, Dr. Steinberg was working for the group practice plan. Id. at 667, 669, 481 N.E.2d at 1345-47. The supreme
Supreme Judicial Court of Massachusetts defined the scope of the MTCA with respect to these physicians by applying a common law direction and control test to distinguish between "public employee" physicians and private practitioners, and, thus, to determine the availability of personal immunity for the physicians.

This article provides an overview of the law regarding government liability in Massachusetts prior to 1978, and discusses the shortcomings of that system of rules which prompted the enactment of the MTCA. The analysis then focuses on the current process for determining the applicability of MTCA immunity to "gray area" physicians; specifically, an analysis of the direction and control test's efficacy in determining physician liability. The article critically examines the supreme judicial court's current interpretation of the MTCA and suggests that the policies that were to be promoted by the Act are not well-served with respect to personal immunity for "gray area" physicians.

An alternative to the direction and control test, based on the concerns and policies that underlie the MTCA, would be to deny personal immunity to all physicians who do not work exclusively for a governmental entity. This article supports such an alternative scheme and offers methods for its implementation.

I. IMMUNITY UNDER THE MASSACHUSETTS TORT CLAIMS ACT

The Massachusetts Tort Claims Act immunizes "public employees" from personal liability for injuries that they cause while working within the scope of government employment. In turn, the government employer assumes liability for judgments on claims asserted against its employees up to a maximum recovery of $100,000.00 per plaintiff. This remedy against the government is exclusive. Consequent upon affirmed an order denying Dr. Steinberg's motion for summary judgment because there was a question of material fact as to whether the physician was a "public employee" and, therefore, whether the physician was within the protection of the MTCA.


5. MASS. GEN. L. ch. 258, § 2 (1986). In Irwin v. Town of Ware, 392 Mass. 745, 467 N.E.2d at 1306. In Irwin, one plaintiff asserted two claims against the municipality for her own personal injuries and for loss of consortium caused by the death of her husband. However, the supreme judicial court adopted a rule whereby each plaintiff can recover a maximum of $100,000.00, regardless of how many claims that plaintiff asserts. Id. at 766-73, 467 N.E.2d at 1306-11.

6. MASS. GEN. L. ch. 258, § 2 (1986) ("The remedies provided by this chapter shall..."
subsequently, a plaintiff who has a claim against a "public employee" physician cannot obtain a judgment against the negligent physician, but may sue the "public employer" and recover a maximum judgment of $100,000.00.

The threshold inquiry in the physician malpractice litigation process, then, is to establish whether at the time of the alleged malpractice, the physician was a "public employee." This often is a difficult question because the legislature did not define the term "public employee" clearly in the statute. "Public employees" are defined as "elected or appointed, officers or employees of any public employer, whether serving full or part-time, temporary or permanent, compensated or uncompensated, and officers or soldiers of the military forces of the commonwealth." 7 Although this provision sets forth some qualifications for status as a "public employee," these qualifications are so broad that almost any person who performs services that are in some way connected to the commonwealth could be considered a "public employee."

The definition's ambiguity is compounded by the inclusion of the term "public employer." Although the term "public employer" is defined in section one of the Act, it is a very broad definition, covering almost all government institutions. 8 Additionally, the Act circularly refers to "public employee" in the definition of "public employer" where it states that a "public employer" is any "agency or authority ... [that] exercises direction and control over the public employee." 9 Because of this ambiguous statutory language and an insufficient legislative history, 10 the supreme judicial court, as interpreter of the Act, be exclusive of any other civil action or proceeding by reason of the same subject matter against the public employer or, the public employee ... ").

7. MASS. GEN. L. ch. 258, § 1 (1986).

8. The definition of "public employer" in the MTCA includes, among other things, "the commonwealth and any county, city, town, educational collaborative, or district, including any public health district ... and any department, office, commission, committee, council, board, division, bureau, institution, agency or authority thereof which exercises direction and control over the public employee ... " MASS. GEN. L. ch. 258, § 1 (1986).

9. Id. Under the direction and control test there is one final requirement for immunity to be applicable. That is, the tort had to occur while the employee was working within the scope of government employment. MASS. GEN. L. ch. 258, § 2 (1986). See Pruner v. Clerk of the Superior Court, 382 Mass. 309, 315, 415 N.E.2d 207, 210 (1981). Even if the individual indisputably was a "public employee," if that person was negligent in the performance of duties that are outside of the government operation then he or she cannot use immunity under the MTCA as a defense.

10. No legislative history about the purposes of the MTCA is recorded. Telephone interview with Christina Coolidge, Reference Librarian at the Library of the State House in Boston, Massachusetts (October 11, 1985). Therefore, this article, and for that matter the courts, cannot declare legislative intent definitively. Nevertheless, the supreme judicial
has had little guidance in resolving the issue of which employees are protected under the MTCA as "public employees."\textsuperscript{11}

A. The Call for Reform

Before critically analyzing the Massachusetts Supreme Judicial Court's approach to physician immunity under the MTCA, the history of governmental immunity in Massachusetts must be explored in order to appreciate the policies behind the Act. The original common law principle espoused by the supreme judicial court provided that the commonwealth was immune from all liability unless the legislature ordered otherwise.\textsuperscript{12} The supreme judicial court modified this principle in \textit{Morash & Sons, Inc. v. Commonwealth},\textsuperscript{13} where the court expressly court has articulated its understanding of what the legislature intended to achieve through the Act by referring to case law preceding the Act's passage. \textit{See}, \textit{e.g.}, \textit{Pina v. Commonwealth}, 400 Mass. 408, 412-13, 510 N.E.2d 253, 256 (1987) (referring to \textit{Whitney v. City of Worcester}, 373 Mass. 208, 366 N.E.2d 1210 (1977)). Thus, in considering the driving forces behind the Act, this article will focus on the supreme judicial court's articulation of the legislative intent.

\begin{itemize}
  \item The difficulty in giving meaning to the definitions in the MTCA posed by the absence of legislative history is reflected in \textit{Recent Development, Sovereign Immunity in Massachusetts}, 13 \textit{NEW ENG. L. REV.} 877 (1978): "[T]he bill's language does not adequately define the scope of governmental liability and judicial interpretation will, of necessity, be guided by prior case law, especially the \textit{Whitney} decision." \textit{Id.} at 878 (referring to \textit{Whitney v. City of Worcester}, 373 Mass. 208, 366 N.E.2d 1210 (1977)).

  \item The court's role in these cases is similar to its role in \textit{Glasser v. Director of Div. of Employment Sec.}, 393 Mass. 574, 471 N.E.2d 1338 (1984). There, the supreme judicial court interpreted a provision in the unemployment compensation statute. \textit{Mass. Gen. L. ch.} 151A, \textit{§} 25(e)(3) (1986). The court stated that it is within its province to interpret statutes "according to the intent of the Legislature, as evidenced by the language used, and considering the purposes and remedies intended to be advanced." \textit{Glasser}, 393 Mass. at 577, 471 N.E.2d at 1340. Because statutes are often written in ambiguous terms, the supreme judicial court must construe these ambiguities in order to determine the statute's applicability. \textit{See also} \textit{Tedford v. Mass. Housing Fin. Agency}, 390 Mass. 688, 696, 459 N.E.2d 780, 785 (1984) (quoting \textit{School Comm. v. Greenfield Educ. Ass'n}, 385 Mass. 70, 79-80, 431 N.E.2d 180, 186-87 (1982), and citing \textit{Massachusetts Turnpike Auth. v. Commonwealth}, 347 Mass. 524, 528, 199 N.E.2d 175, 178 (1964)) ("'Where the draftsmanship of a statute is faulty or lacks precision, it is our duty to give the statute a reasonable construction.' . . . We interpret the statute to best effectuate the legislative intent, viewing the statute as a whole.'").

  \item \textit{See} \textit{Troy & G.R.R. v. Commonwealth}, 127 Mass. 43 (1879). In \textit{Troy}, the supreme judicial court stated that it lacked jurisdiction over a mortgagor's bill of redemption against the commonwealth as mortgagee, because the state could be sued only if the legislature had given its consent. The court characterized immunity as a "fundamental principle of our jurisprudence." \textit{Id.} at 46.

  \item 363 Mass. 612, 296 N.E.2d 461 (1973). In this case, \textit{Morash & Sons, Inc.} claimed that its water supply was polluted by road salt that the commonwealth stored on
rejected the reasoning that immunity had to be abrogated by the legislature and stated that because sovereign immunity was created judicially, it could be abrogated judicially.\textsuperscript{14} In fact, by its holding, the \textit{Morash} court created an exception to the immunity doctrine for circumstances in which the government maintains a private nuisance. In addition to the judicial exceptions, the legislature abrogated immunity in a number of circumstances.\textsuperscript{15} Because of both legislative and judicial exceptions to the common law rule, the system of governmental immunity became a "convoluted scheme of rules and exceptions"\textsuperscript{16} which were applied haphazardly in a case-by-case manner.\textsuperscript{17}

Prior to the MTCA's enactment, the analytical scheme used to determine governmental liability began with a comparison of the facts of each case with the legislatively or judicially enumerated exceptions to the presumption of immunity.\textsuperscript{18} If the case fit into one of these random exceptions, the action against the government proceeded. If not subject to one of these exceptions, the case continued through a two-step common law analysis. In the first step of this procedure, the court characterized the individual claiming immunity as either a public officer or municipal agent.\textsuperscript{19} If the person accused of negligence was classified as a public officer, the inquiry terminated in favor of property adjacent to the corporation's property. \textit{Id.} at 613, 296 N.E.2d at 462. The corporation brought a suit based on a theory of nuisance and sought an injunction against the commonwealth's use of its property and damages. \textit{Id.} at 614, 296 N.E.2d at 642. The trial court dismissed the action, stating that the doctrine of sovereign immunity barred the claim, \textit{Id.} at 613, 296 N.E.2d at 642, but the supreme judicial court reversed that decision. \textit{Id.} at 624, 296 N.E.2d at 468.


\textsuperscript{15} The court in \textit{Morash} cited a number of instances where the legislature abrogated immunity. "[R]ecovery is permitted against a municipality for damages caused by riots (G.L. c. 269, § 8), by unlawful exclusion from public schools (G.L. c. 76, § 16), and by defects in the highways (G.L. c. 84, § 15; G.L. c. 229, § 1)." \textit{Morash}, 363 Mass. at 620, 296 N.E.2d at 466.


\textsuperscript{17} In \textit{Morash}, the court stated that the immunity scheme was "logically indefensible." \textit{Morash}, 363 Mass. at 618, 296 N.E.2d at 466. It further emphasized that the ability of a plaintiff to recover for injuries often rested solely on the fortuity of the circumstances, and that the exceptions to governmental immunity had "no necessary relationship to accepted tort principles, equitable principles, or principles of sound public policy." \textit{Id.} at 621, 296 N.E.2d at 467.

\textsuperscript{18} \textit{Id.} at 620-22, 296 N.E.2d at 466-67.

\textsuperscript{19} A public officer is an individual who performs public duties that are delegated by the Massachusetts Legislature. Molinari v. City of Boston, 333 Mass. 394, 395-96, 130 N.E.2d 925, 926-27 (1955) (school committee members were public officers because of leg-
governmental immunity because, in theory, there was no local control over the officer, and thus the government could not be held liable by way of respondeat superior.20 If the accused was classified as a municipal agent, the analysis proceeded to a second phase, where the court identified the activity of the municipality at the time of the alleged negligence as either a commercial or a public function.21 If the agent was performing a public function, there was no government liability.22 However, the government was liable for the negligent performance of a commercial function by a municipal agent because there was local control over the agent’s actions and the doctrine of respondeat superior applied.23

islatively mandated duty to provide and maintain properly furnished schoolhouses); see also Warburton v. City of Quincy, 309 Mass. 111, 114, 34 N.E.2d 661, 663 (1941).

A municipal agent is an individual who performs duties that are not specifically delegated or authorized by the legislature. See Whitney, 373 Mass. at 213, 366 N.E.2d at 1213-14. See also Russell v. Town of Canton, 361 Mass. 727, 730, 282 N.E.2d 420, 422 (1972) (town selectmen acting in eminent domain action were not municipal agents because eminent domain is controlled by statute); Commonwealth v. Oliver, 342 Mass. 82, 84, 172 N.E.2d 241, 242 (1961) (plant manager at municipal light company was not a municipal agent because department of public utilities controlled his action).


Although the government was not liable for the negligence of a public officer, the determination of personal liability of the officer included another level of analysis—a misfeasance/nonfeasance distinction. The court declared that a public officer performing a public function was liable personally for acts of misfeasance but not for acts of nonfeasance in the performance of ministerial tasks. Fulgoni v. Johnston, 302 Mass. 421, 423, 19 N.E.2d 542, 543 (1939). In Whitney, the court stated, ‘‘[N]onfeasance is the omission of an act which a person ought to do, misfeasance is the improper doing of an act which a person might lawfully do.’’ Whitney, 373 Mass. at 220, 366 N.E.2d at 1217 (quoting Trum v. Town of Paxton, 329 Mass. 434, 438, 109 N.E.2d 116, 119 (1952)). See also O’Neill v. Mencher, 21 Mass. App. Ct. 610, 488 N.E.2d 1187 (1986).

21. In Bolster v. City of Lawrence, 225 Mass. 387, 114 N.E. 722 (1917), the supreme judicial court defined a public function as municipal activity undertaken for the common public good without the necessity of commercial profit. Id. at 389, 114 N.E. at 724. An example of a public function is fire protection, both in the maintenance of fire engines and the employment of firefighting personnel. Fisher v. City of Boston, 104 Mass. 87 (1870).

The supreme judicial court defined a commercial function as conduct undertaken voluntarily and for profit. Bolster, 225 Mass. at 390, 114 N.E. at 723. For example, maintaining a system for distributing and selling water is a commercial function. Iver Johnson Sporting Goods Co. v. City of Boston, 334 Mass. 401, 135 N.E.2d 658 (1956).


23. See id. at 214, 366 N.E.2d at 1214-15. Courts that employed this common law test did not follow this two-step process invariably. For some courts, the sole determinative question for the applicability of governmental immunity was whether the conduct could be considered a public function. See, e.g., Morash & Sons, Inc. v. Commonwealth, 363 Mass. 612, 621, 296 N.E.2d 461, 466 (1973).
This adjudicative process was unsatisfactory; it relied on rules, classifications, and exceptions that lacked justifiable purposes, and resulted in unfairness to both injured plaintiffs and defendants. The supreme judicial court has since noted that many plaintiffs were precluded from recovering for their injuries, and defendants were found personally liable, simply because of a capricious distinction in classification that had no association with sound reasoning or public policy.24

The supreme judicial court's emphatic recognition of the unfairness under the common law system of governmental immunity induced the legislature to enact the MTCA. In Whitney v. City of Worcester,25 the supreme judicial court took a stand against the "convoluted scheme of rules and exceptions" surrounding governmental immunity that had become "unjust and indefensible as a matter of logic and sound public policy."26 The court stated that it would abrogate governmental immunity if the legislature did not take action on the issue by the close of the 1978 session.27

In rejecting the common law approach to governmental immunity, the supreme judicial court made it clear that determination of liability based on superficial employment characteristics was unsatisfactory. The court asserted that a scheme for determining immunity should be formulated with regard to the reasons why a government should not be held liable, and with attention to fairness to the parties.28 These admonitions to the legislature are key to interpreting the legislature's response—the MTCA.29 This article now examines the

24. In Whitney, the supreme judicial court provided an illustration of this unfairness by comparing a person who was injured by a water department employee and, therefore, able to recover, with another person who was injured by a fire department employee, and thus, not able to recover. From the public perspective, because both plaintiffs were injured by the same defendant—the government—the distinction was trivial. Whitney, 373 Mass. at 215 n.9, 366 N.E.2d at 1215 n.9 (citations omitted).

25. 373 Mass. 208, 366 N.E.2d 1210 (1977). In this case, a first grade student and his father brought a negligence action against the city, school committee, superintendent of schools, principal, assistant principal, teacher, and custodian. The student, who was blind in one eye with limited vision in the other, was instructed to go to the playground, which entailed passing through a defective door. The student was struck on the head by the door and injured severely. After the injury, the assistant principal and the student's teacher told the student to remain in the classroom, denying him immediate medical care. Because of the delay in treatment the boy became totally blind. Id. at 221-22, 366 N.E.2d at 1218.

26. Id. at 209, 366 N.E.2d at 1211.

27. Id. at 210, 366 N.E.2d at 1212.

28. Id. at 216-17, 366 N.E.2d at 1215-16.

29. Because there is no satisfactory legislative history, see supra note 10, these admonitions by the Whitney court are used extensively as evidence of legislative intent. See, e.g., Recent Development, supra note 11, at 878 ("Since the bill was drafted and amended to comply strictly with the Whitney decision, the guidelines enunciated [in Whitney] are elevated to a fertile source of legislative intent.").
The Massachusetts Supreme Judicial Court’s interpretation of physician immunity under the MTCA.

B. **The Current Approach**

The supreme judicial court recently addressed the “public employee” provision of the Massachusetts Tort Claims Act in two cases where it decided whether physicians qualified for immunity under the Act. The first case, *Kelley v. Rossi*, 30 involved a physician in a residency program at Boston City Hospital, a public institution. As a condition of her residency, Boston City Hospital required Dr. Rossi to participate in a residency rotation program that included service at the Joseph P. Kennedy Memorial Hospital [hereinafter Kennedy], a private institution. 31 On March 22, 1982, while on rotation at Kennedy, Dr. Rossi examined eight-year-old Duane Kelley, who complained of fatigue, vomiting, nausea, abdominal pain, fever and frequency of urination. 32 Doctor Rossi ordered laboratory tests but before the results were available she diagnosed Duane as having the flu and sent the Kelleys home with instructions to give Duane popsicles and soda. 33 Doctor Rossi did not read the laboratory findings which indicated that Duane suffered from a life-threatening form of diabetes. 34 The next day, Duane lost consciousness and was rushed to another hospital for treatment where he died eight days later. 35

The Kelleys sued Dr. Rossi for malpractice and the physician defended herself by claiming immunity under the MTCA as a “public employee.” 36 The trial court granted Dr. Rossi’s motion for summary judgment but the supreme judicial court reversed because there was a question of material fact as to whether Dr. Rossi was a “public employee” at the time of the alleged malpractice. 37

The court began its analysis by declaring that its determination of whether Dr. Rossi was a “public employee” would be guided by the same principles that establish a principal’s liability for the negligent acts of its agent under the doctrine of respondeat superior. 38 After noting that the MTCA definition of “public employee” was not effec-

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31. *Id.* at 660, 481 N.E.2d at 1341.
33. *Id.* at 3.
34. *Id.* at 4.
35. *Id.* at 4-5.
37. *Id.* at 665, 481 N.E.2d at 1344.
38. *Id.* at 661, 481 N.E.2d at 1342.
tive for determining one's status as a "public employee" under the Act, the court turned to the MTCA definition of "public employer" for guidance.\textsuperscript{39} A "public employer" is defined as an employer that "exercises direction and control over the public employee."\textsuperscript{40} It is the direction and control test that the court found to be the common element between the doctrine of respondeat superior and the determination of one's status as a "public employee."\textsuperscript{41}

Following a brief discussion of the highly skilled and discretionary nature of the physician's profession,\textsuperscript{42} the court summarily stated that there was little question but that Dr. Rossi was a servant in her capacity as a resident physician.\textsuperscript{43} The critical question for the court was whether she was a servant of the city or of Kennedy Hospital.

The court concluded that the facts of the case did not support indisputably the trial court's finding that Dr. Rossi was a servant of the city, and thus entitled to immunity as a "public employee."\textsuperscript{44} Depositions of Dr. Rossi and Kennedy's director of medical affairs indicated that Dr. Rossi was required to follow Kennedy's policies and procedures, work the hours that Kennedy set, and treat the patients that Kennedy assigned her.\textsuperscript{45} Additionally, Dr. Rossi could neither admit nor discharge patients at Kennedy and was subject to removal by the hospital.\textsuperscript{46}

Based on these factors, the supreme judicial court concluded that there was a question of material fact as to whether Dr. Rossi was a servant of Boston City Hospital and, therefore, whether she could be classified as a "public employee" under the MTCA.\textsuperscript{47} Thus, the court reversed the summary judgment order in favor of the physician.\textsuperscript{48}

In *Smith v. Steinberg*,\textsuperscript{49} the second case in which the supreme judicial court reviewed the issue of a physician's immunity under the MTCA, Dr. Steinberg was a professor of orthopedic surgery at the University of Massachusetts Medical School.\textsuperscript{50} Doctor Steinberg's educational affiliation with the university automatically conferred upon

\textsuperscript{39} Id.
\textsuperscript{40} MASS. GEN. L. ch. 258, § 1 (1986).
\textsuperscript{41} Kelley, 395 Mass. at 661, 481 N.E.2d at 1342.
\textsuperscript{42} Id. at 662-63, 481 N.E.2d at 1343.
\textsuperscript{43} Id.
\textsuperscript{44} Id. at 665, 481 N.E.2d at 1344.
\textsuperscript{45} Id.
\textsuperscript{46} Id.
\textsuperscript{47} Id.
\textsuperscript{48} Id. at 665, 481 N.E.2d at 1344.
\textsuperscript{49} 395 Mass. 666, 481 N.E.2d 1344 (1985) (decided the same day as Kelley).
\textsuperscript{50} Id. at 667, 481 N.E.2d at 1346.
him membership in the group practice plan at the medical school.\textsuperscript{51} The group practice plan provided the opportunity for all faculty at the medical school to participate in a clinical practice on a fee-for-service basis, whereby each physician was paid a percentage of the fees collected by his or her department. The physicians in the plan set their own hours and chose their own patients.\textsuperscript{52}

Doctor Steinberg treated Mrs. Dorothea Smith on referral from Mrs. Smith's personal physician for the removal of a ganglion on her right thumb.\textsuperscript{53} Prior to successful surgical removal of the ganglion, Dr. Steinberg ordered routine tests and a chest X-ray.\textsuperscript{54} On the preoperative X-ray, the radiologist noticed a chest growth which he suspected was malignant and recommended further evaluation. Nevertheless, Dr. Steinberg did not review the radiologist's report until a year later when Mrs. Smith returned to her personal physician because she was coughing up blood.\textsuperscript{55} Mrs. Smith died from lung and lymphatic cancer the following year.\textsuperscript{56}

The Smith family sued Dr. Steinberg for malpractice. Doctor Steinberg moved for summary judgment claiming immunity under the MTCA as a "public employee" at the University of Massachusetts Medical School.\textsuperscript{57} The superior court denied his motion and the supreme judicial court affirmed.\textsuperscript{58}

On appeal, Dr. Steinberg argued that the statute which created the group practice plan designated him an employee of the commonwealth, and, thus, he was immune from liability as a "public employee" under the MTCA.\textsuperscript{59} The court rejected this argument, stating that the use of the term "employee" in the statute regarding the University of Massachusetts did not control the definition of "public em-

\begin{itemize}
\item \textsuperscript{51} Id. The group practice plan was established under St. 1974, ch. 733, § 2.
\item \textsuperscript{52} Steinberg, 395 Mass. at 669, 481 N.E.2d at 1347.
\item \textsuperscript{53} Brief for Plaintiff-Appellee at 4, Smith v. Steinberg, 395 Mass. 666, 481 N.E.2d 1344 (1985) (No. 3789).
\item \textsuperscript{54} Id.
\item \textsuperscript{55} Id.
\item \textsuperscript{56} Id. at 5.
\item \textsuperscript{57} Steinberg, 395 Mass. at 667, 481 N.E.2d at 1345.
\item \textsuperscript{58} Id.
\item \textsuperscript{59} Steinberg, 395 Mass. at 668, 481 N.E.2d at 1346. The statute upon which Dr. Steinberg relied states, in part:
\begin{quote}
All officers and employees, professional and non-professional, of the university shall continue to be employees of the commonwealth irrespective of the source of funds from which their salaries or wages are paid. They shall have the same privileges and benefits of other employees of the commonwealth such as retirement benefits, group insurance, industrial accident coverage, and other coverage enjoyed by all employees of the commonwealth.
\end{quote}
\end{itemize}

employee" in the MTCA.60

The court shifted its focus to the commonwealth's direction and control over Dr. Steinberg, pursuant to the standard that it set forth in Kelley.61 It found that the group practice plan's only function with respect to its members was that of billing patients.62 Doctor Steinberg set the hours that he worked, chose his own patients, and generally "practice[d] medicine as he wished, subject to his teaching obligations . . . ."63 Thus, the court concluded that Dr. Steinberg was not subject to the direction and control of the commonwealth and, therefore, could not avail himself of immunity under the MTCA at the summary judgment stage.64

The supreme judicial court's resolution of Dr. Rossi's and Dr. Steinberg's immunity claims centered on the language of the MTCA supplemented by the common law direction and control test. The following discussion more closely examines the MTCA and this common law test.

C. The Issue of Direction and Control

The crux of the analysis in determining the applicability of personal immunity for physicians under the MTCA is the definition of "public employee." Although the Kelley court suggested that this term could be given meaning by utilizing the statutory definition of "public employer," that analysis is nonfunctional without further refinement.65 To claim that one is a "public employee" because he or

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60. Steinberg, 395 Mass. at 668-69, 481 N.E.2d at 1346.
61. Id. at 669, 481 N.E.2d at 1346-47.
62. Id. at 669, 481 N.E.2d at 1347.
63. Id.
64. Id.
65. The classification of employment relationships between hospitals and physicians is particularly difficult because specialization in the health care industry makes these relationships increasingly complex. See A. Southwick, The Law of Hospital and Health Care Administration 347, 378-81 (1978) (discussing hospital liability based on employment relationships with negligent doctors); see generally Physician-Hospital Relationships (Mass. Continuing L. Educ. 1985) (discussing various aspects of physician-hospital relationships in Massachusetts); see also M. Shapiro, Getting Doctored 139 (1978) ("The parallel rise of superspecialization and supertechnology is a striking element in recent medical history . . . .").

In Massachusetts, this complexity and the impracticability of classifying employment relationships is illustrated in a letter from Attorney General Francis X. Bellotti to Alfred E. Franchette, M.D., Commissioner of Public Health, where the Attorney General suggested that physicians employed in a consultant capacity with the commonwealth maintain their own private malpractice insurance because they may not be within the scope of the MTCA's immunity. 1979-80 Op. Att'y Gen. of Mass. 106, 106 (December 3, 1979). The Attorney General claimed that because of the specialized nature of the relationships be-
she is subject to the direction and control of a "public employer" begs
the further question of what qualifies as direction and control. 66
Therefore, in order to give meaning to the direction and control stan­
dard, the supreme judicial court referred to the common law regarding
employment relationships and the theory of respondeat superior. 67

The court in Kelley stated that the principles that establish one as
a "public employee" are the same as those which establish liability for
the employer under the theory of respondeat superior. 68 However, the
court did not explain the nexus between these doctrines.

The common law doctrine of respondeat superior is grounded in
the policy that a servant's negligence should be imputable to the
master because the servant acts under the master's direction. 69 Inher­
ent in this doctrine are the premises that the master is in a better posi­
tion than the servant to compensate those persons injured by the
servant, and that the master is best able to prevent negligent conduct
by exercising control over the servant. 70 Thus, the examination of the
master's control over, or the right to control a servant has become the
preferred test for principal liability under the doctrine of respondeat
superior. 71

The courts in Massachusetts have used the direction and control
test extensively for determinations of liability under respondeat supe­
rior. 72 Together with the direction and control test, the Kelley court

tween the commonwealth and consultant physicians, it was not possible to categorize rigi­
dy the status of the physicians. Id.

66. See supra note 8 for the statutory definition of public employer.
68. See supra note 41 and accompanying text.
69. See Khoury v. Edison Elec. Illuminating Co., 265 Mass. 236, 238, 164 N.E. 77,
78 (1928). Although scholars are uncertain as to the origin of respondeat superior, Oliver
Wendell Holmes proffered an interesting theory based in Roman law in which the leader of
a household was liable for negligent acts of family members. See generally Holmes, Agency,
4 HARV. L. REV. 345 (1891).
70. 2 F. HARPER & F. JAMES, THE LAW OF TORTS § 26.1, at 1363-64 (1956). See
also G. WILLIAMS & B. HEPPEL, FOUNDATIONS OF TORT 113 (1976) (A principal reason
for vicarious liability is "the desire of the judges to give the victim an effective remedy when
he is injured by a person who is likely to have small means.").
71. "The commonest test of a relationship to which the law attaches vicarious lia­
ability is control or the general right of control. . . . [T]his right of control has been used not
only as a test or description but also as a justification for imposing vicarious liability where
control exists." James, Vicarious Liability, 28 TUL. L. REV. 161, 165 (1954). See also

The terms respondeat superior and vicarious liability are often used interchangeably.
See, e.g., id. at 1260; Fitzpatrick & Carman, Respondeat Superior and the Federal Securities
72. See, e.g., Chicopee Lions Club v. District Attorney, 396 Mass. 244, 485 N.E.2d
673 (1985) (Hampden County and commonwealth did not exercise direction and control
utilized the Restatement (Second) of Agency to refine further what constitutes direction and control under the MTCA.73 From its interpretation of the common law principles of respondeat superior and from the guidance of the Restatement, the supreme judicial court articulated three factors for determining a hospital's control over a physician: 1) scheduling of work hours, 2) selection of patients, and 3) establishment of policies and procedures.74 Under the direction and

over district attorney so they could not be held liable under respondeat superior); Konick v. Berke, Moore Co., 355 Mass. 463, 245 N.E.2d 750 (1969) (direction and control test used to determine liability of employer under respondeat superior when employee, while performing an errand for the company in his own car, was involved in an accident); Marino v. Trawler Emil C, Inc., 350 Mass. 88, 213 N.E.2d 238 (1966) (direction and control test used to determine liability under respondeat superior between pilots of planes that crashed and fishing boat owners who hired pilots to spot fish).


In determining whether one acting for another is a servant or an independent contractor, the following matters of fact, among others, are considered:

(a) the extent of control which, by the agreement, the master may exercise over the details of the work;
(b) whether or not the person employed is engaged in a distinct occupation or business;
(c) the kind of occupation, with reference to whether, in the locality, the work is usually done under the direction of the employer or by a specialist without supervision;
(d) the skill required in the particular occupation;
(e) whether the employer or the workman supplies the instrumentalities, tools, and the place of work for the person doing the work;
(f) the length of time for which the person is employed;
(g) the method of payment, whether by the time or by the job;
(h) whether or not the work is a part of the regular business of the employer;
(i) whether or not the parties believe they are creating the relation of master and servant; and
(j) whether the principal is or is not in business.

Restatement (Second) of Agency § 220 (1958).


Because employment relationships differ greatly among trades and professions, reference to other employment situations is of little value in determining what factors are critical in establishing employer control. For instance, the indicia of an oil company's control over a franchise station: (a) "exclusive sales agreements," (b) "clean restroom clauses," and (c) "opportunities for the oil companies to suggest retail prices," Note, An Efficiency
control test with respect to the MTCA, if a public hospital controls these three factors, then the physician is a "public employee." The court also considered ancillary factors such as source of payment, and the parties' beliefs regarding the right to control. However, if the primary factors are missing, these ancillary factors do not seem to create a public employment relationship.

1. Analysis of the Direction and Control Test

In Kelley v. Rossi and Smith v. Steinberg, the court resolved the immunity issue by reviewing the facts of each case and analyzing whether the physicians were under the direction and control of the commonwealth. In implementing this approach, the Massachusetts Supreme Judicial Court took a general statutory immunity scheme which centered on the ambiguous term "public employee," and improperly interposed a common law definition for that term without regard to the specific circumstances of the situation. The court did not take into account the peculiar nature of physician-hospital employment relationships or the policies and interests that application of the common law test impacts.

The supreme judicial court did not articulate its reasons for choosing the control factors that it did in determining the physicians'...
employment status in Kelley and Steinberg. An examination of the physicians' profession and their relations with hospitals reveals that these factors may have been chosen because they are the few areas in which a physician is subject to the control of others. In fact, the physician's profession is noted for being one of particular autonomy. Justice Holmes once wrote, "There is no more distinct calling than that of the doctor, and none in which the employee is more distinctly free from the control or direction of his employer."81

Because it is the individual physician who controls the "content" of his or her work,82 the efficacy of the direction and control test is questionable as applied to them. In other cases in which the government has used the direction and control test to determine liability under the MTCA or other laws, the nature of the profession or trade under examination has been more conducive to "control" analysis.

In his advisory letters, Attorney General Francis X. Bellotti applied the direction and control test to a few employment circumstances to determine liability under the MTCA. The Attorney General once applied it to individuals who provide consultant services to the Executive Office of Energy Resources (EOER) on a contractual basis. The Attorney General suggested that these individuals would be covered by the immunity of the MTCA because the consultants performed tasks under the direct supervision of other EOER employees.83 In a letter regarding individuals who perform volunteer work for the commonwealth, the Attorney General maintained that the particular circumstances of each case control the liability question, but if the "public employer" controlled the "manner" and "detail" of the performance of required tasks, the volunteers probably would be considered "public employees" for purposes of the MTCA.84

81. Pearl v. West End St. Ry. Co., 176 Mass. 177, 179, 57 N.E. 339, 339 (1900). In fact, the Kelley court observed that "physician[s] must use independent judgment," and that "'[t]he position of a physician normally is not that of a servant of anyone.'" Kelley, 395 Mass. at 662, 481 N.E.2d at 1343 (emphasis added) (citation omitted).

Scholars on the medical profession also contend that physicians are not subject to meaningful direction and control. Eliot Friedson wrote that "physician[s] . . . [are] the most prominent among members of generally recognized professions," E. FRIEDSON, PROFESSIONAL DOMINANCE: THE SOCIAL STRUCTURE OF MEDICAL CARE 81 (1970), largely because they are "free to control the content of . . . [their] work." Id. at 84. See also M. SHAPIRO, supra note 65, at 182-205 (medicine is an alienated and authoritarian field); J. MCCORMICK, THE DOCTOR: FATHER FIGURE OR PLUMBER 13-14 (1979); Mechanic, Problems in the Future Organization of Medical Practice, 35 LAW & CONTEMP. PROBS. 233, 236 (1970).

82. See E. FRIEDSON, supra note 81, at 84.


Massachusetts case law dealing with the application of the direction and control test, although not with the issue of employment status under the MTCA, also involves employment circumstances in which the employees are not known for having decisionmaking or decision implementation autonomy in the performance of their jobs. Such cases involve truck drivers, temporary secretaries, and student nurses. In each of these cases, the employer could control the details of the employee's performance—physicians are not subject to similar control. Therefore, the supreme judicial court probably chose the control factors that it did in Kelley and Rossi because the nature of the medical profession dictates that a physician control the details of his or her work. The court chose the few factors in which health care facilities do have control over the physician's employment.

a. A Hypothetical Situation

It seems that in Kelley and Steinberg, the court assumed that the method for defining "public employee" was consistent among various employment circumstances, and that the application of the common law definition satisfied the purposes of the Act in all circumstances.

85. An exception to this proposition is Florio v. Kennedy, 18 Mass. App. Ct. 917, 464 N.E.2d 1373 (1984), in which the court did apply the direction and control test to determine that a physician was protected by immunity under the MTCA. However, that physician worked exclusively for the commonwealth, id. at 918, 464 N.E.2d at 1375, and this article does not analyze the merit of applying the MTCA to these physicians.

89. Cf. 1983-84 Op. Att'y. Gen. of Mass. 87 (July 14, 1983). In this letter regarding volunteers who perform services for the commonwealth, the Attorney General stated that if the volunteer is told to "accomplish an agreed result and to control the means to that result," then he or she would not be a "public employee" under the MTCA. Id. at 89.
90. In Kelley, the supreme judicial court cited the Restatement (Second) of Agency as authority to refine the elements of control. However, careful analysis of the Restatement reveals that the nature of the physicians' profession is antithetical to the existence of "control" in Restatement terms. See supra note 73 for the text of the Restatement. The physician is a member of a highly skilled, distinct profession in which the work generally is performed by a specialist who is not supervised in the details of his or her work. See supra note 81 and accompanying text. These factors are inconsistent with the criteria for establishing "control" under the Restatement.

"The tendency to assume that a word which appears in two or more legal rules, and so in connection with more than one purpose, has and should have precisely the same scope in all of them runs all through legal discussions. It has all the tenacity of original sin and must constantly be guarded against." Id. at 159. The situation involving the MTCA varies slightly from the situation described by Walter Wheeler Cook, but an interesting comparison can be drawn. Rather than assum-
Consider the following hypothetical situations which illustrate the difficulties and inequities that a fact finder faces in distinguishing between public employment and private independent practice using the supreme judicial court's common law direction and control test.

Doctor Silver is on the staff of the Massachusetts Public Hospital (MPH) where he is employed by the hospital and retains an office as a private practitioner. In his employment with the hospital, Dr. Silver spends three days a week in the emergency room where the hospital schedules his hours, assigns him the patients that he must treat, and pays him on a per patient basis. Doctor Silver's employment contract states that he is an employee of the hospital, but he must pay his own health and malpractice insurance and is responsible for arranging and funding his own retirement plan.

One year ago, a private patient of Dr. Silver's called him at his office and complained that she was not feeling well. Doctor Silver instructed the patient to go to the emergency room at MPH the next day, when Dr. Silver was scheduled to work. The physician further instructed the patient to request that she be treated by him, knowing that in the past his patients who requested his services were assigned to him.

The following day, the patient did go to the emergency room, went through all of the usual administrative procedures, and told the receptionist that Dr. Silver had instructed her to request his services. The receptionist then assigned the patient to Dr. Silver.

Doctor Silver examined his patient and ordered a number of laboratory tests. After the examination, but without seeing the test results, Dr. Silver sent the patient home with instructions that were based on a speculative diagnosis. Five days later, the patient died because she did not receive necessary care after the alleged improper diagnosis and treatment. The results from the tests that Dr. Silver had ordered, which clearly indicated the impropriety of Dr. Silver's diagnosis, were available on the same day as his examination of the patient. The patient's family filed a malpractice action against Dr. Silver and he has

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...ing that the definition of a word was the same in one or more legal rules, the court in Kelley and Steinberg assumed that a definition of a word in a legal rule was the same in one or more factual settings. Specifically, the court assumed that the definition of a "public employee" in complex physician-hospital relationships was the same as in all other employment circumstances. The peculiar nature of the physicians' profession makes it significantly distinguishable from others; thus, the rule that applies to other trades and professions should not be applied to physicians without careful analysis of its implications. See supra note 81 and accompanying text.
defended the suit by claiming immunity as a "public employee" under the MTCA.

Doctor Charcoal is employed by MPH in the same capacity as Dr. Silver. Doctor Charcoal works three days a week in the hospital emergency room according to hours set by MPH. The hospital assigns her patients and pays her on a per patient basis. The balance of Dr. Charcoal's work week is spent as a private practitioner in her leased office in another part of the hospital, just as Dr. Silver's is. In fact, all other aspects of her employment relationship with MPH are the same as Dr. Silver's.

Curiously, about one year ago, Dr. Charcoal received a phone call from one of her private patients who complained of mysterious pains. Fearing the worst, Dr. Charcoal told the patient to go to the MPH emergency room immediately. The patient, however, waited until the following day to go to MPH, where he followed the standard admission procedures. By chance, the patient was assigned to Dr. Charcoal.

Doctor Charcoal examined the patient and ordered a battery of laboratory tests. However, before consulting the test results, which were available while the patient was in the hospital, Dr. Charcoal discharged the patient and sent him home with some instructions. Unfortunately, the patient died a few days later. The test results which Dr. Charcoal did not look at before the patient's death mandated a diagnosis different than the physician's. In fact, Dr. Charcoal's diagnosis and instructions delayed necessary treatment that most probably would have saved the patient's life.

Upon learning of the physician's apparent misdiagnosis, the decedent's family filed a malpractice suit against Dr. Charcoal. The physician filed a defense to the suit claiming immunity as a "public employee" under the MTCA. In numerous suits with claims similar to those filed in the suits against Drs. Silver and Charcoal, the average jury verdict is in excess of $450,000.00.\footnote{In a recent Massachusetts case, the appeals court affirmed a trial court decision in which a jury awarded $480,000.00 to an estate in a malpractice action after a physician failed to diagnose cancer that eventually killed the patient. Cusher v. Turner, 22 Mass. App. Ct. 491, 495 N.E.2d 311 (1986).

b. Application of the Direction and Control Test

It is likely that Drs. Silver and Charcoal will file motions for summary judgment based on their immunity claims in their respective cases. It is equally likely that the plaintiffs will object to those motions. In deciding each motion, the trial judge will have to determine the availability of immunity under the MTCA based on the common law direction and control test according to the current interpretation of the MTCA by the supreme judicial court.

In Dr. Silver's case, there is little doubt that two of the three primary factors in the direction and control test as formulated by the supreme judicial court are satisfied—the physician's hours are set by the hospital, and he must follow the policies of the hospital while working in the emergency room. The critical question in Dr. Silver's case is whether the hospital assigned the deceased patient to the physician. Because Dr. Silver instructed the patient to request his services, particularly in light of the fact that the physician expected that the patient could be assigned to him if the patient so requested, it is probable that the motion for summary judgment would be denied. There is a question of material fact as to who selected the patient for Dr. Silver.

As in Dr. Silver's case, in Dr. Charcoal's case the requirements that the employer set the employee's hours and the policies that the employee must follow are satisfied. Again, the disposition of the motion for summary judgment depends on who selected the patient for Dr. Charcoal. It is probable that the motion based on immunity under the MTCA would be granted in this case. Although Dr. Charcoal instructed her patient to go to the hospital, she played no role in the assignment of that patient to herself; the hospital coincidently assigned him to Dr. Charcoal. Thus, all three of the primary factors in the common law test were controlled by the employer, so Dr. Charcoal would be considered a "public employee" and fall under the purview of the MTCA.

c. Critique of the Application

The shortcomings of the common law direction and control test are well-illustrated by this hypothetical situation. These two cases involve physicians with identical employment relationships. Both cases involve treatment of patients while the physicians were subject to MPH policy and were being paid by MPH. Is it fair, then, for the plaintiffs in Dr. Charcoal's case to be limited to a recovery of no greater than $100,000.00, while the plaintiffs in Dr. Silver's case could obtain a judgment in excess of $450,000.00, if averages prevail? From
the defendants’ perspective, is it fair for Dr. Charcoal to incur no financial liability by way of a judgment, while Dr. Silver could be liable personally for a half million dollar judgment?

Because of the importance afforded to the subtle distinction regarding the assignment of the patients, these results are highly probable, regardless of the unfairness. To the deceased patients’ survivors, and perhaps to the physician who is liable, the distinction between a patient requesting her physician on that physician’s advice and being assigned to that physician’s care, and a patient being assigned to his physician by chance is meaningless—similarly situated patients were injured by similarly situated physicians.93 The consequences dictated by the common law direction and control test are unjust and the policies behind the MTCA are not well-served. The following examination of the policies underlying a governmental immunity scheme further delineates the inequities and inefficiencies in the current interpretation of the MTCA with respect to physicians.

II. POLICIES OF AN IMMUNITY SCHEME

In its mandate to the legislature to develop a new governmental immunity scheme, the supreme judicial court proposed three premises as a foundation for the legislation. In Whitney v. City of Worcester,94 the court articulated that immunity should be consistent with: 1) “accepted tort principles,”95 2) the “reasonable expectations of the citizenry with respect to its government,”96 and 3) limitation on governmental liability.97 The court further stated that a viable immunity scheme should reflect a balance between fairness to injured citizens and retention of a vital government.98 The following analysis illustrates that the current immunity scheme under the Massachusetts Tort Claims Act, as implemented under the direction and control test, does not satisfy these premises with respect to “gray area” physicians.

93. From the survivor’s perspective, there is little doubt that the distinction is meaningless and the impact harsh. However, proponents of the current interpretation may argue that the impact on Dr. Silver is justifiable on the supposition that he instructed his patient to request his services while he was on duty at MPH realizing the liability implications. In other words, Dr. Silver should not be protected by immunity under the MTCA because he tried to take advantage of that immunity with his private patient.

95. Id. at 215, 366 N.E.2d at 1214-15.
96. Id.
97. Id. at 212, 366 N.E.2d at 1213 (citing Morash & Sons, Inc. v. Commonwealth, 363 Mass. 612, 623, 296 N.E.2d 461, 468 (1973)).
98. Id. at 216, 366 N.E.2d at 1215.
A. Tort Principles

The primary purposes of tort law are the fair resolution of claims between adverse parties and the protection of social mores. In a situation where a defendant is found culpable, these purposes are effectuated by compensation to the injured party and deterrence of the defendant and others who may be prone to commit similar acts. Most likely, it is the tort principles of compensation and deterrence that the supreme judicial court desired the legislature to consider in formulating an immunity scheme.

Under the current application of the MTCA, the tort principle of compensation is not satisfied adequately in many cases involving serious medical malpractice. Because recovery is limited statutorily to $100,000.00 for plaintiffs injured by physicians who are granted immunity under the MTCA, those plaintiffs who would otherwise obtain a judgment in excess of $100,000.00 are not compensated adequately. While this $100,000.00 recovery limit may be necessary for the economic stability of the commonwealth, it should only apply to those physicians who work exclusively for the government—it is not


100. See Whitney v. City of Worcester, 373 Mass. 208, 215, 366 N.E.2d 1210, 1214-15. Although the supreme judicial court was not explicit as to which tort principles it was referring, based on contemporary commentary on the tort system it can be inferred that the supreme judicial court intended at least two basic tort principles: compensation and deterrence. See, e.g., PROSSER & KEETON, supra note 99, at 25. The authors note that the courts are not only concerned about compensation of victims, but are also interested in admonishing the wrongdoer in order to deter future harm. Liability is one factor that creates a powerful incentive to avoid or prevent harm. Id. See also Sugarman, Doing Away with Tort Law, 73 CALIF. L. REV. 555 (1985). In Professor Sugarman’s opinion, the present tort scheme is based on three goals: deterrence, compensation, and justice. Although he takes issue with the deterrence effect of tort liability, Professor Sugarman recognizes the potential of deterrence in some situations where regulation is most concentrated. Id. at 559. See also R. KEETON, VENTURING TO DO JUSTICE (1969). Professor Keeton asserts that the weightiest reason for the tort system is fairness in having wrongdoers bear the burden for the loss to the innocent victims. Id. at 127 (discussing a theory of liability in the context of traffic accidents).

101. In 1987, the average jury verdict for physician malpractice nationwide was $1,294,160.00 with a mid-point verdict of $700,000.00. Telephone conversation with Diane Weisman of Jury Verdict Research, Inc. (Jan. 26, 1988). Fifty percent of all physician malpractice verdicts fell within a range from $200,000.00 to $1,540,000.00. Id.
necessary for "gray area" physicians.\textsuperscript{102}

The principle of compensation requires that an injured plaintiff be reimbursed completely for all special damages, and to some extent for pain and suffering.\textsuperscript{103} One presumption underlying the MTCA immunity scheme is that "public employees" do not have the resources to compensate fully those persons whom they injure.\textsuperscript{104} This presumption is erroneous with respect to "gray area" physicians. "Gray area" physicians have both the availability of malpractice insurance,\textsuperscript{105} and the resources to afford that insurance and to compensate adequately people whom they negligently injure.\textsuperscript{106}

\textsuperscript{102} This article does not analyze the merit of the current application of the MTCA to physicians who are employed exclusively by the government. \textit{See supra} note 85. However, some of the arguments and policies in support of the proposition that MTCA immunity should not apply to "gray area" physicians are applicable to all physicians.

\textsuperscript{103} \textit{See} Dowling v. Mutual Life Ins. Co. of N.Y., 168 So. 2d 107 (La. App. 1964). In that case, the court stated:

"One who is injured by malpractice [or negligence] is entitled to compensation for all pecuniary losses which he has sustained as a direct and natural result thereof. Particular elements of compensation may include loss of time, loss of services, impairment of earning capacity, expenses actually incurred, bodily pain and mental suffering, and the condition or circumstances of the injured person."

\textit{Id.} at 117 (citation omitted). \textit{See also} Berman v. Allan, 80 N.J. 421, 404 A.2d 8 (1979).

\textsuperscript{104} The principles that underlie governmental immunity pursuant to the MTCA are the same as those principles that underlie the doctrine of respondeat superior. \textit{See} Kelley v. Rossi, 395 Mass. 659, 661, 481 N.E.2d 1340, 1342 (1985); Alves v. Hayes, 381 Mass. 57, 58, 406 N.E.2d 1028, 1029 (1980). A basic premise of respondeat superior is that the government should be liable for the acts of its servants because the servants likely are people of modest means. \textit{See supra} note 70 and accompanying text.

\textsuperscript{105} In 1975, the Massachusetts Legislature created the Joint Underwriting Association (JUA) in order to provide affordable malpractice insurance to physicians. The JUA is governed by \textit{Mass. Gen. L.} ch. 175A, § 5A (1986). Yearly insurance premiums in 1987 range from $4,719.00 for psychiatrists and general practitioner physicians who do not perform surgery to $38,828.00 for neurosurgeons and orthopedic surgeons. The coverage that this insurance provides is one million dollars for a single claim and three million dollars in total claims per year. Telephone interview with Tracy Gehan, Assistant to Richard Moore, Public Relations Director at the Joint Underwriting Association (December 3, 1987).

All insurance is issued according to a full-time rate with the exception of insurance for physicians at three hospitals that have special arrangements with the JUA. Part-time malpractice insurance is issued to physicians at the University of Massachusetts, Harvard, and Tufts at a percentage of the rate that is charged to physicians at other hospitals. Telephone interview with Richard Moore, Public Relations Director at the Joint Underwriting Association (February 27, 1986). Maintaining private malpractice insurance is recommended if the physician sees \textit{any} private patients, thus even the vast majority of "public employee" physicians carry such insurance. Telephone interview with Frank G. Chase, Assistant Attorney General, Chief of Torts Division, Commonwealth of Massachusetts (June 10, 1986).

\textsuperscript{106} Physician income statistics are not available for Massachusetts alone, but American Medical Association statistics show that the average annual income of physicians in 1985 was $113,200.00. Gonzalez, \textit{Physician Income Trends, 1975-85}, in \textit{American Medical Association, Socioeconomic Characteristics of Medical Practice 17} (1986). Radiologists had the highest income level, with 50% of radiologists earning over
The second major tort principle that concerned the supreme judicial court in *Whitney* was that of deterrence. The degree of deterrence produced by lawsuits alleging negligence and resulting in plaintiffs' judgments is subject to considerable debate. Although the value of deterrence is uncertain, it likely has some value, and thus is a recognized goal of the immunity scheme and should be protected. Under the current interpretation of the MTCA, many "gray area" physicians are granted immunity and, thus, the opportunity for deterrence through judicial accountability is reduced significantly as to them.

The argument that personal financial liability acts as a deterrent to negligent conduct assumes that people will exercise a greater degree

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$150,000.00 per year, and pediatricians and general practitioners had the lowest income, with 50% of them earning less than $70,500.00 per year. *Id.* at 20.

As an indication of "public employee" physician salaries in Massachusetts, physicians working full-time for the commonwealth had a salary range from $37,928.80 to $57,524.48 under the collective bargaining agreement that expired September 28, 1987. Telephone conversation with Valian Norris, Labor Management Relations Advisor, Division of Employee Relations (February 9, 1988). According to Ms. Norris, the tentatively approved collective bargaining agreement reflects a "substantial increase" in physician salaries. *Id.*

107. The deterrence aspect of tort law has come under heavy criticism because some legal writers dispute the effectiveness of liability as a deterrent to negligent medical treatment. See Sugarman, *supra* note 100, at 561 n.12. Professor Sugarman argues that liability insurance, the inability of employers or organizations to deal with individual incompetence because they lack strategies to change behavior, the fact that people ignore the threat of danger because they have an "it won't happen to me" attitude, or situations where individuals are motivated to satisfy personal needs regardless of risk of injury to another, all undermine the deterrence aspect of tort law. *Id.* See also Grad, *Medical Malpractice and Its Implications for Public Health*, in LEGAL ASPECTS OF HEALTH POLICY, 397-402 (R. Roemer and G. McKray eds. 1980) (conceding that liability insurance defeats deterrence implicit in medical malpractice because it insulates physicians from financial responsibility for mistakes). This insulation occurs because physicians who have been found to be negligent often do not pay a higher insurance premium and if their insurance costs do increase it is a tax-deductible item on the physicians' tax returns as an "ordinary and necessary" business expense. I.R.C. § 162 (1986).

However, there is substantial support for the position that tort law can deter negligent medical liability. See, e.g., Special Features, *The Costs of Malpractice Litigation*, 70 MINN. MED. 129-30 (1987) (discussing financial and psychological costs of defending a medical malpractice claim); Mechanic, *Some Social Aspects of the Medical Malpractice Dilemma*, 1975 DUKE L.J. 1177, 1179-80 (asserting that medical malpractice claims deter physicians by providing a stigma which encourages prudent behavior); Strodel, *Piercing the Veil of Silence in Malpractice Litigation*, in QUALITY MEDICAL CARE—THE CITIZEN'S RIGHT 114 (Ass'n of Trial Law. of Am., Vol. I (1975)) (advancing the proposition that each well-founded malpractice claim upgrades medical care because physicians do not forget personal liability, thereby reducing the likelihood of repetition). See also CALIFORNIA ASSEMBLY SELECT COMMITTEE ON MEDICAL MALPRACTICE, PRELIMINARY REPORT (WAXMAN REPORT), at 150, 180 (1974). Chairman Henry A. Waxman reported that because malpractice liability is based on the failure of a physician to conform to a reasonable standard of care, malpractice litigation encourages the medical profession to practice quality medicine. The committee found that this fear of malpractice litigation motivated health care providers to be more careful. *Id.*
of care if they know that they will be liable monetarily for the harm that they cause. This financial deterrence probably will not affect "gray area" physicians' conduct because their liability insurance removes the threat of serious personal financial loss. However, fear of undesirable publicity, costs of defending a claim, and the stigma from a judicial finding of fault most likely will deter future negligent conduct of the defendant and other physicians. Because of this probability, the courts should be hesitant to grant immunity to "gray area" physicians.

The need for deterrence through full judicial accountability is bolstered by the fact that the medical profession is largely self-regulated. Unlike other governmental operations where employer supervision and governmental oversight can deter negligent conduct, the highly technical nature of medicine requires that physicians police themselves through peer review boards. Although these boards

109. Even though Professor Sugarman asserts that the deterrence rationale of tort law is overemphasized, he concedes that tort law may deter negligent medical practice because of official determinations of liability, fear of undesirable publicity, and the costs of defending one's position regardless of whether there is a settlement or a full trial. Sugarman, supra note 100, at 560-61. See also Grad, supra note 107, at 401 (a medical malpractice suit affects a physician's behavior because of its threat to one's professional reputation and self-esteem because his or her judgment is questioned and criticized); Mechanic, supra note 107, at 2 (stigma of a lawsuit along with the anxiety, lost time, and uncertainty that litigation produces are significant deterre to careless in medical treatment); R. Keeton, supra note 100, at 153 (formal legal proceedings which identify negligent conduct put a "mark of legal disapproval" on such conduct, thereby influencing the wrongdoer's future conduct and the conduct of others who know about the litigation).
110. Although the efficacy of self-regulation in controlling physician conduct is questionable, self-regulation probably is necessary for physicians. In Kelley, the supreme judicial court discussed the discordant relationship between physicians' needs to exercise their independent judgment while treating patients and the requirements that employers control the physicians' activities, and the court stated that "a physician normally is not...a servant of anyone."
Kelley v. Rossi, 395 Mass. 659, 662, 481 N.E.2d 1340, 1342-43 (1985) (citation omitted). See also Janulis & Hornstein, Damned If You Do, Damned If You Don't: Hospitals' Liability for Physician Malpractice, 64 Neb. L. Rev. 689 (1985). Janulis and Hornstein point out the problems that arise with a hospital controlling physicians' activities. Hospital administrators cannot change or delay care ordered by physicians, and because most medical care must be carried out promptly to assure adequate patient treatment, the hospital cannot even prospectively review physicians' orders. Additionally, hospitals cannot select the best treatment if several acceptable alternatives are available because the choice is the physicians. See id. at 717-18. See also Note, Independent Duty of a Hospital to Prevent Physicians' Malpractice, 15 Ariz. L. Rev. 953, 963 (1973).
111. These peer review boards can exist within a particular hospital or on a broader level. The organization in Massachusetts that is responsible for statewide oversight is the Board of Registration in Medicine, which is governed by Mass. Gen. L. ch. 13, § 10 (1986). The board consists of seven members, five of whom must be physicians. The board
may have some deterrent effect,\textsuperscript{112} their impact is questionable because of the reluctance of physicians to report misconduct and to sanction their peers.\textsuperscript{113} Therefore, physician responsibility must be ameliorated through judicial accountability.

The supreme judicial court in \textit{Kelley} explained that "[t]he legal principles that govern the determination whether the doctor was a 'public employee' . . . are the same as those that have determined whether an agent is a servant for whose negligent acts a principal may

\footnotesize{is charged with the duty of licensing and regulating the conduct of physicians in Massachusetts. \textit{Id.}}

\textsuperscript{112} Peer review offers several benefits in policing the profession and identifying substandard care. Peer review committees have access to relevant information, medical expertise, and have some power to impose sanctions on physicians who do not meet professional standards. \textit{See} Grad, supra note 107, at 417 n.20 (agreeing that hospital supervision of physicians' work has increased over the last few years—but doubting its effectiveness in weeding out incompetents); Note, supra note 110, at 965-66.

In Massachusetts, the Board of Registration in Medicine has the power to impose sanctions, including license revocation. \textsc{Mass. Regs. Code} tit. 243, \textsection 1.05(2) (1987).

\textsuperscript{113} The reluctance of physicians to report misconduct of their colleagues is, perhaps, the most dubious aspect of peer review. A recent survey of physicians in Texas revealed that only 15\% of the respondents felt that a physician's first occurrence of unnecessary surgery or treatment should be reported to the Board of Medical Examiners, and only 32\% would report the first occurrence of negligent surgery. \textit{Peer Review in Texas: A Survey of Medical Staffs, Tex. Med., Mar.} 1987, at 91, 92. Additionally, just slightly over one-half of the respondents thought that recurring negligent surgery should be reported. \textit{Id.} The same survey showed that only 23\% of the physicians thought that the State Board of Medical Examiners was a "very effective" quality assurance mechanism, while 28\% indicated that the board was "not very effective" and 44\% said it was "somewhat effective." \textit{Id.} at 91.

A similar problem has been reported in Michigan, where the examining board received just 225 allegations of misconduct in 1986 in a state with 20,000 physicians. \textit{Board of Medicine Received 225 Allegations Last Year, 86 Mich. Med.} 233, 234 (1987). An administrator of the board stated, "[T]he primary reason we do not investigate more cases is that we just don't get the allegations we should be getting. We get practically no allegations from fellow professionals, either individually or as part of a hospital staff organization, and we get none from professional organizations." \textit{Id.} See also \textsc{W. Robertson, Medical Malpractice: A Preventive Approach} 154 (1985).

The problem, however, extends beyond adequate reporting of misconduct. There is concern that examining boards which are comprised, at least in part, of physicians (the Massachusetts board must have at least five physicians on its seven member board, \textsc{Mass. Gen. L. ch. 13, \textsection 10 (1986)}) may be biased in favor of physicians. The physicians on the boards may not be willing to criticize and sanction the accused because of previous professional relationships with that person or because of empathy toward the individual. It is possible that there may be a problem similar to what Professor Spece found in Arizona medical malpractice panels which consisted, in part, of physicians. Professor Spece reported that, "[p]anels [with physician members] find in favor of defendants in a disproportionate number of cases, and physician panelists are the least likely to find in favor of a plaintiff." \textit{Spece, The Case Against (Arizona) Medical Malpractice Panels, 63 U. Det. L. Rev.} 7, 72 (1985). \textit{See also Kendall, Expectations, Imperfect Markets, and Medical Malpractice Insurance, in The Economics of Medical Malpractice} 167, 190 (S. Rottenberg ed. 1978) (the record of physicians' policing themselves is "indefensible").
be liable under the common law doctrine of respondeat superior."\textsuperscript{114} In this regard, the current interpretation of the term "public employee" in the MTCA may not be consistent with accepted tort principles. Arguably, including "gray area" physicians within the scope of MTCA immunity does not satisfy the tort principles underlying the doctrine of respondeat superior.

The foundation of respondeat superior is the policy that the employer is better able to bear the costs resulting from the employee's negligence, and that the employer has effective means of controlling, and in proper circumstances deterring, the employee's conduct.\textsuperscript{115} As this article has pointed out, however, these policies are not served by granting immunity to "gray area" physicians. Although medical facilities likely have deeper pockets than individual physicians, the concern that the physician will not have the means to compensate negligently injured patients is unrealistic because of the availability of malpractice insurance and the physicians' ability to afford that insurance.\textsuperscript{116} Also, unlike most trades where respondeat superior has been applied, the nature of medical practice does not lend itself to control of its "content."\textsuperscript{117}

In his article, \textit{The Economics of Vicarious Liability},\textsuperscript{118} Alan Sykes argues that the efficiency of the vicarious liability, as imposed through the control test, could improve if attention were focused on at least two policies—agent insolvency and the relative risk-bearing capacity of the parties—that are analogous to the two policies offered above for not applying MTCA immunity to "gray area" physicians—the availability of compensation resources to physicians and the inability of health care facilities to control the physicians' work.\textsuperscript{119} Sykes suggests that vicarious liability is inefficient when the agent has the ability to pay a judgment against himself or herself, and when there is a high transaction cost to the principal because the principal is unable to

\textsuperscript{114} Kelley, 395 Mass. at 661, 481 N.E.2d at 1342.
\textsuperscript{115} See supra note 70 and accompanying text.
\textsuperscript{116} See supra notes 70, 105-06 and accompanying text. See also James, supra note 71, at 171 (rationalizing that the master should compensate the victims of his or her servant's negligence because the master has liability insurance available).
\textsuperscript{117} See supra notes 81-90 and accompanying text.
\textsuperscript{118} Sykes, supra note 71.
\textsuperscript{119} See id. at 1259-80. See also supra notes 81, 105-06 and accompanying text. Sykes' contentions are pertinent to the application of MTCA immunity to "gray area" physicians because the activities of physicians that are likely to cause injuries to their patients are the "details" of the physicians' work, rather than the administrative factors which the hospital may control. See R. Gots, \textit{The Truth About Medical Malpractice} 186 (1975) (a prominent cause of medical malpractice is "careless medicine" due to errors in judgment and shortcuts).
monitor the loss-avoidance behavior of the agent. He further claims that the control test is ineffective in analyzing these factors.

Therefore, because of the ability of "gray area" physicians to satisfy judgments against them, and the inability of hospitals to reduce their risk and transaction costs because of their lack of control over the details of physicians' work, determination of physician immunity—and government liability—through application of the control test does not effectively address the tort principles behind the doctrine of respondeat superior. Thus, the MTCA immunity scheme is inconsistent with accepted tort principles.

In summary, the tort principles of compensation and deterrence are not safeguarded sufficiently under the current interpretation of the MTCA. Many persons who are injured seriously by medical malpractice do not receive adequate compensation because of the statutory limit on recovery. The protection of persons injured by "public employees" who do not have sufficient resources to satisfy a judgment is not a legitimate concern with respect to "gray area" physicians. Additionally, because health care facilities cannot control the details of the physicians' work, extension of immunity to "gray area" physicians eliminates an effective process for deterring medical malpractice. The tort principles underlying the theory of respondent superior also are not well-served. The current application of immunity under the MTCA by way of the direction and control test does not account for these factors and, thus, is prone to inefficiency and injustice.

B. Public Expectations

The Massachusetts Supreme Judicial Court's concern that an immunity scheme be consistent with public expectations of government probably is related to, and perhaps is overlapping with, the concern of protecting accepted tort principles. Indeed, tort law is founded upon public perception of appropriate social behavior. The most basic of these expectations is that one not be injured by the negligent conduct of a person working within the government.

In the context of health care services, this expectation can be de-

120. See generally Sykes, supra note 71.
121. Id. at 1279-80. See also Note, supra note 74, at 192-93 ("[T]he control test is inappropriate, and its legal implications bear no predictable relationship to economic efficiency.").
122. See supra note 101 and accompanying text.
124. See Prosser & Keeton, supra note 99, at 6-7.
fined further as an expectation of quality care at a cost that is not
unduly burdensome to society.125 Perhaps the nature of the service
provided is the most compelling reason to treat physicians differently
than other government employees with respect to immunity under the
MTCA. Aside from the autonomous and authoritarian nature of the
physicians' profession, there is the concern that quality medical care is
a necessity for all citizens, and when the quality of care is compro­
mised the results literally can involve life and death.126 Thus, it is the
expectation of the public that highest quality health care not be com­
promised. This expectation is not met most effectively when physi­
cians are not held personally responsible for their negligence because
there are no satisfactory alternatives to personal judicial
accountability.127

Additionally, patients seeking care from physicians usually are
vulnerable;128 it does not matter whether the physicians are employed
by public or private hospitals. The patients' knowledge and experi­
ence with increasingly complex modern medicines and their physical
or mental states often condition them to surrender their well-being to

125. Because some patients do not have health insurance and cannot pay the costs of
hospitalization, the costs of medical services for these patients are borne by others. Massa­
chusetts has an uncompensated care pool designed to “more equitably distribute the burden
of financing uncompensated acute hospital services.” MASS. GEN. L. ch. 6A, § 75 (1986).
A portion of each hospital's “gross patient service revenue” is dedicated to funding the
uncompensated care pool. Id. Because this type of economic burden is satisfied by medical
service consumers, additional costs by way of government liability must be constrained.

126. Although the matter of life and death is present in other trades and professions,
such as emergency medical services, firefighting, and police services, those jobs are not as
autonomous as that of a physician. The details of the work in the other trades and profes­
sions are controlled by supervisors and formal policies and regulations, whereas the details
of a physician's work are controlled, if at all, by the standards of accepted practice as
determined by the board of examiners. See supra notes 81-90, 110-13 and accompanying
text.

127. See supra notes 108-13 and accompanying text discussing deterrence of medical
malpractice and the ineffectiveness of peer review by physicians.

128. See W. GLASSER, CONTROL THEORY 216 (1984). Glasser asserts that health
care in the United States today causes each patient to feel a definite loss of control because
the patient's responsibility ends after relating symptoms to the physician, who then takes
command of the treatment. See also Price, Health System Agencies and Peer Review Orga­
nizations: Experiments in Regulating the Delivery of Health Care, in LEGAL ASPECTS OF
HEALTH POLICY (R. Roemer & G. McKray eds. 1980). Medical consumers usually do not
have the expertise to make informed choices; therefore, it is the physician who determines
the patient's need for return visits, hospitalization, the need for consulting physicians, and
the necessity for surgery. Id. at 361. Compare B. HOSFORD, MAKING YOUR MEDICAL
DECISIONS (1982). Many patients are still meek about medical decisions and allow their
physicians to dominate the relationship. However, there is a growing number of educated
consumers who are capable of understanding medical options and who demand to make
their own medical decisions. Id. at 2-6, 177.
their physicians without question. 129 Because of the inability of patients to understand completely the technical aspects of their conditions and treatments, they establish relationships of trust and dependence with their physicians. 130 As a result of this unusual vulnerability and trust reposed in the physicians, patients expect that they will be compensated fully for injuries that result from a breach of this relationship. 131 However, if a "gray area" physician breaches this relationship of trust and is found to be a "public employee" under the direction and control interpretation, the patient’s expectation of full compensation is not met if the damages exceed $100,000.00.

Related to ever-increasing complexity in medical care is the rising cost of medical services. If negligently injured patients are going to be compensated fully, the increasing cost of medical services necessarily increases the amount that plaintiffs should receive. 132 Illustratively, the average physician malpractice jury verdict in the United States was $244,607.00 in 1981. 133 By 1987, this figure had skyrocketed to

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129. W. Glasser, supra note 128, at 218. Traditionally, patients have given up control of their health with the idea that their physicians can cure them. Id.

Doctor Arthur Caplan of the Hastings Center perceives the problems of medical specialization and its effects on physician-patient relationships this way:

Not only is professional sovereignty propped up by a cult of mystery within the profession, but health care is now delivered in settings that are themselves distant, mysterious, complex, imposing and awe inspiring both in size and in technological ritual. As medicine becomes, and is encouraged to be become, increasingly faceless and bureaucratic in the name of cost containment, efficacy, and competition, as fewer and fewer patients know or have any sort of personal, intimate relationship with a specific physician, the prospects for conversation and open communication become increasingly dim.


130. See Chapman, The Relationship Between Law and Medicine, in Legal Medicine with Special Reference to Diagnostic Imaging 2 (1980) ("The fundamental principle of medical practice is a relationship of trust between physician and patient."); Stacey v. Pantano, 177 Neb. 694, 697, 131 N.W.2d 163, 165 (1964) ("Mutual confidence and trust are essentials of the relationship between physician and patient.") (citations omitted).

131. See C. McCormick, Handbook on the Law of Damages § 137, at 560-61 (1935) (when a duty is breached tort law requires full compensation); Restatement (Second) of Torts § 901 (1979). See also supra note 103.

132. The United States Department of Labor’s Consumer Price Index for physician services increased 122.43% from 1975 to 1984, while the Consumer Price Index for all items increased 92.99% during that same period. See U.S. DEPT. OF HEALTH & HUMAN SERV., HEALTH UNITED STATES 1985 126 (1985). Also, in Massachusetts, the per capita expenditure for personal health care increased from $760.00 in 1976 to $1508.00 in 1982. Id. at 130.

$1,294,160.00. Therefore, the inclusion of some "gray area" physicians under the MTCA immunity scheme, and the limitation of recovery to $100,000.00, defeats the public's expectation of full compensation for many negligently injured persons.

An alternative to satisfy the public's expectation of full compensation would be to eliminate the $100,000.00 recovery cap for "gray area" physicians. However, this approach would compromise a different public interest—that public medical care be provided at a cost that is not unduly burdensome to society. If the recovery cap were eliminated, the state and local governments would shoulder the burden of the larger judgments obtained by persons injured by "gray area" physicians who are granted immunity. A more effective process of compensation, which satisfies both public expectations of full compensation and minimal taxpayer burden, is to deny immunity to all "gray area" physicians and to permit plaintiffs to recover against the negligent physicians in their individual capacities.

This approach to physician liability satisfies another public expectation—that of personal accountability for wrongful conduct. To some extent related to the tort principle of deterrence is the expectation of injured patients that negligent physicians will be held personally responsible for their actions. If consistently applied, this accountability, whether financial or social, will promote a higher degree of care in the distribution of medical services. If immunity from prosecution is granted to "gray area" physicians this expectation is not met.

In summary, the current interpretation of the MTCA immunity scheme is not consistent with the public's expectations of government services and liability in the medical field. A more effective way to satisfy these expectations would be to deny personal immunity to all "gray area" physicians, thereby imposing personal accountability upon them and requiring that they use their own resources to compensate the persons whom they negligently injure.


135. In 1987, 50% of all jury awards for physician malpractice fell within a range from $200,000.00 to $1,540,000.00. Telephone conversation with Diane Weisman of the Jury Verdict Research, Inc. (Jan. 26, 1988).

136. See R. KEETON, supra note 100, at 127. Robert Keeton discusses the "fault system" of tort liability and argues that the weightiest reason for liability is fairness, and that most people believe that wrongdoers should bear the burden of loss for the innocent victim.
C. Government Liability

The supreme judicial court in Whitney noted that Massachusetts was one of only five states that retained common law immunity at both the state and local levels.\textsuperscript{137} While strongly urging the legislature to abolish immunity, it also stated that there should be limits on governmental liability.\textsuperscript{138} The exclusion of "gray area" physicians from the purview of the MTCA as "public employees" achieves both of the court's goals of reducing the reach of common law immunity and limiting governmental liability.

The government has a number of interests that must be addressed with regard to a viable immunity scheme. Perhaps the most obvious government interest is fiscal stability; generally, if immunity is abolished the government assumes the burden of compensating those persons injured in the execution of governmental functions.\textsuperscript{139} Under the existing interpretation of the term "public employee" in the MTCA, the government does, indeed, assume potential liability for the medical malpractice of many "gray area" physicians. As discussed previously, this liability is not necessary because physicians' private malpractice insurance benefits could provide negligently injured patients with full compensation.\textsuperscript{140} Thus, the governmental interest in fiscal stability is protected most effectively by excluding all "gray area" physicians from personal immunity.

Similar to the public's expectation, the government has an interest in ensuring quality medical care in the commonwealth. A responsible system of medical service will maintain a healthy population, thus minimizing the demand on social welfare agencies. To create a

\textsuperscript{137} Whitney, 373 Mass. at 212, 366 N.E.2d at 1213.

\textsuperscript{138} Id. The court declared that the legislature should adopt an immunity scheme that strikes a balance between "fairness to injured persons and . . . promoting effective government." Id. at 216, 366 N.E.2d at 1215. There were two primary concerns for promoting an effective government, according to the court. One, that there be funds to compensate negligently injured persons, and, two, that the policy development mechanisms of the commonwealth not be burdened unduly. See id. at 216-17, 366 N.E.2d at 1215. In Whitney, the court did not expound upon the fiscal concern, but simply stated that there were funds to compensate victims of negligence in the performance of public functions. Id. at 217, 366 N.E.2d at 1215. However, the court discussed at length the necessity that a government immunity scheme protect the discretionary planning process of government. Id. at 217, 366 N.E.2d at 1215-16. As a result of this concern, the legislature provided for an exception to government liability for certain circumstances in which the "public employee" performs a discretionary function. Mass. Gen. L. ch. 258, § 10(b) (1986).

\textsuperscript{139} The supreme judicial court in Morash warned of the potential fiscal harm that could be created by complete elimination of immunity. Morash & Sons, Inc. v. Commonwealth, 363 Mass. 612, 623 n.6, 296 N.E.2d 461, 468 n.6 (1973).

\textsuperscript{140} See supra notes 105-06 and accompanying text.
responsible system of health service distribution there must be a process for personal accountability to promote careful diagnosis and treatment of the sick and injured. Personal accountability will most effectively deter negligent conduct.\textsuperscript{141} The existing interpretation of the MTCA which provides immunity for many "gray area" physicians diminishes the opportunity for deterrence. The state interest in promoting quality medical care is better served by denying personal immunity to all "gray area" physicians and by stressing personal accountability for negligent acts.

The government has another interest with respect to personal liability of its employees which some would argue is a reason to maintain immunity for "gray area" physicians: attracting qualified persons to government service. Although this argument may be appropriate in some fields of government service it may not be persuasive with respect to physicians.

Physicians are in a unique situation as compared to many others who work, at least in part, for the state. Because physicians, in particular "gray area" physicians, carry private medical malpractice insurance, it is not necessary to provide personal immunity to protect them from tremendous financial loss.\textsuperscript{142} If they do commit an error in judgment they are protected from financial devastation by their malpractice insurance policy.\textsuperscript{143} Thus, because "gray area" physicians already have the protection of private malpractice insurance, it is unnecessary to use personal immunity to lure them into civil service.\textsuperscript{144}

\textsuperscript{141} See supra notes 108-13 and accompanying text.

\textsuperscript{142} Because the JUA does not issue malpractice insurance for part-time work except in a few limited exceptional circumstances, and because most physicians in Massachusetts carry private malpractice insurance, see supra note 105, the proposition that immunity is necessary to attract physicians to public service is questionable. In most cases, physicians do not incur extra liability or save on insurance premiums by working within a public hospital.

\textsuperscript{143} Although the use of a malpractice insurance policy for protection may not be as attractive as personal immunity, the interests of fairness to the injured party and other factors concerning government efficiency, as previously discussed, outweigh the physicians' concerns.

\textsuperscript{144} Of course, there are costs other than financial ones in defending malpractice claims. See supra note 109. However, these costs may be outweighed by the benefits of working for the government, such as the security of a steady patient load as opposed to the uncertain workload in private practice. "Gray area" physicians also may be attracted to public service because of access to equipment and facilities that they cannot afford as private practitioners.

Additionally, as "public employee" physician salaries rise and become less disparate with private practitioners' salaries, see supra note 106, it is possible that the ranks of "public employee" physicians will increase. If that occurs, there should be less demand for "gray area" physicians, and thus, less need for incentives to attract "gray area" physicians into public service.
Therefore, the government interests of a vital economy and quality medical care are best served by an immunity scheme that does not encompass "gray area" physicians. Furthermore, any adverse affect to the government's interest in attracting citizens into civil service by denying immunity to "gray area" physicians is highly speculative.

III. REFORMATION OF THE CURRENT INTERPRETATION

The discussion to this point illustrates that the current status of governmental immunity with respect to "gray area" physicians in Massachusetts does not conform with principles of justice as outlined by the supreme judicial court in Whitney. In fact, the current application of the Massachusetts Tort Claims Act to physicians who are not employed exclusively by a government is flawed in respects that are disturbingly similar to the common law scheme of immunity which the MTCA replaced. Immunity under the common law scheme was based on superficial classifications that had no relation to sound public policy. Similarly, application of the MTCA to "gray area" physicians by way of the direction and control test is founded on insubstantial distinctions that do not comport with tort principles, public expectations, and principles of governmental immunity.

Because the legislature has addressed the immunity issue affirmatively by enacting the MTCA, it is more difficult than at common law for the court to alter the structure of governmental immunity. Action by the court in this area now is subject to the restraint of the separation of powers doctrine. In light of this parameter, there appear to be three alternatives to bring the present governmental immunity scheme with respect to physicians into conformity with sound public policy.

The first alternative involves the basic interpretation of "public employee" as used in the MTCA. The statutory definition of "public employee" is nonfunctional without reliance on other MTCA provisions and common law principles. Because of the Act's ambiguous language, the court, as interpreter of legislation, could adopt a new, purposive interpretation of the term. While declaring the impracticability and unreasonableness of the current determinative categorizations under the direction and control definition, the court could assert

145. See supra note 24 and accompanying text.
146. The legislature is given the power to create laws under MASS. CONST. part 2, ch. 1, § 1 art. IV. The separation of judicial from legislative power is established in MASS. CONST. part 1, art. XXX.
147. See supra notes 38-41 and accompanying text.
148. See supra note 11 and accompanying text.
that the purposes of the legislation and the intent of the drafters, could best be served by the exclusion of "gray area" physicians from the MTCA's grant of immunity.149 Such an interpretation of the MTCA would avoid the disturbing result of immunity based on capricious distinctions in employment relationships, which clearly was a goal of immunity reform as articulated in Whitney.150 As previously noted, this interpretation satisfies public policy in terms of conformity with tort principles, citizens' expectations, and government interests.

This alternative may pose problems, however, with some who would argue that the ambiguity in the definition of "public employee" is not so great as to warrant a definition which excludes all "gray area" physicians from immunity under the MTCA. Assuming that physicians who perform services exclusively for the government would be considered "public employees" under the MTCA, it could be argued that the qualification in the definition of "public employee" which includes persons serving in a "part-time" capacity151 would encompass "gray area" physicians because they dedicate part of their practice to public service. Thus, the ambiguity of the statutory language is not so severe as to exclude all "gray area" physicians from the protection of the MTCA.

The tenuity of the first alternative highlights the desirability of a second alternative for resolution of the difficulty posed by the current interpretation. That is, the legislature could amend the MTCA expressly to exclude from coverage, all physicians except those who perform services exclusively for the government. Although this is not a likely solution politically because it probably would be opposed by medical organizations, who traditionally have exercised strong lobbying power,152 such a remedy would be preferable because it eliminates any separation of powers implications.

149. There is widespread support for this method of construction. Glasser v. Director of Div. of Employment Sec., 393 Mass. 574, 577, 471 N.E.2d 1338, 1340 (1984) ("Our task is to interpret the statute according to the intent of the Legislature . . . considering the purposes and remedies intended to be advanced."); Walsh v. Ogorzalek, 372 Mass. 271, 274, 361 N.E.2d 1247, 1250 (1977) (purpose of statute controls its construction); W. TWINING & D. MIERS, HOW TO DO THINGS WITH RULES 113 (1976) ("[I]t is also a widely held view, which we share, that careful examination of the purpose(s) of a rule is one of the most important aids to resolving doubts in interpretation."); S. EDGAR, CRAIES ON STATUTE LAW 96-98 (7th ed. 1971) (interpret acts in light of law prior to enactment and purpose for changing previous law and discard unreasonable result in favor of "reasonably practical result"); E. BEAL, CARDINAL RULES OF LEGAL INTERPRETATION 275-78 (2d ed. 1908).


151. See MASS. GEN. L. ch. 258, § 1 (1986).

The third alternative to modify the current scheme of governmental immunity with respect to physicians in Massachusetts involves an interpretation of section 10(b) of the MTCA. Section 10(b) provides that the MTCA “shall not apply to . . . any claim based upon the exercise or performance or the failure to exercise or perform a discretionary function or duty . . . .”

The basis of this argument for an alternative interpretation is the definition of “discretionary function or duty.” In *Irwin v. Town of Ware*, the court stated that “discretionary functions” were “those ‘characterized by the high degree of discretion and judgment involved in weighing alternatives and making choices with respect to public policy and planning.’” In light of this language, it is possible to interpret the discretionary clause of section 10(b) of the MTCA to include patient care by physicians.

The definition of a discretionary function provided in *Irwin* is satisfied largely when considering the activity of a physician in administering health care services. A physician’s activities often include a “high degree of discretion and judgment in weighing alternatives.” In many cases the physician, with the informed consent of the patient, will have to choose among alternative courses of treatment depending on a multitude of factors, including the patient’s present condition, prognosis, proven effectiveness of alternatives, and sometimes the availability of financial resources. However, part of the *Irwin* definition needs to be modified to account for the particular nature of a physician’s services. Although the court stated that there must be discretion and judgment in decisions with respect to public policy and planning, the usual interpretation of policy and planning is unsatisfac-

153. MASS. GEN. L. ch. 258, § 10(b) (1986).
154. 392 Mass. 745, 467 N.E.2d 1292 (1984). In *Irwin*, the plaintiffs instituted a negligence action against the Town of Ware after a police officer failed to take an intoxicated driver into protective custody and that driver later struck and injured the plaintiffs. *Id.* at 746-747, 467 N.E.2d at 1295.
155. *Id.* at 753, 467 N.E.2d at 1298 (quoting Whitney v. City of Worcester, 373 Mass. 208, 218, 366 N.E.2d 1210, 1216 (1977)).
156. *Id.*

Medical decisions often are made on inconclusive evidence and are influenced by non-medical considerations. See J. STEIN, MAKING MEDICAL CHOICES: WHO IS RESPONSIBLE? 83-99 (1978).

For a discussion of the factors in health care decisionmaking from the patient’s perspective, see W. WINSLADE & J. ROSS, CHOOSING LIFE OR DEATH: A GUIDE FOR PATIENTS, FAMILIES AND PROFESSIONALS 255-56 (1986).
tory in the realm of physician services.\textsuperscript{158} In the circumstances of a physician's activities, there is not an analogous public policy or plan to follow, as there was in \textit{Irwin} where the legislature implemented a plan to remove intoxicated drivers from the road.\textsuperscript{159} Rather, medical care by a physician is guided by policy and planning considerations that are specific to each patient's needs.\textsuperscript{160} Therefore, a physician providing

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\textsuperscript{158} In \textit{Irwin}, the court determined that the police officer's decision not to take the intoxicated driver into custody was not discretionary because the legislature had already made a policy judgment to remove those drivers from the roads. \textit{Irwin}, 392 Mass. at 753, 467 N.E.2d at 1299. \textit{See also} Doherty v. Town of Belmont, 396 Mass. 271, 485 N.E.2d 183 (1985) (maintenance of town parking lot not discretionary).
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\textsuperscript{159} Although the supreme judicial court in \textit{Kelley} explicitly rejected the proposition that Dr. Rossi was "engaged in a discretionary function," 395 Mass. 659, 665 n.6, 481 N.E.2d 1340, 1344 n.6 (1985), the court's reasoning is tenuous and the discussion should, therefore, be distinguished. The court stated that "[t]he doctor was governed by the standard of accepted medical practice," and thus, the activity was not discretionary. \textit{Id.} This reasoning may oversimplify a complex issue.
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In situations involving relatively clear diagnoses and proven courses of treatment, the court's analysis holds true. However, accepted medical practice does not provide direction for physicians in choosing among alternative courses of treatment where the diagnosis is complicated and the treatments are more untested. \textit{See} L. \textsc{Israël}, \textsc{Decision-Making: The Modern Doctor's Dilemma} 39-59 (1982) (medical decisionmaking and uncertainty in the treatment of cancer); H. \textsc{Bursztajn}, R. \textsc{Hamm}, R. \textsc{Feinbloom} \& A. \textsc{Brodsky}, \textsc{Medical Choices, Medical Chances: How Patients, Families and Physicians Can Cope with Uncertainty} 54-84 (1981) (general discussion of uncertainty in medicine because it is a new science). It is arguable that these decisions are the ones that involve a high degree of discretion and judgment for which the \textit{Whitney} court sought to avoid governmental liability because there is no ascertainable standard. \textit{Cf.} \textit{Whitney}, 373 Mass. 208, 218, 366 N.E.2d 1210, 1216 (1977) (government should be liable where the alleged tortious conduct involves "the carrying out of previously established policies or plans"). \textit{See also} Pina v. Commonwealth, 400 Mass. 408, 415 (1987) (quoting \textit{Bartel v. FAA}, 617 F. Supp. 190, 196 n.29 (D.D.C. 1985) (citing Dalehite v. United States, 346 U.S. 15 (1953))) (Discretionary functions are those "based on an individual, case-by-case analysis and in which [the decisionmaker's] decision includes elements of judgment and discretion.").

As far as accepted medical standards as established by state examining boards are concerned, Professor Southwick has claimed:

State medical licensing laws certainly do not constitute a satisfactory vehicle for establishing and controlling professional standards. . . . Licensing furnishes no continuing control over an individual's professional competence; the statutes in no way recognize the demands placed upon the doctor by the ever-increasing specialization of medicine; accordingly, they do not adequately protect the public from incompetence. . . . The present licensing statutes for physicians, nurses, and other professional personnel also impede rather than facilitate improvements in the quality of health care by failing to clarify scope-of-practice problems.

\textsc{A. Southwick, supra} \textit{note} 65, \textit{at} 430 (footnote omitted).

\textsuperscript{160} The only underlying policy considerations are prevention of negligent treatment and, moreover, provision of high quality care through enforcement of regulations promulgated by the Board of Registration in Medicine. But again, policies established by the Board cannot specifically address all medical conditions and treatments and, thus, cannot eliminate the discretion in physician care. Indeed, the discretionary decisions made by a
medical care should be considered to be engaged in a "discretionary function," thereby precluding application of the MTCA, and, thus, governmental liability.

However, this rationale for preclusion of governmental liability is problematic in two respects. First, if the MTCA is inapplicable, and thus the government is not liable, the question of whether the physician will be personally liable under a common law cause of action still remains. Specifically, if section 10(b) precludes recovery from the government, can the patient bring a common law negligence action against the physician personally?

If the patient could bring such an action, in most cases it would be unsuccessful because at common law a public officer is not liable for the negligent performance of a discretionary act. However, there may be liability for negligence if the activity could be classified as commercial.

It could also be contended that the enactment of the MTCA was designed to eliminate the distinctions between public officers and municipal agents, as well as those between public and commercial functions, and as a pervasive statutory scheme it displaces completely the common law system of liability. Thus, the physician could not be held personally liable if the government was not liable under section 10(b).

The second problem with this interpretation is that its implications exceed the thesis of this article. Specifically, if a physician's activity is discretionary, it is discretionary for "gray area" physicians and physicians employed exclusively by the government. Therefore, this interpretation would preclude application of MTCA immunity for all physicians—a position not necessarily supported by this article.

Of the three alternatives which could be used to modify the current application of the MTCA to exclude "gray area" physicians, an amendment to the Act by the legislature would be most effective. This method would eliminate any separation of powers concerns and difficulties in interpretation. However, absent action by the legislature, the court would be within its province in interpreting the ambiguous

physician, with the consent of the patient or patient's family, can be profound—sometimes involving life and death.

163. See S. EDGAR, supra note 149, at 339 (it must be unmistakably clear that the legislature intended to abrogate entire common law scheme).
statutory language to modify the current interpretation of the MTCA to exclude immunity for "gray area" physicians.

IV. CONCLUSION

In response to the inequities that resulted from absolute governmental immunity under the common law, the Massachusetts Supreme Judicial Court in Whitney v. City of Worcester\(^\text{164}\) mandated that the legislature develop a new immunity scheme. Beginning with the premise that "governmental entities should be liable for tortious acts in the same manner as private individuals,"\(^\text{165}\) the court proposed three rudiments which the legislature was to consider: 1) accepted tort principles, 2) public expectations with respect to the government, and 3) limitation on governmental liability.

In defining the bounds of the legislative response, the Massachusetts Tort Claims Act, the courts have had to interpret the meaning of "public employee," because only those persons are granted immunity under the Act. The courts' interpretations have been based on a direction and control test which focuses on nebulous distinctions in the nature of the employment relationship. With respect to physicians, this direction and control test is not consistent with the guidelines espoused by the supreme judicial court. The direction and control test disregards the realities of modern health care delivery systems and fails to take into account the unique characteristics of physicians, as compared to many other government employees. Under this system, many physicians who are employed both privately and by the government and who negligently injure their patients fall within the Act's shield of immunity, and the policies underlying the immunity scheme are frustrated.

A more appropriate and effective system of immunity would exclude all "gray area" physicians from immunity. As discussed throughout this article, such a scheme better addresses the concern of the supreme judicial court in striking an appropriate balance "between the public interest in fairness to injured persons and in promoting effective government."\(^\text{166}\)

\(^{165}\) Whitney, 373 Mass. at 216, 366 N.E.2d at 1215.
\(^{166}\) Id.